North Wales Regional Partnership Board

‘NO WRONG DOOR’

A Community-based Regional Strategy for Child and Adolescent Mental Health

2022 -2027

DRAFT

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1 Introduction and strategic environment

1.1 Objective

The Children's Commissioner for Wales has highlighted the need for transformation in the way services work together to support children and young people whose needs are not deemed severe enough to require specialist support but, who are emotionally distressed and/or have behavioural issues. The aim is to produce a strategy that enables the North Wales Local Authority and Health Board partners to support the emotional resilience and mental health of children and young people in this group, across the region. The strategy proposes how agencies can best work together to respond to the full spectrum of needs of children and young people who are experiencing mental health problems. It identifies opportunities for the future development of services drawing on models of good practice in Wales and beyond.

1.2 Horizon

The review indicates that North Wales is a place where dedicated and hard-working staff are undertaking good work but, despite this, services are struggling to cope with significant increases in demand. As the pressures within the system increase and resources become even more stretched it is clear that tensions are raised.

The staff who engaged with the review and strategy formulation process wish to see change and would like to see leaders commit to a strategy that is radical and offers an opportunity to create a world class service that will deliver great outcomes for children and young people that is in line with national policy objectives and aspirations.

This strategy does not offer a short term or simple solution to a long-standing and complex problem. It does however offer a plan for change that can realise the vision created by staff within the service. This, in turn, will help meet the challenge of increasing mental health and wellbeing problems in North Wales.

Successful implementation of this strategy will require a significant change in culture from all partners, in order for the service to become more fully integrated. Not only will this require new systems and process, structures and governance, but must also include clinical governance which places the child or young person at the centre of a whole system approach.

The strategy emphasises the importance of managing demand through increased used of earlier intervention and preventative (both primary and secondary) services. Investment in these services cannot be at the expense of reduced capacity in other parts of the pathway. Demand is increasing across the whole system and investment needs to be planned to balance respond to current pressures as well as future demand management.

2 Policy Context

The Welsh Government is committed to making Wales a country where people want to live and work, and where children, no matter what circumstances they are born into, are able to

thrive and achieve their potential. The five-year strategic plan, *Taking Wales Forward*, sets out clear aims for giving every child in Wales the best possible start in life, and for supporting families to create stable, nurturing environments in which children can thrive.

Welsh Government is committed to using the *Wellbeing of Future Generations Act 2015* in all of its policy decisions to improve the social, economic, environmental and cultural wellbeing of Wales both now and over the long term. The introduction of the *Wellbeing of Future Generations Act 2015* and the *Social Services and Wellbeing Wales Act 2014* have placed several statutory responsibilities on local authorities and their partners.

It is important the North Wales Regional Partnership Board "No Wrong Door" Strategy" is developed with this legislation in mind. The concept of early intervention and prevention is firmly embedded as a way of working. Also, people will be placed at the heart of new systems and given an equal say in what happens to them. These concepts, which are not new are promoted in the Welsh Government guidance document, "*Families First"*, which places an emphasis on early intervention, prevention, and providing support for whole families, rather than individuals.

Families First is designed to improve outcomes for children, young people and families. Its stated intention is to provide early support for families with the aim of preventing problems escalating. It emphasises the importance of providing support to families, when they need it the most, and to help build communities which are confident and more resilient. The programme promotes greater multi-agency working to ensure families receive joined-up support when they need it.

It is widely agreed that it is important for families to be supported in ways that are appropriate to their need to build and create resilience and self-reliance. Interventions which support these principles are more likely to lead to improved longer-term outcomes for both families and individuals within families. *Families First* was set up with the aim of ensuring these principles are embedded in both service design and delivery.

The Welsh Government is committed to the *United Nations Convention on the Rights of the Child* (UNCRC) as a basis for policy making for children and young people in Wales. In keeping with the UNCRC principles it is determined to ensure all young people fulfil their potential no matter what their background or circumstances. Policy aims to encourage, enable, and assist young people, either directly or indirectly to make an effective transition into independent adulthood through:

- Effective participation in education and training and the life of their communities
- Taking advantage of opportunities for employment

Good mental health will facilitate these objectives. Not all young people get the support they need from their home environment, and it is vital parents are able to receive the right services which can help them cope with the pressures of raising children. Children and young people must also be able to access targeted mental health services which can help them reach their potential and improve their life chances.
In this North Wales Regional Partnership Board "No Wrong Door" Strategy we have sought to embody Welsh Government's policy principles to inform how we will support children and young people to achieve their best mental health

3 Vision for the New Service

We want the children and young people of North Wales to enjoy their best mental health and well-being.

We will do this by ensuring the organisations that support them are easily accessed, work effectively together, and aim to deliver outcomes in a timely way, based on children and young people's choices and those of their families.

This vision statement was developed from the key themes identified during the professionals' workshops and consultation with children and young people.

4 Principles

The strategy proposes a regional approach based on a shared vision and an agreed set of common principles that will apply across the whole of North Wales. It however recognises that there are significant differences across the region reflecting culture, language, population density, economic factors, amongst other things. The model is therefore flexible and implementation can be tailored to local circumstances. The RPB will ensure that there is local accountability for compliance with the principles and system performance. We refer to this approach as Tight – Loose – Tight: Tight adherence to the principles and outline service model – Loose (flexible) implementation of the service model – Tight accountability and monitoring of performance against the strategy.

The aim of this strategy is for partner agencies to collaborate in a service which enables effective joint working and reduction and management of risk. It is important that all partner agencies agree to adopt these common principles and that these are contained with an explicit partnership agreement.

- Children and young people will be valued for themselves, and their worth appreciated.
- We will listen to children, young people, and their families to understand their world and experiences. Their opinions will help us to shape and evaluate our services.
- We will reduce the numbers of children and young people requiring targeted support by investing in preventative measures.

- We will reduce the number of children of young people requiring more intensive support through timely, early intervention.

- We will make it easy for children and young people and their families to find information about mental health and, if required, to obtain help that is accessed using simple and convenient arrangements.

- There will be better support for mental health in schools.

- No child should be excluded from a service because of their family circumstances

- All the children and young people will have access to co-ordinated help from a range of professionals, when this would be in their best interests.

- All children and young people will have the opportunity to form a trusting relationship with appropriate professionals. They, and their families, will have the support of a co-ordinator who will manage their case and help them to navigate the system.

- Intervention will be timely, avoiding long waits for services and will be based on needs not diagnosis. Services will be child-centred, evidence based and flexible to ensure that needs are met and provided in ways that are suitable and convenient, including on-line.

- The pathway will operate seamlessly across health and social services, education, community provisions and the criminal justice service.

- We will have effective governance of system resources and professional activity.

5 Scope

The strategy recognises that there is much good work already taking place between Local Authority, Health CAMHS and partner services across North Wales. It calls upon all agencies to build on what is already there and working well, and to seek to avoid duplication. Our recommended Tight – Loose - Tight approach seeks to allow for local determination of where the current practices work well and where there is scope for improvement, identifying what are the factors that impact negatively on the services working together at optimum effectiveness. It is important to integrate mental health hubs with other local arrangements, making adjustments where needed, and avoid children having to move unnecessarily between different systems.

The strategy draws on models of good practice elsewhere that demonstrate effective working between Local Authority, Health and CAMHS services and identifies what factors contribute towards them being successful.

6 Mental Health and Wellbeing

In line with local aspirations, national policy and international best practice this strategy embraces:

- A definition of mental health need advocated by the Welsh Assembly (Mind over Matter) a report on the step change needed in emotional and mental health support for children and young people in Wales) that spans beyond diagnosis and includes a wide range of emotional behavioural and psychological problems. [1]
- Diagnosis or psychological formulation as a way to understand the child or young person's strengths and challenges rather than seeing diagnosis as a gateway to services. [2]
- A definition of complex needs that is as broad as possible to include all children who experience distress and require help and support from multiple agencies as outlined by the Children's Commissioner for Wales in 'No Wrong Door.' [3]
- A focus on mental wellbeing, strength-based approaches and recovery advocated by the Welsh Assembly (Together for Mental Health, an all-age strategy for mental health and wellbeing).[4]
- The involvement of children and young people, their parents or carers in all decisions and plans that affect them. This includes involvement in the design, planning, delivery and review of services.[5]

This strategy recognises that some children and young people experience emotional distress that is a normal part of life and that it is important to avoid unnecessary

[1] hiips://senedd.wales/laid%20documents/cr -ld11522/cr-ld11522-e.pdf
[2] hiips://www.cdc.gov/childrensmentalhealth/basics.html
hiips://phw.nhs.wales/services- and-teams/improvement-cymru/news-and-publications/publications/matrics-plant/
[3] hiips://www.childcomwales.org.uk/wpcontent/uploads/2020/06/NoWrongDoor_FINAL_EN230620.pdf
[4] hiips://gov.wales/sites/default/files/publications/2019 -04/together-for-mental-health-summary.pdf
[5] hiips://www.england.nhs.uk/wp- content/uploads/2014/12/delvr-with-delvrng-well.pdf

labelling of these as episodes on mental ill-health. The hub's outreach function in supporting resilience and is also essential to the support of children and young people who experience problems but do not require the specialist support of formal mental health services.

7 Age range

- The strategy covers ages 0-25
- 17-25 transitioning to adult services.

8 Duration

- 5 years in line with Welsh Government Funding Cycle
- Implementation to be monitored with an aim for the principal elements to be delivered in years 1-3

9 Strategic Context

This strategy applies to the population of North Wales living in 6 local authorities: Anglesey, Conwy, Denbighshire, Flintshire Gwynedd, and Wrexham. Its development has been commissioned and overseen by the North Wales Regional Partnership Board which forms part of the North Wales Social Care and Wellbeing Services Improvement Collaborative.

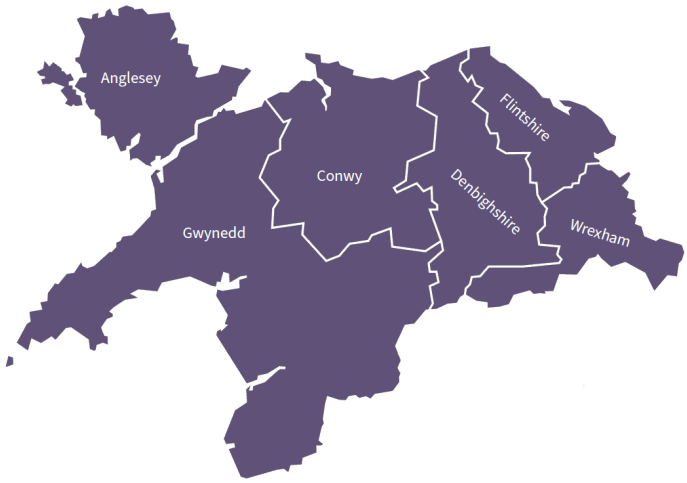


Figure 1 : North Wales

The Members of the RPB represent the 6 local authorities, Betsi Cadwaladr University Health Board, Third Sector Organisations, North Wales Fire and Rescue Service, Service Providers, North Wales Police, North Wales RLB and North Wales VSCs and WAST.

The strategy recognises the commitment of the Regional Partnership Board to ensure that Welsh speakers receive health services, social services and social care and their mother tongue, without having to ask. Gwyneth has the second highest number of Welsh speakers in the country (90,700) and the highest percentage of Welsh speakers can be found in Gwyneth (76%) and the Isle of Anglesey (66%).

10 The Population

North Wales has a resident population in the region of 690,500 people living across an area of around 2,500 square miles. North Wales consists of one health board and 6 local authorities. Public services may also be planned or delivered at a sub-regional level. The sub regions are west, central and east and are not all coterminous with local authority boundaries.

Number of children and young people in North Wales[6]

	Aged 0 to 4	Aged 5 to 15	Aged 16 to 24
Isle of Anglesey	**3,323**	**8,598**	**6,000**
Gwynedd	**5,691**	**15,061**	**15,966**
Conwy	**5,232**	**13,623**	**10,128**
Denbighshire	**4,920**	**12,479**	**9,010**
Flintshire	**7,967**	**20,830**	**14,699**
Wrexham	**7,321**	**18,605**	**12,778**
North Wales	**34,454**	**89,196**	**68,581**

Table 1: Mid-year estimates 2020 [7]

- The population in the East Area is the largest and the youngest.
- In North Wales, 2.6% of the population are Black, Asian and minority ethnic, ranging from 1.9% in the East Area to 3.9% in the Central Area.
- Deprivation is a risk factor for developing mental health problems. North Wales has some of the most deprived areas in Wales, particularly along the north Wales coastline. Rhyl West 2 and Rhyl West 1 are the first and second most deprived Lower Layer Super Output Areas (LSOAs) in Wales**.**
- The strategy must take account of both the rural and urban nature of the region. The region has a significant rural population whilst urban centres are concentred on the north coast and towards the east of the region. Gwynedd in the west is the least densely populated area and Flintshire in the east is the most densely populated area. Wrexham is the largest town followed by Rhyl. The two university towns Wrexham and Bangor add to the population of young people in the region during term times.
- The population of children and young people is further increased by local authorities outside of North Wales placing children in residential units in North Wales. **Such**

[6] **Source:** hiips://statswales.gov.wales/Catalogue/Population- and-Migration/Population/Estimates/Local-Authority/populationestimates-by-localauthority-region-age

[7] **Source:** hiips://statswales.gov.wales/Catalogue/Population- and-Migration/Population/Estimates/Local-Authority/populationestimates-by-localauthority-region-age

placements increase demand on local mental health services. The east sub-region is a net importer of looked after children.[8]

10.1 C&YPO Mental Health Needs in North Wales

Major surveys of the mental health of children and young people in England were carried out in 1999, 2004, and 2017 and 2020. English studies are routinely used to calculate mental health needs of C&YP in North Wales, alongside Welsh Government studies.

There are significant differences in mental wellbeing scores across North Wales. Young people aged 11 to 16 years in Gwynedd have the highest mental wellbeing scores in North Wales (24.5) and is statistically significantly higher than the average for Wales (24). Young people in Wrexham have the lowest score (23.6) and is statistically significantly lower than the average for Wales.

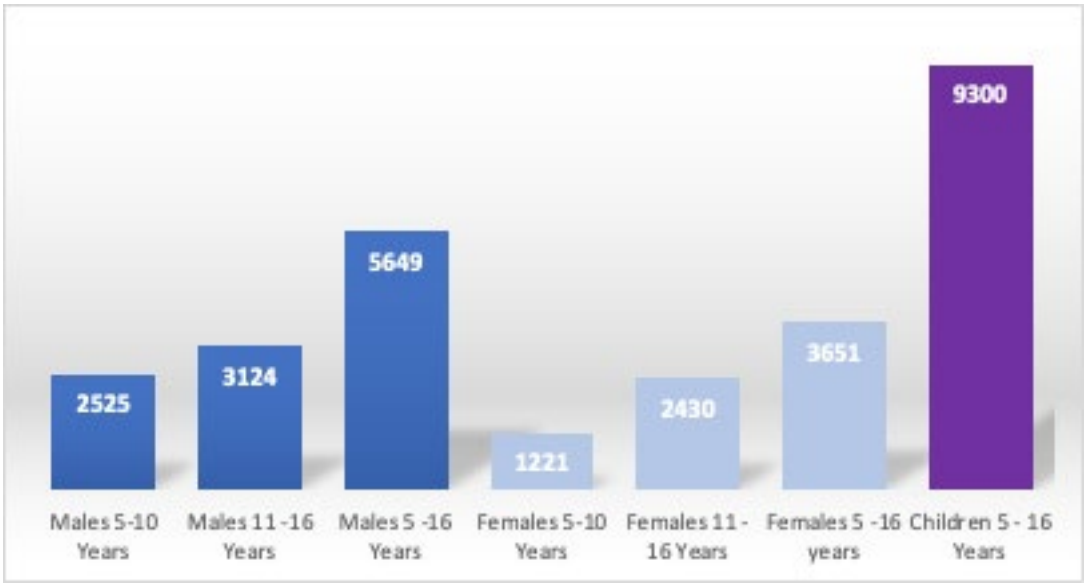
Estimated number of children in North Wales with different mental health problems (obtained by applying prevalence data form the Mental Health of Children and Young People in England 2017 (NHS Digital 2018), to mid-year population estimates for 2019 from ONS).

Betsi Cadwaladr UHB	9,280
Isle of Anglesey	874
Gwynedd	1,566
Conwy	1,446
Denbighshire	1,300
Flintshire	2,167
Wrexham	1,927

Source: Daffodil Cymru database

Table 2: Estimated number of children aged 5 to 16 years, with any mental health problem, Betsy Cadwaladr UHB and unity authorities, 2020

[8] hiips://gov.wales/sites/default/files/statistics-and-research/2020-05/summary-statistics-regions-wales-2020-629.pdf



Source: Daffodil Cymru database

Figure 2 : Estimated number of children (aged 5-16) with any mental health disorder Betsi Cadwaladr UHB, 2020

Since this prevalence data was last calculated for North Wales as part of the updated draft needs assessment NHS Digital has published a follow-up study that suggests **1 in 6 children aged 5-16** have a probable mental health problem in England (16%) **This is an alarming rise** from one in ten in 2004 and one in nine (10.8%) in 2017. The increase was evident in both boys and girls. (NHS Digital, 2020)

Factors associated with children and young people's mental health problems include deprivation, challenging family relationships such as a parent in prison or parent with a mental health condition or addictions, looked after children, issues relating to identity, risky behaviours such as substance misuse or criminality, negative early life experiences, presence of other health conditions, NEETs, and the impact of COVID 19.[9]

Local CAMHS and Neurodevelopment Teams have reported demand for services is outstripping services ability to respond and children and young people report long waiting times. Workforce supply is a major issue for both services. Increase in prevalence may be exacerbating this situation in North Wales and further analysis is required.

10.2 Key facts BCUHB

- In 2019/2020 6871 referrals were received for CAMHS and the longest wait for CAMHS assessment was 140 days compared with 147 days in 2016* *additional investment was made in 2016*
- In 2019/2020 2427 referrals were received for the neurodevelopment Team and the longest wait was 1372 days compared with 238 days in 2016
- In 2019/2020 there were 34 admissions to the inpatient unit with an average length of stay of 58 days

[9] hiips://digital.nhs.uk/data -and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up

Demand for foster care and residential placements has risen significantly across North Wales since 2016 coupled with a shortage of specialist placements. The Centre for mental health reports that ¾ of children in care have a diagnosable mental health problem, therefore there is a potential important association between LAC and mental health need. The rise in prevalence of mental health conditions and associated risk factors in the population may also be contributing to increasing pressure on services for looked after children. Further analysis is required.

10.3 Key facts Looked After Children in North Wales [10]

- The number of children who require a foster placement increased by 34% during the period April 2016(735) to March 2020 (945)
- As at the 31st March 2020 there were 945 children living with a foster carer 272 (source QDBR) were living with independent foster carers and the majority of those children required specialist placements in order to support their needs
- Some children living in residential placements could live in a foster placement but there are not enough foster carers with the right skills to support them
- As at 31st March 2020 there were 105 North Wales children living in a children's home
- The total number of children living in a children's home increased in North Wales during the period 31st March 2016 (40) to 31st March 2020 (105)
- Conway and Denbighshire are developing some inhouse residential provision in order to build capacity

10.4 Projecting future mental health needs of children and young people in North Wales

The Royal College of Psychiatrists highlights that prevalence and demand for CAMHS is affected by population level risk factors, including deprivation and the proportion of the general population who are under 18 years old[11]
Therefore, although the number of children and young people is set to decline slowly up until 2040 across North Wales (given the increase in prevalence in recent years), it may not result in an equal decline in mental health needs in the population and is more likely to slow down the rate of increase in demand for services.

10.5 Digital Services [12]

There are limitations and geographical variation in access to digital services across North Wales that must be taken into account in developing the strategy.

- Digital poverty is a major factor within North Wales, for example with 40% of families on the Isle of Anglesey in digital poverty.

[10] hiips://www.centreformentalhealth.org.uk/fact-sheet-children-and-young-peoples-mental-health

[11] hiips://www.rcpsych.ac.uk/docs/default -source/improving-care/better-mh-policy/college-reports/college-report-cr182.pdf?sfvrsn=8662b58f_2

[12] hiips://gov.wales/sites/default/files/statistics- and-research/2020-05/summary-statistics-regions-wales-2020-629.pdf

- Access to broadband: up to 93% of homes and businesses in Conway, Denbighshire Wrexham and Flintshire, compared with up to 89% in Gwynedd and Isle of Anglesey having access to superfast broadband.
- Indoor access to 4G from all 4 network providers max 84% homes in Wrexham and Conwy compared with 49% or less across the Isle of Anglesey

10.6 Workforce

Ability to recruit and retain the workforce is a major issue across health and care services across Wales including North Wales.

- There is a 25% vacancy factor in BCUHB CAMHS and in 2019 /2020 over a fifth of community CAMHs spend was on agency staff.
- A major reason causing increasing waiting lists within the BCUHB neurodevelopment team was staffing issues
- A key priority for BCUHB is workforce retention
- Alongside finance workforce is the biggest challenge reported by local authority children's services managers across North Wales. For example, one of the biggest issues in continuing new ICF and Transformation Fund innovations longer term was the ability to recruit sufficient trained staff.
- Recruitment of staff who are able to use the Welsh Language must be a priority in line with the "More than Just Words" Action Plan

***Development of a multiagency workforce plan will be critical to the success of the strategy.** The workforce plan will need to interface with the health board workforce strategy, the regional social care workforce strategy (and each LA also has workforce group) and regional education workforce strategy.

10.7 Finance

10.7.1 **Health**

- There is no formula for determining optimum funding for CAMHS services. Local health commissioners are required to take account of local population needs assessment and competing priorities in allocating resources. In 2012 the Royal College of Psychiatrists produced UK wide guidance on recommended workforce and beds per 100,000 population which may also assist local planners, however this data has not been updated to take account of current population needs or new models of care so need to be interpreted with caution.[13] The percentage of health spend on CAMHS across Wales in 20-18/2019 ranged from 0.6-1.3% of health board budgets. BCUHB was at the top of that range at 1.3 % of health spend on child and adolescent mental health services which is £27.93 per head of population (2018/2019). A 2016/2017 study of spend on CAMHS across 209 English CCGs reported spend was on average £46 per head (excluded tier 4 services commissioned by NHS England), higher than in BCUHB, however the health systems operate differently in the 2 countries so any comparison should be made with caution.

