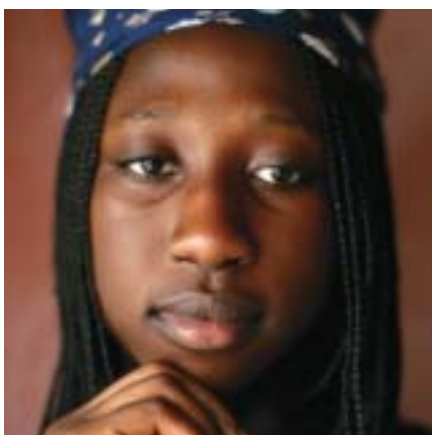


Needs Assessment Report on Child and Adolescent Mental Health Final report – May 2003



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ACKNOWLEDGEMENTS

Mary Gallagher was nominated for the Core Group by the Association of Directors of Social Work.

Helen Hammond was nominated by the Royal College of Paediatrics and Child Health.

Thanks to Allyson McCollam of the Scottish Development Centre for Mental Health for advice with survey design and strategy.

Thanks to Alex McConnachie and Gillian Penrice for their help with the analysis of survey findings.

Thanks to the Association of Directors of Education in Scotland for assistance with the Phase 2 surveying.

Thanks to Judy Furnivall and the Scottish Institute for Residential Child Care for the development and distribution of the questionnaires.

Thanks to Bryan Ritchie and the Fostering Network Scotland for the distribution of the questionnaires.

Thanks to Jackie Willis, Sharon Wilson and Anita Hastie for administrative support.

FOREWORD

The Scottish Needs Assessment Programme (SNAP) was set up in 1992 across all Scottish Health Boards to assist them in carrying out their required task of health needs assessment. It developed into a key resource in the commissioning process and produced over 60 reports on a wide range of health issues.

With the establishment of the Public Health Institute of Scotland in January 2001, the decision was made to incorporate the SNAP programme within the overall work programme of the Institute. This report on Child and Adolescent Mental Health was commissioned before January 2001 and therefore makes reference to the SNAP processes.

As of 1 April 2003, the Public Health Institute of Scotland merged with the Health Education Board for Scotland to become NHS Health Scotland.

INTRODUCTION



This needs assessment of the mental health of Scotland's children and young people was commissioned in autumn 2000 by the Scottish Executive Health Department. It has proved a rich and challenging task and we have followed an ambitious but, we hope, rewarding process.

From the wide range of issues three have emerged as core themes. The first is recognising the right of children and young people to be heard, and their capacity to play a full part in thinking about mental health and in influencing the arrangements that we make to improve mental health.

The second is the importance of "mainstreaming" mental health. Too readily does the subject become relegated and too easily are those with mental health problems marginalised or excluded. Yet it is clear from our research that it is a common problem and an important issue amongst children, young people and parents. The main focus of mental health work with children and young people should be in their communities, schools and families. The challenge to services is to find ways of working, and in particular, of working together, that will bring that widely agreed aim closer to being realised.

But there are important difficulties in terms of capacity for this work. Those in the mainstream services are looking for opportunities and support in developing their role but those in the specialist services are under very substantial pressure. Despite this, there is striking consensus about the need and the desirability of making this happen.

We put the case for steps to enhance our capacity to address these issues. Central to that is our third theme – the integration of promotion, prevention and care in our approach to this picture of substantial need. We have many skilled practitioners in Scotland, and we need many more. But we also need a broad alliance which focuses on the mental health of children and young people, and maintains that focus, as we work on enhancing the capacity to make a difference.



We have encountered remarkable openness and willingness to contribute to this work from children, young people, parents, practitioners and agencies. This report tries to capture the essential elements of the work, but is inevitably only a partial account. We have been able to distil some of the survey findings into this report. However, much of the detail cannot be accommodated here. We intend to publish detailed evidence from our surveys elsewhere.

Finally, thank you to all those who have contributed willingly and generously to this work and, in particular to the young people who got up early in various corners of Scotland one day last September, to travel the road and the miles to the SNAP seminar in Dundee.

EXECUTIVE SUMMARY



About a quarter of Scotland's population is under the age of 19. At any one time, about 10% of them, 125,000 young people, have mental health problems which are so substantial that they have difficulties with their thoughts, their feelings, their behaviour, their learning, their relationships, on a day to day basis.

In 2000, the Scottish Executive commissioned the Scottish Needs Assessment Programme (SNAP – now part of the Public Health Institute of Scotland) to provide a report on the mental health of children and young people in Scotland.

The main aim of that work has been to identify ways of better addressing the mental health needs of children and young people in Scotland. That has led us to look at how best to promote mental health, how to prevent mental health problems, and at when and how to provide appropriate help for those children and young people who are experiencing mental health problems.

The report discusses a wide range of activities, from specialist child and adolescent mental health services to the wide network of agencies working with children and young people, resilient or struggling, wherever they are.

In the course of this work, we gathered evidence both from published formal sources, for example, published research and policy documents, and from children, young people and those who care for them and work with them. The process involved surveys, seminars and consultations across Scotland. Those with first hand knowledge and experience were given the opportunity to have their say about mental health and mental health initiatives and services and were invited to comment on the emerging findings and conclusions.



TALKING ABOUT MENTAL HEALTH

Across the network of services for young people different terms are used to denote difficulties of living, learning and relating which, in this report, we will refer to as mental health problems. Attempting a short and simple definition of mental health runs the risk, as one author puts it, of “either coming up with something pithy but so banal as to be meaningless, or inclusive but so packed with nouns as to be impossible to follow.” While acknowledging this difficulty, it is important to be clear that we use the notion of mental health to denote a bigger concept than an absence of illness and, in particular, to include the notion of well-being.

Language and culture are central considerations in discussions about mental health. For example, people working within education services might refer to young people who are experiencing “emotional and behavioural” problems, while those working within health services might speak of “psychiatric disorder” or “psychological difficulty”. These terms are not simply interchangeable and we will highlight the importance of recognising and working carefully and constructively with such differences of language and culture.

“Mental health” is not, therefore, a neutral term. In some cultural contexts, for example amongst many young people, the term has largely negative connotations. We acknowledge this, while using the term as a practical convention. This mainly indicates that health service culture provides the major context for this report.


IDENTIFYING MENTAL HEALTH NEED

Mental health is more than the absence of a mental health problem. This report therefore considers both how to work with young people with mental health problems and the importance of developing and sustaining mental health and well being. It considers the potential benefits, for young people, families and communities, when young people feel well, and are emotionally fit for learning, playing, working and relating.

Although knowledge about mental health and well-being is accumulating, the question “is mental health improving?” remains difficult to answer. Useful indications, however, come from considering patterns and trends in relation to those young people who are vulnerable to mental health problems and those who have mental health problems.

There are some factors which are well established as increasing children’s vulnerability to mental health problems. These include a learning disability of any kind, enduring physical ill health such as epilepsy, physical or sexual abuse, witnessing domestic violence. A child whose parent has a serious mental health difficulty is also more likely than others to develop a mental health problem.

There are also factors which protect against the development of a mental health problem. These include attributes of the individual child, such as an adaptable nature or good self esteem, and a range of relationship factors, including peer and family relationships. For children who experience adversity, the consistent availability of a person whom they can trust and in whom they confide fosters resilience.



The relationship between trends in risk and protective factors and the prevalence of mental health problems in populations is complex. So, although it provides only part of the answer, the ability to measure accurately the prevalence of mental health problems remains the most reliable and readily available indicator of mental health need in a community.

In 2000, the Office for National Statistics (ONS) published the results of a UK study of over 10,000 children aged 5-15. They found that 9.5% overall had what they called a “mental disorder” – a problem of sufficient severity and persistence as to have a significant impact on the child’s functioning or relationships.

- The rate was higher in boys than in girls.
- The rate increased with age.
- The rate amongst young black people (12%) was higher than the average (9.5%), while children whose ethnicity was reported as Indian had the lowest rate (4%).
- The rates amongst children living in lone parent households and in children in low income families, 16%, were almost twice the overall rate.
- The rate amongst the 892 young Scots surveyed was 8.5%.

Other studies of younger children and older teenagers reveal similarly substantial rates of significant mental health difficulty. It is worth noting that the risk accumulates, and so a child with three risk factors is at substantially higher risk than a child with one. A recent Scottish study demonstrated how children who had become looked after and accommodated by their local authority had rates of difficulties which were five times higher than their peers in the ONS study group.

Therefore we conclude that significant numbers of children and young people in every community experience mental health problems and these rates are substantially increased by several factors, many of which are now referred to as the components of social exclusion.

While numerous reports suggest that mental health problems amongst children and young people are on the increase, there are, so far, few studies which convincingly demonstrate this. One recent Scottish study has found that levels of “psychological distress” amongst 15 year old girls in West Central Scotland increased from 19% in 1987 to 33% in 1999. This finding, along with the rising suicide rate amongst young males and the steady increase in many of the risk factors, provide some support for an increasing prevalence. Further study is indicated.

WHAT HELPS?

Some young people get help with their difficulties, but there is evidence to suggest that problems often go unidentified and that when they are recognised, getting the right support is often difficult.

“Real improvements in public health will only be effected by tackling the variations in health status between the social groups and between different parts of Scotland”. This quote from *Designed to Care – Renewing the National Health Service in Scotland* makes it clear that initiatives and services to tackle mental health have to be seen in context. As the



ONS study indicates only too clearly, employment and educational opportunities, good housing and fairness and stability in relationships play the major part in determining the mental health of children and young people.

Underpinning the national health plan is a recognition that illness cannot be tackled simply by providing better treatment services. A whole system approach demands that attention is given to the promotion of better health, the prevention of ill health and then good quality services for those who require them. This is particularly pertinent for children's health as promoting good health early in life has the potential for life-long impact.

The recent health improvement action plan *Improving Health in Scotland – the Challenge* specifically addresses “early years” and “teenage transitions”. NHS Scotland's investment in the work of the National Programme to Improve the Mental Health and Well-being of Scotland's Population reflects an acknowledgement that mental health is one of the major public health challenges in Scotland.


The feasibility of promoting positive mental health and preventing mental health problems has been increasingly studied in recent years. Some studies suggest that it is possible to promote resilience – the capacity to cope with stress – through school-based programmes. Carefully designed and implemented preventive programmes can reduce the rate of subsequent mental health and other problems in “high risk” populations.

There are many kinds of interventions of proven effectiveness with children who are in emerging or established difficulty. These are most likely to be effective when:

- they are introduced early in the problem cycle and preferably early in age
- they involve familiar people or people who will be able to empower parents and work in partnership with professionals (e.g. health visitors or trained volunteers)
- they are intensive and sustainable
- they are multifaceted and use interventions of proven effectiveness.

Although accumulating steadily, the evidence is still patchy. There are also issues of “transferability” of evidence. For example, much of the health promotion evidence derives from research carried out in other parts of the world. Furthermore much of the treatment evidence is derived from research with children with single problems, while most studies suggest that children with a mental health problem commonly have co-existing problems. Not all treatment methods have been evaluated, nor are there effective interventions for the whole range of mental health difficulties which children and young people experience. There is, therefore, a pressing need for continuing research.

The existence of effective interventions does not guarantee that services will be effective. The availability of appropriately skilled staff, properly supported and supervised, able to work in culturally sensitive ways and committed to involving families also has an important influence on effectiveness. It is, therefore, important to evaluate services.



The monitoring and evaluation of child and adolescent mental health services (CAMHS) has been constrained in the NHS by the lack of suitable data collection systems. ISD, the NHS Information and Services Division, is currently developing a new system for collecting mental health data.

PLANNING AND DELIVERING MENTAL HEALTH

There are now a number of Scottish initiatives which have a bearing on the mental health of children and young people, for example the recently published report, *For Scotland's Children* and the First Minister's declaration, in his inaugural address, of a commitment to the well-being of children.

There is, as present, no national strategy comparable to that which the Welsh Assembly developed, and adopted in 2001, "as the first essential step in addressing the present deficiencies and inequities in CAMHS in Wales". In England, child and adolescent mental health is now prominent in the arrangements to develop the National Service Framework for Children.

In Scotland, the Mental Health and Well-being Support Group, whose primary task is to monitor the implementation of the 1997 Framework for Mental Health, had held the NHS strategic overview of child and adolescent mental health. Since autumn 2002, the more recently established Child Health Support Group has taken the lead role, making "championing the development of child and adolescent mental health services" one of the five themes in its work programme. Visits by both support groups to NHS Board areas had identified widespread concern that NHS specialist CAMHS were under enormous pressure and, in many cases, appeared not to have resources to meet the demands they face.

The 1995 HAS Report, *Together We Stand*, established that expenditure on CAMHS in England and Wales often reflected local NHS history rather than the mental health needs of local children and young people. Parry-Jones and Maguire confirmed that this was also the case in Scotland. It is, however, difficult at present to derive robust and comparable data on what local NHS Boards are spending on child and adolescent mental health. It appears that while some NHS Boards are beginning to redress this historical pattern, in many parts of Scotland there are yet to be convincing moves towards funding which is more directly related to level of need.

SNAP PHASE 1 FINDINGS

In responses to the SNAP survey, the majority of NHS Boards report that they had recently introduced a strategic plan for child and adolescent mental health. Most of those included early intervention and assessment and treatment services, but only half of those responding included health promotion and prevention measures. This was despite evidence from the NHS Board Health Promotion departments of rising awareness and activity around young people and mental health. In almost all cases, local authority social work departments and NHS Boards now participate in one another's planning arrangements for children's services.

All NHS Boards who responded (12/15) report rising rates of mental health problems, with attention deficit/hyperactivity disorder (ADHD) and, particularly, autistic spectrum disorders



specifically mentioned. Two NHS Boards have consulted young people about service use, but none reported having arrangements in place to consult young people about service development and planning.

The substantial majority of NHS Boards, heads of NHS specialist CAMHS (psychology only and multidisciplinary) and those social work departments who replied report that the CAMH services available are patchy. The links between the specialist CAMHS and the wider network were limited, with delays in referrals and access. The specialist CAMHS teams were reported as being under very heavy pressure and the highly specialised services, such as inpatient units, were often described as difficult to access.

Where specialist CAMH services are available, NHS Boards most often described them as basic. The recurrent theme is of services, often with good qualities, working at and beyond capacity. There are, nonetheless, examples of good and innovative practice, including initiatives for children and young people who are being looked after and accommodated and young people with learning disability and mental health problems. These groups have historically been poorly served by many CAMHS, so these are clearly important, if overdue, developments.

In most areas waiting lists are “usually” or “always” present and are recorded, along with stigma and poverty, as major constraints on access to specialist CAMHS.