[13] hiips://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr182.pdf?sfvrsn=8662b58f_2

- BCUHB received an additional £5 million p.a. investment from Welsh Government in 2021 to invest in CAMHS to tackle waiting list and improve services. This is a welcome investment for CAMHS however funding for the neurodevelopment team is insufficient to meet demand. exacerbated by COVID 19 which has led to long and increasing waiting times for community CAMHs and the neurodevelopment team.
- 2020 Standard reference costs for a one-to-one school nurse contact in is £70 rising to £225 for a Community CAMHs contact. The standard reference cost per contact for CRHT is £252 rising to £778 admitted and rising again to £1536 admitted intensive psychiatric care. Cost per contact for community CAMHS and admitted were slightly higher for BCU compared to reference costs which may be due to a number of reasons including, geography, local population health need and waiting lists leading to greater acuity of need when services are eventually accessed? The health board is looking to develop a CRHT service for CAMHs which would be expected to reduce the percentage of children needing admission and thus may also have a positive financial impact, creating opportunity for more children to be treated.[14]

We were unable to collect data in respect of primary care or education services.

10.7.2 **Local Government**

- Children's service budgets are under significant pressure from increasing demands. In 20219/2020 across North Wales all local authority children's services budgets were in deficits in most part due to high demand for placements for looked after children. Given that LAC have risk factors in their lives that mean they are more likely to experience mental health issues than their peers this is an area where health and care services could work together to a greater extent in the future to potentially prevent both needs and costs escalating.
- Standard reference cost LAC – foster care £622 per week rising to £3,847 - £3,862 per week for voluntary and private sector care homes. BCUHB local authorities do not routinely collect financial data spend on CAMHs need. Local authority dashboards are being developed but no available at the time of writing.

10.7.3 **Education**

- No financial information was available for spend across schools within BCUHB. However, prevention and early intervention school-based programmes are generally lower cost. For example, a school based social and emotional learning programme to prevent conduct disorders would cost circa £174 per child per year.

10.8 COVID 19

- On 13th May 2020 the children's commissioner for Wales launched a consultation on the impact of Coronavirus involving over 23,000 children and young people 'Coronavirus and Me' (ref). A follow-up consultation was completed with 19,000 children in January 2021 There are some marked differences in reported feelings between the January 2021 respondents and the May 2020 respondents. Strong negative feelings are expressed by

[14] hiips://www.pssru.ac.uk/project -pages/unit-costs/unit-costs-2020/

many children and young people, expressing frustration and, in some cases, anger about the impact of the pandemic on their lives. The results also indicate that children answering in January 2021 are slightly less likely to say they know how to get help if they need support to feel happy.

- In June 2021, Public Health Wales published "Children and young people's mental well-being during the COVID 19 pandemic Report "[15] which built on the above findings. The report highlights that although the pandemic had some positive impacts for some young people evidence overwhelmingly pointed to negative impact on all aspects of mental health. Improvements in wellbeing scores for all age groups at the end of summer 2020 (when restriction were eased and schools reopened) may suggest negative impacts of the pandemic could be short lived, however further analysis is required.

- Demand for child and adolescence mental health services has been increasing over the last decade in most areas of the UK including North Wales and services have struggled to meet increasing demand. Over the last 18 months COVID 19 has exacerbated an already challenging situation and BCUHB children's services report that the pandemic has had a significant impact on service provision, demand and capacity with subsequent impact on waiting lists and delivery of targets. This finding is echoed in the report "Coronavirus and Me' which highlighted that in May 2020 less than half (47%) of children and young people in Wales felt confident they would get help from mental health services should they need it declining to only 41% in Jan 2021. (ref)

- Moving forward it is not yet clear if and to what degree COVID 19 will impact on children and young people's mental well-being in North Wales. The implementation of the strategy will need to build in contingencies for any likely future impact of COVID 19.[16][17]

[15] hiips://www.childcomwales.org.uk/wp- content/uploads/2021/02/CoronavirusAndMe_Jan21_ENG_110221_FINAL.pdf

[16] hiips://phw.nhs.wales/news/coping-strategies-made-a-difference-to-young-peoples-mental-well-being-during-pandemic/

[17] ***PERFORMANCE AND QUALITY INDICATORS FOR HELATH AND SOCIAL CARE CAN BE ACCESSED VIA STATS WALES*** hiips://statswales.gov.wales/catalogue/health- and-social-care

11 Case for Change

11.1 Children and their families want change

Children tell us that finding information and getting access to services is confusing and difficult. A particular problem is that there can be a lengthy wait for services, with little or no support available.

Children want to be involved in discussions and decision making on all aspects of their care planning and management. If we are to put children at the centre of services that care for them, it is essential that we increase the ability of children and their families to self-manage their mental health, to improve local knowledge of what is available, what the care pathway is and to be able to identify where there are gaps to feed into service evaluation.

The things that children and families have told us in North Wales is mirrored by research findings in the UK.

- 75% of young people with mental health problems aren't getting the help they need[18]
- There is an average 10-year delay between young people displaying first symptoms and getting help. [19]
- Only Two-thirds of children with a mental health problem have had contact with professional services. Young people's education is being damaged because they can't access good mental health support[20]

11.2 Professionals want change. Professionals have told us:

- The commissioning and planning arrangements for services have resulted in pathways that are fragmented and disjointed, leading to delays and inconsistency in how children are supported.
- Waiting lists for CAMHs and the neurodevelopment team are long and may rise further because of COVID without intervention
- There is rising pressure on local authority children's budgets, particularly looked after children.
- Ability to recruit and retain the workforce across health and social care is a major issue.
- Time and time again change initiatives have fizzled out and this time staff want leaders to be brave and make changes happen at scale and pace.
- That a transformation in culture is vital to change mind-sets.
- There should be no service delivery barriers to working with a child and their family if the presentation indicates a need that we can collectively help with

11.3 Research indications for change

Population health needs are increasing. This tells us change is needed to meet the challenge.

[18] hiips://www.childrenssociety.org.uk/what -we-do/our-work/well-being/mental-health-statistics
[19] www.centreformentalhealth.org.uk
[20] hiips://www.mind.org.uk/news- campaigns/campaigns/children-and-young-peoples-mental-health/improving-mental-health-support-for-young-people/#problem

- 1 in 6 children aged 5-16 have a probable mental health problem. This is an alarming rise from one in ten in 2004 and one in nine (10.8%) in 2017. The draft updated population needs assessment (page 13) has estimated the number of children aged 5 to 16 years, with any mental health problem, Betsi Cadwaladr UHB & unitary authorities, 2020 is 9280. ** to note calculations are based on 2017 data (1 in 9 prevalence rate), therefore actual number are likely to be significantly higher based on most up to date prevalence rates of 1 in 6. And these figures do these take into account of early years and mental health needs of 17 – 24 year olds. Further work is required to calculate the needs of these group across North Wales.* [21]

Research tells us change requires a holistic approach.

Factors associated with poor mental health
Although no one is immune from poor mental health some children are more likely to need help than others therefore close working across health, public health, social care, education and youth justice is critical. Factors associated with mental health problems include

- Income and adversity e.g. living in poverty, parental separation, financial crisis, homelessness, ACES *Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%. (Morrison Gutman et al., 2015)*
- Family relationships e.g. a parent with a health/mental health condition, parental substance misuse, parent in prison, parental unemployment, young carers
- Looked after children *LAC are 4 times more likely to experience mental health problems than their peers*
- Identity e.g. LGBTQ, ethnicity
- Behaviours e.g. criminality, drug misuse, risk taking behaviour, how social media is used, unhealthy lifestyles. A third of people in Youth Justice system are estimated to have a mental health problem. Young people in the youth justice system are 3 times more likely than their peers to have mental health problem*. (Mental Health Foundation, 2002).*
- Pupils who have a mental health problem are more likely to be excluded from school than their peers. Research suggests that school exclusions are linked to long-term mental health problems. (Ford et al., 2017).
- Early life experiences e.g. early life environment and social factors, perinatal mental health, substance misuse in pregnancy
- Presence of other health conditions e.g. physical or neurodevelopmental conditions Nearly three quarters of children with a mental health condition also have a physical health condition or developmental problem. (LGA) Children and young people with a learning disability are three times more likely than average to have a mental health problem. (Lavis et al., 2019)
- Adolescents 16-18-year olds Not in Employment, Education or Training (NEETs)
- The Covid-19 pandemic

[21] hiips://digital.nhs.uk/data -and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up

Children and young people look for help most often at school

- Research suggests teachers are the most commonly cited source for seeking help with mental health issues (48.5%), followed by primary care (33.4%) and mental health specialist (25.2%). Therefore, all of these groups will have a critical role to play in making change happen. [22]

Early Intervention and Prevention needs to start in pregnancy and early years

- There is good evidence that antenatal and perinatal programmes have a positive impact on the psychological health. Perinatal mental health problems which occur during pregnancy or in the first year following the birth of the child and affect up to 20% of new and expectant mothers and cover a wide range of conditions. If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child and the wider family.
- Since mid-20th century, attachment theory and associated research has documented the crucial role of continuity of care and stable caregivers to serve as attachment figures.[23]
- The timing of early interventions is crucial. Those designed for the perinatal period are shown to generate the most solid and long-lasting outcomes in two areas, both highly relevant to our own objectives here: promoting the welfare of children and families and preventing poor outcomes in later life such as mental health problems, low educational attainment and crime; and economic benefits because preventive policies cost less to implement than reactive policies.[24] Programmes for children and families 'starting big school' is another powerful time for early intervention

Young people transitioning from children's to adult services are often at risk of experiencing poor health outcomes when their transfer is not appropriately supported and coordinated.

- It is well reported across the UK that transition arrangements are often poor for children with only half of all children receiving support from a lead professional to ensure a smooth transfer.
- 17-22 year old women are the group most at risk of developing a mental health problem.[25]
- Between five and 10 years old, the split between girls and boys is just about even. But by 17, a **quarter of young women have a mental health disorder**, more than twice the number of young men. Half of them have self-harmed or attempted to take their own life. [26]

[22] hiips://www.mind.org.uk/news- campaigns/campaigns/children-and-young-peoples-mental-health/improving-mental-health-support-for-young-people/#problem
[23]The Lancet October 2020 'From attachment to mental health and back'
hiips://www.thelancet.com/journals/lanpsy/article/PIIS2215 -0366(20)30337-0/fulltext
[24]House of Commons briefing August 2021'Early Intervention: policy and provision'
https://commonslibrary.parliament.uk/research-briefings/cbp-7647/
[25] hiips://www.childrenssociety.org.uk/what -we-do/our-work/well-being/mental-health-statistics
[26] hiips://www local gov.uk/about/campaigns/bright -futures/bright-futures-camhs/child-and-adolescent-mental-health-and

- Self-harm is more common among young people than other age groups. **25% of women and 9.7% of men aged 16-24 report that they have self-harmed.** (McManus et al., 2016) [27]

- **Common mental health issues, such as depression and anxiety, are increasing** amongst 16-24 year olds, with 19% reporting to have experienced them in 2014, compared to 15% in 1993. They are about three times more common in young women (26.0%) than men (9.1%) (McManus et al., 2016) [28]

11.4 Economic case for change

Investing in children's and young people's mental health and wellbeing will not only make the lives of children young people and their families better, research evidence suggest it is also likely to be more cost effective in both the short and longer term across a whole lifetime. 50% of all mental health problems start by the age of 14 and 75% of adults with a diagnosable mental health problem experience the first symptoms by the age of 24 (Kessler et al., 2005; McGorry et al., 2007).

In 2012 Dr Jason Strelitz published the economic case for a shift to prevention in child and adolescent mental health. The analysis estimated the annual short-term costs of the 3 most common mental health disorders - emotional, conduct and hyperkinetic disorders among children aged (NB costs are at 2012 prices)

- Short Term - £2,220 health social care and education costs per child with a mental health problem (2012 costs) with average UK inflation rates applied this rises to circa £2559 in 2020 **public sector inflation is often higher*
- Long Term £3,310 long term societal costs per child with mental health problems (2012 costs) with average UK inflation rates applied this rises to circa £3764 in 2020**public sector inflation is often higher*

Strelitz provides costed examples of how prevention of childhood mental health problems saves money in both short and longer term

- Parenting programmes for prevention of conduct disorders – likely long-term savings to society £17,500 per family (2012 costs) over 25 years
- Psychological or educational programmes to prevent child and adolescent depression may result in saving of £5 million (2012 costs) in England

Public Health England report on Mental Health of children in England (2016) cites further evidence of cost benefit of investing in early intervention and prevention.

- Anxiety - for every £1 spent on cognitive behavioural therapy saves £31 group therapy and £10 therapy via parents
- Depression – for every £1 spend on cognitive behavioural therapy return £32 saving for group therapy and £2 saving for individual therapy

[27] www.centreformentalhealth.org.uk
[28] www.centreformentalhealth.org.uk

- Conduct disorders - For every £1 invested in early years saves £45 in school and family-based interventions. For every £1 invested in adolescence saves £38 in therapeutic interventions. Potential saving for each case prevented through early intervention £150,000 severe £75,000 moderate
- Long term cost for every child with ADHD £102,135 – the high cost supports the economic case for early intervention

The Personal Social Services Research Unit (PSSRU) also cites early intervention projects that have shown to be cost effective.

- **Bradford B Positive Pathways** incorporated 2 practice models (A "No Wrong Door" multi-agency, multi-disciplinary team and "Mockingbird" family support). Among its aims were to reduce the number of looked-after children by a total of 75 and the number of out-of-authority placements by 20 over a 2-year period. A total of 172 young people were reported to have stayed at home following BPP outreach support. The base programme cost was £2,578,080. A total saving of £8,614,368 was achieved over the 2-year period of the programme operation. £4,167,540 in foster care, £108,000 in adoption, £118,668 in other accommodation, £4,075,968 in local authority residential and £144,192 for those placed with a parent.

- **SafeCORE2** was implemented in Greenwich and aimed at families with Domestic Violence and Abuse (DVA) as a presenting need. Greenwich has a high rate of repeat contacts, referrals and child and family assessments where this is a feature. Prior to the project, families received no active help from statutory services. The total project funding, minus 10% to allow for start-up costs, was £1,950,000. The estimated average cost of supporting a family through SafeCORE was £19,918. The average saving per family was £14,701 for the engaged families and £9,459 for the disengaged families.

- **Multisystemic Therapy** *(*ICF& TF pilot Flintshire and Wrexham) is intensive family therapy that targets the causes of antisocial behaviour.* A costs and benefits analysis of Cambridgeshire multisystemic therapy transition to mutual delivery model was conducted in September 2016. The evaluation showed that one team delivered a return on investment that increased when 2 teams were in operation. When total service costs (delivery costs and overheads) were considered, the mutual with one team was cost-efficient relative to the 2014/15 baseline - with a return on investment of 3.0. With two teams there was an increase to 3.6. This can be attributed to a greater number of cases served and sharing of overheads. [29]

- **School Counselling**. *(*ICF pilot Denbighshire)* In 2016 the charity Place2Be commissioned Pro Bono Economics to conduct an economic evaluation of counselling services in primary schools covering 4,548 pupils in 251 schools around the UK. Results showed that in 2016/17 every £1 invested resulted in £6.20 worth of benefits in terms of improved long-term outcomes, and the potential benefit of counselling per child was just over £5,700.00[30]. Also, in 2011 the Welsh Government conducted a wide-ranging evaluation

[29] www.mstuk.org/mst-outcomes/uk-

[30] Pro Bono Economics (2017). Economic evaluation of Place2Be's Counselling Service in Primary Schools: A Pro Bono Economics report for Place2Be In association with Dr Allan Little, p8. Available at hiips://www.place2be.org.uk/media/5cgpoqiz/economic -evaluation-of-place2be-counselling-service.pdf (Accessed 30th March 2021)

of school-based counselling that included four primary school-based pilot projects[31]. Although the data was limited, findings suggest that primary school-based counselling is associated with large and significant reductions in psychological distress.[32,33,34]

[31] Welsh Government Social Research (2011). Evaluation of the Welsh School-based Counselling Strategy: Final Report. GSR report number 23/2011. Available at hiips://dera.ioe.ac.uk /13164/1/110712schoolcounsellingen.pdf (Accessed 30th March 2021

[32] hiips://www.gov.uk/government/publications/chief -medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

[33] www.centreformentalhealth.org.uk

[34] hiips://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_childre n_in_England.pdf

12 UK and International Research Findings

Introduction

The case for change highlights both regional challenges and issues related to broader economic, demographic and social pressures not unique to North Wales. Understanding how health and social care bodies in the UK and internationally have attempted to address similar situations can help inform the design of a bespoke strategy for the region. In this section, we consider a range of models implemented beyond North Wales that demonstrate effective working between Local Authority, Health and CAMHS services and attempt to identify the factors that contribute towards their success. The initial research was conducted early in the project to stimulate ideas in the Organisational Stakeholder (OS) workshops, where sub set of models were presented and discussed. Ongoing work has expanded the depth and breadth of this understanding, ultimately informing many aspects of the strategy. Details and links relating to the reviewed models and their respective evaluations can be found in Appendix A.

The term 'best practice' in relation to service models can imply the existence of significant operational evidence that a specific system or approach can be reliably replicated to achieve the same results. Although there is a clear understanding in the literature of what is wrong with the current systems and a broad vision of where we need to get to, designs of new integrated care systems of this nature are still in the process of being established and evaluated around the world. Commentators agree we are not yet able to draw on evidence-based best-practice service models as templates for service design.[35] [36] Our investigation was also limited to the material accessible via the internet in the public domain. It focussed on identifying operational services with successful evaluation evidence that address one or more of the key features highlighted by guidance and reports such as the Children's Commissioner for Wales', 'No Wrong Door', NEST/NYTH and others. Broadly, the good practice features sought were:

- The provision of integrated services that wrap around the child, young person, family
- Simple access, simple pathways, clear boundaries of responsibility
- Timely joined-up help
- Response on the basis of need not just diagnosis
- Involving panel or hub models, drop-in centres, multi-disciplinary teams, local care
- Children, young people and their families as active participants in the development and provision of services
- Shift of focus towards prevention and early intervention
- Co-ordinated, integrated services through transition
- Evidence of success

12.1 What we found

A wide range of innovative and informative examples from the UK and beyond with at least one aspect of interest were identified. All involved forms of multi-sector partnerships and the notion of a simplified pathway guiding children and young people to the right support .

[35] Fusar-Poli, P. on behalf of the Health London Partnership (2019) hiips://www.ncbi.nlm.nih.gov/pmc/articles/PMC6567858/

[36] Vusio, F. et al (2021)hiips://onlinelibrary.wiley.com/doi/full/10.1111/eip.13009

Apx A Ref.	Service	Country	Context	Physical Hubs	Est.	Age Range	Scope	Evaluation Evidence
1	Space-Wellbeing (Gwent)	Wales	Region	0	2019?	0-25	MH/WB	Y
2	Liverpool Integrated CAMHS	England	City	3	2019	0-25	MH/WB	Y
3	Take 5 MH & Wellbeing Oldham (Mind)	England	City	1	2019	8-18	MH/WB	Y
4	Solar (Solihull, Birmingham)	England	City	0	2018	0-19	MH/WB	Y
5	Headspace	Australia	National	110	2006	12-15	MH/WB/Phys/Voc	Y
6	Trieste Whole life whole system	Italy	City	4	1973	All ages	MH/WB/HS	Y
7	Hertfordshire - Thrive	England	County	0	N/A	0-25	MH	N
8	Jigsaw	Ireland	National	5	2008	12-25	MH	Y
9	Access Open Minds	Canada	National	3	2016	11-25	MH/WB/Phys/Voc	Y
11	SPOT: Supporting Positive Opportunities with Teens	US	City	1	2007	13-24	MH/WB/ Physical	
12	The Well Centre (London)	England	City	1	2011	13-20	MH/WB/Physical	
13	Your Choice Programme	New Zealand	City	0	2008	10-24	MH/WB	Y

MH – Mental Health, WB – Wellbeing, Phys – Physical Health, Voc- Vocational services such as employment support, HS, Housing services

Table 3: UK and International Integrated Service Models supporting Children and Young People's Mental Health

12.2 Open Access Early Intervention Hubs

Easy-to-access physical spaces in the community where children, young people and families can drop-in or self-refer for low level mental health and wellbeing support are being recognised as an effective approach internationally with networks of services being established around the world.[37] Common characteristics include:

- Dedicated services for young people, often up to the age of 25, available to all without the need to meet thresholds for support
- A mix of clinical staff, counsellors, youth workers and volunteers - range of support
- A single, visible trusted location where services are delivered under one roof
- A safe and youth-friendly environment providing a timely response to young people
- Accessible in terms of location and hours of operation
- Needs focussed with children and young people involved in decision-making.

The Headspace integrated, multi-disciplinary model of care, pioneered in Australia, has inspired and provided evidence for the development of similar, culturally adjusted models, in the UK, Ireland and Canada. It's nationally funded network currently providing 110

[37] The Children's Society (2020) (hiips://www.childrenssociety.org.uk/information/professionals/resources/case-for-open-access-hubs
National Institute for Health and Care Excellence. Transforming mental health care for children and young people with long-term conditions: mental health and psychological wellbeing drop in centre. February 2019.
hiips://www.nice.org.uk/sharedlearning/transforming -mental-health-care-for-children-and-young-people-with-long-term-conditions-mental-health-and-psychological-wellbeing-drop-in-centre
Youth Access. Another Way: Defining the functions and characteristics of YIACS (2018).
hiips://www.youthaccess.org.uk/downloads/another -way-defining-the-functions-and-characteristics-of-yiacs.pdf

specially designed youth friendly walk-in centres. These spaces are a soft entry point for primary mental healthcare supplemented by other youth services (physical and sexual health, alcohol and drug, and vocational services) that support 12-25 year olds. A recent evaluation confirmed the Headspace approach reduced psychological distress, suicidal ideation, and self-harm.[38] In the models reviewed, walk-in services were integrated with services handling web, email, and telephone referrals. Other examples of physical hubs include Jigsaw (Ireland), Liverpool (UK) and Access Open Minds (Canada) etc.