SNAP PHASE 2 FINDINGS

The wider network of those who work with children and young people was surveyed in the second phase of the SNAP study. This included teachers, social workers, residential child care workers, foster carers, police, children’s hearing reporters, children’s hearing members, health visitors, general practitioners, school nurses, paediatricians, voluntary sector workers – over 900 replies, a response rate of between 40% and 50% for most groups.

The main themes in these replies are discussed in the report with the detail to be teased out in subsequent publications. There was prominent concern about levels of mental health problems and about the difficulties in being able to offer an appropriate response. Many respondents cited a lack of training on their own part and lack of readily accessible routes of support. Long waiting times at NHS specialist CAMHS were often cited, but young people’s reluctance to be referred elsewhere was also important.

There was evidence that, among the “universal” services, a number of agencies have been developing health promotion programmes. The substantial majority in almost every group indicated that they were interested in further training in relation to mental health issues. In other words, people across this network of agencies are already working to develop, sustain and improve the mental health of the children and young people with whom they work. Many of them report the need for additional skills, support and time to do this work more effectively.

The survey was also addressed to nurses, psychologists, psychiatrists, psychotherapists, social workers and other therapists who work primarily in specialist mental health or psychology agencies. This included local authority psychological services, specialist teams in



the voluntary sector and NHS departments of child psychology and multi-disciplinary (sometimes referred to as psychiatric services) mental health teams. Some 260 replied, a response rate in excess of 55%.

Our survey of young people and parents was carried out by the Scottish Development Centre for Mental Health. In the main, meetings were held with pre-existing groups of children and young people, either in a classroom setting or where the young people would normally meet. Some 77 young people, aged between 9 and 24, and 10 parents were involved.

Groups consulted included a primary 6 class, a secondary 2 class, young people attending a psychiatric hospital, young people who have visual impairments, young people from a minority ethnic community organisation, young people with experience of using mental health services, young people who had been active in work on Primary Care Services and young people who are in or leaving the 'care' system. Parents of young children and parents of young people aged 12 and over were also consulted.

Many important themes came up in this work. These are highlighted in the main report, but the full findings of the young people's survey and the proceedings of the subsequent young people's seminar are published together in an accompanying report. This work has been important in the development of a number of our recommendations. Here is one illustration:

"There are also opportunities to work with young people in schools on 'everyday life' issues. Young people feel that they are missing out on some valuable discussions which would both fit into and enhance their curriculum studies. They want to be able to look at their lives and see how they might deal with the challenges and ups and downs that come along and they would like professional support in doing this. For example, the lives of many young people are affected by family separation, divorce and bereavement and this needs to be recognised in the provision of information, advice and support. Young people raised the question of whether this type of discussion and support is or should be the responsibility of teaching staff."

The young people's seminar highlighted many similar themes and there was a clear view that young people should attend and could speak for themselves at workers' seminars.

There was one national seminar midway and three regional seminars (in Nairn, Edinburgh and Glasgow) towards the end of the process, with more than 300 participants in all. Again these raised a wide range of important themes and the reports of these seminars are available on the Public Health Institute of Scotland website (www.phis.org.uk). As with the young people's work, there are key themes which are reflected in the subsequent recommendations: the importance of involving children and young people in decision-making processes and the need for better linkage within the network of services.

RECOMMENDATIONS



1. KEY QUALITIES OF SERVICES FOR CHILDREN AND YOUNG PEOPLE

Awareness and appreciation of their rights should be fundamental in an agency working with children and young people and respect for those rights should be a core value of such an agency.

This awareness and appreciation should also be a central concern for agencies working with the parents of children and young people. Those agencies should also consider how to promote those rights within their communities.

Those agencies should therefore develop and adopt policies which clearly value and respect young people and acknowledge the important role they play in their own health and well-being. The potential contribution of youth advocacy services to this area should be noted.

Services should be offered to children, young people and their parents in ways that are respectful of their own culture and appropriate to the developmental stage of the young person.

The rights of children, young people and parents as users of services should be carefully considered, particularly in relation to issues of consent and confidentiality.

The right of participation in the evaluation and development of services within NHS Scotland was established in *Our National Health* (2000). Given limited progress, so far, it now seems clear that particular measures, including the commissioning of pilot projects, will be required to ensure that young people and their parents have the opportunity to exercise this right. There are some examples of good practice emerging within the NHS, but lessons can be learned from elsewhere in the network of agencies who work with children and young people.

2. “MAINSTREAMING MENTAL HEALTH”

Mental health is not a discrete entity which can be meaningfully considered in isolation from the rest of life. Although it is sometimes necessary to offer specific help to address a particular struggle, for example, with difficult feelings or worrying thoughts, it is important to offer that help in a way that “connects” with the contexts of that child or young person’s life.

Themes in our surveying and consultations echo these comments in the Scottish Executive report, *For Scotland’s Children* (2001):

“In many parts of Scotland, services are not pulling together. Children and families experience services as having different objectives which are sometimes in conflict.”

The Action Team who compiled that report concluded that these were “manifestations of workers believing themselves to be part of a profession/a department/an agency operating autonomously in relative isolation” (p. 74). Such is their emphasis on the importance of this issue, they subtitled their report “Better Integrated Children’s Services.”

The SNAP findings suggest that “operating autonomously in relative isolation” is an issue for NHS specialist mental health teams and in some cases is particularly important. At the same time there were numerous accounts of interest and willingness to build connections between teams and agencies and some where substantive links had been achieved.

Throughout this report runs the assumption that mental health is an integral part of life and that attention to mental health “promotion, prevention and care” should be integral to all agencies working with children and young people. It is very important that the relationships between agencies support rather than undermine this integration.

In relation to the work of NHS specialist child and adolescent mental health services, continuing efforts are needed to find ways of integrating more fully with the wider network of children’s services. Increasing evidence is emerging of viable models of collaboration, in some cases around people with particular needs, such as looked after children, or children with a disability, and in others around settings, such as schools. While further evidence will be useful, inter-agency discussion should be underway in every area about how to improve integration.

3. AN INTEGRATED APPROACH TO PROMOTION, PREVENTION AND CARE

Our review of evidence makes it clear that a comprehensive approach to the mental health of a population of children and young people requires a range of initiatives from promoting health and well-being to offering a service to those with emerging or established mental health difficulties.

Although we present (and regard) these themes as entirely complementary, we note that they are often discussed as separate or even competing approaches. We suggest that this is an important area for further professional debate and discussion amongst those interested in mental health.

In the meantime, this integration has important implications for those who plan children’s services, for example, in health, education and social services. We suggest that they will want to make sure that the whole breadth of approach is implemented.



For those who are working with groups of children and young people, awareness of the contribution of promotion, prevention and care approaches will be also important, as will opportunities to develop related skills.

This also has implications for those who work specifically with children with mental health problems. These practitioners will often have long experience and valuable intervention skills in assessment or treatment. They, too, should consider how promotion and prevention approaches would enhance the quality of the service they can offer to children.

4. ENHANCING THE CAPACITY OF THE NETWORK OF CHILDREN'S SERVICES

It is already clear that this process has identified a significant mismatch between the level of mental health need and the capacity to work with that need. There will need to be a sustained commitment to building this capacity.

Capacity is not a fixed property of an organisation or group. It is clearly dependent on the available resources and, in particular, the range and level of skill within an agency or team. However, these exist in a dynamic balance with a range of contextual and environmental factors, which can operate to enhance or reduce effective capacity. An environment which is demanding by virtue of geography, e.g. with a widely scattered population, or by virtue of limited amenities or services will effectively reduce the capacity of a service. At the same time, good collaborative arrangements between agencies will almost certainly enhance the capacity of each.

This attribute of networks is particularly important when capacity is under pressure: agencies responding "unilaterally" at such times can unwittingly compound their capacity problem by sacrificing the contribution to their capacity from previously successful collaboration.


We now discuss three strands which contribute to the capacity across the network of children's services. These are learning opportunities, contexts for consultation and evolving arrangements for joint working and referral.

Running through each of these strands is the issue of time and resources required by workers, often from different professional and theoretical backgrounds, to build relationships which will underpin good collaborative work. The SNAP survey provides evidence of much interest in this but concern that there is, at present, little room to achieve such development.

Learning opportunities

The SNAP survey clearly indicates that across the network of people who work with children and young people, many practitioners recognise mental health need amongst young people and are looking for ways to develop their own capacity to make a difference. There is a need for formal learning opportunities which will both support that aspiration and lead to enhanced capacity.

Successive reports have recommended that mental health, in the broad and inclusive sense in which we use the term in this report, should be on the curriculum of all



professional training leading to work with children and young people. We add our weight to this consensus.

There are also emerging opportunities, through a variety of post-qualifying routes, to study aspects of mental health work in more detail, for example with training in systemic practice or therapeutic skills with children.

Contexts for consultation

Alongside formal learning opportunities, consultation is an effective method of practice-based learning where practitioners meet with colleagues for discussion about issues and dilemmas in their own practice. Consultation is a particularly useful way of convening discussion between practitioners from different backgrounds and can be used for a wide range of tasks from developing a health promotion programme to an inter-agency discussion about a young person in difficulty.

Effective consultation takes place in a non-hierarchical atmosphere where the differences in skill and perspective are understood as a strength. These arrangements already exist in many settings, including schools, social work services and health settings, but there is a need to develop and extend this activity.

For Scotland's Children recommended that agencies working with children should develop shared assessment and planning in relation to individual children's needs, rather than operate independently. This work, which is already underway in some areas, needs both agreed protocols and good contexts for consultation. Both aspects of this issue should be under discussion in each area.

Evolving arrangements for joint working and referral

In the SNAP survey many practitioners in the wider network reported significant difficulty in accessing specialist services for the young people with whom they work. One clear implication of the discussion about building capacity is that more help will be available to young people "closer to home", i.e. within the universal services. But it is also important that when specialist services are needed, they are readily accessible.

Clarity about what the specialist services should offer is clearly an important part of this. In reaching for such clarity, numbers of specialist services have adopted, and sometimes published, clear advice about how to get the best out of these services. It is important that where referral criteria are being developed, this is done through discussion between specialist services and the wider network. The indications from those who use these services are that these criteria can compound access problems rather than improve them. Referral processes should be implemented and monitored with a view to ensuring outcomes for children which are socially inclusive.

The proposal here is that services for children and young people operate better as relationship-based or intelligent networks. Any protocols must run against that background and be designed to facilitate rather than govern these arrangements.



5. SOME SPECIFIC EXAMPLES OF NETWORK CONNECTIONS

A range of models of relationships between the network partners in the service of “promotion, prevention and care” is now available. Some are established, while others, currently emerging, will require evaluation before they are disseminated. Some illustrations are given here of how these themes might apply in different contexts.

Primary care

There are numbers of well evaluated models under this heading. One involves a health visitor embarking on a short training course in parent training, then, with consultation from a mental health specialist (this work was pioneered by clinical psychologists), offering a service to the local area.

A second model, now being developed widely across the UK, including Scotland, is that of the “primary care mental health worker”. In this model, a practitioner with a specialist mental health background is based in a primary care setting. They are then well placed to offer consultation, rapid intervention and to facilitate referral of those children who cannot readily be supported in that context.

Education

Over recent years, traditional approaches to health education have evolved into the notion of the health promoting school. Here the focus broadened from the curriculum and the individual pupil to the “whole school approach”. This is a very rich area for collaboration between health and education which, in Scotland, is facilitated by a national joint project, the Health Promoting Schools Unit. They will shortly be “mapping” what is going on in schools and inviting young people, parents and services to indicate their views about mental health and schools.

One of the opportunities this relationship affords is to develop primary prevention initiatives, using both risk reduction and, increasingly, practices aimed at increasing strengths.

The role of school nurses is in transition, with indications that they will increasingly develop a role in health promotion and early intervention work. One recent study indicated the viability of a drop-in advice service for young people.

There are now projects running, including in West Lothian, looking at direct involvement of NHS mental health specialists in school teams. This would enhance the feasibility of shared assessment protocols and earlier interventions, delivered in a way which many young people say they would prefer.

Social work services

Social workers are routinely involved with the most vulnerable and disadvantaged children in the community. Many of these children and their parents and carers have mental health and other problems which impact significantly on their relationships. Close working between social work services and health, including mental health services, should be a cornerstone of children’s services and many practitioners from both agencies reported experience of this working well. However, the pattern across Scotland is very variable.

There are well described, though few fully evaluated, accounts of how social work and mental health can work together. Social workers and mental health practitioners have much to contribute to one another's practice in relation to child protection, child abuse, fostered and adopted children, many of whom have can be thought of as having attachment and post-traumatic disorders.

It seems likely that resource and other "network confounding" variables have meant that much needs to be done to restore these relationships. We suggest that this should be a priority issue wherever it is a problem.

Child health

Child health teams provide universal services and fulfil a very important role in the whole network of children's services in that they cover the spectrum from school health services to work with children with complex needs, including emotional and behavioural difficulties. They act as "network facilitators", promoting communication and collaboration between all professionals to ensure that all children and young people requiring services are identified early and treated promptly and appropriately.

There is significant potential for joint service initiatives with mental health, particularly in relation to children with complex developmental issues, and with complex needs, such as abused children and those who are looked after and accommodated.

Hospital paediatric (and other medical) services

Mental health issues commonly arise for children whose primary problem is of illness, abuse or disability. As a result there is a need for practitioners skilled in mental health and related interventions who can work closely with paediatric colleagues.

Paediatricians are therefore often in contact with many children and families who can and do benefit from the "promotion, prevention and care approach." The quality of relationship with mental health specialists therefore plays an important part in the care of the whole child and family.

These services also have contact with children who are in crisis and present to hospital because of self-harming behaviour. The importance of well established arrangements at such times is currently under intense pressure in numbers of areas, compounded by problems in recruiting and retaining consultant psychiatrists.

6. RESHAPING AND REFOCUSING NHS SPECIALIST CAMHS

NHS specialist child and adolescent mental health services exist in three main forms: single discipline clinical psychology services, multi-disciplinary services without clinical psychology and multi-disciplinary services which include clinical psychology.

Some services offer a service only to children, some only to adolescents, while most work with both. In almost all instances, services work with young people up to the age of 18. All services offer community based assessment and treatment. Residential (inpatient) facilities are, at present, provided for children at one unit, in Glasgow, while there are



three units for adolescents in Dundee, Edinburgh and Glasgow. Two units, one for children and one for adolescents have closed during the SNAP study period. The pattern of development of these services is highly variable across Scotland. Most NHS Boards now have a child and adolescent mental health strategy, and numbers of Boards have completed local needs assessment exercises. Although Boards report similar processes in developing their strategies, the outcomes in terms of investment in specialist child and adolescent mental health services vary widely. The data SNAP collected cannot account for these differences.

Capacity

This is a potentially serious problem, with some areas reporting great difficulty in sustaining clinical services, as reported by the Child Health Support Group from their visits in 2001 and 2002. It seems possible, if not likely, that these capacity issues may become more pronounced as clinical governance risk assessment procedures begin to examine the adequacy of service infrastructure.

It seems clear from our evidence that there is a lack of capacity in the specialist sector. This will require attention over a period of time, since problems in recruitment and retention, as well as problems in resourcing, contribute to this state of affairs.

These capacity issues were thrown into sharp relief by a very sharp rise in demand, across Scotland, in the late 90's, for consultation on the subject of attention deficit hyperactivity disorder. It appears that this has had a significant and persisting impact on service organisation and culture – with greatly increased rates of prescribing medication – and, in many cases, on the functioning of local networks. Associated with this, among other factors, many child and adolescent mental health services now have relatively substantial (by previous standards) cohorts of young people attending their clinics for prolonged periods. This has implications for resources within these teams and for the relationships with adult services when the time for transition comes up.

Reshaping the services

When it proves possible to enhance the capacity of this sector, it will be important to reshape and refocus. As discussed under heading 5, practitioners from these specialist services will have an important part to play in enhancing the wider network. The SNAP survey makes clear that they are already involved in liaison, consultation and training, but this will occupy a larger percentage of their time and will increasingly lead to joint working with colleagues in schools, primary care, social services, child health teams and others.

The effect of this will be to move the centre of gravity for specialist CAMH input increasingly towards the universal services, enhancing the capacity of that network for earlier intervention. This also has the potential to change the pattern of demand on the specialist services, allowing them to develop their role more fully for children with more complex and severe mental health problems.

This development in the conceptualisation of the specialist service role can be likened to a node in the network – non-hierarchical, with multiple connections. We contrast this with

the earlier notion of specialist CAMHS as occupying the upper “tiers” or apex of a pyramid, popularised in *Together We Stand*. Although not proposed in these terms by the authors, some had taken this to suggest a hierarchical model of service relationships.

Specific challenges

There will continue to be residential or inpatient units for young people with severe mental health difficulties provided by the NHS, crucially supported by local authority education and social work staff. Current indications are that investment in and expansion of that highly specialised sector is urgently needed. Young people should be treated in the kind of developmentally appropriate settings which the specialist child and adolescent units offer, but are often unable to gain access to them at present, because of limited bed numbers. It is not appropriate to locate them in wards designed for working age adults, unless very specific arrangements have been made to adapt that environment to meet the young person's needs. This cannot be said to be the case for the majority of adolescent admissions to adult wards.

This is one of a number of issues that cannot be addressed adequately by single NHS Boards. In the medium term, regional planning may be appropriate, but in the short term, it appears that a national framework for addressing the issue of child and adolescent mental health beds will be necessary to prevent continuing attrition of this resource.

There is also the need for the development of links between specialist mental health teams and the work done by social work and education services with very vulnerable groups of young people, such as those who are looked after and accommodated and those who have been abused. There are now examples emerging across Scotland, some of them described in the Good Practice Summary, to be found on the Mental Health and Well-being Support Group's website.

As with the rest of the network, consultation, joint working and models of joint service delivery should be explored as ways of making the best interventions available to these most vulnerable young people.

Where there are effective treatments and evidence of the benefits of early intervention – as in early intervention in psychosis – development of strategies to promote early identification and protocols to guide rapid intervention is encouraged.

This is a proposal for continuous service evolution, informed by rolling needs assessment, which seeks excluded groups and unmet need. In this respect it is important to acknowledge that there are groups of children and young people who have not been well served by these services: in particular those with a learning disability, those who are looked after and accommodated, those involved in substance abuse and those who are offending.

It is also important to note the challenges to service delivery associated with rural and island communities. There have, however, been important developments in models of service delivery, in a variety of Board areas, including Dumfries and Galloway, Borders and Highland. Evaluation of these developments will be important in the process of service evolution.



7. ENHANCING THE CAPACITY FOR ENQUIRY

There are many opportunities for participating in research which relates to child and adolescent mental health. Much important research is going on, for example, in mental health epidemiology, basic sciences and social sciences, as well as clinical research in child and adolescent mental health.

Nonetheless the cohort of clinical academic child and adolescent mental health specialists remains modest and almost entirely confined to psychiatry. It seems important, as this capacity is developed, that it also diversifies to include other professional groups, such as clinical psychologists and nurses.

There is already collaborative work going on, for example, between mental health specialists and social scientists and social work academics. In this domain, too, such partnerships often generate significant synergy, and enhance the capacity of each party.

This report talks about integrating promotion, prevention and care. This development, as well as the proposals for service development and reform, will provide opportunities for further research, as well as the need for evaluation.

There are, therefore, opportunities for primary research and for service research - evaluating the most effective methods of delivering interventions of known effectiveness. Both are important.

The SNAP survey found that few of the NHS specialist mental health services were involved in any service research. It was also reported that few were involving young people or parents in formal evaluation of their experience of these services. These are matters for early attention.

8. LEARNING AND TRAINING OPPORTUNITIES

As well as those opportunities for learning made available through professional supervision and consultation, there is a need for formal learning opportunities.

NHS Education Scotland has now begun work on the “educational needs of child and adolescent mental health services”, and is considering course content and also the contexts in which any child and adolescent mental health training opportunities could be offered.

In the “narrow” domain of NHS specialist CAMHS, there is evidence, from across the country, of problems with recruitment and retention. Approaches to training have not enjoyed a strategic infrastructure and the indications are that they are often piecemeal and reactive. Few services have a training strategy and most indicate that staff interests and available training opportunities have a particular influence on the use of training budgets.

There are sources of training for specialist CAMHS, from basic post-qualifying training, with introduction and orientation to child and adolescent mental health work, through to

specialised training in psychological therapies, e.g. cognitive behaviour therapy, family therapy and child (analytical) psychotherapy. Many of these resources, on which the NHS relies for the development of its skilled workforce, exist at or beyond the edge of the NHS and operate with tenuous infrastructure jeopardising their capacity and reliability.

In the wider network, the clear majority of survey respondents indicated a wish for training in relation to mental health. Numerous references were made during the SNAP seminars and surveys to the possibilities of joint training, with the model used in child protection training cited as an example.

There is, therefore, an opportunity for agencies to join together to explore ways of developing and sustaining training opportunities around the broad themes of mental health and of promotion, prevention and care.

For Scotland's Children emphasised capacity to work with families as a core attribute of children's service workers, adding that it was often underdeveloped. We note that the US Surgeon General's report on child and adolescent mental health listed family work and "cultural competence" – the ability to work respectfully and sensitively with people of different backgrounds – as the core skills for effective practice in this area.

Those who take up this task should note that at various points in the consultation with young people, the suggestion was made that they (and we surmise that this would also be true of parents) could make a significant contribution to training.

9. AN EVOLVING AND DEVELOPING WORKFORCE

For Scotland's Children discussed problems with the workforce and recommended (p. 108) that the Scottish Executive establish "a workforce planning group to take forward plans for the children's services workforce." The SNAP work certainly confirms the importance of such a development and our surveying has gathered data which could contribute detail to that process.

The NHS already makes provision for considering some elements of the child and adolescent mental health workforce, e.g. nurses, psychologists and psychiatrists. There are, however, additional groups who will need to be considered in any strategic review of CAMHS workforce: those who offer the "psychological" therapies mentioned above and those who offer "developmental" therapies, in particular speech and language therapists and occupational therapists.

There are specific difficulties in recruitment in relation to some disciplines within the sector, which suggest that staff mix will be substantially affected by supply rather than need. For example, some services are already finding that they have difficulty recruiting psychiatrists, others are having difficulty recruiting psychologists or psychotherapists.

This suggests that, over the coming years, role allocations within services will need to be reviewed and adapted, while steps are taken at workforce planning level to try to re-establish a throughput of appropriately trained staff.



10. STRATEGIC CONSIDERATIONS

NHS Scotland and its local authority partners need to make clear, effective arrangements for sustaining attention to child and adolescent mental health and ensuring that processes are established to drive change and secure long-term development in this area. These processes must be resilient if they are to endure the changing strategic environment and resist marginalisation of this theme.

The appointment of a Children's Commissioner is currently under consideration at the Scottish Parliament. The outcome is keenly awaited, given the prospect of long-term independent oversight of children's issues.

The National Programme for Improving the Mental Health and Well-being of Scotland's Population will play an important part in keeping issues relating to children and young people at the forefront of the health improvement programme.

The Child Health and Mental Health and Well-being Support Groups have played an important role in drawing attention to child and adolescent mental health. The former group's role in "championing the development of CAMHS", as part of an integrated work programme around children's services, is particularly welcome.

The broad notion of mental health and the integration of promotion, prevention and care need to be reflected in the work of planners at local level: notably child health commissioners at NHS Board level and their partners in local authorities.

Urgent measures, within a Scotland wide framework, are needed to secure the child and adolescent mental health residential (inpatient) sector. Steady progress will be required thereafter to transfer this responsibility to NHS regional commissioning structures. That environment would also be a suitable context for considering other vulnerable areas related to child and adolescent mental health, including low volume, high cost clinical services, services amenable to networked delivery and post-qualifying training.

We note that the Scottish Executive is currently considering the need for secure mental health provision for young people.

The SNAP survey attracted many comments about resources. Earlier remarks support the view that investment will be required to redress the capacity problems. However the way funds were introduced also caused repeated comment: there has been a perceived over-reliance on project funding as a way of bringing new resources into child and adolescent mental health work. In particular this was seen, by many service leaders, as a very mixed blessing: they were able to develop a new initiative but not able to afford to sustain a mainstream part of their service. This was one of a number of issues in financing these services which merit further work.

Where successful arrangements for joint planning and joint service delivery exist, they need to be studied and lessons learned to support more extensive joint working, including joint commissioning between NHS and local authority and other partners.

CHAPTER 1

MENTAL HEALTH AS AN ISSUE FOR YOUNG PEOPLE



WHAT DO WE MEAN BY “MENTAL HEALTH”?

The term mental health can be taken to mean many different things, and is used in different, and sometimes conflicting ways, by different people. This may not be a new situation, given that Jahoda observed in 1958: “...there is hardly a term in current psychological thought as vague, elusive and ambiguous as the term mental health”¹.

As if confirming Jahoda’s view, a variety of definitions can be found across Scotland and internationally in various key documents, with the same words being given very different meanings. This report will, however, use the term mental health throughout and so, before indicating how we propose to use the term, we begin by setting our discussion in context.

Weare writes lucidly on this subject:

“Exploring the concept of mental health can never be a culture-free or morally and ethically neutral activity..... What we understand by mental health will depend on our values, preconceptions and assumptions, for example about the nature of health and illness, the nature of society, the place of the individual within society, what constitutes normality, desirable behaviour and attitudes and so on.”²

In other words, professional groups, communities, societies and cultures are each likely to hold distinctive, and potentially unique, ways of conceptualising the nature of mental health, the factors critical to any meaningful consideration of the subject and what constitutes appropriate measures to address notional concerns about mental health.

In contrast to Jahoda’s reading of the use of term as “vague” and “ambiguous”, this report treats the absence of a shared definition as a function of diversity.



In acknowledging that mental health is not a neutral term, we need to recognise that, for some groups and cultures, it may hold negative connotations. This young person was reflecting on attendance at a NHS specialist child and adolescent mental health department:

*"I didn't think I was mental but when they said for me to go (to the department) then I thought, maybe I'm a wee bit mental"*³

Repeated indications of this kind, particularly from young people and those who make use of specialist mental health services, led us to consider whether a different set of terms might be helpful. At the SNAP young people's seminar (whose proceedings are published separately), the point was made by a number of young people that the term, as well as having negative connotations, "does not describe usefully or well the types of difficulties facing young people."⁴

Our conclusion, at this final stage of the SNAP process, is that we should, nonetheless, continue to use the term, given its considerable practical utility and in recognition of its increasingly wide use amongst agencies.

However we would advocate that it be used both with care, in recognition of these drawbacks, and with circumspection, given the diversity of the groups which use the term. Throughout the report runs the invitation to readers to consider the culturally located nature of their own perspective and to view the different positions held by others as a stimulus to dialogue.

As Kathryn Weare further argues, "we need not conclude from this, however, that mental health is so socially contextualised that it is impossible to define or explore". Nor should we assume that any way of thinking about mental health is just as good as any other. Ways of thinking – paradigms – "succeed not just because they are held by more powerful groups, but also because they fit and work better by providing more comprehensive and convincing accounts of what is known about the world."²

We therefore go on to discuss the particular use of the notion of mental health in this report, beginning with a consideration of some common conceptualisations, or models, of mental health.

MODELS OF MENTAL HEALTH

The single continuum or illness approach

In this model, mental well-being and mental ill-health (or mental illness or mental health disorder) are notionally at the opposite ends of a spectrum. Behaviour is considered in terms of this continuum where "healthy" means "not ill" and so mental health is identified by the absence of mental illness. In the literature and practice of adult mental health in the UK, it would be commonplace to find that the notion of "illness" is used to denote the problem end of the spectrum, while it would be usual, when talking about children, to use the term "disorder".

Single continuum

Mental Health ————— Mental Illness

The single continuum approach does not allow one condition to be present at the same time as the other – it does not allow us to be ill and healthy at the same time, as it is not possible to be located at two different points on the continuum at the same time. So a person who is thought of as having a mental illness has no potential for mental health other than the removal of their existing illness.

Under this model improving child and adolescent mental health would refer to reductions in prevalence of recognised “disorders” such as depression or eating disorders.

The dual continuum or health approach

This model⁵ proposes that a person’s situation can be considered simultaneously on two continua. So a person’s position on the “mental disorder/illness” continuum, which can range from severe to mild (or, indeed, absent), would not necessarily dictate where they fall on the (separate) mental health continuum. Indeed, in this model, it is possible to conceptualise the mental health continuum as containing several components, including the development of abilities (or not) and the subjective experience of well-being or distress.

Mental illness continuum

Minimal Mental Illness ————— Maximal Mental Illness
range of intensity from mild to severe

Mental health continuum

Optimum Mental Health ————— Minimal Mental Health

including for example:

*Optimum development
Subjective well being*

*Underdevelopment of abilities
Subjective distress*

Source: Based on Tudor (1996)⁵

With this dual continuum approach in mind it becomes reasonable to think more widely with someone who has a “mental disorder/illness”, about how to promote their mental health as well as how to improve their specific difficulties.