The research shows that young people respond better to youth specific provision offering more flexible support on their own terms, and studies in the UK and Australia show that walk-in centres located in the community, and involving the community, appear to reach marginalised groups who may not otherwise engage, for example those from Black, Asian and minority Ethnic backgrounds.[2, 34] Establishing a physical presence where young people know they can get help may also raise the profile of mental health treatment pathways with young people and their families in the surrounding community. Based on the wide range of evidence supporting physical hubs, Mind has partnered with others in the voluntary sector to call on the UK Government to fund a network of centres for children and young people across England.[39,40]

There are a variety of ways that hubs can be implemented, examples include: as part of a network, a central hub with satellite sites, a stand-alone one-stop-shop facility, and as a virtual hub.[41] Physical hubs may be more suited to urban or sub-urban environments with good public transport links allowing and young people to access services in person independently from their parents/carers if they so wish. Given the rural nature of some parts of the North Wales region, the feasibility of physical hubs and their particular configuration should be considered in accord with conditions in each locality.

12.3 Accessible, visible, timely

All the models reviewed were concerned with providing easy access to the right level of support for the child, young person or family at the right time. Cross-sector agreements that ensure clarity in respect of access to services were a common theme, often implemented in the form of a Single Point of Access (SPA)/Single Access Arrangement (SAA) with features such as:

- Highly visible single point of contact across multiple channels as an entry point for signposting, universal services, professional advice, consultation, assessment and onward referral.
- Management of referrals from all frontline staff working with children and young people, their families, and self-referrals.

[38] Is Headspace making a difference to young people's lives? Australian Government Department of Health (2015) hiips://headspace.org.au/assets/Uploads/Evaluation- of-headspace-program.pdf
headspace

[39] Counselling for young people and young adults in the voluntary and community sector: An overview of the demographic profile of clients and outcomes. 2018. hiips://onlinelibrary.wiley.com/doi/full/10.1111/papt.12206

[40] Catanzano M, Bennett SD, Kerry E, *et al* Evaluation of a mental health drop-in centre offering brief transdiagnostic psychological assessment and treatment for children and adolescents with long-term physical conditions and their families: a single-arm, open, non-randomised trial. *Evidence-Based Mental Health* 2021;**24:**25-32. hiips://ebmh.bmj.com/content/24/1/25

[41] Bostock, L., Britt, R. (2014) Effective approaches to hub and spoke provision: a rapid review of the literature hiips://www.alexiproject.org.uk/assets/documents/Effective -approaches-to-Hub-and-Spoke-service-provision_final-report-25-09-14.pdf

- Triage and initial risk assessments to ensure those at high risk are seen as a priority.
- Prompt decision-making about who can best meet the child/young person's needs
- Effective administration underpinned by consistent data gathering and case management systems.
- Appropriate levels of data sharing between agencies.

Given the diverse regional context of North Wales, single access arrangements, combined with walk-in centres in locations with good transport links could be considered. Bilingual Welsh/English language support is necessary for all front line access portals.[42]

12.4 Multi-agency panels

Many models involved the use of a multi-agency panel or a form of informed triage to determine the appropriate next steps for the individual/family once a referral has been made. In many cases, panels go hand in hand with a SAA or 'virtual central hub' facility that collates referrals and ensures they are presented for consideration with adequate information for a decision to be made. Teams typically incorporate representatives from health, social care, education, the voluntary sector providing a cross-sector knowledge of available interventions to be considered. The research suggests, there has been a growth in the popularity of multi-agency panels for decision making in mental health services with evidence of improved outcomes, reduced costs and better utilization of services.[43] Collaboration of this kind requires shared values and goals, a good understanding and respect for the competencies of team members, and an ability to learn from other disciplines and respect their different views and perspectives in order to maximise effectiveness.[44] Children whose needs fall outside the skills set of primary mental health support may require the support of a highly skilled practitioner who can triage, refer and negotiate access to effective support and/or offer help until the young person is successfully engaged.

12.5 Needs-led approaches

A needs-led approach involves moving away from service designs developed for and by organisations, such as referral criteria based on diagnosable mental disorders, and towards flexible service provision based on the holistic evaluation of the needs of the child or young person and their families/carers. This wide-lens approach was a feature of the Trieste, Headspace and Hertfordshire models. The Nest Framework supports this change and many other bodies are suggesting it is key to addressing the needs of the 'missing middle.' Transformation of this kind has implications for pathway development, opening the possibility of achieving the 'no wrong door' ideal, and for shaping population-based and targeted strategies and services.

[42] Rocks, Stephen & Glogowska, Margaret & Stepney, Melissa & Tsiachristas, Apostolos & Fazel, Mina. (2020). Introducing a single point of access (SPA) to child and adolescent mental health services in England: a mixed-methods observational study. BMC Health Services Research. 20. 10.1186/s12913-020-05463-4.

[43] Kutash, K., Acri, M., Pollock, M. *et al.* Quality Indicators for Multidisciplinary Team Functioning in Community-Based Children's Mental Health Services. *Adm Policy Ment Health* **41,** 55–68 (2014). hiips://doi.org/10.1007/s10488 -013-0508-2

[44] M. Cooper, Y. Evans, J. Pybis. Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors. *Child: care, health and development* 2016 41:3;325-342 hiips://doi.org/10.1111/cch.12322

12.6 Participation in care

Participation is the rights-based principle that young people (and parents and carers where appropriate) should have an active role to play in decisions around their care by understanding the care options available to them, the risks and benefits associated with each and how these align to their personal priorities and values. This kind of engagement has been shown to make relationships between young people and the professionals supporting them more open. It can also help young people to feel a greater involvement in their care and increase commitment to following their care plans.[45]

12.7 Mobile Apps and Technologies

Digital mental health apps, such as BlueIce and Calm Harm, and services providing low-level intervention such as Kooth on-line counselling, have the potential to be important assessment, management and treatment tools as part of a strategy oriented towards prevention. They offer easier access to low level mental health support, with less of the capacity issues of conventional services. A number of the models presented (Liverpool, Hertfordshire and Headspace) included on-line counselling as part of their overall strategy and we are aware that Education Psychology in Denbighshire and possibly others in the region are already employing these applications.

Recent reviews of the research suggest young people engage well with these types of tools and they demonstrate some positive effects in emotional self-awareness. [46] There is also some support for their clinical benefit, however, further research is needed in order to validate these effects.[47]

Clearly access to broadband and/or mobile phone services are critical to the effective deliver of these services and we are aware there are areas across the region that are poorly served in this regard. Socio-economic factors may also have an impact. Again, bilingual support and local conditions should be considered when implementing provision in each local authority or geographical area.

12.8 Multi-agency Data

Most of the models did not explicitly address the issue of data collection across multiple-agencies in the publicly available documentation, although clearly this would be an important element of any new design. The exception was the Headspace model which, as a national service, offers an aspirational example with a common system infrastructure and data gathering requirements for each multi-agency hub in the network. Each hub feeds data into a central 'head office' system that collates input from across the country and provides hub managers with a dashboard, national comparisons and detailed analysis.

Detailed consideration should be given to the data and systems underpinning any new service. Minimum levels of data sharing will need to be agreed and the implications for

[45] Abrines Jaume, Neus. Inattention and hyperactivity in children adopted from Eastern Europe : : description, causes and implications. hiips://ddd.uab.cat/record/114277/

[46] Punukollu M, Marques M. Use of mobile apps and technologies in child and adolescent mental health: a systematic review *Evidence-Based Mental Health* 2019;**22:**161-166.

[47] Chris Hollis, Caroline J. Falconer, Jennifer L. Martin et al. Annual Research Review: Digital health interventions for children and young people with mental health problems – a systematic and meta-review *The Journal of Child Psychology and Psychiatry* 2017;58;4;474-503

legacy systems and the ability to interoperate between agencies across the region should be investigated.

12.9 Transition to Adult Services

Transitions between children's and adult services is a policy area wider than mental health alone. In this strategy we consider only the issue of transitions for children and young people experiencing mental ill health. There should be consideration of a wider review of transitions strategy (strategies) in North Wales to reflect the good practice model outlined below which we believe could be satisfactorily implemented as part of this strategy.

The Solar model (Solihull, UK) proposes an approach that could be considered as part of this further enquiry. The tier free service (supporting 0-19 year olds) works with individuals to make the discharge process as smooth as possible by liaising with Adult Mental Health Services (AHMS) and continuing to provide support until they are fully ready to transition at a pace that suits their needs. Pre transition questionnaires are used to gauge readiness for the receiving service. In cases where the outcome suggests the person is not ready, support continues alongside work to help them prepare for transition. Pre transition questionnaires are readministered at appropriate intervals up to their 21st birthday. Post transition, a further questionnaire is used to ascertain whether the AMHS services are meeting the individual's needs.

A review suggests "the flexibility of the model utilised by Solar offers service users a guarantee they will not face a "cliff-edge" transition at the age of 18." However, it also implies that extending the cut-off point to age 25 would bring the service in line with other models and, in particular, research that shows the critical period for the appearance of mental health problems in young people extends to age 24. [31,32]

13 Children and young person's engagement – Key Findings and Illustrative Stories

13.1 Introduction

In developing this strategy, we have conducted a very extensive children and young people's consultation, the outcomes of which are central to the development of the strategy. Full details of this work are provided in a separate report along with an expanded version of this summary, see Appendix C.

Following an initial step of raising awareness about the consultation and engagement to generate interest and involvement, the Children and Young Persons consultation was delivered in three core stages

13.2 Stages of the Children and Young People's Engagement Programme

Stage 1 – Children and young People's Engagement

This included interviews (virtual and face to face), completion of Young Leaders workbooks (specially designed, age-appropriate questionnaires), and engagement in workshops across North Wales. To ensure that feedback remained as consistent as possible for data analysis purposes, the questions from the Young Leader workbooks were used to help guide workshop feedback where participants did not complete the workbooks in written format.

82 children and young people participated in stage 1:

- 64 participants were based in the East
- 9 participants were based in the West
- 9 participants were based more centrally

Stage 2 – Professional Engagement

The findings from the Stage 1 of the children and young people's engagement were presented to the staff in the professional's workshop for consideration. The information was used to shape and validate the work undertaken to generate potential solutions and encourage strategic developments that may contribute towards improvement in children's mental health services.

Stage 3 – Children and Young People's Review of the Professionals Work

Children and young people were shown the indicative proposals that were being developed through the professional workshop process and asked for their comments and further ideas.

All the participants who engaged during Stage 1 received an invite to attend a workshop review event. By offering two workshops, with the capacity to accommodate larger groups, it was possible to involve children and young people who use children's services across North Wales but who may not have initially participate during Stage 1 consultations. One event was held in the East and another in the West. This allowed for the process to be as inclusive as possible include, recognising the need to accommodate travel and support requirements.

33 children and young people attended the events in total:

- 28 Central/East Area

- 5 West Area

All participants had the opportunity to provide feedback through completion of a workbook, or verbally. 24 children and young people did so, with 9 choosing not to.

13.3 Themes from Stage 1

Using 5 key questions from the Young Leaders Workbook, we studied the completed workbooks alongside verbal feedback provided during workshops to establish recurring themes using coded theme analysis. Several themes arise from the children and young people's personal experiences that demonstrate a need for improvement within children's mental health services.

Overall, 91.5% identified situations where they felt that the services they accessed could have been better and offered suggestions on what they would like to see in the future. Of the 8.5% of participants who said that services did not need improving some had not needed to access mental health services. The six most frequently recurring themes are listed in the table below:

Themes	Number sharing theme	%
To have online services that enable users to access support, book appointments, conduct appointments etc	29/82	35.3.%
To have better and quicker access to mental health professionals/services/resources	26/82	31.7%
To have clearer/uncomplicated information of where or who to go to when support is required	25/82	30.4%
To feel supported, valued and listened to	24/82	29.2%
To have shorter waiting lists	24/82	29.2%
To have better communication and consistent relationships with professionals/therapists	22/82	26.8%

*Of 82 children and young people taking part

Table 4: Frequently recurring themes

Analysis of feedback suggests children and young people would like to see:

- A major reduction or preferably elimination of waiting times for mental health services (young people's unhappiness with excessive waiting for mental health appointments was a highly recurring theme)
- Development of simple up to date information on how to get support that is easily accessible, and available online
- Development of digital offers e.g. for online booking, video, and telephone appointments etc.
- Simplified access to services that communicate well with each other

- Professionals who listen, seek to understand, show compassion, and can communicate better with children and young people.
- Help that is person-centred and consistent which then helps young people to build trusting relationships with professionals
- Help that is readily available even at lower-level support and including a wider range of support and therapies such as help with gaming addiction.
- Better support in school including, mental health awareness raising in schools and their communities, teacher and peers that are more knowledgeable about mental health, and more available counselling in schools

13.4 Messages shared with professionals

The following key messages from Stage 1 of children and young persons' engagement programme were shared with participants in the professionals' workshop series and taken account of in the development of the strategy and "To Be" model. The new model should be:

- Based on experiences of children young people and families
- Have a shift in focus to prevention and early help - to prevent mental health difficulties occurring and offer help in the community at an early stage to stop mental health difficulties getting worse
- Be integrated so that children, young people and their families have one simple way of accessing the services they need - this could look like an integrated team of health and social care staff that works together with schools and other community support services
- Be flexible so that children, young people and families can move between services as their needs increase or decrease e.g., without waiting or having their case closed and opened again.
- Be available as locally as possible
- Be accessible - make it as easy as possible for you to get to the service or for the service to reach you

13.5 Children and Young People's response to proposals for the "To Be " model

Overall feedback demonstrates that participants were pleased to see the initiatives and ideas developed in the professional workshops. Of the initiatives presented to children young people and families and based on their experiences, the following three proposed developments received the most positive feedback:

- **A Central Door**: A single entry point to get help and access services
- **A Prevention Door**: Have a shift in focus to prevention and early help - to prevent mental health difficulties occurring and offer help in the community at an early stage to stop mental health difficulties getting worse
- **A Supporting Door:** Be accessible - make it as easy as possible for you to get to the service or for the service to reach you

Details on the limitations of the consultation and engagement process are included in Appendix C.

14 Our voice Our Future!

Children and young people's views about how they would like services to be are summarised in the following "I Statements". These represent the user's vision for good practice.

When I think about my ideal experiences with children's services, I visualise that...

1. I am being listened to and have someone to talk to whenever I require support
2. I am being taken seriously no matter how small other people might think my worries and anxieties are
3. I am able to access the support I need without waiting for a long time
4. I am being treated with respect
5. I am someone who is considered of value with good ideas and advice
6. I am considered to be an important part of a community with a positive role to play
7. I am able to access information easily and can educate myself when I need to
8. I am equipped with good knowledge of to go when I require extra support with my mental health
9. I am being well supported and cared for and have complete trust that children's services will always help me
10. I am able to easily access techniques or therapy online to help myself when needed
11. I am able to use and access transport easily when I have appointments
12. I am given the right treatment at the right time
13. I am able to have regular conversations about mental health with my family, friends and in my school
14. I am not ever left feeling like I am being judged
15. I am able to feel well informed on my choices
16. I am absolutely confident that I receive my therapy and support for as long as I need it
17. I am confident that my 'complicated' needs will be addressed effectively
18. I am in a good, consistent relationship with my therapist
19. I am fully confident that my information will be shared suitably with services so that they can get the right support, diagnosis and referral for me

15 Outcomes Framework

15.1 Introduction

The outcomes within the North Wales "No Wrong Door" strategy are derived from strong consistent themes that emerged from:

- The views expressed by children, young people and their families as expressed during the children and young people's consultation. These are presented as "Our VOICE, Our FUTURE!", a series of "I" statements representing their thoughts about their ideal experiences with children's mental health services and are listed on the previous page.
- Research in to best practice models and associated principles.
- The views of professionals as expressed during the strategy formulation process
- Important guidance frameworks for the development or transformation of mental health services for children, young people and families were used to develop the proposed strategy. In particular, NEST/NYTH (published by NHS Wales in 2021) which integrates best practice research and initiatives including the work of the Children's Commissioner for Wales, aligned with and informed every aspect of the work, from co-production to a children's rights-based focus, to the principles of equity, diversity and inclusion, ease of access, being values led, and more.
- The Matrics Plant guidance (published by Improvement CYMRU 2017). This informs the approach to widening access to therapies and increasing capacity in the system. It underpins the proposed needs-led perspective and corresponding transition from a professional roles orientation to one that is competency based.

We recommend that implementation of the strategy, particularly as it manifests in the different localities across the region, ensures continued alignment with NEST/NYTH and Matrics Plant. Summaries of both these frameworks can be found in Appendix D.

We have reviewed each outcome with stakeholders to identify strengths, opportunities for improvements and gaps in service that need to be addressed within the strategy to deliver the outcomes.

The following table is a summary gap analysis that

- outlines the key strength within each sub-locality that can be built on and shared across the region
- major gaps in service that need to be addressed to deliver outcomes

The gap analysis looks at both the hard elements of service delivery and the soft elements that influence culture as it was recognised by stakeholders early on that building a different kind of culture across North Wales will be essential to success.

GAP ANALYSIS							
	Service Elements						
	HARD ELEMENTS			SOFT ELEMENTS			
Desired Outcomes	**Strategic** Organisations working together effectively	**Operational** Easy access to the right services for the child and family	**Service** Responsive services Timely intervention	**Shared Values** Organisations working together effectively	**Style** Responsive services	**Staff** Responsive services Timely intervention	**Skills** Responsive services Timely intervention
Examples of strengths & good Practice *What do we do well now that we could do more of to deliver desired outcomes ?*	**West** Service Trauma informed service model **Central** - joint funded projects. SSWBA is well embedded **East**- One agreed approach Prevention and Early Help Framework	**West** - Interagency electronic communications **Central** - *Families First* family centred working **East** - *Flying Start.* Innovative range of services & good referral processes	**West** - Increasingly integrated services, **Central** –MDT working of complex cases **East & West** - projects showing evidence of reducing upstream demand	**West –** Staff committed to continuous improvement - Solution focus **Central** - proactive management of resource conflicts **East –** open to sharing	**West** - Bilingual, flexible, person- centered, solution focused services **Central** – value MDT and collaborative approach – good relationships **East -** can do attitude	**West** – good communications **Central** – Resiliant and tenacious staff **East** - good communications and commitment	**West** - Well qualified, well motived staff - Training in trauma informed practice **Central** – Experienced workforce **East** - wide skill set
What do we need to stop doing start doing or do differently to deliver desired outcomes ?	**All – Develop joint planning across health social care and education leading to a whole system approach, one strategic plan, aligned corporate plans and integrated governance framework**	**ALL - develop integrated MDT hubs and transition pathway and shared governance frameworks** **West –** Use technology to improve efficiency **Central -** develop a coherent integrated pathway and resilient agreed operating system **East** - increase joint working in early intervention and pathways for children that don't engage	**ALL – develop fully integrated services, procedures processes and protocols based on outcomes and elimination of waiting lists** **West –** develop flexible services based on need and virtual platforms **Central** - develop outcome focused needs based services with access criteria based on need **East** - flexible locus of delivery & fast track	**All – need for collective reflection on working together, develop shared values and joint management of risk** **West** – develop and improve understanding **Central** – model collaborative working and develop holistic joined up models **East -** develop a consistent approach with education	**ALL – embed staff behaviours that empower children and families and measuring more of what is important to them** **West** – Use more creative thinking **Central** – develop integrated delivery **East** – try new opportunities when gaps are identified	**ALL- develop and integrate workforce plans that deliver enough capacity and develop the capabilities needed** **West** – improve recruitment and build even better communications **Central** - more effective management of complex cases **East** – develop fully staffed workforce of sufficient capacity	**ALL – develop core competencies, review capabilities and develop joint training plans** **West** – create alternative skill sets **Central** - develop better crisis management, develop flexible delivery of joint training **East** – develop a skilled workforce with a broader skill set that is asset based

During the professionals' workshops stakeholders reflected on the gap analysis and were asked to consider what needed to be in done to enable each outcome to be delivered across North Wales. Stakeholders then developed a series of enablers for each outcome which is summarised below in Figure 1. This chapter describes each enabler in detail.

In this section below we provide a framework consisting of the 4 key outcomes that need to be achieved (see figure 3):

- Easy access to the right services for the child and family
- Timely intervention
- Responsive services
- Organisations working together

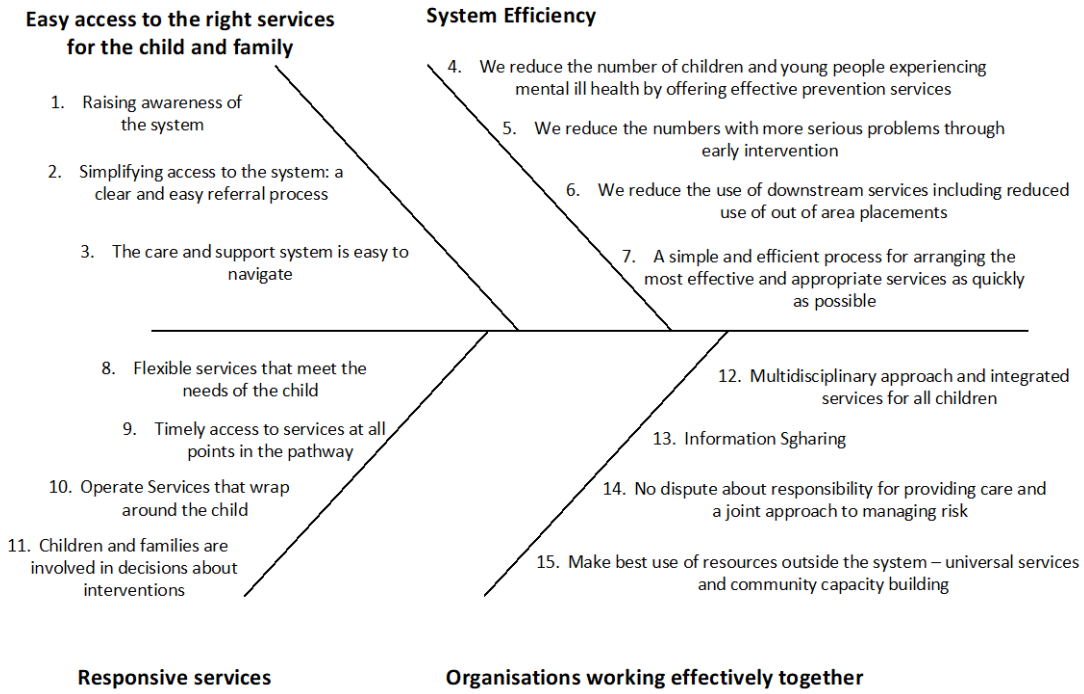


Figure 3: Summary of North Wales "No Wrong Door" Strategic Outcomes and Enablers

15.2 Outcome: easy access to the right services for the child and family

1. **Raise awareness of the system**

Ensuring that members of the public and potential referring agencies are aware of what is available and how to make contact/refer in to the system. This can be achieved by making information available in variety of ways, including online and in places where it is most likely to be useful. The information should be available in a variety of languages so that it is accessible to everyone. It should also be written in plain language so people can understand

the system, the support available and what help is provided to find their way into, and around it.