In addition this approach advocates the promotion of mental health among the general population – there will be people who, while not on the “disorder” continuum or in contact with services, could be thought of as scoring low on the mental health continuum (for example low self esteem or a lack of social support networks) and experiencing a poor quality of life as a result of this.



This young person who attended a mental health department described very articulately a disquiet that her/his experience was, to use the earlier parlance, being assessed using a single continuum approach:

*“I did feel as if they were picking bits out, rather than seeing the whole picture. They would ask me things and you know they would hit on things and, you know, they would piece these bits together, rather than getting the whole picture.”*³

But although the dual continuum approach helps to broaden our conceptualisation, there is still no one accepted or consensus definition for mental health. For the purposes of our discussion, mental health also needs to include the capacity to develop psychologically, emotionally, creatively, intellectually and spiritually; the ability to play and learn; the ability to develop a sense of right and wrong and the ability to face problems and setbacks and learn from them, in ways appropriate for that child’s age.⁶

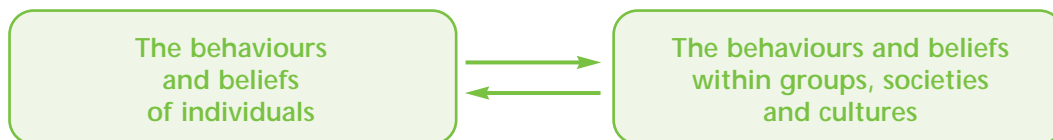
Secker, however, cautions that attempts to address this challenge by developing inclusive accounts of the “ingredients” of mental health run the risk of being “reductionist”.⁷

We therefore approach this problem by referring to the following description, from the 1997 International Workshop on Mental Health Promotion, not as a definition, but to indicate the breadth of thinking that informs the subsequent discussions of mental health:

*“Mental Health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity”.*⁸

One particular strength of this description is that it emphasises that mental health is at once both personal and social. Throughout this report we will draw particularly on those approaches which acknowledge these connections between personal well-being and relationships, structures and social discourses, variously described as the “public mental health”⁹ approach, the “whole school approach”² and “working systemically”.

The concept of public mental health



TALKING ABOUT PROBLEMS OF MENTAL HEALTH

Turning to consider problems of mental health, we find similar issues. The lexicon of mental health problems, particularly that used in relation to children, is open to many interpretations dependent on the model that is used. Thus we hear about mental health problems and disorders, mental illness, emotional and behavioural difficulties, psychological problems and troubled children.

This variation in terminology can create difficulties between agencies, children and their families. Here is what the Audit Commission report, *Children in Mind*, said about this:

“For example, a child psychiatrist might categorise certain symptoms in a child as ‘conduct disorder’. An educational psychologist, seeing the same symptoms in a child in a classroom, may describe them primarily as ‘emotional and behavioural difficulties’.... A social worker seeing the same child looked after by the local authority may describe him or her as having ‘challenging behaviour’ or express concerns about ‘the emotional development of the young person’. Non-medical professions, in particular, fight shy of stigmatising the child by labelling him or her as mentally ill.”¹⁰

Taking the Audit Commission’s quote as an example, we can see that the practice of making use of diagnostic labels, associated with doctors, principally psychiatrists in this context, has a number of risks attached.

As well as the risk of stigma already mentioned, there is the risk that a diagnosis serves to “locate” the problem inside the child, potentially ignoring “interactional embeddedness”¹¹, i.e. the multiple contexts which influence the child’s position. There is also the risk that a diagnosis appears to privilege a deficit-based view and devalues the child’s strengths or, in other ways compromises the very qualities that are central to the development of resilience. This dilemma appears to have increased in recent years, as indicated in this excerpt from *For Scotland’s Children*¹²:

“The Action Team found there to be a general consensus among mental health professionals consulted that the increased diagnosis of ADHD was as a consequence of improved sensitivity to the condition. However, a few dissenting voices among the specialists were more in tune with the more sceptical attitude found more generally. Many of those working with children expressed concern that what had previously been identified as a behaviour/conduct problem, sometimes in the context of problematic family relationships, was now being labelled in a different way which made approaches other than medication unavailable, and which removed children from the potential assistance available within a multi-disciplinary approach.”

The risk in presenting these brief accounts would be that different views are caricatured and the associated professional positions are depicted as arbitrary or idiosyncratic.

The responses from NHS Boards and NHS specialist child and adolescent services (CAMHS) to the SNAP survey appear to indicate a rise in the number of children identified, in most areas of Scotland, as having autism, Asperger’s syndrome and attention deficit hyperactivity disorder (ADHD). These are concerning findings although there are, as yet, no available serial prevalence studies which would allow us to confirm whether, in any of these cases, this is a true prevalence rise.

It seems possible, if not likely, that in one case there is a rise in true prevalence, while in the others more children are being identified, but the prevalence rate is unchanged.



Nonetheless, the increasing identification is associated with different responses across the network of children's services. There is particular concern attached to the increase in ADHD.

This seems to indicate that, in relation to this category, there is less confidence in the appropriateness of the medical-diagnostic paradigm, a concern which is less marked in relation to the other two diagnoses.

It seems appropriate to sound two notes of caution here. The first is about the use of diagnostic labels without due reference to wider contextual issues. The second is that when a particular approach to children's difficulties begins to flourish (in this instance, the medical-diagnostic approach to ADHD), it is important to consider whether this is happening because that model "fits better and works better" or whether different influences, such as changing resource profiles or changing agency policies, are at work.

We conclude this section by endorsing the advice of the team compiling *For Scotland's Children*¹² that "no medical/psychiatric diagnosis should remove a child from the potential assistance available within the range of multi-disciplinary children's services." (p.98). In practice, this will mean that practitioners both within teams and across each local area will need to engage in discussion about their differences, with a view to developing shared accounts of the young person's needs, and negotiation of the most appropriate paradigm(s) for interventions. The report discusses joint assessment and joint protocols at a later stage.

For the purposes of this discussion we shall use the term "mental health problem" and, where appropriate, add further detail to indicate specific patterns and issues of severity and complexity.

EPIDEMIOLOGY OF CHILD AND ADOLESCENT MENTAL HEALTH IN SCOTLAND

What is "mental health need"?

Guidance issued by the Reference Group for the Mental Health Framework sets out definitions of mental health need¹³. At its simplest, it means the need for an intervention that can improve the mental health of an individual, a family or a community.

In practice, it is common to find a range of need types: expressed need, felt need, normative need and demand. These are generated and met in different ways. The best way to arrive at a consensus about this is through a combination of methods – sometimes described as "triangulation", which enables stakeholders to consider patterns of need expressed in different ways – through epidemiology, service utilisation and qualitative information.

Given the range of need covered by the definition of mental health, it is clear that some needs are more easily expressed than others. Given that a part of good mental health is the feeling of being heard, it is important to try and reach those who do not normally feel they have a voice in generating a picture of mental health need. This is particularly true of children and young people, who frequently complain that interventions are aimed at them, rather than designed with them.

We go on to set the demographic scene, before turning to epidemiology and then other approaches which allow us to develop this three dimensional picture of mental health.

Demographic backgroundⁱ

Scotland is one of the relatively few countries in the world whose overall population is currently declining. Although this decline is gradual, the Registrar General's figures make it clear that there are "big changes in the age structure and geographical distribution of the population within Scotland"¹⁴. One of the main features is the falling number of children. The recently published 2001 Census results indicate that Scotland's population was 5,064,200. Table 1.1 shows the breakdown of the young Scottish population.

AGE GROUP	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29
Number	276,261	305,813	322,923	317,605	315,395	314,885
Percentage of total	5.5	6.0	6.4	6.3	6.2	6.2

Table1.1: Scotland's young population in 2001 (Source: Registrar General, 2002)

Comparing these figures with those from 1981, we see (figure 1.a) that the number of young people in Scotland has declined sharply over those twenty years.

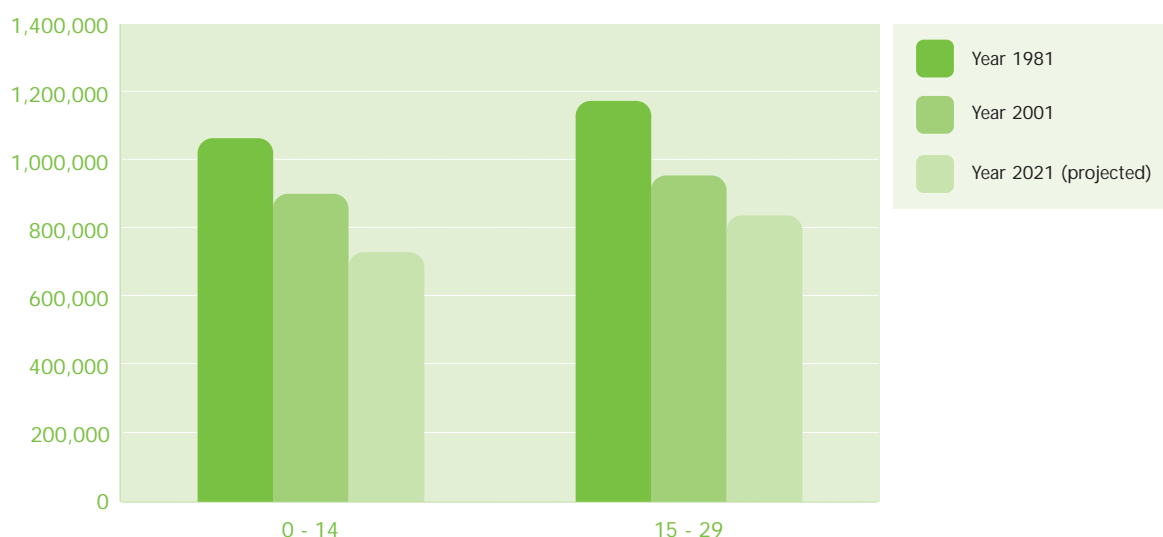


Figure1.a: Time trends and the population of young Scots (Source: Registrar General, 2002)

ⁱ The data in this section are derived from "Scotland's Census 2001: Report to the Scottish Parliament". Download from Registrar General's website: www.gro-scotland.gov.uk



Geographical distribution

The age structure of communities varies across Scotland. Over the whole country 18% of the population are under the age of 15. This ranges from just over 15% in Aberdeen City and Edinburgh City to 20% or more in East Renfrewshire, Shetland and West Lothian.

The distribution of the Scottish population is also changing. The number of people in urban areas, apart from Edinburgh, is declining, while in areas around the bigger cities and many rural areas the number is increasing. Migration is often the most important component of population change at this local level. Generally, areas in the south, east and north of mainland Scotland have experienced migration gains over the last ten years, with the largest relative gain taking place in the Borders. In contrast, nearly all of the migration loss has been in the west of Scotland with the largest relative rate of migration loss in Glasgow.

Finally, population density is a critical issue. Behind the average – 65 persons per square km – lies wide variation, from less than 10 in Highland and the Western Isles to over 2,000 in Dundee and over 3,000 in Glasgow City. This statistic alone illustrates graphically the challenges involved in delivering services equitably across Scotland.

While attempting to hold in mind this broad map of Scotland, it is also important to attend to the finer detail found within every family and community. So we must also consider how wealth and poverty, religion and culture, family structure, emigration and immigration, among other factors, inform and influence the way that young people live their lives wherever they are in Scotland.

The contexts of children's lives

These changes in age structure and distribution of the population have important implications for planning and delivery of services. The more local contexts in which children live almost certainly begin to give clearer indications of issues which have a direct bearing on mental health and emotional well-being.


Between 1991 and 2001 family households became smaller – on average from 2.26 to 2.12 persons. This decline was more marked amongst “large family” householdsⁱⁱ (from 18 per cent in 1991 to 15 per cent in 2001), although households headed by a member of an ethnic minority did not follow this trend. Over the same period “cohabiting couple” families increased – 3.5 per cent to 6.9 per cent. In 2001 more than 170,000 households were headed by a lone parent, with 91% of them led by mothers. As with the other trends mentioned here, this continues a trend developing over the last 30 years.

Multi-cultural Scotland

Some 2 per cent of the population of Scotland in 2001 were from a minority (non-White) ethnic group, compared with 1.3 per cent in 1991. After the White ethnic group, the largest numbers of people were in the Pakistani, Chinese, and Indian ethnic groups.

In terms of ethnicity, Scotland is less diverse than England. The recent census also affords an insight into the diversity and the changing nature of Scotland's religious make-up.

ⁱⁱ Defined as two adults under pensionable age with three or more children



Some 42% record Church of Scotland as their religion, almost 16% are Roman Catholic, 7% record “other Christian” and 1% are Muslim. Almost 28% report that they have no religion, with over 40% of them indicating that they had left the religious tradition of their upbringing.

So the picture from this brief demographic account of Scotland indicates important changes across Scotland: age structure, geographical distribution, household composition, ethnic, religious and cultural make-up. These social and demographic changes are having a dramatic effect on children’s lives. The rise in divorce and the range of circumstances leading to the increase in the number of lone parent households can have a variety of impacts on children, which can affect their emotional lives. A lone parent is often unsupported in the task of parenting, leading to difficulties in behaviour management. These parents are often unable to work and are more likely to be living in poverty, which again affects the emotional lives of children.

We move on now from the context to consider the evidence about the mental health of children and young people.

Prevalence studies

Mental health is more than the absence of a mental health problem. But when we come to measure the mental health of a population or community, it is difficult to identify factors that can serve as direct and reliable indicators of mental health. In other words, for the moment, using the broad notion of mental health espoused by this report, it is difficult to answer the question “is mental health improving?” Given the potential difficulty in establishing mental health as a reliable, measurable construct, this situation may persist.

Useful indications, however, come from considering patterns and trends in relation to those young people who are vulnerable to mental health problems and those who have mental health problems.

There are some well established factors that increase children’s risk of developing a mental health problem. These include a learning disability of any kind, enduring physical ill health such as epilepsy, physical or sexual abuse, witnessing domestic violence. The risk is increased for children growing up in a conflict-laden two-parent household and for children growing up in a lone parent household. A child whose parent has a serious mental health difficulty is also more likely than others to develop a mental health problem.

There are also factors which protect against the development of a mental health problem. These include attributes of the individual child, such as an adaptable nature or good self esteem, and a range of relationship factors, including peer and family relationships. For children who experience adversity, the consistent availability of a person whom they can trust and in whom they confide fosters resilience.

The relationship between trends in risk and protective factors and the prevalence of mental health problems in populations is complex. We can say that where there is evidence of increase of a risk factor within a population, for example the rate of family households



dividing evident in the recent National Census, then it is likely that the number of children developing mental health problems will increase. But this does not prove that this is happening.

The South East London study

One recent study¹⁵, which goes some of the way to addressing this problem, was carried out by Davis and his colleagues, who assessed 253 children, aged 0-16, from a deprived part of London. They used a schedule designed to identify mental health problems and also to identify the presence of risk factors for the development of mental health problems. In terms of number of lone parents, unemployment, low income and low level of home ownership, this sample is comparable to much of the Scottish population, particularly that in the cities. The ethnic diversity of the sample was much richer than that found anywhere in Scotland, with almost 30% coming from a non-white ethnic background.

They found that 71.9% of the sample had at least one significant problem, as defined by severity, persistence and impact. 36.7% had three or more problems. The mean number of problems for the total sample was 2.9. Reporting the mean number by age groups, they found that amongst 0-4 year olds the rate was 1.9; among those aged 5-10 and those aged 11-13, the rate was 3; the oldest group, those aged 14-16, had a mean problem rate of 4.7.

There were important gender differences, with the age 5–10 group of boys having more problems, but the rate of problems rose sharply amongst the teenage girls. This study did not use standardised measures and so the extent to which one can compare these findings with other studies is limited. However, the study did examine the relationship between risk factors and the existence of problems and demonstrated a significant positive correlation. In other words, this provides strong support for the notion that the prevalence of risk factors will give a good indication of the prevalence of mental health problems.

The MRC 11-16 study

This is a longitudinal study¹⁶, one of a number by Sweeting and West which reveal important mental health data, which followed a cohort of 2586 11 year olds in Central Clydeside. Patrick West summarised their findings:

“Evidence from ‘11 to 16’ reveals high levels of malaise symptoms. At age 11, a significant proportion reported being nervous (42%), irritable (41%), sad (35%) or having sleep problems (37%) within the past month, females having significantly higher rates for each except the latter. By age 13, excepting sleep problems (33%), rates for nerves (51%), irritability (48%) and sadness (40%) had all increased, the gender difference having widened. By age 15, rates for nerves (60%), irritability (55%), sadness (54%) and sleep problems (51%) had increased again, the gender difference widening even further. The percentage reporting any of these malaise symptoms at this age is extremely high; 76% of males and 88% of females. Among females the prevalence of all malaise symptoms exhibits a highly significant increase over this period, while for males this only occurs in respect of nerves. The dramatic change in levels of malaise symptoms between 11 and 15 is therefore predominantly a female phenomenon.”

These studies indicate that mental health symptoms are commonplace amongst children and young people, including young people in West Central Scotland. They do not tell us how severe or persistent or intrusive these difficulties are. These data are, however, now available from the ONS study.

The ONS study

In 2000, the Office for National Statistics (ONS) published the results of a UK study¹⁷ of over 10,000 children aged 5-15. They found that 9.5% overall had what they called a “mental disorder” – a problem of sufficient severity and persistence as to have a significant impact on the child’s functioning or relationships.

- The rate was higher in boys (11.4%) than in girls (7.6%).
- The rate amongst 11-15 year olds (11.2%) was higher than the rate in the younger ones (8.2%).
- The rate amongst young black people (12%) was higher than the average (9.5%), while children whose ethnicity was reported as Indian had the lowest rate (4%).
- The rate amongst children living in lone parent households (16%) was twice that of children living with two parents.
- Children in low income families (16%) experienced almost three times the rate of those in high income families (6%).
- The rate amongst the 892 young Scots surveyed was 8.5%.

Table 1.b illustrates the different rates of the main categories identified in the samples. As well as the age and gender patterns described above, we can see that the commonest problem recorded in this study is conduct disorder amongst boys, followed by emotional disorder amongst girls.

Age group	5 - 10			11 - 15			Total
	Boys	Girls	All	Boys	Girls	All	All
Emotional disorders	3.5	5.7	4.3	3.9	5.8	4.8	4.6
Conduct disorders	7.0	1.3	3.6	7.8	3.8	5.8	4.6
Hyperkinetic disorders	1.6	0.4	1.0	2.5	-	1.3	1.1
Less common disorders	0.3	0.4	0.4	1.0	0.4	0.7	0.5
Any disorder	8.2	7.3	7.7	10.1	8.8	9.4	8.5

Table 1.b: Prevalence of mental health disorders by age and sex. Source: ONS study¹⁷

Hyperkinetic disorder, a more narrowly defined syndrome than ADHD, is reported as occurring in 1.1% of the whole sample, with boys substantially over-represented. We know of no Scottish prevalence studies, based on the wider criteria of ADHD, but the prevalence of ADHD in the United States and in Canada has been estimated at about 3% to 5%, with a wider range of prevalence reported across studies¹⁸. Such claims are likely to galvanise the debate already touched upon about the appropriateness of this paradigm.



Rates of depression were recorded in the ONS study as 0.9% overall. These rates increased with age, such that 1.7% of the older boys and 1.9% of the girls were recorded as experiencing depression. Eating disorders were found in 0.3% of the older group, with the rates four times higher amongst girls. Pervasive developmental disorders were present amongst 0.3% of the whole sample. No young people with schizophrenia were identified during the study.

How does this rate of 8.5% for “mental health disorder” amongst Scottish 5-15 year olds compare to other countries? Waddell and her colleagues recently compared a number of what they regarded as methodologically robust prevalence studies¹⁹ from across US, Canada, Australia, New Zealand and Britain (the ONS study). The British study recorded lower rates than any other country. The authors argued that (Canadian) policy makers should assume that 14% of young people up to the age of 19 were likely to be experiencing a “clinically important disorder” at any one time. Using this approach, the overall numbers of children and young people in Scotland would range from a conservative 105,000 (ONS) to a possible 170,000 (Canadian study).

Whether we use the more conservative figures of the ONS study or amend them in line with the Canadian proposition, it is clear that significant numbers of children and young people in every community in Scotland experience significant mental health problems.

Vulnerable groups

Having established that there are factors increasing the risk of developing a mental health problem and that the risks accumulate, it should be possible to identify high risk groups. That this is the case is confirmed by a recent Scottish study of children who had become looked after and accommodated by the local authority²⁰. The rates of “depression” and “conduct disorder” in this group of 70 children aged between 5 and 12 were over five times higher than the average rates found in the ONS study group.

An asylum seeker is someone who has applied to the government to be recognised as a refugee. Since the introduction of the 1999 Asylum and Immigration Act, it is estimated that 9000 asylum seekers have been dispersed to Glasgow²¹. Glasgow is now the top dispersal destination in the UK. So far around 80% of asylum applications are reported as have been successful, and around 50% are preferring to stay in Glasgow.

About 1000 principal asylum seekers (i.e. not counting family members) have also arrived directly into Scotland. West Dunbartonshire, Fife and the City of Edinburgh are in negotiations with the Home Office to receive dispersed asylum seekers.

Many asylum seekers come from countries recognised as having chronic human rights abuses or conflicts. In Scotland most asylum seekers today are from Iraq, Iran, Afghanistan and Somalia. There is as yet no systematic information available about the mental health of the young people within the asylum seeking and recent refugee population. However, as Fazel and Stein point out²², “the available literature shows consistently increased levels of psychological morbidity among refugee children, especially post-traumatic stress disorder, depression, and anxiety disorders.” As well as any trauma experienced before arriving, asylum-seeking children

have to negotiate complex social and cultural tasks, and studies have shown that asylum seekers in the UK are the most likely of the non-white population to encounter hostility.

Scottish early onset psychosis study: a brief report

A research group based at the Young People's Unit at the Royal Edinburgh Hospital is just completing a Chief Scientist's Office-funded study into early onset psychosis (5-17 years inclusive), although the final report has still to be submitted. The principal aims were to establish the disorder's three-year prevalence (excluding those with co-morbid learning disability), to identify the duration of untreated psychosis, and to evaluate clinical and social outcomes and treatment provision.

The study was carried out in Edinburgh and Lothians, Lanarkshire and South Glasgow (total population 1,754,160). One hundred and three adolescents were identified using OPCRIT²³, a structured diagnostic assessment based on examination of case records. Almost two-thirds of the group were identified as suffering from schizophrenia while very few adolescents suffering from bipolar disorder with psychotic symptoms were identified. Subjects appear to have had a relatively short duration of untreated psychosis, and just under half were admitted to hospital at their first contact with the mental health services. Over the entire follow-up period the vast majority of the cohort had been admitted at some stage to inpatient care.

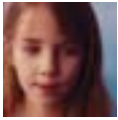
Interviews were carried out with 53 patients. These subjects were found to be experiencing considerable symptomatic problems, including mood problems, negative symptoms of schizophrenia, and significant cannabis misuse. The carers reported frequent episodes of aggression. The Developmental Needs Schedule (a needs assessment tool specially developed for the study) demonstrated high levels of specific needs for care that were unmet in both clinical and social domains.

In summary, despite a short duration of illness and the relatively prompt provision of acute treatment, many young people in this study have already experienced considerable ongoing morbidity. This highlights the importance of enhancing the level of service delivery for this vulnerable group of adolescents.

The SNAP team are grateful to the researchers and the Chief Scientist for their willingness to release this information to the SNAP report.

Are mental health problems increasing?

Numerous reports suggest that mental health problems amongst children and young people are on the increase. Some caution is necessary in arriving at conclusions about this, as with comparisons of rates of child and adolescent mental health problems between different cultures, given the differences in methodologies which have been used in different studies. So, for example, a 1998 review²⁴ of 52 prevalence studies concluded "there appears to be no trend for increasing prevalence among studies carried out since the early 1950's". By contrast Rutter and Smith concluded²⁵ that there had been a significant rise in the prevalence of psychosocial disorders during the same period.



There is evidence in routine NHS data of increasing demand over time for health services for children and young people, although this has levelled off in the last few years²⁶. These changes can reflect changing prevalence, increased recognition as a result of changing awareness and attitude, and even increasing availability of services. One recent Scottish study²⁷ has found that levels of “psychological distress” amongst 15 year old girls in West Central Scotland increased from 19% in 1987 to 33% in 1999. This finding, along with the rising suicide rate amongst young males and the steady increase in the magnitude of many risk factors, provide some support for an increasing prevalence. Further study is indicated.

CHAPTER 2 PROMOTING MENTAL HEALTH



INTRODUCTION

Health promotion is a rapidly developing field at every level: policy, research and practice. In this chapter we discuss the role of health promotion in relation to child and adolescent mental health. Beginning with a brief consideration of policy issues, we then discuss the characteristics of a health promotion approach. We briefly review the available evidence in relation to health promotion before turning to some relevant findings from the SNAP survey. We conclude with a discussion of the implications for child and adolescent mental health in Scotland.

POLICY

Health policy

Mental health promotion (MHP) is an important and evolving aspect of overall health promotion. As with definitions of mental health, there has been considerable debate over the scope of mental health promotion.

Since 1997, when health promotion had a relatively low profile in the *Framework for Mental Health Services in Scotland*²⁸, health policy has moved on. The White Paper, *Our National Health: A Plan for Action, A Plan for Change*²⁹, published in 2000, set out to “renew the health service” and, in particular, committed NHS Scotland to addressing health inequalities.

From that time, health improvement has formed an increasingly prominent and clearly articulated part of policy. This has been crystallised in the recent health improvement action plan *Improving Health in Scotland – the Challenge*³⁰. Mental health is understood as a central part of that policy drive, and the Executive has established the National Programme to Improve the Mental Health and Well-being of Scotland’s Population.



The local NHS health promotion departments, the newly formed NHS Health Scotland (an amalgamation of the Public Health Institute of Scotland and the Health Education Board for Scotland) and the National Programme will therefore play an important part in addressing the challenge posed by Scotland's mental health problems. The scope and scale of this network may be regarded as attempting to match the scale of the challenge: the evidence, as we shall see, suggests the need to address these issues at every level of society.

In the Child Health Template, the Child Health Support Group has set out the importance of health promotion as a component in its approach to the young population across the age range, specifying different ways in which this might be expressed at different developmental stages.

Education policy

Two particular developments in education policy are of relevance to the discussion of health promotion. The first is the emphasis on social inclusion, a strand running through much of current education policy and central to the New Community School concept. This resonates strongly with the health policy focus on inequality.

The second is the evolution of health education approaches into the notion of the health promoting school. Here the focus has broadened from the curriculum and the individual pupil to the "whole school approach". This is a very rich area for collaboration between health and education which is facilitated in Scotland by a national joint project, the Health Promoting Schools Unit.

Health promotion approach

Picking up the theme from chapter 1, there is some debate about the health promotion role in relation to mental health. A "single continuum" perspective may see MHP as the reduction of mental illness or the primary prevention of mental illness. This might include promoting awareness that mental health problems, such as depression, affect children and young people. So a "single continuum" mental health promotion approach might also seek to promote the need for services and treatment, and the reduction of stigma and nothing more.

By contrast, those from a "dual continuum" perspective view mental health as more than the absence of disease and see potential for positive developmental consequences as a result of promoting mental health. We shall continue to develop this approach.

Some reserve the term mental health promotion solely for activities on the mental health continuum which involve improving mental health as opposed to preventing mental health problems i.e. "activities which enhance competence, self-esteem and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders."³¹ These authors add that "the focus on health, rather than illness, is what distinguishes it from enhancement of protective factors within a risk reduction model for prevention interventions".

However, for others mental health promotion covers both the promotion of mental health and the prevention of problems as they are viewed as one and the same – efforts to promote mental health will prevent mental illness and vice versa and measurements

The Intervention Spectrum

Adapted from Mrazek and Haggerty (1993), via Barry(2001)

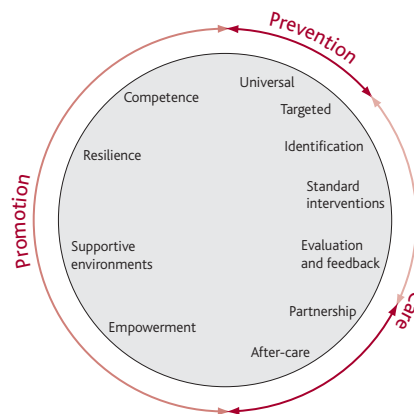


Figure 2a: The Intervention Spectrum

of mental illness and mental health actually overlap considerably as do the intervention methods. In a major meta-analysis of prevention and promotion efforts for children and adolescents, Durlak and Wells³² highlight that programmes designed to promote mental health also tend to reduce problems, while those that seek to prevent mental health disorder usually also enhance competence and resilience.

Throughout this report we discuss a “promotion, prevention and care” approach. This is done to emphasise the contribution of each of these traditionally discrete approaches to the mental health of young people and the importance of considering, as far as possible, integrating them in planning contexts and in the development of programmes and services.