2. **Simplify access to the system**
Ease of access can be achieved by creating an open access, single access arrangement (SAA). This should be the only route into targeted services where these are required. The SAA may operate through multiple local access points and permit multi-channel referrals, including online. The SAA should be operated by with suitably qualified/well-trained staff using clearly mapped and understood and agreed processes to inform decision making.

There should be sufficient capacity in the system. This should include staff who can make calls, chase information, follow up on people who have been signposted to other resources and contact people who aren't engaging.

3. **Ensure the care support and treatment system is easy to navigate**
Each service should have clear service access criteria with expectation of flexibility. Services' workload and pressures should be monitored and managed to minimise waiting lists. Where necessary a Resource Panel, which is responsible for the operational management within the system, should have the authority to require flexibility in access. In order to assist communication and system navigation the child or young person should be assigned a lead professional/coordinator.

Disputes about responsibility for funding should not be a determining factor in choice of the most appropriate resource. A single point of decision making (the Resource Panel noted above and described in the proposed model) should facilitate the child or young person's journey within mental health services.

Outcome timely intervention

4. **Reduce the number of children and young people experiencing mental ill-health by offering effective prevention services.**

The "No Wrong Door" policy emphasises the importance of understanding and tackling the causes of mental ill-health and the benefits to the whole system of investment in prevention and early intervention.

Factors that have a positive impact on mental wellbeing starting from the mother's pregnancy and early years through to young adulthood are well reported. In recent years early help and preventative interventions have been greatly reduced, and there are limited programmes concerned with the psychological and emotional wellbeing of babies and children and their parents. Further work should be undertaken to develop an early intervention prevention strategy jointly across services. This might include investment in these areas, for example, widening access to targeted Early Years programmes for families with children under 4 years of age, for example:

- Welsh Government's "Flying Start" scheme [48]
- Evidence-based and highly accessible programmes that generate better outcomes for children's cognitive development, relationships and resilience to cope when life gets tough, such as PEEPLE's Antenatal Programme[49] (typically NHS funded) and PEEPLE's 'Supporting parents and children to learn together'
- PARTNERSHIP FOR CHILDREN's Zippy's Friends (an early years programme, typically education funded) 'Good mental health for children – for life'. Both these organisations – PEEPLE's and PFP's also have a comprehensive range of other programmes for children and families[50]
- Domestic violence prevention

5. **Reduce the number of children and young people with more serious mental health problems through early intervention**

Research, referred to elsewhere in this strategy, indicates a strong economic case for investment in prevention, early intervention, and less intensive services, rather than intervening later, when problems have amplified, and resolutions are more difficult. This is a major factor in the case for change

To facilitate improved identification of children and young people it will be important to ensure that, staff and volunteers employed in the wider system are able to recognise causal factors such as adverse Childhood Experiences (ACEs), detect the early signs of developing problems and be able to respond appropriately.

Training for these groups of people is a necessary enabler for this is. It should include awareness raising and mental health first aid. Where staff have already been trained it will be important to ensure that they are able to use the knowledge and skills they have acquired, build effective relationships with staff in the proposed mental health hubs. Improved system access will help to make staff from outside the formal mental health system, including those with training and who may be willing to provide support, more confident in working with children and young people experiencing psychological problems.

The value of these trained staff must be recognised as they are able to make a major contribution to the lives of children and young people and system efficiency and effectiveness. Where necessary their training should be consolidated and built upon.
An important early intervention success factor is the availability of services that can support children and young people with lower levels of need. This may require expansion of the range and volumes of "upstream" (early intervention, prevention, and services to meet lower levels of need) interventions both in universal services and targeted support. We recommend that commissioners examine the outcomes from upstream services and interventions to determine how these can be made more effective and where necessary improved so as to reduce the numbers referred to more intensive, "upstream services."

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[48] hiips://gov.wales/sites/default/files/publications/2019 -07/flying-start-health-programme-guidance_0.pdf

[49] PEEPLE's Anti-natal programmehiips://www.peeple.org.uk/peep -antenatal-programme

[50] Zippy's Friends for 5-7 year olds hiips://www.partnershipforchildren.org.uk/what -we-do/programmes-for-schools/zippys-friends.html

Transitioning from CAMHS to adult mental health services is time of heightened risk but also an opportunity for early intervention and recovery. Therefore, it will be critical that a transition plan for 17-24 year olds is developed in partnership with adult mental health service.

6. Reduce the use of "down-stream" services (intensive and specialist services for individuals with higher levels of need), and reduced use of out of area placements

This outcome is linked to the early intervention and prevention outcome. Professionals emphasised the importance of a local offer of effective upstream services to avoid the need for more specialist placements.

The professionals' workshops also highlighted concerns about the effectiveness and quality of currently available services for children and young people who have the most complex needs and require more intensive interventions. Staff suggested that services should aspire to treatment and resolution of mental health problems, rather than containment.

There is an opportunity to either develop the market to create an effective local offer or to directly provide the required services. This may be helped by a shift to outcome-based commissioning and investment in market development activity.

Older teenagers that don't need to enter the care system but don't want to be living at home are a group whose needs could be met through a down-stream resource: accommodation based independent living with support to meet their mental health and emotional welfare needs

7. **Develop a simple and efficient system process for arranging the most appropriate and effective services as quickly as possible**

The access arrangements should include a proportionate assessment of need to provide an understanding of the needs of the child, that is sufficient to determine what service or services would best meet these.

If signposting to resources outside the system is indicated, staff should have access to good information about what is available and to provide to children and young people to facilitate their access. If onward referral is required for access to an additional resource(s), this should be through a single onward referral mechanism that ensures that neither children and young people nor their families required to repeatedly provide the same information.

Staff involved in responding to enquiries and decision making should have full information about all available services. This calls for good information sharing between services and about community resources.

Access arrangements need effective business support to ensure smooth functioning and systems and to ensure that the scarce professional resources are most efficiently and effectively used.

Outcome: responsive services

8. **Operate Flexible Services that meet the needs of the child**
Services should operate on "best fit" principles with flexible service acceptance criteria and simplified decision making with respect to funding so that children and young people can be matched with a service able to meet their needs. Service access and acceptance criteria should be needs and not diagnosis based (especially in the case of learning disability, which is no longer assessed for, but is the criteria for referral to LD services).

Each child/young person should be supported by, or have access to, a lead professional or case coordinator during the assessment process, intervention planning and during the period of any service delivery. The lead professional case co-ordinator should perform the function of 'system navigator' and, if necessary, with the authority of a resources panel (see below), manage access to any suitable services that would best meet the needs of the child or young person.

9. **Ensure timely access to services at all points in the pathway**
There should be oversight and proactive management of waiting lists. This should monitor system dynamics and formulate and monitor clear performance criteria in respect of timely access to ensure that the system activity focuses on what matters most. There should be protocols in place if a service rejects a referral, declines to provide a service or there is a substantial delay before the service can be provided. There should be arrangements in place for a management panel to have the authority to override service level decision making.

When waits for support do occur, there should be self-help support and advice available for those waiting.

10. **Operate Services that wrap around the child**
The child or young person should have their needs assessed by, and have access to care, support and treatment provided by, the most appropriate professionals for their individual circumstances. Each child, who may benefit from a multi-disciplinary or multi agency approach should have access to assessment, support or intervention from the staff team best able to meet their needs. The "Team Around the Child" (TAC) and "Team around the Family" (TAF) are well-established good practice models, widely used for delivery of a multidisciplinary team working in children's services and could be usefully developed for all children experiencing mental health problems, irrespective of the level of need. They are currently a feature in Welsh Government's "Flying Start" programme. It will be important to use terminology for the approach that avoids any confusion with services that are using a similar practice model described as TAC or TAF.

TAF and TAC models ensure that the child and family members have a voice in their own treatment. The complexity of multi-intervention plans can be daunting for children and young people and their primary point of contact should be through a lead professional/case coordinator as described above. A TAC/TAF model should include an integrated response which involves schools and education services. This will help to prevent the school non-attendance or exclusion and may provide the support necessary to increase the resilience of schools in coping with children who have needs arising from mental health problems.

If problems arise out of hours the child or young person, or their families, or indeed other agencies such as the police, may need advice and guidance on the management of a situation or additional support. This could be provided by a multidisciplinary out of hours crisis response service. Consideration may be given to the inclusion of CAMHS staff in emergency duty team arrangements.

11. **Ensure Children and their families are involved in decisions about interventions**
There should be an agreed operating model for care, support and treatment planning. This should provide clear processes and clarity about decision-making, responsibilities, and who will deliver support, including the role of family members.

The model should also include guidance on shared decision-making. The TAC and TAF models provide mechanisms for children and their families to be involved in decision-making with respect to interventions. There are also other well-established mechanisms/tools for shared decision-making.

System pathways should seek to be child/young person centred with their perspectives fully integrated into all aspects of the mental health and wellbeing system, including service and strategic planning. This will help to achieve cohesion and continuity.

Outcome: organisations working effectively together

12. **Operate a multidisciplinary approach and integrated services for all children**
The multi-disciplinary approach should be delivered through an integrated, child/young person centred, "wider system" model in which the service offered is matched to individual needs of the child/young person. To facilitate this, everyone working within the system, whether in education, the NHS, CAMHS, social services or third sector organisation should seek to see themselves as part of a single system with a common, shared identity. The development of a pooled or blended budget with the intention of eliminating inter-agency disputes about funding responsibility will also help to create the sense of working for a single agency, allowing maximum focus on the best way to meet the needs of the child or young person.

The component parts of the mental health system should not be characterised as being at different levels in a hierarchy but organised so that the support provided is bespoke to individual needs and delivered by suitably competent people across the whole system.

It is essential that schools become more involved in the process as this is where children and young people spend significant periods of time. Schools could play a much larger role in identifying and responding to the mental health and wellbeing of their students. School nurses are an important resource in relation to mental health but what they can currently achieve is constrained by lack of capacity, competing demands on their time and lack of specialist training. In view of their potential to identify and support wellbeing and mental ill-health, we would see expansion of their contribution as strategic priority.

The service offer should be based on needs, not diagnosis. The ethos of the mental health system should be an approach that routinely seeks to understand the context and ecology that has led to the challenges faced by the child or young person and how this is affecting their mental health and wellbeing. If a multi-disciplinary intervention will deliver a better outcome to a child or young person, this should be available at all levels of need and not be restricted to those with higher or more complex needs. The Wales Children's Commissioner has directed Regional Partnership Boards to agree a broad definition of children with complex needs to include all children who experience distress and require help and support from multiple agencies.

However, not all children and young people will require a multi-disciplinary initial assessment. Where it is clear what the most suitable service response should be, and needs can be met by a single service (even if that is itself multi-disciplinary) the lead professional working alone may be sufficient to undertake the necessary functional responsibilities without the involvement of other professions. It is important to avoid over committing resources to those children and young people who needs can be met with lower levels intervention. The initial assessment/triage function should differentiate between simple and complex needs pathways.

As the strategy is implemented there may be scope to consider amalgamating services to ensure the best skill mix to meet the child or young person's needs and to avoid duplication.

Implementation of this strategy should ensure that there is an organisational development programme to support to the development of joint/multi agency working. This should include opportunities for reflective and learning space so professionals can better understand each other services and appreciate the advantages of multi-disciplinary working. A training and development programme should also address the need for a shared language, and ways of facilitating joint working. Co-location and regular multi-disciplinary activities will also help to develop effective collaboration.

13. **Information Sharing**
Multi-disciplinary working will be improved by better information sharing between services, ideally a single record for the child or young person, who should only have to tell their story once.

14. **Have no disputes about responsibility for providing care and a joint approach to managing risk**

These enablers overlap with those associated with multi-disciplinary approaches, integrated services and system navigation.

An essential factor in the "To Be" model should be a commitment to avoid disputes about the funding of individual care and packages and, if these do occur, to resolve these without creating uncertainty and delay. Good practice models point to the value of pooled or blended budgets as a means of achieving this. The size of the budget pool and scale of individual contributions to the pool will require strategic decisions at management board level, with individual care package resourcing decisions delegated to operational managers,

where necessary agreed by multi-agency Resources Panel. Holistic assessment and care and support planning combined with the use of a single decision point in respect of funding care were features of the proposed model that were widely supported by professionals in the workshops.

The multi-agency resources panel should also provide a mechanism for resolution of different professional perspectives, values and opinions. It will be particularly important for partners to jointly agree an approach to the assessment and management of risks.

15. **Making best use of resources outside the system – universal services and community capacity building**

There should also be a commitment to work with communities to build community capacity. This requires staff within the system to know about, and understand, the services that are available, their strengths and limitations. Universal services have an important role to play in helping children and young people to achieve good mental health and wellbeing. They are particularly important in early years and may be more used by hard to engage families and individuals than targeted services.

The findings of the children and young people's consultation draw attention to their preference for services to be available in communities and familiar setting such as schools. This emphasises the importance of universal services. During the professionals' workshops school nurses described how they felt there was an opportunity to play a greater role in prevention and early intervention but were not able to do so because of competing priorities and scarce resources. Other professionals also called for a re-look at the role of health visitors and school nurses to enable preventative mental health work to be prioritised.

It is in the interests of the statutory services to make best use of the value provided by universal services. "Up-stream" investment will ease pressure on both NHS and local authority services and may be considered as delivering benefits to individuals, in terms of their quality of life, to communities and economic advantages for the funding partners. The responsibility for upstream investment should be jointly shared.

This may require investment in raising awareness of mental health matters and in providing training and support to increase the capability of staff within universal services to work with children who may have some additional needs.

16 Proposed “to be” model

The new service model developed to implement the North Wales ‘No Wrong Door” strategy is designed to be flexible and responsive to different levels of need, with each level providing treatment and support tailored to, and proportionate to the child or young person’s need, with a focus on providing early help and preventing problems becoming more severe. This approach, in common with good practice models replaces a model of tiers based on diagnosis and a hierarchy of access criteria.

The new system is for children aged 0 - 25 years and aims to get the right help to the baby, child or young person as quickly as possible. In a complex multi-agency network of services this is best achieved through a managed process characterised by good joint working, information sharing and mature partnerships. The strategy therefore involves a multi-disciplinary service model which operates as if it were a single agency. This demands a change in culture, new systems and processes and funding arrangements. Where necessary there will be flexibility between children’s and adult services.

We recommend that the model is given a distinctive brand identity. This has been done to good effect in other service redevelopment projects. It will mark a new beginning of collaborative working between the partners, make it more attractive to children, young people, and their families and facilitate the change in culture necessary for its success. Ideally Children and Young People will be involved in naming the brand.

The model is designed to respond quickly to mental health problems and find early resolution in the community where the baby, child or young person lives, ideally without the formal involvement of mental health services. Universal services, and especially education, have an important role in nurturing children and young people’s mental health and the early identification and support of those with developing issues. Training and support to these services is therefore essential to reducing the demand for formal mental health services, this should include mental health first aid.

The proposed formal mental health system is designed to respond to 4 different levels of need:

Low Needs - These are experienced by babies, children and young people who have had a wellbeing concern and have made good overall progress using preventative and non-specialist channels. There are no additional, unmet needs or there is/has been a single need identified that can be/has been met by support from educational support services, or a universal service.

Additional Needs – Babies, children and young people in this category have needs that cannot be met by universal services and require additional, co-ordinated multi-agency support and early help. It also includes those whose current needs are unclear.

Complex Needs – Babies, children and young people with an increasing level of unmet needs and those who require more complex support and interventions and coordinated support to prevent concerns escalating.

Acute/Specialist Needs, including Safeguarding - These occur when babies, children and young people have experienced significant harm, or who are at risk of significant harm including those where there are significant welfare concerns. These children have the highest level of need and may require an urgent or very specialist intervention.

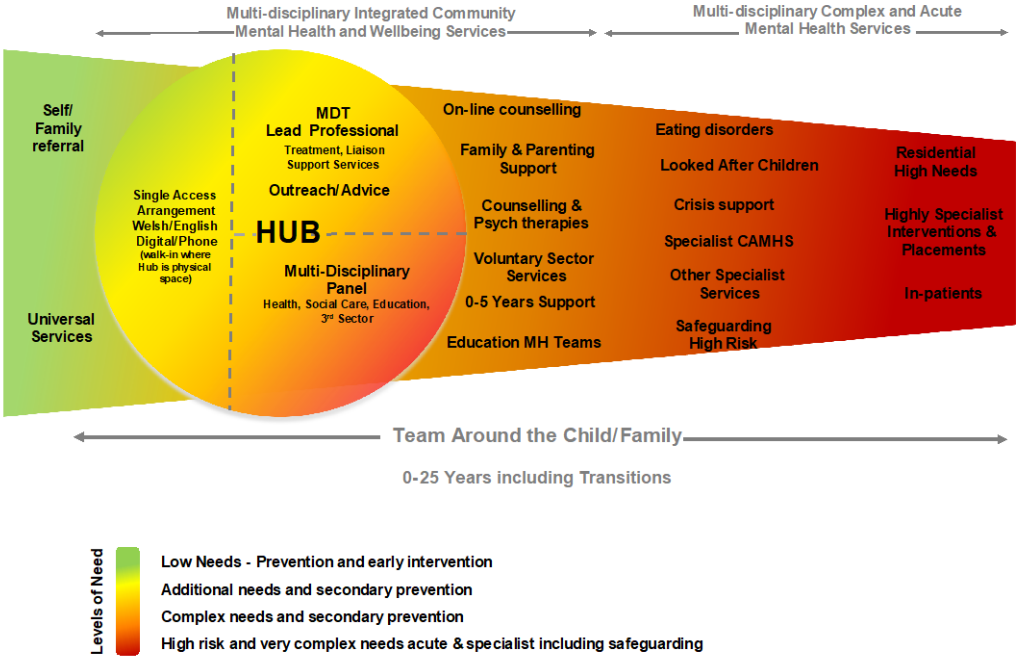


Figure 4 : the Proposed Model

16.1 A Children's Rights Approach in Mental Health Services

Policy and legislation on children in Wales are underpinned by the United Nations Convention on the Rights of the Child 1989 (UNCRC). The Rights of Children and Young Persons (Wales) Measure 2011, the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 all establish duties on public authorities that contribute toward the realisation of children's rights. A Children's Rights Approach is consistent with these duties and must be followed for the North Wales Regional Partnership Board and its constituent organisations to meet their statutory duties.

All children and young people in Wales have the following rights:

- to be treated as individuals

- to be treated equally and not to experience any discrimination against them
- to be respected
- to have privacy
- to be treated with dignity
- to be protected from danger and harm
- to receive support and care that meets their needs, considers their choices and keeps them safe
- to communicate using the communication methods and language of their choice
- to be able to obtain information about themselves.

Effective mental health services are an important aspect of ensuring that all children have an equal opportunity to fulfil their potential. In developing the North Wales "No Wrong Door" strategy we have sought to place children's rights at the heart of service planning and provision. The development process has involved listening to children and paying meaningful attention to their opinions.

16.2 CASE STUDIES

16.2.1 Gareth's Story – the missing middle

From a young age I felt something was different about me and when I started school my mum and teacher noticed I was struggling to learn and got upset about going to school. My GP referred me to the neurodevelopmental team for an assessment and I waited 2 years to be seen. During the wait I was falling behind with schoolwork, feeling more upset and finding it hard to make friends at school. I was eventually told I had borderline autism and due to the diagnosis being borderline I didn't get any help at school I was in. It felt like nobody cared. I struggled through school, struggled to make friends and did not achieve any qualifications. When I was 17 I finally got a diagnosis of autism, but it was too late, I ended up homeless and felt a complete failure. I know I could have done much better because I receive support now but it's too late.

Opportunities for Improvement

- Intervening early
- Outreach, training, advice and building resilience in universal services
- Support in early years based on need not diagnosis
- Continuity of support

The nursery staff have regular mental health training and have access to advice and support from a link worker. My nursery noticed I was struggling to join in, play and make friends so the nursery spoke to the xx-team outreach worker for advice. I was referred to xx team for an assessment and in the meantime the link worker provided advice to the nursey and supported my mum and got to know me. I was visited at home by an occupational therapist from the team within the month. The occupational therapist spoke to me and my mum and watched me at home and in the nursey over the next month. The occupational therapist then worked with me my mum and the nursery to build on my strengths and help manage my sensory needs. The occupational therapist also suggested we look at a particular school that could support me and asked for another member of the team to assess me further. Due to the detailed information about how I functioned, the team diagnosed my autism early, I

had a support package and went to a school that was able to support my needs. As I grew up and needed a bit more help the school nurses linked back with the team when I needed it. I felt more confident at school and made some friends. The team also suggested a youth club where I have learned to cook, and centre has a drop in where I have met other boys similar to me and have met a good friend Ben that way.

I am now 17. I have 5 qualifications and am training to be a chef. Ben goes to the same college so it's fun too. I am hoping to get a flat of my own and a job some day and I know the team will be there again to help me with that if I need it.