Current approaches to promoting mental health

The landmark Ottawa Charter³³ outlined the broad range of actions required to achieve health as:

- Building healthy public policy
- Strengthening community action
- Reorienting health services
- Creating supportive environments
- Developing personal skills

We revisit this concept since it seems that, in practice, it will often be more straightforward to develop health promotion initiatives focussing on the more local and personal targets. However, this foundational charter makes it plain that the health promotion approach also seeks to explore and address the social and structural roots of health inequality.

Therefore, promoting mental health involves local and individual initiatives to create and sustain supportive environments which enable young people to deal with adversity – the development of resilience. However, it also involves influencing cultural and strategic



environments, and contributing evidence to debates about how public policy can promote the health of the young Scottish population.

Current approaches to prevention

Durlak and Wells³² in their meta-analytic review of 177 primary prevention programmes, identified two major dimensions amongst prevention approaches: level of intervention, that is whether it was person or environment centred, and the way the target population is identified, i.e. is it a whole population (“universal”) approach, is it aimed at groups at known risk because of pre-existing risk factors, is it groups at potential risk because of current or imminent experiences, e.g. children of divorcing parents or children facing stressful transitions.

In their study, person level interventions outnumbered environment level interventions by more than five to one. Most of the programmes examined targeted universal populations, with interventions targeting high risk groups being least common.

Effectiveness

Although there is currently much activity designed to promote mental health, few activities are measured in terms of effectiveness. A key problem is the current shortage of agreed indicators of mental health and methods of measurement. As a result there are few fully evaluated initiatives in the literature relating to promoting mental health as opposed to prevention of mental illness. Further research on this area will therefore be important.

There are, however, sources which indicate how children develop resilience³⁴, how resilient families operate³⁵ and the qualities of school environments which promote the mental health of pupils². It is important that clear information about this evidence is widely available and discussed amongst those who work with children and young people and their families. These factors are as outlined in Chapter 1.

It is also clear from the work of Durlak and Wells, among others, that effective methods of prevention are established. They conclude “most types of primary prevention programmes achieve significant positive effects. Furthermore, most interventions significantly reduced problems and increased competencies, and affected functioning in multiple adjustment domains.”³²

The implications for research and training are discussed later.

CURRENT PRACTICE – SOME FINDINGS FROM THE SNAP SURVEY

In the survey work conducted as part of the SNAP process, health promotion activity was studied in a range of settings. In phase one of the studyⁱⁱⁱ, conducted at the end of 2001, 12 of 15 Directors of Public Health responded as did 15 out of 15 health promotion units.

NHS health promotion units (HPU's)

14 of the 15 HPU's had a member of their team with responsibility for mental health promotion (MHP). Half were part-time and time allocated specifically to children and young people varied greatly.

iii The structure and stages of the SNAP process are described in Chapter 4.

11 of the 15 HPU's had a strategic approach to child and adolescent mental health in place or in development. HPU's tended to work with a variety of partners in relation to MHP among young people. All indicate that they work with formal education, while 13 worked with informal education and with those looked after by the local authority. Over half (8/15) reported working with voluntary organisations.

Evaluation was a prominent theme amongst the work on child and adolescent mental health although some indicated difficulty with identifying adequate measures. 11 of the 15 indicated that they consult children and young people about their views and their perceived needs in relation to MHP work.

Particular concerns were recorded concerning shortage of resources, perceived lack of priority within NHS Boards for mental health, and the tendency to equate "mental health" with mental illness.

Health promotion in NHS Board CAMH strategies

12 of the 15 Boards replied, the majority having, by the end of 2001, established a strategic plan for child and adolescent mental health. However, there was little evidence of linkage between the mental health strategy and the health promotion work. So for example only 3 Boards involved a health promotion worker in the development of the CAMH strategy.

What is happening in services?

Of the NHS specialist CAMH services replying, half said they were involved in health promotion activities. However the phase 2 study suggests that this involvement is modest. 225 specialist CAMHS practitioners responded to the survey, a 55% response. 126 of those (56%) indicated that they spent little or no time on mental health promotion.

In the survey of those who work across the network of children's services over 900 responses were received, a rate of between 40% and 50% for most of the groups surveyed. 793 responded to the question "do you offer any sort of health promotion for young people?", with 68% indicating "yes". The rate amongst class teachers and school nurses was particularly high, at 88%. The clear majority of most other groups responded positively, including residential child care workers (76%), health visitors (69%), nursery teachers (67%) and community paediatricians (60%). There was no specific definition of mental health promotion and therefore some caution is needed in interpreting the significance of these figures.

In summary, the indications from the SNAP survey are that health promotion is an active part of professional culture. The NHS health promotion units are linking with the education sector and there are indications that health promotion has a significant profile amongst other children's services. By contrast it appears that health promotion has a low profile in relation to NHS specialist mental health services, both at strategic and operational level.

IMPLICATIONS

We now discuss briefly the implications for the contribution from the rapidly developing field of health promotion. These appear under the headings of strategy, interventions, research and training.



Strategy

*Improving Health in Scotland – the Challenge*³⁰ provides a new strategic framework for health promotion activities in Scotland. That whole programme is likely to be of importance to the mental health of children and young people, but two of its themes, early years and teenage transitions, are clearly of direct relevance.

The National Programme to Improve the Mental Health and Well-being of Scotland's Population, along with its partners, particularly in Education, will be involved in developing and promoting new initiatives in this area. It is likely that this will include discussion of priorities for health promotion and prevention work in relation to child and adolescent mental health, for pursuit at the various levels identified in the Ottawa Charter³³. This would be welcome.

Each NHS Board should develop, integrated with its child and adolescent mental health strategy, a multi-agency mental health promotion strategy. The child health commissioners, who would be central to this work, should also ensure that services for children and young people integrate promotion and prevention into core service delivery.

NHS Boards and their partners should also ensure that the mental health needs assessment work they undertake incorporates ways of consulting children, young people and carers about the issues which they identify as important in the protection and maintenance of their mental health.


Developing interventions

The Mental Health Foundation report, *Bright Futures*³⁶ and the recently published Mental Health Improvement briefing for the Scottish Executive³⁷ offer comprehensive accounts of health promotion approaches to the mental health of children and young people to which the interested reader is directed. This account turns to the more particular issues involved in developing health promotion activities in Scotland.

The work of Durlak and Wells³² and the SNAP report, *Mental Health Promotion among Young People*³⁸, among others, give clear evidence not only of the general effectiveness of promotion and prevention approaches but also indicators of which populations to target and which are the most effective strategies for which problems. The evidence of effectiveness is at least comparable to other interventions in the medical and social science fields. It appears that NHS Scotland and its partners are involved in exploiting this evidence but, in many areas, we are in the early stages of this important development.

Services and organisations should develop preventative interventions directed at risk and protective factors rather than at specific problems. Within that approach, it is important to identify strengths, in children and in families, and work to enhance these, as well as working on risk reduction.

Advice and support relating to mental health needs should be “mainstreamed” as far as possible, to promote accessibility and reduce stigma. The views of children, young people and parents about forms of support and methods of delivery are likely to be very helpful in developing effective promotion and prevention initiatives.



Community resources, such as availability of pre-school provision, good quality child care and recreational facilities for children and young people were rated as high priority issues by those contributing to the SNAP consultations.

There is ample evidence to shape initiatives which support families, for example pre- and post-birth support for parents and readily accessible support at times of transition. These are initiatives likely to be of value to whole populations. They should certainly be widely available to children, young people and parents who are at high risk of mental health problems. It is worth noting that, as well as professional workers making effective contributions, there is evidence indicating the value of appropriately supported community volunteers.

As the health promotion evidence base develops, the place for universal initiatives will become clearer. Agencies in Scotland should play a part in the development and piloting of initiatives which will contribute to the knowledge of what constitutes acceptable and effective interventions.

Many children and young people have to manage particularly challenging transitions, for example the death of a parent, parental separation or parental mental illness. There are also many young people who have to manage particularly complex transitions, for example those who are refugees, those who spend time being looked after by local authorities, those who experience chronic health difficulties, young carers, those who inhabit very different cultures at home and school. Much can be done to help children and young people negotiate these potentially stressful transitions. It is particularly important that such initiatives are developed and delivered in ways that can adapt to the complex contexts of such young people's lives.

Agencies will want to ensure that their services are 'young people friendly'. There are now a number of good resources available to help with this task. Health services, for example, can refer to the guidance in the report *Walk the Talk*³⁹.

Research

It appears from the SNAP evidence, and the previous SNAP report on youth mental health promotion, that there is limited infrastructure for developing projects to promote the mental health of children and young people. As the scale of initiatives increases, there will need to be accompanying investment in infrastructure for research, development and evaluation.

The emergence of evidence-based health promotion guidelines, which agencies can adapt to their particular circumstances, would be very welcome.

Training

Two of the themes that run through this report are building capacity and integrating promotion, prevention and care. It follows that health promotion should be an important theme in the learning and training developments we envisage.

CHAPTER 3

INTERVENTIONS FOR EMERGING AND ESTABLISHED PROBLEMS



EARLY INTERVENTION

Early intervention began as a concept in the USA in the 1960's with the development of the Headstart Programmes for disadvantaged children. These gained a great deal of publicity as they were shown to "raise the IQ" of disadvantaged children thus giving them a "head start" in education.

The concept of early intervention has grown and developed substantially in the intervening years. It has broadened to incorporate a focus on groups of children at risk and therefore has much in common with prevention. The concept has moved from being a deficit based model to one where families and the community are seen as having personal strengths and positive resources. The shift is towards empowering families and communities and recognising their strengths. It has also come to mean not only interventions with young children but also interventions which occur 'early in the problem cycle'.³⁶

There is a recognition that there are many kinds of formal and informal supports which function as forms of early intervention and that there are many resources within families. Early intervention is best where 'practitioners are identified as members of a family's informal support network'.⁴⁰ There is, for example, research evidence to show that involving people from the support network which is familiar to the family can result in considerable gains in terms of preventing behavioural problems and juvenile delinquency.⁴¹

We shall go on to consider some of the main developments in early intervention, before concluding 'not whether we should intervene but how, for whom and to what end?'⁴²

Early intervention projects have been developed in three main areas:

- Early intervention aimed at enhancing development
- Early intervention projects with families
- Early intervention in the community.

Early intervention aimed at enhancing development (compensatory programmes)

The Headstart programmes in the USA began as a six week summer school for disadvantaged children. These developed into a variety of full-time community based programmes. They were subsequently criticised as gains diminished after two years of normal schooling.

Yoshikawa⁴³ suggests that Headstart programmes could be improved by incorporating the features of other successful programmes, i.e. initiated in the first five years of life, intensive, prolonged and incorporating educational and parent directed approaches. The advantage of Headstart over the other programmes is that it is a nationwide initiative.

Other compensatory programmes have been able to demonstrate gains for children with autism⁴⁴ and children of low birth weight⁴⁵.

Early intervention with families

Reviews of early intervention programmes⁴⁶ have shown that a combination of factors contribute to programme effectiveness and promote the emotional well-being of children and their parents. These are:

- Intervention commencing with children below age five
- Intensive intervention over a sustained time period
- Community based intervention with familiar people in partnership with parents and other professionals
- A programme which incorporates both an educational aspect (focussing on children) and a support and educational component (focussing on parents).

Programmes based on these principles have been established in the UK, including NEWPIN⁴⁷ and Homestart (see below).

The government-funded Sure Start initiative in the UK aims 'to promote social inclusion through a positive start in young children's lives'. The Scottish initiative is targeted on children up to 3 years old, with the aim of:

- improving the child's emotional and social development
- improving the child's health
- improving the child's ability to learn
- strengthening families and communities.

Early intervention programmes such as Sure Start can promote mental health in babies and young children in the following ways:

- The promotion of stimulation and play opportunities which facilitate cognitive and social development
- Good nutrition fostering brain growth at a sensitive and critical period
- Supporting and enhancing the quality of the parent-child relationship, which can be undermined, for example, by maternal depression
- Promoting positive parenting: preventing and disrupting any cycle of poor parenting which can lead to the maintenance of emotional and behavioural problems in families.

Some early intervention programmes, such as Homestart, are designed for families under stress, for example, by virtue of post-natal depression. This programme, based on principles of partnership and prevention, involves locally based volunteers visiting families with at least one child under age five in their own homes.



The scheme has been developed in several areas of Scotland (mainly Fife, Tayside and Grampian) and recently evaluation⁴⁸ has indicated gains for both the parent in terms of self-esteem and a decrease in the rate of behavioural problems in the children.

Parent training

Parent management training has been shown to be the most effective method for preventing and intervening in behavioural problems in children⁴⁹. There is evidence⁵⁰ that a parenting programme which combines parent management training with problem solving skills training for the children is more effective than either intervention alone.

Webster-Stratton⁵¹ emphasises the importance of children's perceptions and of social circumstances; parent training approaches should also address this issue and involve training in problem solving, anger management, learning empathy and other social skills. Webster-Stratton also emphasises that parent programmes must be focussed and delivered in the community where families live⁵².

A recent publication from a research team based in Oxford⁵³ looked at demand for a parenting programme. Parents of 1788 children aged 2-8 years who were registered with three general practices were sent the Eyberg Child Behavior Inventory (ECBI)⁵⁴ and were asked if they were interested in attending a parenting programme. The response rate was 70%. One fifth of the children exceeded the score on the ECBI defining the likelihood of "having a behaviour problem of clinical severity." Among the respondents, 58% of parents said they would be interested in attending a parenting programme, the group expressing most interest being parents of 2-4 year olds. The only other predictor of parental interest in attending was the ECBI score. These findings suggest that there is likely to be a high demand for parenting programmes, and that it is those parents who would benefit most who express most interest.

The parents of those children who scored above the median on the ECBI scale were asked if they would take part in a randomised controlled trial of the parenting intervention⁵⁵. Thirty percent (116 parents) participated. The intervention consisted of a Webster-Stratton type group facilitated by health visitors who had received three days' training, while the control group received no treatment. Compared to controls, the children of the intervention group had significantly better Strengths and Difficulties Questionnaire (conduct subscale)⁵⁶ and ECBI scores at six months follow up.

Early intervention in the community

Preventing conduct problems and delinquency

The Audit Commission's report *Misspent Youth*⁵⁷ stressed that early intervention with families could aid prevention. One of the recommendations of this report was that "In conjunction with education, health visitors and mental health services, social services should consider piloting schemes in deprived areas to provide guidance on parenting and assistance to those with difficulties through family centres and volunteer programmes." They also recommend parenting programmes and early intervention in schools.