16.2.2 Graces story – at risk of becoming a looked after child

I am 14 and live with my mum who has a mental health condition. My dad took drugs and died of an overdose when I was young, he could get very angry with us sometimes. My older brother has now started using cannabis and missing school and can get angry at me and mum which is frightening. I feel pretty sad and hopeless and scared about life right now and have secretly started cutting my arms again to get some relief. My mum's mental health is getting worse, I could be taken away from her any time and the social worker has spoken to us about residential care and there are no suitable foster homes. I have been seen and discharged by CAMHS twice now and spent 6 weeks in hospital 3 years ago. When I need their help, it takes too long to be referred. Last time I saw CAMHS they sent me to counselling and I have not heard anything from CAMHS in 2 years. My support system has fallen apart, there is no one to talk to anymore, I used to have a school counsellor, but she retired, no one has replaced her, the social worker is more focused on what my brother may do next and if my mum is coping with looking after us properly, and I have no idea how to contact CAMHs. I am worried about mum, feel hopeless, am falling behind at school and don't care about much anymore. I am also wondering if there is any point in living. I think my brother takes drugs to cope and some of my brother's friends are offering me drugs and if they help my brother cope they might help me.

Opportunity for improvement

- Intervening early
- Recognising attachment issues and help in early years
- Access to the services that can cope with complexity and servery of needs
- Access to universal services in community to help her develop peer support network
- Provide navigation support in a complex system
- Develop personal resilience to stay safe
- Outreach services giving training advice building resilience in universal services
- Care co-ordination focused on Graces needs
- Continuity of support.

New system

Outreach functions of the hub are helping to increase awareness to identify her needs and to get help and so avoid the escalation – training and awareness raising and building resilience

- Once in hub care coordinator to help system navigation – child centred approach focused on her needs and the co-ordinator works with family social worker
- Refer to family support model like MST which includes intensive support
- New system crisis resolutions home treatment 24/7

- Access to universal services which will help her develop peer support and build resilience
- Access to trauma informed therapy

16.3 Features of the proposed model

16.3.1 Easy Access with a Clear and Easy Referral Process

The entry point for all enquiries for help and advice will be through a single access arrangement (SAA). In this strategy we will use the term Single Access Arrangement rather than the term Single Point of Access (SPA) as the latter term can be misleading as it can imply a single location, whereas the SAA refers to a single system which can operate in one or more places.

The SAA manages entry into the child and adolescent mental health system. Enquiries/referrals can be made by anyone, and all means of referral are acceptable. This includes (but is not limited to) children's and young people themselves or their families, as well as staff from schools, education providers, health and social care organisations, criminal justice agencies; third sector organisations and providers of universal services.

Referrals will require only limited information. Collection of additional information, sufficient to make decisions about the most appropriate response, will be the responsibility of staff operating the Single Access Arrangement (SAA).

Enquiries that require further action, will be assigned to the most appropriate child and adolescent mental health "hub". These are described in more detail below. Hubs act as a source of advice, signposting to universal (non-specialist) services and offer an outreach function. The hubs will also provide some treatment and support interventions and are also a gateway into other targeted services.

The SAA will ensure that there is a single route to get help for a baby, child or young person. Schools and education providers told us how currently, there are multiple and different routes, depending on where a child lives. This should be eliminated in the new SAA where the process will direct the enquiry to the most appropriate hub.

Onward routing will be made using a common data set and agreed protocol, and should aim to avoid children, young people and their families having to tell their stories and provide the same information repeatedly.

16.3.2 Organisations Working Together - "Hub" model

The hubs are multi-agency, multi-disciplinary services which undertake a variety of functions, both reactive and proactive. We recommend that hubs are given a child and young person friendly name as part of a rebranding of the service which presents all child and adolescent mental health services as a single, integrated identity, even if staff remain employed by separate organisations

Children and young people, their families and professionals all identified responsiveness as a necessary requirement. A strategic aim is therefore to create joined up services that are

adaptable to the collective needs of children and young people and their families, delivered in a system that seeks to both simplify children and young people's experience in the pathway and treat them in the ways that is consistent with the aspirations set out in "Our VOICE, Our FUTURE!" Of particular importance is the wish to avoid or minimise moves between agencies and services as these are seen as causing additional stress and uncertainty.

Hubs have an important triage and onward referral role. Currently there are examples of "scattergun" referrals to different which result in children and young people spending time on waiting lists for sometimes inappropriate services. This has the effect of artificially inflating waiting lists, thus distorting demand data and does little to alleviate the child or young person's problems.

The hub's role in initial assessment and triage will be important in avoiding unnecessary labelling of children and young people experiencing emotional distress that is a normal part of life. The hub's outreach function in supporting resilience is also essential to the support of children and young people who experience problems but do not require the specialist support of formal mental health services.

It is very important that staff within hubs are able to make resource allocation decisions that aim to get the child or young person to the most appropriate service as quickly as possible. This requires an effective allocation system with management oversight of system dynamics and performance. In order to reflect capacity issues, there may have to be compromises between speed of access to the intervention and the best intervention. It is however essential to avoid people waiting for services which are clearly inappropriate or insufficient to address needs.

A responsive service is one where the child or young person can receive flexible support, which is tailored to their needs. Interventions should take account of what children and (young people and their families) say they need. This requires those involved in all aspects of their care, support in treatment listening to them, understanding their world, and treating them as experts by experience.

Hubs should incorporate arrangements to fast track some individuals, for example Children who are looked after by the local authority and others who have already been subject to comprehensive assessment processes.

The hub model aims to facilitate joint working and delivery of a seamless service to the child or young person. Its processes will facilitate joint ownership of cases and joint care packages. Co-locating staff (or enabling virtual collaborative working) will help to break down barriers and so shift away from an approach that some professionals reported as 'siloed'. Joint working in the context of a hub model will also assist with developing a shared language to better enable better and effective communication between disciplines and agencies and a shared understanding of processes and roles to promote agencies working for better outcomes.

The operations of the hubs should be informed by the NEST and Welsh language equivalent NYTH Framework. This is a tool for planning mental health, wellbeing and support services for babies, children, young people, parents, carers and their wider families across Wales. It was developed in response to a need to improve mental health support and to make sure early help and the right help was available at the right time. NEST identifies good practice in relation to making expert help and advice more available. Possible ways of achieving this include helplines, information provision, regular visits from a specialist to a school or youth service, and multi-agency teams with mental health professionals embedded in them.

The essential aim is that the grown-ups in children's lives know where to go for help and can get it quickly if they need it. This makes them more likely to feel confident to work through difficulties with young people, instead of feeling out of their depth and passing them on to someone else for help. This is termed 'holding on' instead of 'referring on' and the aim is to stop families being passed from service to service, and telling their story lots of times, and never quite feeling that they are in the 'right' place. Of course, sometimes specialists are needed to take a bigger role, but always with the aim of supporting those closest to children and young people first. This recognises that 'everyday magic' can be very powerful therapeutically.

The number, location and staffing of hubs will be determined during the implementation phase. Staff may work in one or more hubs, where this is in the interests of efficiency and effectiveness.

16.3.3 Hub models as physical entities or virtual spaces

A hub represents a multi-agency, multi-disciplinary team working together. This does not necessarily require staff to be co-located in a single physical space, provided effective joint working is facilitated. There are however many advantages for a hub to be child and family friendly environment located in a suitable physical space. This may be a fixed or mobile base, or a venue that is used periodically, for example in a community centre or library. Accessibility and collaborative working is however very important. The hub models could be adapted to use ICT to creating virtual working environments, which could be combined with a network of geographically dispersed locations. Some hub functions could take place in schools.

16.4 Functions undertaken by child and adolescent mental health "hubs"

Reactive functions may include:

- Reception of referrals
- Signposting to universal services and community resources
- Prioritisation (triage)
- Processing of referrals
- Proportionate assessment of need
- Provision of interventions

Proactive (outreach) functions may include:

- Provision of advice to referrers
- Provision of general advice and information about mental health and well-being

- Providing awareness raising and training to relevant groups/individuals, which might include mental health first aid
- Working with agencies to identify CYP with, or at risk of developing mental health problems. This is essential to targeting individuals who may benefit from early intervention or prevention strategies,
- Where people have been signposted, checking if the issues which lead to contact have been resolved and whether additional support or intervention may be required.
- Developing and maintaining a directory of community resources

During the strategic planning process professionals noted the difficulty of engaging with some children/families. This may be helped by offering services that are delivered in a way, time and place that meets their preferences. The cost of inflexibility might be less engagement, poorer outcomes and quality of life and associated costs throughout the person's life.

16.4.1 Areas for further development during the implementation phase

Further work needs to be undertaken to develop the hubs. The main priorities include development of :

- Local operating frameworks
- Recording and information sharing protocols
- Agreement of staffing and other resources

This is likely to address how different levels of complexity of need will be most efficiently managed once an enquiry has been received, initially assessed and prioritised.

16.4.2 Early Intervention and Prevention

Prevention and early intervention are key objectives of this strategy, helping to reduce avoidable escalation of problems as well as contributing to reducing the levels of psychological distress in the population. The integrated and co-ordinated service hub model should undertake proactive outreach work in addition to the reactive functions of access and direct service delivery. The outreach functions should assist with identification of at-risk individuals and include provision of training and information with the aim of broadening awareness of mental health matters and especially the importance of timely action. Outreach work with schools can help to build their resilience and support functions.

16.4.3 Hub Models and Case Co-ordination

Case co-ordination should be an essential feature of the operating framework for the hub model.

The need for individuals to be supported to navigate the care and support pathway is a key feature in best practice models. Both children's and young people and professionals indicated that this should be an essential requirement for the future model. Assignment of a designated and named lead professional to co-ordinate case work is a well-established means of providing the necessary support to the individual and their family. The co-ordinator, who may be any of the professionals involved with the child, can have a responsibility to:

- Develop the relationship with the child or young person
- Act as a point of contact for the child or young person and their family and other involved agencies
- Where there are other professionals/agencies involved co-ordinate or broker the involvement of other professionals involved in the assessment of needs and/or the provision of care, treatment, and support (the team around the child/family)
- Manage and review the child's assessment and plan
- Support other professionals to identify actions they can undertake and communicate appropriately with all parties, including the family.
- Record the desired outcomes for a child and communicate this to all parties involved
- Refer directly to any services/interventions and liaise as necessary
- Be responsible for ensuring that plans are sufficiently resourced to deliver timely and effective interventions that will achieve desired outcomes, where necessary by involvement of the Resources Panel
- Monitor progress and check if outcomes are being met through a suitable and effective review process

16.4.4 Practice Model

A useful model for ensuring that the child or young person has appropriate support from the people with the best knowledge and skills is that of the "team around the child/family". This is a network of practitioners working together to agree a plan and deliver of support to meet a child or young person's assessed needs, and the needs of the family where these impact on the child or young person. They work directly with the family or young person. It is essential that parents are supported in managing their children's mental health and wellbeing. A strengths-based, relationship focused approach using collaborative conversations and working holistically with families based on the key principles of the SSWBA should be seen as essential to this strategy. Where the child or young person's parents are themselves experiencing mental ill-health or alcohol or substance misuse, adult services should prioritise their action based on the needs of the family system.

The team around the child/family is linked together by a lead professional who co-ordinates the delivery and review of the plan. The child, family and young person's participation in their plan underpins this model and they should be central in all considerations, including deciding the level of involvement they feel appropriate.

The concept has been developed in relation to the implementation of integrated processes in services for children. It encourages principles, behaviours and practices which put the needs of the child or young person at the centre. It can be helpful to consider two levels of involvement: core team roles, for those with greatest involvement with the child or young person and extended team roles – those who contribute but are less central to the delivery of the outcomes. See figure 2 below

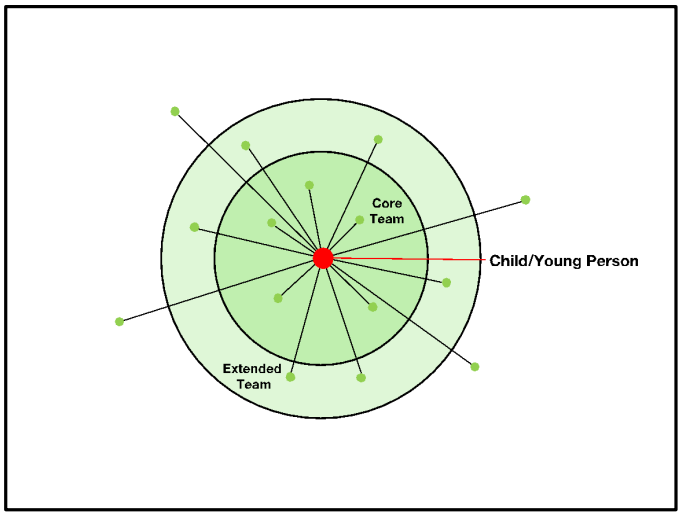


Figure 5 : Team around the child/family

16.4.5 Practice Methods

Strengths-based practice, which build on people's abilities, personal assets, and community resources, without ignoring difficulties, is an approach that will help to deliver the outcomes of this strategy. During the professionals' workshops reference was made to this practice method, whose features are also aligned to the views of children and young people, as expressed during the engagement process. Strength-based working is relationship-based and since it seeks to use people's support networks – personal resources, family and friends networks and community assets as an alternative to, or in association with targeted services. This is consistent with this strategy's aims for early intervention and prevention and making greater use of "up-stream' resources.

Families First takes a strengths-based approach where families are supported to recognise what is working well in their situations to support empowerment and ownership of their growth and development. These earlier interventions are designed to prevent families from needing expensive remedial care through statutory services in the future. We note that health services provision is not eligible for Families First funding but in a pooled/aligned budget this should not be relevant.

16.5 Areas for further development during the implementation phase

16.5.1 Role of the Resources Panel

The function of the resources panel is to plan and manage the use of resources in the system. It will also support case co-ordinators by acting as an authoritative broker to ensure timely access to pathway services and resources, where necessary by directing internal services to undertake service provision or to approve externally commissioned services.

Professionals clearly identified long waiting time for children and young people to access the pathway, and/or to be treated by some targeted services. This was also noted as a problem by children and young people during the engagement process. Notably, children

and young people talked of the sense of hopelessness that can be engendered by long or indeterminate waits. Professionals saw delays as being a significant factor in system dynamics, contributing to stress and (avoidable) amplification of mental ill health.

Clearly the level of resources within the system will be a major factor resulting in unacceptable waiting times, however it is not the only factor and management oversight and intervention by the Resource Panel may help to mitigate waits and avoid bottlenecks. The Resources Panel should therefore have the authority to require flexibility of services within the pathway in order to optimise the service to the child or young person however only a proportion of cases will require action by the resources panel to secure a particular intervention. There should be a protocol for referral and service access with delegated responsibility wherever possible.

The primary functions of the Resources Panel are to:

- Implement and interpret the policies set out by the joint management board
- Allocate service provision, where direct access is not indicated/possible
- Oversee expenditure and performance against the pooled or aligned budget
- Monitor and waiting lists/times
- Monitor outcomes for children and young people.
- Monitoring the quality and standards of care
- Identify gaps in provision or underutilised resources and the changes in provision required to reflect individual needs

16.5.2 Areas for further development during the implementation phase

Agree membership of the Resource Panel
Develop Terms of Reference
Agree Scheme of Delegation

16.6 Services in the Pathway

16.6.1 Universal services

Aim – promote mental wellbeing and recognise when a child or young person may have developmental or mental health problems

- early years services
- voluntary sector
- local authority children's services
- all primary care agencies including general medical practice
- midwifery,
- school nursing,
- health visiting
- schools

16.6.2 Targeted Services

Aim – support children and young People with less severe mental health problems (these are services where there is usually a single practitioner involved in supporting the child, young person or family. Staff may work with the child or young person directly, or indirectly by supporting practitioners working in universal services) .

- youth offending teams
- local authority children's services
- 'managed care network' of voluntary sector targeted services
- primary care mental health services,
- school and youth counselling.

16.6.3 Specialist Community Services

Aim – support children and young people with more severe mental health problems requiring specialist intervention and or a multidisciplinary approach (practitioners may also provide outreach training advice and support to universal and targeted services). System capacity could be improved by extending the numbers of practitioners with the necessary competencies to deliver psychological interventions, in line with the recommendations of Matrics Plant.

- multi-disciplinary teams of practitioners providing a range of interventions to children, young people and families, including teams with specific remits

16.6.4 Highly specialist services

Aim – support children and young people at the greatest risk and those with specialist needs e.g. gender dysphoria These are generally services for a small number of children and young people who are deemed to be at greatest risk of rapidly declining mental health, or from serious self-harm who need a period of intensive input and are often provided on a regional or supra- regional footprint.

- very specialised outpatient services.
- crisis resolution home treatment as an alternative to admission
- inpatient services
- specialist inpatient e.g. intensive care or medium secure

17 Whole System Working and Governance

The North Wales Regional Partnership Board "No Wrong Door" strategy aims to ensure that children and young people have access to services that seamlessly meets their needs. This requires effective joint working between professionals, teams and organisations in a managed health, care and support system that is responsive to children's needs. The "To Be" proposal is therefore designed as an integrated service model. This does not require creation of a new organisation as staff can continue to be employed individual partner organisations, as now. It does however require a commitment to an integrated approach, managed through an agreed common operating framework. System governance should ensure compliance with the operating framework.

There should be tight adherence to agreed principles and operating model across all areas of North Wales. Detailed implementation of these should reflect local circumstances and there can be flexibility (loose) of local arrangements. The development of local arrangements should be made ensuring that there is co-production in service design. There should be tight accountability for performance through the governance arrangements. We refer to this as a Tight – Loose - Tight approach.

The service must be cost effective. Demand for services currently exceeds system capacity and in increasing. Although there is some recent additional investment, it is essential that the partner organisations agree a strategic approach to system design and governance which makes the best use of available resources.

It is a legal requirement that children's rights must considered at all levels of decision. Governance must therefore facilitate a coordinated Children's Rights Approach across the mental child and adolescent health system involving all partner agencies and externally commissioned organisations. Partners should be accountable to children for decisions and actions that affect their lives. Governance must aim to realise children's individual abilities, so they can better benefit from their rights and engage with, influence and hold to account the individuals and organisations that affect their lives.

In order to ensure effective governance we recommend that partners commit to an explicit partnership agreement that includes the principles and common operating model and governance structures.
We propose a governance model consisting of three inter-connected levels of activity.

The **Services Level** is responsible for service delivery. In the proposed "To Be" model this consists of two elements: the mental health hubs and all provider services (both directly managed and commissioned services). Each profession will operate its own clinical governance; however the operating frameworks will need to include arrangements for resolution of different professional opinions and prioritisation decisions.

The **Operations Level** is responsible for management and performance of the health, care and support system. The responsibility is discharged through the roles of line managers for the services that they oversee, and jointly through membership of a Resource Panel.

The Resources Panel will have oversight of waiting lists and onward referrals for interventions, and to seek to address capacity issues. It will be responsible for ensuring that children and young people are able to enjoy timely access to suitable services from practitioners who possess the necessary competencies.

The **Strategic Level** is responsible for setting strategy and policy, holding the operations level to account for performance and resource use and itself being accountable to The North Wales Regional Partnership Board and the Boards of each partner organisation.

18 Implementation

18.1 INTRODUCTION

This is a radical and complex strategy that will require a substantial and well-resourced implementation programme to address the necessary culture change, development of an aligned/blended budget, structural changes, infrastructure requirements and development of the operating frameworks. Despite differences between the partner organisations, there are shared values and objectives, which will be essential in creating a new and cohesive service delivery arrangements.

The recommended 'Tight – Loose - Tight' approach allows for local solutions to realisation of the strategies ambition and its principles. Some of the implementation programme will require a regional approach, as the change requirements will be common across all areas, whereas some will require local development of those aspects of the strategy that are 'loose. The strategy assumes that there will be local implementation arrangements that allow for the full engagement of local staff and local people in designing and creating a means of implementing the principles and model in ways that reflects what is there already and in development.

The full strategy document outlines a five-year implementation plan, with the main changes taking place in years 1 -3. It will require organisational commitment and commitment of resources by all partners, overseen by the RPB and Children's sub-committee, strong programme management and external specialist support to the transformation process. It proposes an overarching regional approach, supported by local implementation groups, which would include some staff seconded from operational roles to undertake the necessary development work. These released operational staff will require temporary replacement. Implementation should align with, and contribute to parallel change process, for example the Betsi Cadwaladr University Health Board Mental Health Maturity Matrix.

Implementation of the North Wales "No Wrong Door" Strategy will represent a major service transformation. Success will depend on a managed change process supported by a project management office (PMO) and almost certainly an external partner to work with local staff.

The main parts of the new system steps are illustrated in Figure 6 below and the implementation plan can be found in section 18.2. Major risks and mitigating actions are shown in section 18.3.

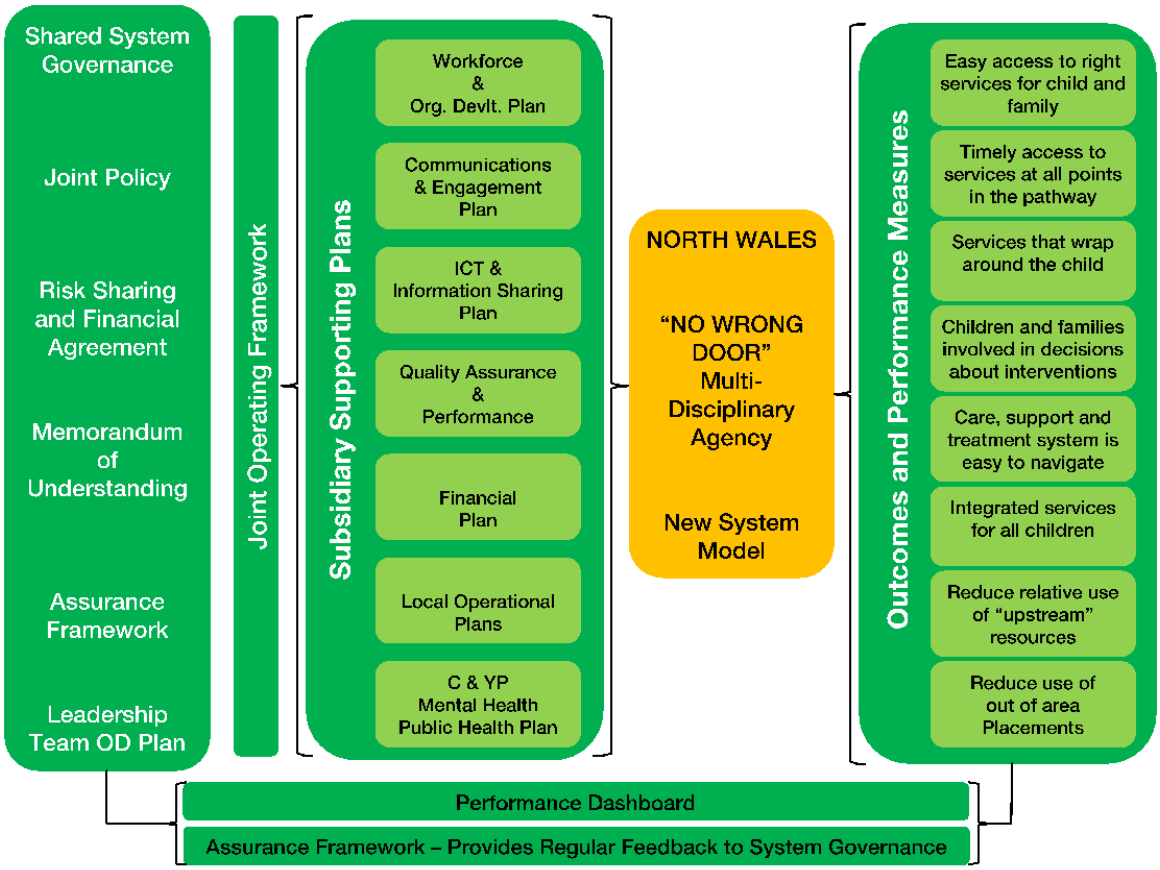


Figure 6 : New System Overview

18.2 Implementation Plan

YEAR	ACTION	DUE DATE	KEY PERFORMANCE INDICATORS	LEADS
PRE-LAUNCH PHASE				
10/21 – 03/22	High level sign-off of strategy	12/21	All partner organisations sign off Strategy agreed by RPB	All Partners
	Formulate the Partnership agreement including principles and model. This should reference Tight – Loose - Tight approach	03/22	Signed Partnership Agreement	All Partners
	Formulate Transformation Plan	01/22	Complete Plan	Regional Team
	Each partner to Identify Board level and political sponsors	01/22	Sponsors agreed and fully briefed	All Partners
	Engage clinical and practice leads	01/22	Clinical and practice leads fully briefed and engaged	All Partners
	Initial Communications Plan	01/22	Communications Plan	All partners Comms teams
	Agree and recruit external transformation partner	01/22	Agreement to procure external partner	RPB
	Partner organisations allocate financial and human resources to support transformation	03/22	Transformation budget contributions agreed by partners	All Partners
			RPB agrees transformation budget	RPB
	Set up PMO agreed (mix of seconded staff and specialist project management)	03/22	PMO structure and resources agreed	RPB
	New Service Branding	03/22	New brand agreed and launched	RPB
	Develop ToRs for JMB	03/22	Agreed ToRs signed off by partners and RPB	RPB
	Structure and membership for Joint Management Board(including OD)	03/22	Structure and membership of JMB agreed	All Partners RPB
	Appoint transformation partner	03/22	Transformation partner recruited	RPB
SHORT TERM (YEAR 1 - 2022)				
2022-2023	Recruit PMO	04/22	Project Management Office staffed and operational	RPB and JMB
	Joint Management Board starts to work	04/22	Fully attended meeting of JMB	JMB

	Identify and work towards alignment of all strategies and plans with NWD strategy	08/22	Strategies and plans are aligned	JMB
	SAA options appraisal	05/22	Agreed option for SAA	PMO
	Hub options appraisal	05/22	Agreed option for hub	PMO
	Leadership team OD plan	05/22	Agreed and funded plan	JMB
	Establish financial and performance reporting	06/22	Reporting framework and dashboard agreed	JMB PMO Finance Leads Performance Leads
	Assurance Framework	06/22	Assurance Framework signed off	JMB
	Updated Communication and Engagement Plan	07/22	Communication and Engagement Plan signed off	JMB All partners Comms teams
	Financial Plan, including review of short-term funding and need for double running costs during the strategy implementation	11/22	Financial Plan signed off	JMB Finance Leads
	Risk sharing and financial Agreement	12/22	Risk sharing and financial Agreement signed off	RPB JMB Finance Leads Clinical and practice leads
	Joint Operating Framework (Including clinical governance)	09/22	Agreed and signed off joint operating framework	JMB
	Operating model footprints and phasing	10/22	Operating model footprints and phasing signed off	JMB Clinical and practice leads
	Memorandum of Understanding & Joint Policy	12/22	Agreed Memorandum of Understanding & Joint Policy signed off	JMB Clinical and practice leads
	Workforce plan	12/22	Local operational plans agreed and signed off	JMB Workforce leads

				Clinical and practice leads
	Local operational plans	02/23	Local operational plans agreed and signed off	JMB NHS and LA service heads
	IT and information sharing protocol	12/22	IT and information sharing protocol agreed and signed off	JMB IT leads Clinical and practice leads
	Community resource information database	03/23	Information is a suitable form is available to staff in hubs	
	Prevention Strategy	03/23	Prevention Strategy agreed and signed off	Public Health Commissioners
	Refresh strategy and review PMO requirements	03/23	Revised strategy	JMB
	Develop a culture change plan and cultural audit	06/22	Completed plan and Audit	PMO JMB OD leads Clinical and practice leads
	Deliver culture change plan with implementation of pilot projects and new operating frameworks	12/23	Delivery of plan and follow up audits	PMO JMB OD leads Clinical and practice leads
MEDIUM TERM (YEARS 2/3 2023 – 2025)				
2023-2024	Launch / phasing of hubs begins	04/23	At least 1 hub operational	JBM and all partners
	Testing and revising model complete	12/23	Evaluation report	JMB PMO
	Performance finance and quality reporting system operational	04/23	Regular effective reporting to governance functions	Finance and performance leads
	Refresh strategy and review PMO requirements	03/24	Revised strategy	JMB
2024-2025	Hubs fully operational	04/24	All hubs up and running	JBM and all partners
	Design audit/service review	12/24	Audit/service review tool agreed	JMB
LONG TERM (YEARS 4/5 2026 -2027)				

2025-2026	Complete audit/service review and make recommendations	Tbc	Audit/service review completed	JMB
2026-2027	Implement changes	Tbc	New ways of work are routine and fully operational	All partners

19 Major Risks

No.	Description of Risk	RAG Likelihood X Consequence	ACTION	Leads
1	Lack of workforce to deliver the strategy short term and long lead in times to train a new workforce	4x5=20 high	Prioritise development of a workforce & OD plan	Workforce Leads
2	Partners can't agree funding allocation to a joint budget Competing priorities across health and social care are prioritised for resources and investment resulting in insufficient investment	4x4=16 high	Identify political and board level sponsors early on Calculate current levels of expenditure by all agencies Develop a benefits case for pooled budget	RPB Finance Leads Finance Leads
3	Authority to act is stymied by lack of whole system governance resulting in slow, limited and fragmented change Failure to agree a joint operating framework	4x4= 16 high	Identify political and board level sponsors early on Engage clinical and practitioner leads early on OD support to leadership team to help drive development and maintenance of whole system governance	RPB JMB & PMO JMB & PMO
4	Cultural change required to implement new ways of working is lacking resulting in change initiatives losing momentum.	4x4=16 high	OD support to leadership team to help drive development and maintenance of whole system governance Workforce & OD plan	JMB & PMO Workforce Leads
5	Lack in investment in transformation (funding and or human resources)	3x5= 15 high	Develop joint financial plan (transforming funds, pump priming, ROI) Identify opportunities for secondment and backfill	RPB & Finance Leads JMB

6	Partner Agencies can't agree the Strategy	3x5 =15 high	Identify political and board level sponsors early on Consultation plan identifies approaches for all key partners in positions of influence / power to support the strategy	RPB RPB
7	Lack of finance and performance data sufficient to plan and manage the service	3x5=15 high	Establish routine data collection and monitoring and develop dashboard	Finance Leads Performance Leads JMB PMO
8	Fear of failure to deliver the strategy -the larger the ambition the greater damage to reputations caused by failure	3x4=12 moderate	Identify political and board level sponsors early on OD support to leadership team to help drive development and maintenance of whole system governance Workforce & OD plan Develop assurance framework	RPB JMB &PMO PMO
9	Prevalence of mental health needs in the population continues to rise faster than can be managed diverting resources to crisis and short-term management	3x4=12 moderate	Model scenarios as part of implementation plan and develop contingency plans Develop finance and performance monitoring frameworks	Finance and Performance Leads Finance and Performance Leads
10	Ineffective sharing of information results in siloed working	3x4=12 moderate	Develop information sharing protocols Develop IT Plan	Clinical / Practitioner Leads

20 Appendix A: Reviewed Service Models

Method

A search of the published academic literature produced limited information on whole system approaches and single point of access (SPA) models relating to CYP mental health and wellbeing. Internet searches were then used to locate publicly available policy documents, evaluation reports and websites (grey literature) to build a picture of a range of models, pathways and approaches that could be used to inform strategy development in North Wales. Recommendations and intelligence from the North Wales regional partners were also reviewed.

A number of useful examples from the UK and internationally were identified and reviewed, providing insights into the solutions developed by a range of different health and social care authorities and partnerships. Priority was given to models that had been recently evaluated with good evidence of success. Two examples with no evaluation were included; Gwent Space-Wellbeing as it is highly relevant to the context of North Wales it was the only regional model with available documentation, and Hertfordshire adapted iThrive model as it proposed other innovations that could inform strategy.

Scope

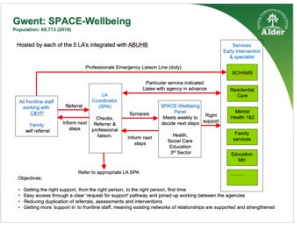
Integrated CYP mental health and wellbeing models of service delivery searches were conducted in:

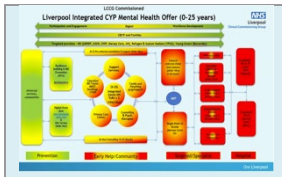
- Published literature
- Grey literature
- Seeking Welsh, UK and international examples
- Focus on age group: 0-18/25

Models Presented

Five of the models reviewed were presented at the Stakeholder Workshop 2.1. These were selected to illustrate a range of different approaches and principles. The models were:

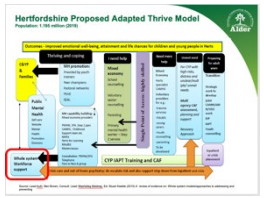
- Gwent: SPACE-Wellbeing
- Liverpool: Integrated Mental Health
- Hertfordshire: Proposed Adapted Thrive Model
- Trieste, Italy: Whole life, whole system
- Australia: Headspace – National Mental Health Foundation

Model	Attributes	Evaluation/ Review	Key Findings /Comments
Space- Wellbeing: Gwent **Region** **Population 69,713 (2018)** hiips://www.childcomwales.org.uk/faqs/case -study-gwent-space-wellbeing/ hiips://abuhb .nhs.wales/healthcare-services/community-services/mental-health/child-and-adolescent-mental-health-camhs/information-for-parents-and-carers/  Sketch model produced from documentation by author JvH	- Age 0-25 years (assumed) - Early intervention & specialist help - Access via referral from all frontline staff with C &YP, family self-referral - LA co-ordinator checks and provides synopsis to the MD assessment panel for consideration. - Multi-disciplinary assessment panel – LA, UHB, Ed, 3rd sector (review with panel members (2020) suggests inclusion of Education needs to be strengthened) - Panel reports back to LA co-ordinator who communicates outcomes to CYP and/or family. - Common protocol and processes across 5 LA's integrated with ABUHB - Common process language	Draft Initial Evaluation – Views of Panel Members (Not in the public domain)	Key findings from Draft Initial Evaluation – the Views of Panel Members (2020) - Best things about SPACE Wellbeing (theme analysis in order of strength 1= strongest): 1) Multiagency collaboration, 2)learning about other services, 3)productive professional discussions, 4)right service right time, 5)networking, 6)structure of meeting and organisation, 7)referrals being accepted easily and willingly - Areas for improvement (as above): 1) Strengthened links with Education, 2)more detailed and accurate referrals, 3) process improvements, 4)better understanding of other services/agencies, 5)filter unsuitable or 'bounce back' referrals out, 6) time management, 7) more pre-allocation and possible allocations, 8) more contextual discussion Notes: - Draft Initial Evaluation not in the public domain. - No common assessment framework (as far as known) - No, or very minimal joint funding (each LA host its own process) - Minimal integration - C&YPF not directly involved in treatment decisions. - Dependent on the skill of the LA coordinator in investigating and summarising case details and relaying information (evaluation suggests improvement is needed here)
Integrated CAMHS Offer (IAG): **Liverpool** **City** **Population: 496,784 (2019)** hiips://www.liverpoolccg.nhs.uk/media/2490/38266-description-of-liverpool-camhs-offer.pdf	- Age 0-25 yrs Asset-based approach - Stepped model of care that can be accessed at any stage dependent on their needs - Services delivered by voluntary and statutory sector - Access via SPA run by Alderhay – telephone consultation, triage to ensure most appropriate support for needs, assessment, passport of accepted referrals to the most appropriate CAMHS Provider/Clinician for intervention - **Access** via Universal Services (GP school Health visitor, youth worker etc.)	Review 2019: hiips://www.liverpoolcamhs.com/wp -content/uploads/2019/01/Liverpool-CYP-MHEWB-Transformation-Plan-2018-19-refresh.pdf	Key Evaluation findings - Increase in confidence to support children and young people's mental health - 98% identified their lives had improved after receiving the IAG service. - 76% improved mental health and wellbeing. - 2% stepped up to specialist CAMHS. - 79% said things in school had improved. - 90% have an improved wellbeing. - 97% said they were happy or very happy with the service.

	- **Access** – 3 Open Access Hubs across the city – offers services to CYP & Fam 1) Drop in, Information & guidance (incl ASC and ADHD), CYP group MH support, parent/carers MH support groups, therapeutic support & interventions, Youth-based mental health support , GP Drop-in, Specific support for LGBTQ - **Access** via 1) education (every school has dedicated time for a CAMHS practitioner to offer support to staff, CYP and fam., 2) CAMHS practitioner in every GP practice, 3) Children's Centres – dedicated time with CAMHS practitioner - Training and awareness, consultation, support given to professionals working in universal services – ensure know how to get additional support if needed - Digital support offer - Open access online booking		- Reduction in A&E presentations (Self-reported – CYP would have attended A and E if not for YPAS). - Self-reported decrease in rate of self-harm and suicidal ideation with 16% of - CYP reporting that they would not be alive without the service following access to LGBTQ+ provision. - Prevented 23 attendances at A&E across Alder Hey and Southport and Ormskirk hospitals. - Saved 41 bed days in Liverpool. -
Take 5 Mental Health and Wellbeing Hub: Oldham, Manchester **City** **Population: 233,759 (2017)** **hiips://www.togmind.org/youth -in-mind/take-5**	- Age 8-18yrs – youth focussed - Integrated Community Health Hub - Holistic non-clinical approach - Early and brief intervention – referral to other services - Open access community-based physical space - **Access** via parent/carer/guardian, self-referral, Early Help, CAMHS, Adult services 16+, YJ, Paediatricians, Primary Care, Youth Centres, Schools, referrals from other services…..etc. - 6 pathways: Low Mood, Anger, Anxiety, Stress, Self-esteem, Bereavement. - Drop-ins, guided self-help, focus on strategy building, 20 min 1 to 1's over 5 weeks. - Therapeutic Groups, Counselling, Art Therapy, Arts for Wellbeing, Digital Friendship, Integrative tailored care. - On-line offer	Evaluation 2021: hiips://e -space.mmu.ac.uk/627735/	Key Evaluation findings relating to the implementation of the hub: - reduction in reported levels of CYP psychological distress - improved family function - Waiting times for access to services more than halved Note: 11 members of staff, supporting approx. 600 children and young people, 100 parents/carers also supported through family support and brief interventions
Forward Thinking: Birmingham (FTB) **City** **Population: 1.149 million (2019)** **hiips://www.forwardthinkingbirmingham.org.uk/**	- Age 0-25yrs - On-line and phone SPA 24/7 - Access (all levels of need) via self -referral, friend/family, professional - Seamless pathway	Evaluation 2017: hiip://wrap.warwick.ac.uk/100545/	Key evaluation findings: - Strong support for the model in particular the integration of CYP & Adult MH services in the hubs - FTB model improving access to MH services for all ages.

hiips://www.priorygroup.com/blog/forward-thinking-birmingham-a-new-mental-health-partnership	- Community hubs for assessment and therapy – by appointment. - Hubs integrated with adult mental health services. - Digital: NHS approved mobile apps - Support for: ASD assessments, early intervention psychosis, eating disorders, LD, on-line therapies, talking therapies etc. - Partnership: Birmingham Children's Hospital, Worcestershire Health and Care NHS Trust, Priory Group, Beacon UK and The Children's Society. - One-care-plan-patient management system.		- Concerns about staffing - Questions about capacity to meet demand - Inadequate and incompatible data mgmt. systems - Poor service infrastructure (availability of space & equipment, age appropriate environments)
Headspace: Australia **National** hiips://onlinelibrary.wiley.com/doi/full/10.1111/eip.12740 	- Age 12-25 yrs. – life-stage of high vulnerability yet marked reluctance to seek help (Arnett 2013, Slade et al, 2009) - no one turned away on the basis of severity no wrong door policy - Australia's national youth mental health foundation (established 2006) – federal government funded through Department of Health – Physical Centres in towns and cities over 120 now across the country - Easy access youth-friendly multi-disciplinary primary care service that builds on the capacity of local services to provide early intervention approach - Designed specially with/for Young people (grey circle & central figure – 1)Centre specific Youth Reference Groups input to service development (design, delivery, implementation 2) Governance process. - Young people participate in their own care at all points in the care pathway – involved in decisions (orientation, policies & procedures) - Family and friends involvement (in discussion with the YP) – encourage involvement. Service devt Family and Friends reference group, governance - Staff engage in community awareness work + national - Youth participation core component – treatment plan, own care, service development at each centre informed by youth panel	Evaluation 2016: hiips://headspace.org.au/assets/Uploads/Evaluation-of-headspace-program.pdf headspace	Key evaluation findings: - **s**ervices reduce suicidal ideation and self-harm - accessible to a diverse group of young people with high levels of psychological distress - attracts young people from marginalised and at-risk groups, and people traditionally disadvantaged in their access to health care including Indigenous young people, young people living in regional areas and those identifying as LGBTI - young people using **headspace** services had better outcomes than young people receiving other treatment or no treatment - generally speaking the more services young people accessed, the better the outcome (i.e. people accessing 7+ sessions improved more than those attending once or twice) - young people receiving **headspace** support took fewer days off work and study due to mental health issues so there were significant social and economic outcomes - clients were overwhelmingly positive about **headspace** and generally satisfied with the services they received

	- Regular centre evaluation through standardized service user satisfaction survey – dashboard – identify service gaps - Recent strengthening by integration with specialised services - Culturally and developmentally appropriate care – priority group recognition cultural groups LGBTQ etc. - On site integration (co-location of services) and off site. - Strong links with local service providers - Supported transitions - Lead Agency independent organisations set up and run the centres responsible for delivery - Consortia – local service providers that collaborate to provide strategic direction. - Multi-disciplinary teams – psych, social workers, youth workers, nurses GP's		
Whole life whole system: Trieste Italy **City** **Population: 204,234 (2017)** **hiips://www.livingwellsystems.uk/trieste** **hiip://www.triestesalutementale.it/guida/guida_dsm.htm#organizzazione** **hiips://www.psychologytoday.com/us/blog/saving-normal/201512/worlds-best-and-worst-places-be-mentally-ill**  	- All-ages – whole community - 4 Community MH Centres (6-8 beds each and open around the clock including the University clinic. - 1 small unit in the General Hospital with 6 emergency beds - Service for Rehabilitation and residential support (12 group homes with a total of 60 beds, provided by staff at different levels) - 2-day centres including training programs and workshops - 13 accredited Social Co-operatives - Families and users associations, clubs and recovery homes. - Staff: 215, 1/1000 population (26 psychiatrists, 9 psychologists, 130 nurses, 10 social workers, 6 psychosocial rehabilitation workers)	Evaluation: hiips://www.livingwellsystems.uk/trieste	Key evaluation findings: - 70% reduction in days of admission. - 50% reduction of emergency presentations at the general hospital over 20 years. - Evidence that CMHCs are effective in crisis resolution and in preventing relapses. - Qualitative research highlighted the connection between recovery, social inclusion and participatory citizenship. - 40% reduction in suicide rate over 15 years. - The lowest rate of involuntary treatments across the whole of Italy: in 2016 only 20 people underwent involuntary treatments. This is equivalent to less than 7/100.000 inhabitants. - No psychiatric service users are homeless: there are no homeless clients because the CMHC beds function as shelters until suitable accommodation can be found. - Employment and integration: about 250 people every year are in grant-funded professional training and about 10% of them find jobs in the social or private sector. - Forensic hospital closure: the number of inpatients in forensic hospitals had been steadily declining, from an average of 20 in the '70s to an average of 0.5 in the noughties. Trieste's forensic hospital was finally closed in 2015.