School based early intervention

One of the early multi-disciplinary, multi-agency projects where there was intervention in the early stages of a problem was that carried out by Kolvin et al in the 1970's in Newcastle upon Tyne⁵⁸. This research project embodied a number of principles which have been proved to be effective in early intervention, namely:

- Help is offered in a situation which is familiar to the child and non-stigmatising
- Interventions carried out by workers who were not mental health professionals
- Necessary training made available via consultancy with mental health professionals.

A review⁵⁹ of the literature on school-based preventative projects concludes that, although many studies have methodological limitations, there is evidence that aggressive and acting out behaviours can be modified by behavioural and cognitive behavioural programmes for children and young people.

Webster Stratton's work, among others, indicates that engaging both the child's capacity to problem solve and the parent's concern contribute to the effectiveness of family based interventions. In school based approaches there are parallel indications about the importance of involving pupils in initiatives to promote better behaviour and better learning.⁶⁰

Where such interventions are delivered in schools it is, therefore, important to consider outcomes both in terms of indicators specific to the young person and whole school outcome measures such as attendance and exclusion rates.

Starting Well-Glasgow

This is one of NHS Scotland's current national demonstration projects. It is a multiagency programme linking Health and Social Services, Glasgow City Council, voluntary agencies, Children's Panel and police. This programme aims to improve the health and well-being of young children and parents in two deprived areas of Glasgow. The programme is based on ecological principles with a model of empowering parents and parent education. It is directed at several levels, including child, family and community.

There are two main interventions:

- Intensive home-based intervention by health visitors and "para-professionals" (family development plans, focus on parenting, mentoring, weekly visits). The NHS child psychology service provides support through consultation.
- Community based support and education (using existing groups and practical initiatives).

Early intervention for psychosis

The incidence of schizophrenia begins to rise during the 15-18 year age range, with the result that these young people are often poorly served by both child and adolescent and adult mental health services. There is a body of evidence that early intervention in psychosis, including both medication and psychotherapeutic approaches, is associated with better psychosocial functioning, both in the short-term and at 20 year follow-up. Effective early intervention requires greater public awareness of psychosis and services geared towards early diagnosis and interventions in an age-appropriate setting.



EARLY INTERVENTION SUMMARY

Several themes emerging in the literature and from well-controlled studies indicate that effective programmes incorporate the following features:

- They should occur early in the problem cycle and preferably early in age.
- They should involve familiar people or people who will be able to empower parents and work in partnership with professionals (e.g. health visitors or trained volunteers).
- They should be intensive and sustainable over a period of time.
- They should be multifaceted, incorporating several interventions (e.g. to both parents and child; focussing on health, education and parent training.)
- They should incorporate interventions of proven effectiveness (e.g. behavioural methods and cognitive approaches; focussed interventions for parents who are, for example, psychotic).

The best programmes will take place at several levels (tiers). This might involve GPs, health visitors, teachers, social workers, trained volunteers and others delivering the service, CAMHS professionals, educational and clinical psychologists working in programme design, consultancy, evaluation and training.

To facilitate these interventions we recommend that:

- Programmes should be rigorously evaluated and an evaluation strategy should be established before the programme commences.
- Programme designers should take note of the features described above.


INTERVENTIONS FOR ESTABLISHED MENTAL HEALTH PROBLEMS

There is a considerable amount of evidence of direct relevance to mental health work with children and young people and a number of well written recent summaries^{61,62,63}.

We do not aim to reproduce or distil this now broad and detailed field. There is however an important discussion to be had, which we begin with some examples of effective interventions⁶⁴:

- Carefully structured parenting programmes are an effective way of intervening with children under 8 years of age who have established behaviour problems.
- Multi-systemic therapy, an intensive form of intervention which closely involves families, can reduce delinquent behaviour.
- Cognitive behavioural therapy is an effective treatment for generalised anxiety, phobias and depression.
- Stimulant medication is an effective treatment for the core features of attention deficit hyperactivity disorder.
- Family intervention reduces the risk of relapse where a family member has a psychotic illness.

While there are many more examples, those chosen will serve to illustrate that within a network of agencies providing mental health services for children and young people there should be a range of treatment modalities on offer.



Much of the evidence is derived from the treatment of children with single conditions, while most children presenting to child and adolescent mental health services have several co-existing mental health problems. Not all treatment methods have been evaluated, nor are there effective treatments for the whole range of mental health difficulties which children and young people experience. Further research is needed both to identify effective intervention methods and to test the feasibility of translating them into everyday practice settings.

A number of issues besides the technical aspects of the treatment method have a bearing on the effectiveness of the help offered. For example, behaviour management work with young children is not uncommonly confounded because the parent is depressed.

In a different domain, research with young people who have made use of mental health services suggests a number of contextual factors which can have an important effect on how helpful the experience of involvement turns out to be.

In one study⁶⁵, four main themes characterized the kind of adult identified as “helpful”. They were: general qualities (including empathy, availability, genuine concern); counselling skills; an ethical stance and the ability to make helpful outcomes happen.

A study in Glasgow⁶⁶ highlighted “the considerable stigma young people experienced when attending a psychiatric clinic. They were often scared when attending, particularly on the first occasion, and this affected the way they related to services. Of particular concern was the finding that half had been taken initially against their will to see a psychiatrist, and some did not feel that they had given informed consent to treatment.”

The existence of effective treatment methods does not guarantee that treatment services will be effective. Services must have available staff who are appropriately skilled and have adequate resources to allow them to work efficiently and effectively. Quality of relationships within teams and agencies expressed, for example, in regular supervision, encourages the development of a capacity for learning through reflection on practice.

Cultural competence, that is the ability to work sensitively and respectfully with people from different backgrounds and cultures, and the commitment to working collaboratively and seeking full involvement of families have an important influence on effectiveness.

In these circumstances, it is important to evaluate services. The evidence from the SNAP survey was that, at the end of 2001, very few NHS specialist CAMHS were doing this. A range of domains should be covered in evaluation, including the views and experiences of children, young people and carers who use the service.

CHAPTER 4

THE CAMH SNAP PROCESS



THE SNAP PROCESS AND FINDINGS

The initial groundwork for the report made it clear that a more extensive research process than was initially envisaged was required, such was the scope and scale of this issue.

The aim of this process was to secure wide involvement. In particular a broadly based description of the current strengths and weaknesses was seen as essential, as was the engagement of those involved in the generation and refinement of proposals about how to improve the situation. We hoped that by the time that this final report was to be written much of the evidence would already be known and the conclusions, to be reported to the Scottish Executive Health Department and to the Scottish NHS Boards, would have already had wide discussion. Our aim has been to conduct our assessment in a way which is inclusive and collaborative. That has led us to follow a demanding and fairly lengthy path (Figure 4.a) but one which, we hope, has the merit of being transparent and accessible.

The “field work” was conducted in two phases. In the **first phase** we were looking at the strategic environment and so surveyed Directors of Public Health, Social Work Services planners, managers of NHS health promotion units and leaders of NHS services. This took place at the end of 2001 and the beginning of 2002.

We then published our Interim Briefing in May 2002 as the background to the second phase. This set out five themes which would permeate the final report. These were:

- Awareness of child and adolescent mental health
- Health promotion and the prevention of mental health problems amongst young people
- The work of “multi-agency child and adolescent mental health services”
- A strategic approach to specialist child and adolescent mental health services
- Involving young people and families.

Figure 4.a: The CAMH SNAP process



The **second phase**, which was supported by funding from the Scottish Executive Health Dept, had two main components.

One was a survey in which we approached three main constituencies: young people and parents, people who work routinely with children and young people, people who specialise in mental health and work with children and young people.

The second component was a series of seminars: a national one for workers in June 2002 and then, during September and October 2002, a national one for young people and three regional seminars (held in Nairn, Edinburgh and Glasgow) for workers. The aim of the seminars was to set out our findings and engage a wide constituency of interest in the interpretation of those and in the development of recommendations. The proceedings of those seminars are available on the PHIS website (www.phis.org.uk).

PHASE 1

The aim of this phase was to develop an account of strategic and operational activities related to child and adolescent mental health within public sector services. A number of questionnaires were developed^{iv} specifically for this exercise. These were sent, with an explanatory letter, to Directors of Public Health (n=15), Managers of NHS Health Promotion Units (n=15), Senior Officers in Social Work responsible for Commissioning Children's Services (n=34) and Lead Clinicians in NHS specialist CAMH services^v (n=34).

iv Copies of all SNAP questionnaires are available from the PHIS office.

v This number included both those services delivered by clinical psychologists operating as a single discipline and services delivered by multi-disciplinary teams of mental health practitioners, sometimes (potentially misleadingly) referred to as "psychiatry" services.



NHS Boards

Prior to the publication, in June 2001, of the Child Health Template, individual Boards decided upon the arrangements for the strategic planning of NHS CAMH services. The template indicated that Lead Commissioners for Child Health should become responsible for these arrangements. This part of the SNAP survey took place at the end of 2001 and 12 Boards responded. In 3 Boards, CAMHS were part of child health commissioning arrangements, in 2 Boards, they were part of mental health arrangements. All but one of the remaining Boards involved both systems. That single Board reported a stand-alone commissioning arrangement for CAMH.

Nine of the 12 NHS Boards reported that they had a CAMH strategy in place. One Board had had this for 4 years, but all of the others were of two years or less standing. In developing their strategy, NHS Boards had involved NHS Trust managers, clinicians, social work, public health, NHS Board planners, education and primary care, in the majority of cases. In less than half was there involvement of the child, parents or voluntary sector. Paediatricians and health promotion officers were also seldom involved.

Although there were no independent measures to quantify these issues, Boards reported that, in their area, there were rises in the number of young people presenting with autism (10), ADHD (7), deliberate self harm (5) and eating disorders (4).

In terms of service delivery, waiting lists were recorded as usually present by 5 Boards and always present by 4. While most Boards had information on "clinical activity", in terms of new and return attendances, only 2 out of 12 had any information available about the outcome of service interventions.

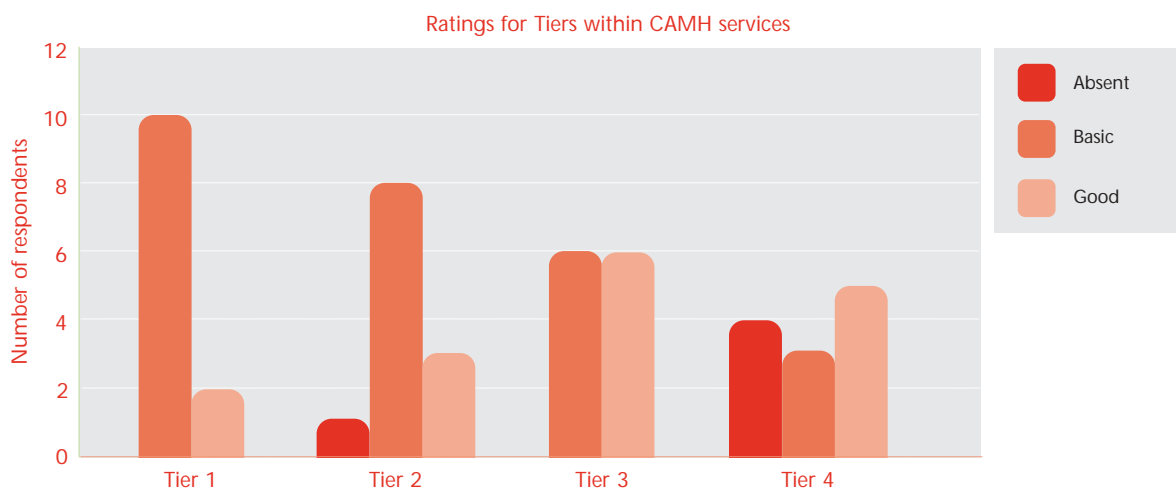


Figure 4.b How NHS Boards rated their local services

Boards were invited to rate each "tier"^{vi} of their CAMH services according to a three point scale: absent/basic/good. No guidance was given on how to derive a rating and so no claim is made about the validity of these categories. However, (fig 4.b) it is noteworthy that almost all

vi A reference to a pragmatic and widely used planning framework, described in the 1995 HAS Report "Together We Stand."⁶

Boards (10/12) rated their “tier 1” service as “basic” and 8/12 gave the same rating to “tier 2” services. Tier 3 and tier 4 services were more likely to attract the description “good”.

NHS Health Promotion Unit results are presented in the health promotion chapter.

Local authority social work services

Of Scotland’s 34 local authority Social Work Services, 17 responded to the SNAP survey. While it may be that some of these findings would hold generally across Scotland, it is important not to assume that this is the case.

In terms of joint working with the NHS, all 17 responding authorities reported that local NHS Boards were involved – 4 to some extent and 13 fully – in the development of their Children’s Services Plans. Fourteen of the 17 Plans made specific reference to the mental health and well-being of young people.

Half of the authorities had located social work staff within NHS CAMH services, but only 3 authorities out of the 17 recorded that their social work staff had access to training in relation to mental health and well-being of children and young people.

A series of questions was asked of both Health and Social Work about identifying young people at risk of exclusion from CAMH services. There was agreement that there were gaps, with both sides identifying looked after and accommodated children and those with behaviour problems.

NHS specialist child and adolescent mental health services

Clinical psychology services

Thirteen NHS Board areas in Scotland have Child and Adolescent Clinical Psychology Services although Argyll and Clyde (North of the Clyde) had no Child and Adolescent Clinical Psychologists at the time of the survey. Of the thirteen services, four services operate wholly within CAMHS whereas the remaining nine services are Child and Adolescent Clinical Psychology Services working within the NHS.

The age range covered by the service is variable but within the range of 0 to 19 years. In some areas there are separate services for children and adolescents but this is not usual. All services see children and young people with emotional and behavioural problems but all except three services would exclude children with severe learning difficulties who would be seen, instead, by Learning Disabilities Services. Many would not see children where the difficulties are almost all educationally based. They would refer suspected psychosis cases to Psychiatry.

Almost all services see the rate of referral as increasing and in many cases patients have to wait for more than twelve weeks (up to 70% of referrals). The severity of problems is seen as increasing by many departments with there being a particular rise in referrals for ADHD and/or autistic spectrum disorder. The most common kind of problems seen are behavioural problems with referral rates between 25% and 70%, followed by ADHD and children with anxiety and phobia. Two departments also mentioned child abuse cases.



Most services describe themselves as over-stretched with long waiting lists and difficulty in recruiting staff (although posts can usually be filled in October each year following graduation from the two training courses).