			- Lower cost: in 1971 the budget for mental health services amounted to the equivalent of €26 Million. In 2001 it was €14 million. - Fewer staff: in 1971 there were 524 members of staff. Today they are 220. - Lower cost: in 1971 the budget for mental health services amounted to the equivalent of €26 Million. In 2001 it was €14 million.
Proposed Adapted Thrive Model: Hertfordshire **County** **Population: 1.195 million (2019)** **hiip://implementingthrive.org/implementation-sites/i-thrive-accelerator-sites/accelerator-site-5/** **hiip://www.westsuffolkc cg.nhs.uk/wp-content/uploads/2013/01/APPENDIX-5C-Whole-System-Model-Single-Point-of-Access.pdf** 	- Proposed model only – adapted from Thrive principles (I'm doing well, Coping, Getting Help, Getting more help, Getting Risk Support, I need help preparing for adult years) - A single well promoted gateway to get help - Support based on a child's needs not their diagnosis - A multi-sector partnership approach focusing on shared assessment processes and outcomes; also where each partner understands their role in the system - Improved information-sharing and coordination between universal, targeted and specialist services - Support for parents, children and young people to give them the knowledge to promote their own wellbeing and to know how to get help if they need it. - A strong foundation of universal mental health promotion and self-care - Early help or youth hubs (primary and specialist MH work along with other multi sector activity including early years services, schools, children's services the voluntary sector and youth work - Common language – assessment framework - Whole-system pathway – priority for those who self-harm, ADHD, anxiety, behaviour issues, LAC - Primary MH professional as bridge between services – delivering simple evidence-based interventions - A highly skilled single-point of access worker: For children whose needs fall outside the skills set of primary mental health support, who can triage, refer and negotiate access to effective support; offer help until the young person is successfully engaged; and troubleshoot access problems. - Effective crisis care - Needs-based	No documentation available	Note: Hertfordshire is one of the 10 iThrive Accelerator sites evaluating Thrive principles as part of the NHS Innovation Accelerator programme.

	- Outcome monitoring		
Jigsaw **hiips://jigsaw.ie/**	- Early intervention service - Offer **expert mental health advice and support, online and in person**, to young people across Ireland, aged 12 - 25 years-old. - Currently 11 Jigsaw services throughout Ireland.	hiips://pubmed.ncbi.nlm.nih.gov/30185279/	- Evidence that Jigsaw is an accessible and effective service which plays a key role in the continuum of mental health care for young people in Ireland
Access Open Minds **hiips://accessopenminds.ca/**	- culturally relevant mental health services and as well as access to physical health and sexual health services, traditional Indigenous programming/support, and other social services, under one roof - Early identification, rapid access, appropriate care	hiips://accessopenminds.ca/impact/ hiips://onlinelibrary.wiley.com/toc/17517893/2019/13/S1	
SPOT: Supporting Positive Opportunities with Teens **St Louis** **hiip://thes pot.wustl.edu/**	- access to health and prevention services - focus on positive educational and vocational outcomes - remove barriers that currently impede youth from seeking or obtaining health and prevention services; - centre separate from a child or adult clinic environment that is youth-specific - combined health and social services into a single setting - engage youth in all aspects of the program development and allow opportunities for their leadership to be fostered; - successfully link youth into the existing healthcare system by addressing and eliminating specific barriers.		
The Well Centre **hiips://www.thewellcentre.org/** **Age 13-20**	- Access to youth worker, counsellor or doctor to for health concerns or worries in a safe and confidential space. - Sexual health - Liaison with CAMHS - Teen health Check	hiips://www.cqc.org.uk/location/1 - 681486807/contact	
Your Choice **New Zealand** **hiips://www.healthwest.co.nz/our -services/the-youth-health-hub/primary-mental-health-services** **Age 12-24**	- access to early intervention for young people with mild to moderate mental health concerns.	Evaluation 2014 hiips://www.researchgate.net/publication/267627602_Facilitating_Access_to_Effective_and_Appropriate_Care_for_Youth_With_Mild_to_Moderate_Mental_Health_Concerns_in_New_Zealand	

21 Appendix B: Summary Evaluations of Four Integrated Care Fund (ICF) Projects in North Wales

Part of the North Wales Regional Partnership Board Strategic Review included an evaluation of 4 projects funded by the ICF. These were:

- East Area (Flintshire 7 Wrexham) Multi Systemic Therapy (MST)
- Central Area (Denbighshire) Primary School-based Counselling Service
- Central Area (Conwy): OT Seconded to Strengthening Families Team
- West Area (Gwynedd & Anglesey) Virtual School Head (VSH)

A comprehensive evaluation report was published on 23rd April 2021. The following 4 pages provide one-page summaries of each of the projects.

Pilot Description: ICT MST East Area Flintshire and Wrexham

The project aimed to research and test Multisystemic Therapy (MST) intervention to support adolescents at risk of entering care or custody in East Area. Because these children often have problems, which are emotional and behavioural, rather than mental disorders, they can struggle to get therapeutic and other support services they need. Young people living in the counties of Wrexham and Flintshire, aged 11 to 17 years old, at risk of out-of-home placement due to antisocial and/or offending behaviors, including young people involved with the youth justice system plus a responsible adult

Objectives

1) Reduction in established emotional and mental health problems in young people of secondary school age by earlier identification and intervention to address emerging issues with primary school aged children, building their resilience and self-esteem. Reduction in referrals to specialist mental health services.
2) A clear understanding of how a primary school-based counselling service focussed on support for children at Key Stage 2 might operate and what the practicalities and requirements might be on the ground.

Pilot Comparison Summary

Project Delivery

How long has it been running	10 months
Capacity current funding	circa 57 treatment slots PA
Objectives delivered	Yes
Outcomes defined	Yes
ICF Funding 2020-2021	£66,000
Extent of COVID-19 disruption	Moderate
No. CYP full course therapy	10 (01/06/2020 – 30/11/2020)

Outcomes

Emotional health-wellbeing	Evidence of Improvement
Family/carers feel supported	Evidence of Improvement
CYP at home, in school, no new arrests	80-100% Success
No. CYP avoided specialist services/crisis	More Data Needed
Wider workforce confidence	Strong (6 interviewed)

Therapeutic Evidence Base

Current evidence base for service	Strong
Potential evidence base for service	…….Strong

Sustainability/Scalability

Service infrastructure	Strong
Evidence of potential cost-benefit	Strong (research)
Potential Scalability	Strong

Evaluation Quality

Quantitative evidence	Strong
Case studies	2
Other material	Strong
Interviews conducted	9 Professionals, 2 Parents

Findings

- The project was well planned and researched prior to implementation and is well supported by a multiagency agency steering group.
- A huge amount has been achieved and learnt as a result of setting up a service in the middle of a pandemic, which will inform next stage developments.
- The service model is well research and based on over 30 years of international evidence including UK studies.
- The service has been implemented well, and adherence to the service model and reporting on outcomes is monitored robustly at a local level. Meeting targets for adherence outcome measures is overall good but not yet optimal. Likewise meeting targets for the 3 ultimate outcome measures is also good but not yet optimal. That said the service has only been operational for 10 months, which could account for this.
- On face value taking account of intensity of service, on call and the licence fee the service could appear expensive. A cost benefit analysis of the service is currently underway and a recent published UK study showed a similar stand-alone service was cost effective relative to baseline and cost effectiveness increased with economies of scale.
- All interviewees unanimously valued the service and were able to give qualitative examples of how the service had delivered on 'National Outcomes Framework Measures'. The intensity of the offer and on-call service was particularly valued.
- In common with a published study a number of interviewees questioned the potential gap in-service when cases are closed, which may or may not be an issue as longer term outcomes from the project are evaluated.
- Demand and capacity planning, pathway development and local data systems have yet to be developed. There is a rich source data from the project thus far that could be used to develop assumptions to inform service planning and service modelling.

Conclusion

- The project is based on over 30 years of evidence including UK studies, was well planned, well delivered and is well monitored. Local outcomes although limited at this stage show positive impact on young people and their families. Further work is now needed to realise full benefits of the project

Key Recommendations

- Build the local case for return on investment and model impact.
- Development of local pathways; demand and capacity plans and local data systems to monitor impact.
- Build marketing case studies for different audiences.
- Start planning ahead now for the next stage of the project (April 2022 onwards) to avoid disruption to the current phase of the project in 2021-2022 (there is a 5 month lead in time base on standard 20 week MST therapy).

21.1

Pilot Description: Central (Denbighshire) Primary School Counselling

The pilot is testing the expansion of the Denbighshire Independent Young Person's Counselling Service (DIYPCS) to provide evidence-based counselling to primary aged (KS2) children. This includes the recruitment of an independent School Counsellor and provision of training for Counsellors in Therapeutic Play. The service is a Tier 2 provision, focussed on meeting the gap in existing wellbeing and resilience support services for children between Tier 1, school-based pastoral interventions and specialist mental health interventions at Tier 3.

Objectives

1) Reduction in established emotional and mental health problems in young people of secondary school age by earlier identification and intervention to address emerging issues with primary school aged children, building their resilience and self-esteem. Reduction in referrals to specialist mental health services.
2) A clear understanding of how a primary school-based counselling service focussed on support for children at Key Stage 2 might operate and what the practicalities and requirements might be on the ground.

Pilot Comparison Summary

Project Delivery

How long has it been running	16 months
Current funding capacity circa.	48 pupils per year
Objectives delivered	Yes
Outcomes defined	No
Funding 2019-2020	£33,000
Funding 2020-2021	£33,000 (+ £2400 train)
Extent of COVID-19 disruption	Severe
No. CYP supported by service p.a.	30 (expected 60 - COVID)

Outcomes

Emotional health-wellbeing	Evidence of improvement
Family/carers feel supported	No interviews
No. CYP avoided specialist services/crisis	1
Wider workforce confidence	Strong (1 interview)

Therapeutic Evidence Base

Current evidence base for service	Weak
Potential evidence base for service	Strong

Sustainability/Scalability

Service infrastructure	Strong
Evidence of potential cost-benefit	Strong (research)
Potential Scalability	Strong

Evaluation Quality

Quantitative evidence	Weak
Case studies	4
Other material	Moderate
Interviews conducted	3 (professionals)

Findings

- Service infrastructure, professional standards and ethics framework regulated through BACP accreditation, are established and working well.
- DIYCPS staff committed and enthusiastic about working with KS2 children.
- The key progress measure (YP-CORE) used by the wider service is not suitable for some KS2 children therefore evidence of service impact could not be determined.
- Approaches for counselling with primary children different to secondary and requires specialist training.
- Onward referral rate is currently 0.3% which considerably lower than the 5% rate of the secondary school service (this should be read in the context COVID disruption and the low number pupils who accessed the service).
- The remote working skills and protocols developed in response to the pandemic offer a new and more flexible range of service options for delivery where children request it or where face to face is not possible.
- Academic research indicates: 1) significant cost-benefits from using primary school counselling to avoid pressure on specialist service later in a child's life; 2) likely to be higher demand for children's mental health services post pandemic; 3) improved outcomes, reduced costs and better utilization of services can be achieved when a multi-agency panel is used to consider which mental health intervention will best meet the individual's needs.

Conclusion

- A well-run pilot that, despite COVID-19 disruption, has pioneered the delivery of primary school-based counselling services across Denbighshire and has the potential to be rolled out across the region.

Recommendations

- Investigate and implement age-appropriate post evaluation questionnaires and pre and post counselling measures for younger children (replacing YP-CORE) to evidence individual progress and can be collated to provide evidence of service impact.
- If rolling out across the region, review the evidence strategy to ensure all elements can be gathered consistently across all LA's.
- Consider the potential for increased demand for counselling post COVID-19
- Take account of the additional time it takes for the Counsellor to gain consent and build relationships with parents/carers and teacher in comparison to secondary school service when estimating the funding required to continue or further expand.
- Investigate Multi-agency panel approach to decide the appropriate response to each referral, involving DIYCPS, schools, and other relevant services.
- Consider continuing to develop remote working skills and protocols developed in response to the pandemic to offer a more flexible range of service delivery options going forward.
- While face to face counselling Training in creative approaches suitable for younger children will be required going forward - £2400.00 training budget remains unspent due to COVID

Pilot Description: ICF Occupational Therapy Central Area Conwy

An Occupational Therapist (OT) was seconded from the Vulnerable People Team to the Strengthening Families Team between Nov 2019 and April 2020. The aim was to research and test if occupational therapy could improve the emotional health and wellbeing of children and young people and avoid children and young people needing care or managed care by providing evidence based positive behavioural support in early intervention. The OT identified a gap is service for children with challenging behaviours who were either awaiting assessment or who had received a diagnosis but no offer of support services from health in relation to ASD and ADHD with sensory processing difficulties and worked with this group.

Objectives

1) Improve the health and wellbeing of children young people and their families
2) Improve the life chances of children and young people by intervening early before the need for care becomes established.
3) Avoid unnecessary care and support and avoid unwarranted escalation of need.
4) Inform and up-skill existing staff in the Strengthen Families Team, FIT, and Family Centres

Pilot Comparison Summary

Process

How long has it been running	6 months
Objectives delivered?	Yes
Outcomes defined?	No
Funding 2019-2020	£33,000
Extent of COVID-19 disruption?	Mild- moderate
No of CYP supported by service?	15

Outcomes

Emotional health and wellbeing	Evidence of Improvement
Family and carers feel supported	Evidence of Improvement
No of CYP avoided specialist services?	3
Wider workforce confidence	Strong
Current Evidence base?	Weak
Potential Evidence base	Strong

Sustainability/Scalability

Service infrastructure - Strong, OT infrastructure - Weak

Evidence of potential cost-benefit	Moderate
Potential Scalability	Strong

Evaluation Quality

Quantitative evidence	Weak
Case studies	2
Other material	Moderate
Interviews conducted	6 Professionals, 1 Carer

Findings

- The project was set up in just a few weeks as a result of the last minute availability of time limited funding, with limited opportunities to plan and source/ resource project management support. That said there was real enthusiasm for the project by staff involved. **The project has informed a larger business case for an Early Intervention Behaviour Support Team** to take this approach forward at scale, this initiative is also grant funded.
- Published evidence for sensory interventions is inconclusive and evolving. However, the project OT used a wide range of practical and behavioural interventions in addition to sensory interventions to achieve outcomes. **The RCOT recommends that children and young people have access to an occupational therapist as part of early intervention services** and describes a case study where an investment of £817 in OT generated potential savings circa £13,000 PA in educational placement. Similar saving calculations could illustrate project case studies.
- **Evidence from the project is consistently positive but very small in scale and limited in nature.** Evidence described how the OT had filled a gap in service for children with diagnosed and undiagnosed autistic spectrum disorder and attention deficit hyper activity disorder and in all likelihood prevented needs from escalating.
- There was a lack of an outcomes framework or routine reporting against project outcomes.
- Professional OT supervision was limited and informal and given the evidence base for sensory based interventions in OT is still evolving formal **specialist OT supervision may have enhanced the project ability to evidence outcomes.**
- Seconding an OT to the project was easy. **Recruitment of OTs to Early Intervention Hub has so far been unsuccessful**. Recruitment of occupational therapists is tricky as demand outstrips supply. Recruitment to specialist OT posts in social care is particularly difficult as OTs with similar experience can earn up to £10,000 more in health settings, can work in private practice in significant numbers and are less inclined to apply for short term posts.

Conclusions

- The project was very small in scale and lacking project management infrastructure to support the project lead. That said the project lead and OT were very committed to the project and still achieved a lot with very little. Outcomes were overall positive and the project showcased some compelling example of how the OT had helped children, young people and their carers and potential prevented needs escalating, but the project very small scale and the evidence was limited.

Recommendations

- This is an area where OT can add value but further local research is needed coupled with project rigour that a larger project such as the Early Intervention Behaviour Support Team brings with it. **RCOT recommends Audits of the effectiveness of interventions including Ayres Sensory Integration® and sensory based interventions should be systematically conducted to inform local evidence.**
- **Building the evidence locally for return on investment** will be critical including identifying where cost and benefits lie across the system.
- **Formal professional OT supervision** (in addition to line management supervision) in line with RCOT guidelines would maximise outcomes going forward. It would be worth exploring potential partnerships with local OT services and the department of OT at Wrexham Glyndwr University (who have lectures with special interest in children and young people, mental health, neurology and social services practice). Alternatively, RCOT have a register of potential supervisors.
- **Taking a fresh look at recruitment** will be critical, either partnering with health to second an OT, partnering with the Wrexham Glyndwr University or looking at creating a different grading mix (for example a junior grade support by a highly specialist grade rather than 2 specialist posts would much easier to recruit to, cost similar and highly specialist grade would be well placed to tackle gaps in evidence base). Longer-term funding and/or job security would also need to be considered to make post attractive.

Pilot Description: West Area (Gwynedd & Anglesey) Virtual School Head (VSH)

This pilot aimed to draw on Sir Alasdair Macdonald's (2020) to research the potential benefits of instituting a Virtual School Head (VSH) to champion the educational attainments of all looked after (LAC) in the authority – both within and beyond its boundaries. The role would potentially be responsible for co-ordinating all parts of the system to ensure LAC receive an excellent education and equal opportunities regardless of their circumstances.

Objectives

1) Support children in care and those who work with them to maximise education outcomes and remove barriers to success
2) Monitor progress of all looked after children in the care of the LA
3) Gain access to appropriate data
4) Use the status of the role to influence and be a champion for all looked after children.

Pilot Comparison Summary

Project Delivery

How long has it been running	N/A
Capacity with current funding	N/A
Objectives delivered	No
Outcomes defined	No
Funding 2019-2020	£66,666.00
Funding 2020-2021	£63,333.00
Extent of COVID-19 disruption	Severe

Outcomes

No of CYP supported by service	N/A
No of CYP avoided specialist services	N/A
No of CYP referred to other services	N/A
No of crisis intervention required	N/A
Current Evidence base	N/A
Potential Evidence base	N/A
Local voices – no interviewed	None
Local voices – impressions of quality	None

Sustainability/Scalability

Service infrastructure	No existing infrastructure
Evidence of cost-benefit	Strong (Research)
Potential Scalability	N/A

Evaluation Quality

Quantitative evidence	N/A
Case studies	N/A
Other material	N/A
Interviews conducted	N/A

Findings

- N/A.

Conclusions

- N/A (see considerations in VSH report)

22 Appendix C: CYP Consultation

No Wrong Door - Children and Young People's Consultation

July 2021

Executive Summary

The objective for this consultation was to gain the feedback, experiences and opinions of children and young people (CYP) who access children's services across North Wales. The number of CYP entering the care system and accessing services is significantly increasing along with the need and demand for providers to deliver their services appropriately.

This consultation aimed to co-produce and work alongside CYP to support and/or design any potential, long-term considerations for strategic development within children's services across North Wales. The CYP consultation process was delivered in three core stages:

Stage 1 – **CYP Engagement**

Presenting CYP with the opportunity to share their experiences, opinions and recommendations and identify any strong, recurring overall themes

Stage 2 – **Professional Engagement**

Share the CYP's engagement feedback (Stage 1) with professionals engaged in the professional stakeholder workshop to consider the feedback and generate potential solutions, provision, strategic developments etc that may contribute towards improvement in children's services

Stage 3 – **Information Review**

Present CYP with the information and ideas provided by the professionals to gain their feedback/review

Stage 1 – CYP Engagement

To gain insights and feedback directly from CYP to support the development goals for this project, the following considerations and strategies were created and delivered:

Engagement Workbook (Young Leaders)

A specialised engagement workbook was created which provided participants with the opportunity to provide their feedback in a variety of formats. The workbook could be completed remotely or during face-to-face sessions.

Workshop Engagement (Face-to-Face)

Participants were offered opportunities to engage through several workshop style approaches. To ensure that feedback remained as consistent as possible for data analysis purposes, the Young Leader workbooks were used to help guide workshop feedback where participants did not complete the workbooks in written format.

To offer both the above approaches and encourage engagement participation, we used the following platforms to raise awareness:

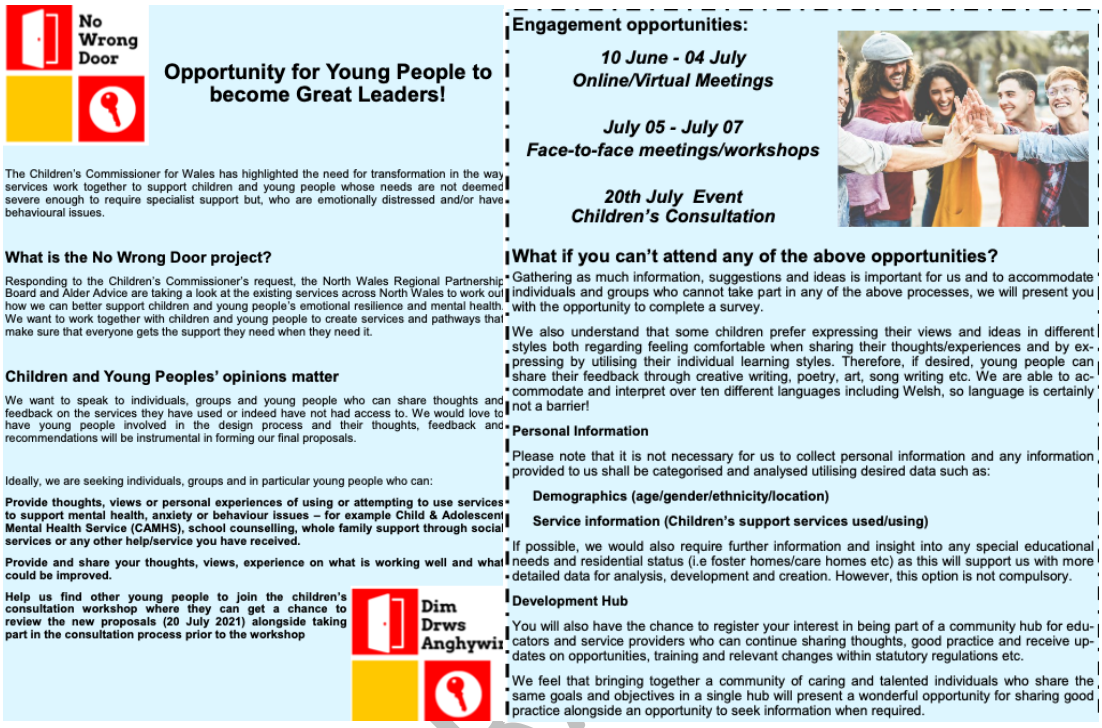
- **Email Campaigns**
- **Article entry in the North Wales Patient Experience newsletter**
- **Social care and third sector forums**

The above platforms aimed to reach the following providers/services using a robust database. The providers, through the services they provide, shared the consultation engagement opportunity with CYP based in North Wales:

- **85 services across social service and third sectors**

- **7 CAMHS teams**
- **Over 50 members of staff within the Neurodevelopment Development Services for CYP**
- **5 Local schools**

The below image is an example of the Patient Experience Newsletter:



No Wrong Door

Opportunity for Young People to become Great Leaders!

The Children's Commissioner for Wales has highlighted the need for transformation in the way services work together to support children and young people whose needs are not deemed severe enough to require specialist support but, who are emotionally distressed and/or have behavioural issues.

What is the No Wrong Door project?

Responding to the Children's Commissioner's request, the North Wales Regional Partnership Board and Alder Advice are taking a look at the existing services across North Wales to work out how we can better support children and young people's emotional resilience and mental health. We want to work together with children and young people to create services and pathways that make sure that everyone gets the support they need when they need it.

Children and Young Peoples' opinions matter

We want to speak to individuals, groups and young people who can share thoughts and feedback on the services they have used or indeed have not had access to. We would love to have young people involved in the design process and their thoughts, feedback and recommendations will be instrumental in forming our final proposals.

Ideally, we are seeking individuals, groups and in particular young people who can:

Provide thoughts, views or personal experiences of using or attempting to use services to support mental health, anxiety or behaviour issues – for example Child & Adolescent Mental Health Service (CAMHS), school counselling, whole family support through social services or any other help/service you have received.

Provide and share your thoughts, views, experience on what is working well and what could be improved.

Help us find other young people to join the children's consultation workshop where they can get a chance to review the new proposals (20 July 2021) alongside taking part in the consultation process prior to the workshop

Dim Drws Anghywir

Engagement opportunities:

10 June - 04 July
Online/Virtual Meetings

July 05 - July 07
Face-to-face meetings/workshops

20th July Event
Children's Consultation

What if you can't attend any of the above opportunities?

Gathering as much information, suggestions and ideas is important for us and to accommodate individuals and groups who cannot take part in any of the above processes, we will present you with the opportunity to complete a survey.

We also understand that some children prefer expressing their views and ideas in different styles both regarding feeling comfortable when sharing their thoughts/experiences and by expressing by utilising their individual learning styles. Therefore, if desired, young people can share their feedback through creative writing, poetry, art, song writing etc. We are able to accommodate and interpret over ten different languages including Welsh, so language is certainly not a barrier!

Personal Information

Please note that it is not necessary for us to collect personal information and any information provided to us shall be categorised and analysed utilising desired data such as:

Demographics (age/gender/ethnicity/location)

Service information (Children's support services used/using)

If possible, we would also require further information and insight into any special educational needs and residential status (i.e foster homes/care homes etc) as this will support us with more detailed data for analysis, development and creation. However, this option is not compulsory.

Development Hub

You will also have the chance to register your interest in being part of a community hub for educators and service providers who can continue sharing thoughts, good practice and receive updates on opportunities, training and relevant changes within statutory regulations etc.

We feel that bringing together a community of caring and talented individuals who share the same goals and objectives in a single hub will present a wonderful opportunity for sharing good practice alongside an opportunity to seek information when required.

Data analysis: Using 5 key questions from the Young Leaders Workbook, we studied both the completed workbooks alongside verbal feedback provided during workshops to create coded themes that establish recurring themes.

Key dates:

24 May – 08 June 2021 – Consultation preparation (workbooks, consent forms, welcome packs)

09 June 2021 - Consultation opportunity shared with providers

14 June 2021 – **12 July 2021** – CYP consultations commence (Virtual and Face-to-Face)

04 July – 07 July 2021 – Visit and workshops conducted with CYP across North Wales

20 July 2021 – Review Workshop 1 (East Area)

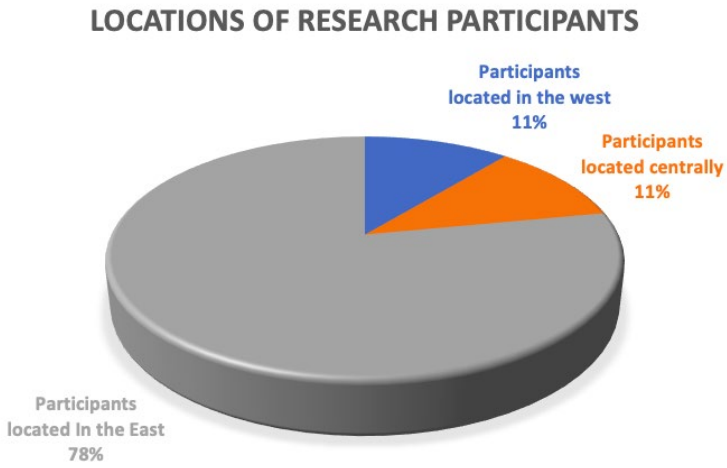
23 July 2021 - Review Workshop 1 (East Area)

CYP Engagement

Total number of CYP who engaged in totality (workbook completion and face-to-face consultations) during Stage 1 = 82

The below chart demonstrates how the 82 total participants are geographically located.

Diagram A



Below is a chart which illustrates the percentage of each gender who took part in the overall research project.

Diagram B

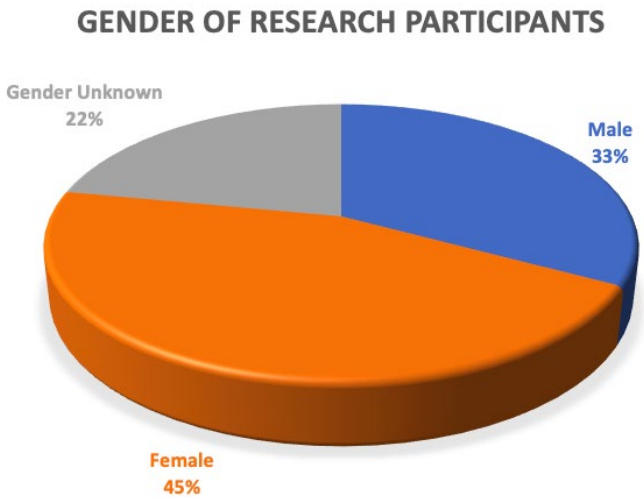
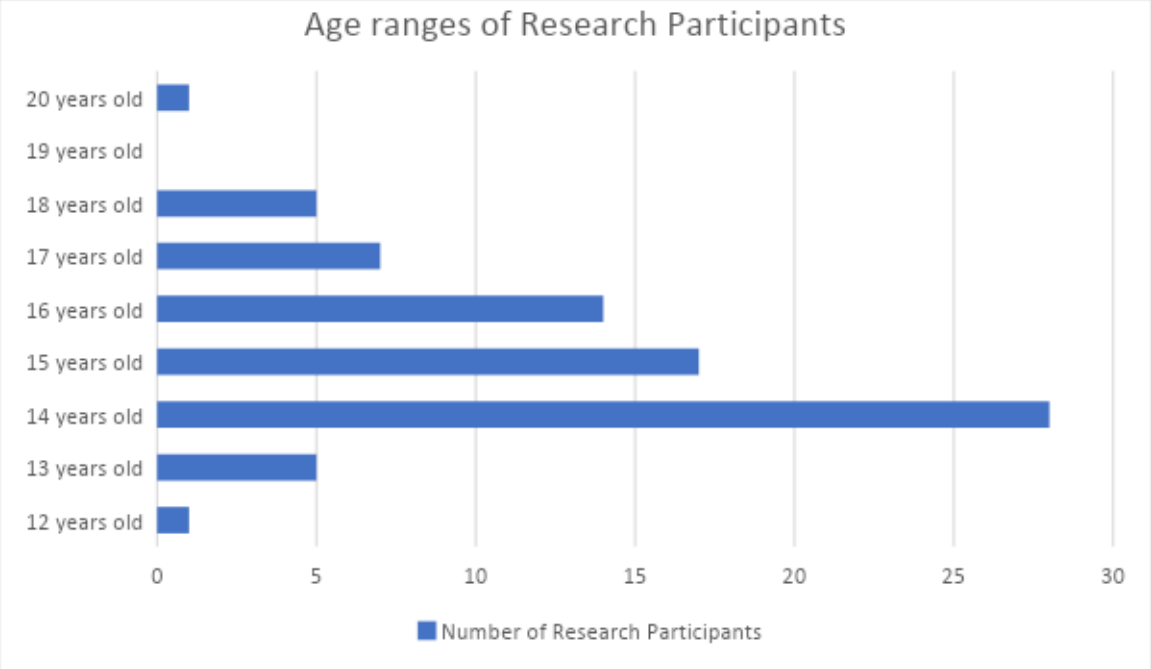


Diagram C



82 participants were aged between 12 and 20 years of age (see diagram C).
When considering their geographic locations across North Wales:

- **64 participants are based in the East**
- **9 participants are based in the West**
- **9 participants are based more centrally**

37 of the participants identified as female, 27 as male and the remaining 18 did not state any gender (see diagram B)

Analysis and Themes

When analysing the feedback collectively, several reoccurring themes arise from CYP's personal experiences that demonstrate a need for improvement within children's services. 91.5% identified situations where they felt that the services they accessed could have been better and offered suggestions on what they would like to see in the future. Though a general, overall sense of dissatisfaction is apparent, there are some trends and recurring themes that are more powerful and recurring.

The most powerful and recurring themes when analysing the feedback provided by 82 CYP, the following themes recurred most using coded theme analysis:

Themes	Number of Participants (out of 82) who shared theme	Percentage
To have online services that enable users to access support, book appointments, conduct appointments etc	29/82	35.3.%

To have better and quicker access to mental health professionals/services/resources	26/82	31.7%
To have clearer/uncomplicated information of where or who to go to when support is required	25/82	30.4%
To feel supported, valued and listened to	24/82	29.2%
To have shorter waiting lists	24/82	29.2%
To have better communication and consistent relationships with professionals/therapists	22/82	26.8%

Analysis of feedback suggests children and young people would like to see:

- A major reduction or preferably elimination of waiting times for mental health services (young people's unhappiness with excessive waiting for mental health appointments was a highly recurring theme)
- Development of simple up to date information on how to get support that is easily accessible, and available online
- Development of digital offers e.g. for online booking, video, and telephone appointments etc.
- Simplified access to services that communicate well with each other
- Professionals who listen, seek to understand, show compassion, and can communicate better with children and young people.
- Help that is person-centred and consistent which then helps young people to build trusting relationships with professionals
- Help that is readily available even at lower-level support and including a wider range of support and therapies such as help with gaming addiction.
- Better support in school including, mental health awareness raising in schools and their communities, teacher and peers that are more knowledgeable about mental health, and more available counselling in schools

Limitations

- **Timescale:** The consultation process with CYP was delivered under a period of three weeks and the total time allotted to the consultation was approximately seven weeks. A longer, more extensive timeframe would present the potential for wider engagement and analysis to establish stronger themes and feedback
- **Age:** The youngest participant age was 12 therefore the evaluation does not include CYP accessing children's services aged below twelve years old
- **Gender:** Though the gender of participants was generally balanced, a larger cohort of participants would have provided an opportunity to further analytically research gender vs themes trends
- **Location:** Though attempts to engage learners across North Wales were made equally, the response rate from eastern districts were much higher (83%) therefore this does not represent a balanced outlook pertaining to CYP feedback geographically
- **Covid-19:** Both restrictions such as lockdown and general uncertainty may have affected participation and engagement levels

Stage 2 – Professional Engagement

Professionals were presented with the opportunity to view and discuss feedback shared by CYP during Stage 1. After considering the themes, feedback and recommendations, the professional stakeholder workshop participants developed concepts for new ways of working that:

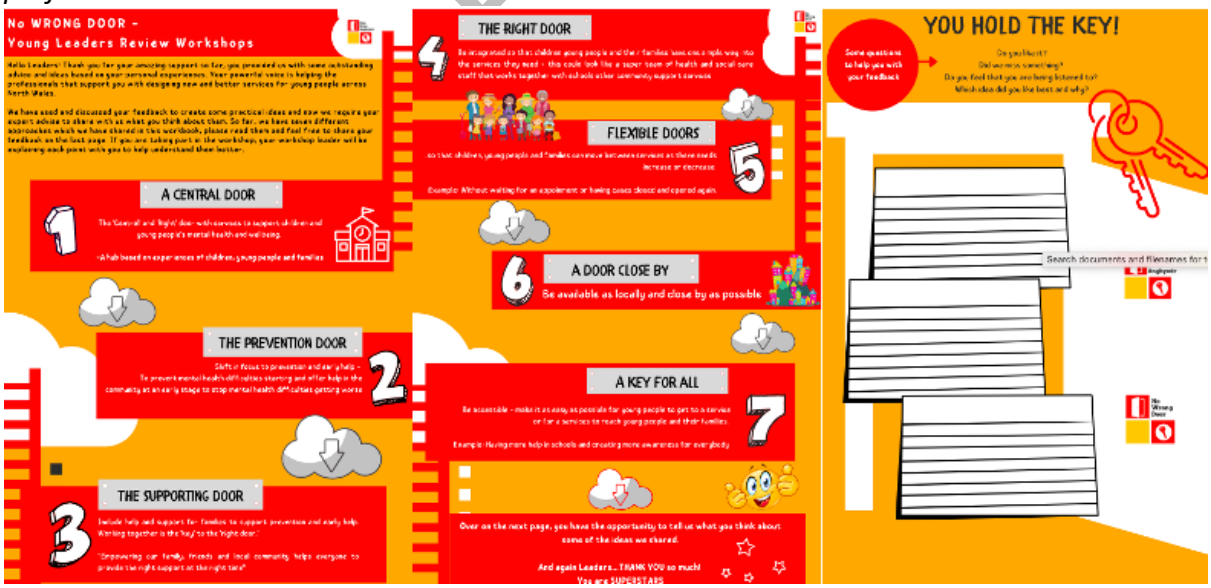
- Are based on experiences of children young people and families
- Have a shift in focus to prevention and early help - to prevent mental health difficulties occurring and offer help in the community at an early stage to stop mental health difficulties getting worse
- Be integrated so that CYP and their families have one simple way into the services they need - this could look like an integrated team of health and social care staff that works together with schools and other community support services
- Be flexible so that children, young people and families can move between services as their needs increase or decrease e.g., without waiting or having their case closed and opened again.
- Be available as locally as possible
- Be accessible - make it as easy as possible for you to get to the service or for the service to reach you

The above concepts were formulated into a child friendly format and delivered through workshops that took place on:

- **20 July 2021** (Halkyn Castle Wood – Central/East Area)

- **23 July 2021** (Gwaith Powdwr – West Area)

Below are samples taken from the workbook designed for CYP sharing ideas presented by professionals.



All the participants who engaged during Stage 1 received an invite to attend the workshop review events. Facilitating two workshops with the capacity to host larger groups, this engagement opportunity was also extended to CYP who access children's services across

North Wales whom did not initially participate during Stage 1 consultations. Having two event locations namely one in the East and another in the West, accommodated and supported CYP with further travel/location needs and flexibility.

Workshop Attendance Figures

Date and Venue	Number of Participants
20 July 2021 (Halkyn Castle Wood – Central/East Area)	**28**
23 July 2021 (Gwaith Powdwr – West Area)	**5**
Total	**33**

Number of participants who completed the workbook	9
Number of participants who provided verbal feedback	15
Number of participants who did not provide feedback	9

Overall feedback demonstrates that participants were pleased to see the initiatives and ideas sharing a positive feedback on the information provided to them by professionals engaged in the professionals workshop.

From the initiatives presented to CYP, the following three received the most positive feedback:

A Central Door - *based on experiences of children young people and families*

- This initiative received the most feedback with CYP feeling that this will support or eliminate issues surrounding waiting times, provide a faster route to receiving information online and better access to mental health support

<u>Quotes from CYP</u>

1	I agree with the central door although there needs to be the right teachers to talk to so they understand your position.
2	I agree with the central door as they will have a good understanding.
3	The ideas all seem good but having a central door is best idea
4	I think there will be less waiting time with central door
5	One single point would be good as not then being passed from one service to another.

The Prevention Door - *Have a shift in focus to prevention and early help - to prevent mental health difficulties occurring and offer help in the community at an early stage to stop mental health difficulties getting worse*

- Participants and their families felt that education in the community would support improvement. Many shared how their first place to receive support is at home or amongst family and friends

Quotes from CYP

1	The best idea as having one easy method is the most convenient for getting help.
2	We don't have to rely on services then
3	When I most need help, I get it from my friends and family which is why this is my favorites
4	This seems like the best solution because we don't always have to get annoyed for waiting

The Supporting Door - *Be accessible - make it as easy as possible for you to get to the service or for the service to reach you*

- Participants felt that this initiative could offer support that they currently lack

Quotes from CYP

1	The supporting door is most important
2	Schools really need to improve, its where we spend most of our time
3	Feeling supported is important which is why I like this one
4	Travel is always an issue for my mum so I think this will help
5	Integrate with schools: flexible hours for people who need them

Limitations – Review Workshops

- **Participation numbers**: The feedback provided was based on 33 participants
- **Age:** The youngest participant age was 11 therefore the evaluation does not include CYP accessing children's services aged below eleven years old
- **Demographic Data**: Due to a large cohort of new participants who had not engaged during Stage 1, it was difficult to determine and analyse the feedback with demographic data as this was not provided

- **Geographic Data**: out of 33 participants, only 5 attended the event in the West. Therefore, the feedback was predominately provided by CYP located in the East and only a small representation of service users in the West is included
- **Timeframe**: The feedback and deliverables are based on participation levels gained across North Wales over a period of seven weeks. An extended commitment to the timeframe would enhance both participation and feedback quality
- **Covid-19:** Both restrictions such as lockdown and general uncertainty may have affected participation and engagement numbers

23 Appendix D: Guidance Frameworks

Matrics Plant Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales

Matrics Plant published in September 2017 provides organising principles for psychological interventions. Services should be designed to ensure that they are able to meet the needs of the child or young person at the earliest appropriate opportunity as well as at the earliest possible stage in their development. This would include ensuring that suitably qualified practitioners are available to provide evidence-based psychological interventions. Matrics Plant does not recommend specific service models, rather the formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing. As such, evidence-based psychological interventions encompass a wide range of courses of action including:

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Intervention with main carers/parents
- Intervention directly with child or young person.

It is essential that the expertise and support that exists within the system is available to practitioners in embedded services in the form of easy to access consultation, advice and role appropriate supervision, as well as skilled psychological and other practitioners being embedded within these systems.

Nest/Nyth

Published in 2021, Nest/Nyth is a planning tool for Regional Partnership Boards that aims to ensure a whole system approach for developing mental health, well-being and support services for babies, children, you people, parents, carers and their wider families across Wales. It is intended to help those seeking to develop or transform such services to focus on the following core values and approaches:

- A rights-based approach. Are children and young people in their care aware of their rights? How does this get enacted day to day?
- Equity, Diversity and Inclusion. Ensuring a feeling of inclusion regardless of race, ethnicity, culture, religion, gender identity, sexual orientation, physical health and disability, neurodiversity, additional learning needs, learning disability, adversity and poverty.
- Values Led – focus on supporting children of all ages with their mental health and wellbeing.
- Child development. Supporting the uniqueness of each child as they develop rather than focussing on age.
- Psychologically informed. Keeping up with emerging learning and incorporating it into the way we work.

- Trusted adult – the vital role that proximal grown-ups have in helping babies, children, and young people with their mental health and wellbeing.
- Wellbeing across education – ensuring that there is a good understanding of mental health and wellbeing across the sector and that this is used to support children and young people in every way possible.
- Co-produced innovation – taking on everyone's ideas, especially those of young people and their families.
- Easy Access to Expertise -grown-ups in children's lives know where to go for help and can get it quickly if they need it.
- Safe and supportive communities – ensuring environments that children and young people grow up in and the services around them are safe for them to live, play socialise and exercise.
- No Wrong Door – ensuring families get the right help at the right time
- Working together – services and those they support working together with a focus on prevention and intervention.

24 Appendix E: The Review Process

The main steps of the North Wales Regional Partnership Board "No Wrong Door" strategy development process is illustrated in the Figure xx below.

The core activity consisted of a series of workshops for professionals, and a parallel programme of engagement with children and young people. Due to the Covid-19 pandemic emergency restrictions and to facilitate attendance across the North Wales, workshops were held by video conference. Each workshop consisted of two parts.
The workshop method was based in Appreciative Inquiry (a strengths-based approach to organisational development).

Professionals' Workshop 1: **Defining** the vision for mental health services for children and young people in North Wales and **Discovering** what is currently working well.

Professionals' Workshop 2: **Dreaming** what might be possible and **Designing** a "To Be" model

Professionals' Workshop 3: Considering what is possible and how it might be **Delivered**

Data collected from children provided their views, which were used to inform the analysis and design of the future model. They then had an opportunity to comment on the emerging proposals. Key findings of the children's and young people's engagement are included in the body of the strategy document. A summary report of the Children's and young people's consultation of forms Appendix C. A full report of the Children's and young people's consultation is separately available.

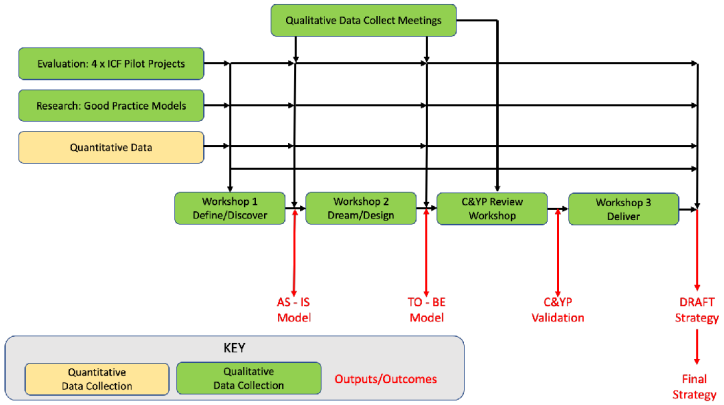


Figure:The North Wales "No Wrong Door Strategy Review Process