A range of assessments is provided including cognitive behavioural assessment, family/systemic, neuropsychological and psychometric assessment, with psychodynamic and occupational therapy type assessments occurring to a lesser extent. Most departments do not see themselves as having significant gaps in the range of assessments although some mentioned assessment for adoption and fostering as an area they would want to develop.


Departments see themselves as offering a range of therapies, in particular behavioural and cognitive behavioural therapy, family systemic therapy, parenting counselling with most departments providing some group work and parenting skills training. There are some other therapies being practiced to a lesser extent, for example, narrative therapy and solution focused therapy.

There were many reports of innovative work going on within departments. In particular services for looked after children, forensic services, health visitor consultancy, services for children who have been abused and developing services for children with autistic spectrum disorder and for some types of paediatric work. Some services however describe the gaps in services as being exactly those services which have been innovative in other areas, in particular services for autistic children and looked after children and children who have suffered abuse, services for children who having learning disability and forensic services.

There has been much expansion in multi-disciplinary working and many of the teams that are described operate on a multi-disciplinary basis. However there are problems with developing good multi-disciplinary team services partly because of the lack of concordance between the different local authority structures and the Trust structures, large geographical areas and isolation. Because of high demand on services it has been difficult to develop multi-agency working as much as might be desired. There is however much joint work, consultancy, training and supervision to professionals from other agencies.

Despite difficulties Child and Adolescent Clinical Psychology Services are forward looking and have developed specialist projects in the last few years. Particular mention might be given to substance misuse service, drop-in clinics for young homeless people, a range of paediatric services (such as sleep and soiling clinics, diabetes services), school based assessment for adolescents with depression, cognitive behavioural therapy groups for children and young people with Asperger's Syndrome, Early Bird for parents of children with autism and a variety of parenting projects.

There seem to be some problems with the development of health promotion and health prevention services although some of the good parenting work falls within these areas. Many respondents commented that there are not enough resources to cover the



development of these areas and there is said to be a major problem with input to tier 1 and tier 2 although many clinical psychologists offer consultancy and training to Tier 1 professionals such as health visitors and nursery nurses.

Multi-disciplinary child and adolescent mental health services

The number of referrals to CAMHS is going up, with up to 91% of patients being on a waiting list for more than 12 weeks.

The most common problems among referred children and young people are attention deficit hyperactivity disorder (ADHD), behavioural problems, anxiety problems and mood disorders. In addition there is increasing demand for services for children and young people with ADHD, autistic spectrum disorder (ASD), neurodevelopmental problems and deliberate self-harm, with the severity of problems seen as increasing.

The vast majority of services have problems with staff recruitment, notably with psychiatrists, nurses and clinical psychologists. This is worse outside cities. Almost all social workers in CAMHS are funded by local authorities, but half have no budget for training and development.

All CAMHS provide a variety of assessments, with 9/13 stating that there are gaps in what they can provide, e.g. proper assessment of children and young people with learning disabilities and mental health problems.

All provide a variety of treatments, for example, cognitive behaviour therapy (CBT), behavioural therapy, family therapy and parent counselling. 13/14 state that there are gaps in what they can provide because of shortage of resources – money, time and availability of trained personnel.

12/14 services provide a 24-hour on call service, with all respondents having difficulty managing on-call provision. This often requires a consultant to be first on call, means cancelling planned clinical activities and there are widespread difficulties in accessing appropriate inpatient placements for young people.

There is a huge variety in the specialist services provided. Approximately one third of CAMHS have services for looked after children and young people, a third for children and young people who have harmed themselves deliberately, and some offer a service to young people with a history of sexual and other abuse but these are usually separate services.

Seven out of 13 services report being involved in mental health promotion and there are many links with other agencies in preventative and treatment work e.g. with social work, education and health visitors.

The most unhelpful change in services provided by other agencies has been seen in social work departments, with their lack of resources and reorganisation having an adverse impact on the work CAMHS can provide.



The main problems with service delivery are due to lack of resources, which was regarded as a severe problem, and large waiting lists. Lack of direct involvement in “Tier 1 and 2” services was also a problem along with problems with multi-agency planning.

Overall there are many examples of innovative practice, but they are patchy and un-coordinated, services are overstretched and struggling to cover all the bases and there is huge variation in the services offered to families.

PHASE 2

Survey of non CAMH-based professionals


We sought the views and experiences of a wide range of professionals who work with children and young people, but who do not work in specialist mental health services. The questionnaire sought details of respondents’ working environments as well as their experiences working with young people with emotional, behavioural or mental health problems.

The sampling arrangement was based on numbers needed to examine trends down to local authority level. In some groups with smaller numbers, “whole populations” were surveyed. Table 4.1 sets out those involved. A full report on the quantitative results from this survey will shortly be available on the PHIS website – www.phis.org.uk. Some of the quantitative and qualitative data are summarised in this section.

Type of Work	Number of responses	Number sent	Response rate (%)	% of respondents
Class Teacher	230	603	38	26
General Practitioner	135	284	48	17
Field Social Worker	101	234	43	12
Residential Social Worker	89	289	31	11
School Nurse	83	230	36	10
Health Visitor	71	142	50	9
Community Paediatrician	27	70	39	3
Reporter	21	34	62	3
Other	71	-	-	9
TOTAL	828	1886	44	100

Table 4.1: Structure of sample.

The majority of respondents (68%) is female. Only amongst general practitioners (38%) and Children’s Reporters (43%) were women in the minority. The whole sample reported



working with children of all ages, male and female, from a range of social backgrounds, but with a preponderance of children from deprived communities.

Only 19% of respondents reported any training in child and adolescent mental health. Community paediatricians reported the highest rate (44%), followed by school nurses (27%) and residential social workers (24%). The rate amongst class teachers was 9%.

Indications were invited as to factors which “make access difficult”. Respondents were able to choose any number of factors and so total scores for each item give us a broad indication about the prominence of that particular issue. 828 of our respondents answered this question, and made over 2,500 nominations, an average of three each. Waiting lists were nominated by 78% of the group, twice as many as the next nearest: “lack of information about services”. Within this overall picture, 35% indicated that reluctance among young people was an important factor influencing access. When we look more closely at this, we find that over half of the social workers selected this factor. Amongst residential social workers this factor was chosen more often than any other.

In describing their caseload, many GPs stated, with evident anger, that they have to deal with families in the face of waiting lists of over six months, and some reported that they have no access to CAMH services.

We were interested to gain an impression of the extent to which these colleagues were involved with children and young people with mental health, emotional or behavioural problems. 47% of those responding indicated that they dealt with 10 or more young people with such difficulties in the previous year. One third said that they dealt with a young person with these difficulties at least five times a week.

Over half (54%) estimated that they spend at least two hours each week dealing with children and young people with mental health, emotional or behavioural problems. There was a wide range, from GPs, only 1.5% of whom spend this amount of time, through a third of health visitors and school nurses, to social workers, where nine out of ten spend at least two hours a week with these young people.

We asked about any initiatives to address mental health, emotional or behavioural problems. 54% overall, but two thirds and more of teachers and social workers, reported that they made arrangements to identify such problems. We asked about formal prevention strategies and while 59% overall said that they had these in place, almost all teachers and school nurses replied positively to that question. Readers may remember (from chapter 2) that 67% of the group reported involvement in health promotion. Almost half said that they had “in-house” arrangements in place for dealing with children or young people with such problems: in primary care, this was the case for only 21% of health visitors and 8% of GPs. By contrast, more than 70% of teachers and residential social workers had such arrangements.

When we asked “would you wish to have any further training in dealing with emotional, mental health or behavioural problems, or in mental health promotion for young people?”, the majority of every professional group said yes, with the average for the whole group a



striking 84%. An additional question allowed us to gather more information about what, in particular, people wanted to learn more about.

The final question was whether they would wish to be involved in the planning of services for young people with these problems. 44% of our respondents said they would, with the majority of those in social work, in schools and in school health indicating their interest.

Respondents were asked: "if you could have access to a new sort of service for children with mental health, emotional or behavioural problems, or an improved version of a service which exists already, what would it be?" The vast majority of respondents answered this question, giving a rich database, which is still to be studied.

GPs and health visitors did however express clear views on how they would like services configured, the most common preferences (apart from existing services having shorter waiting lists) being for a rapid assessment service, a CAMHS "link" person, easier access to community psychiatric nurses and a "one-stop shop" design for services.

We asked professionals to tell us about a case which had given them most satisfaction, and most respondents from each professional group detailed cases where they had been actively involved in management – in most of these cases no referral was made to CAMH services.

Survey of NHS specialist CAMHS practitioners

The survey of mental health practitioners included nurses, psychiatrists, clinical psychologists, social workers and therapists working in CAMHS or clinical psychology departments. A minority worked within general paediatric teams, child development teams, in-patient and day units.

The total number of respondents was 225. This is in excess of 50% of those surveyed; an exact response rate will be published in due course. 137 of the 225 respondents were male. 152 of the respondents were full time. 210 reported their ethnic background as white.


Among respondents 46-100% had additional qualifications relevant to their mental health role e.g. family therapy, forensic psychology, group analysis etc.

Most had formal supervision of their clinical work, with personal development plans still being developed. On average they had 10 days of professional training in the past year.

Elements of the job

The vast majority of respondents' time is spent on assessing and treating children and young people with mental health problems, with very little spent on promotion/prevention work. All professionals spent some time consulting with other agencies, supervision of others, personal and service development.

Eighty five percent of respondents work with children and adolescents and spend most of their time in team based work in a specialist setting. Although they work in a variety of settings e.g. community bases, children's, general and psychiatric hospitals, very little time is spent outside their main workbase, for example in homes or health centres.



All professionals provide a wide range of assessments and treatments, with some specific to professional groups e.g. 98% psychiatrists prescribe medication and many clinical psychologists provide neuropsychological and psychometric assessments.

Treatments offered either related to specific kinds of problems e.g. a child with an autistic spectrum disorder or a young person with an eating disorder or relate to particular ways of working, e.g. working with a young person using cognitive behaviour therapy or working with a group of parents on parenting skills.

All acknowledged the recent marked increase in prescribing, particularly of stimulants. CAMHS workers of all professional groups indicated a range of views about the current use of stimulants, with support for thorough assessments and complete treatment packages where medication is thought appropriate. It is not yet clear whether the SNAP data will prove useful in the study of the wide inter-area variation in the rates of stimulant prescriptions issued⁶⁷.

Over 75% of respondents were involved in innovative work which provided services for specific groups of children and young people or those with specific conditions, involved service developments or mental health promotion. Examples were services for looked after children, early intervention for ASD, waiting list initiatives, promoting self-esteem in teenagers and parenting groups.

Over 70% reported changes in the nature of their work in the previous two years (very few of which were positive). These included an increase in the number and complexity of referrals, increase in ADHD and ASD and more time spent on service development and management.

Working with Others

Most CAMHS professionals worked sometimes or often with other disciplines in delivering services. This usually took the form of case discussions, joint assessments and screenings, with most professionals, except for psychiatrists, carrying out joint therapeutic work either often or sometimes.

Almost all were involved in inter-agency work involving liaison over joint cases, case reviews, consultation and meetings about services. However few participated in joint work or in providing joint services.

Some professionals are involved in specific projects e.g. 23% of nurses use Webster-Stratton and Triple P with occasional input into Home Start, Mellow Parenting and Early Bird. None was involved in Starting Well. Up to 28% were involved in New Community Schools and up to 36% carried out formal joint work with local authorities.

Service Commissioning

Over 50% of professionals are involved in service review and development activities, with most involved with local CAMH team or service reviews. Less than 25% are involved in Trust or NHS Board commissioning of services.



Strengths and Difficulties

Identified strengths included working in multi-disciplinary teams with experienced, dedicated colleagues. Some described their services as being of high quality, evidence based, flexible and responsive. A few had no waiting list. Other qualities included having a good relationship with other services and offering a range of assessments and treatments.

Difficulties described included having inadequate resources with respect to staffing, accommodation, available training and funding for training and research. The increased rate of referrals associated with greater complexity had not generally been linked to an increase in staff.

Gaps in Service Provision

Identified gaps were for:

- Services for particular groups e.g. adolescents with learning disability, looked after children and young people and for older teenagers
- Services for particular conditions e.g. abuse, ADHD, alcohol and substance abuse
- Tier 1 and 2 services
- Lack of connection with primary care, lack of social work input, early intervention and prevention work.


Other survey results

Other groups, including local authority educational psychologists, voluntary and independent sector agencies, Children's Panel members and police, were also surveyed. It was not possible to complete the analyses of these responses in time for this report. They will, however, be reported at a future date.

THEMES AND CONCLUSIONS FROM REGIONAL SEMINARS

Regional seminars were held in late September and early October 2002 in Glasgow, Nairn and Edinburgh. The seminars were set up to bring together people who have an interest in the mental health of children and young people or who provide services relating to child and adolescent mental health. The seminars aimed to provide an introduction to the work of the SNAP group, to describe the main questions and emerging findings of the research and to give participants the opportunity to express their own views both on the SNAP process and on how resources for children and young people with emotional or behavioural difficulties should be developed. Participants came from a wide variety of backgrounds and included:

- People who use mental health services
- Academics and researchers
- Staff from voluntary organisations and community health projects, including managers, development staff, counsellors, lay community health workers
- Health service staff including nurses, health visitors, psychologists, psychiatrists, managers, health promotion officers, family therapists, speech and language therapists
- Education staff including teaching and support staff, managers, psychologists, nursery staff
- Social workers, social work managers and youth workers
- Partnership staff from New Community Schools and Social Inclusion Partnerships.



Young people with an interest in this area or who had been part of the SNAP consultation with children, young people and parents were invited to a seminar in Dundee in September 2002.

Participants were given an introduction to the SNAP process and feedback on the findings of Phases 1 and 2 of the research process. They were then asked to consider the following questions in workshop discussions:

- What do you think so far of what you have heard of the SNAP process?
- How does this fit into the picture locally?
- What needs to happen in your area? What can you change?

Priorities for attention and action

Discussions on each of the three days raised a number of key issues for the future development of resources for children and young people with emotional or behavioural difficulties and their families and communities. Some of these issues relate closely to the local service environment while others touch on global shifts in attitude which it was felt are required to enable young people's voices to be heard. There were some key themes, however, which underlined views expressed at all three seminars:

Key themes

- The importance of beginning with the child or young person, not the problem – and of involving children and young people in decision-making processes.
- Any national framework introduced must allow for local flexibility.
- Better links must be established between CAMH and other specialist services and youth and community health services. There is a role for community health projects in contributing to and sustaining the process of change.
- Introduce a cascade model of training and learning which builds on existing expertise and makes it more readily available to all those working with children and young people. This should include the legislative basis for our work.
- Learn from our experience and gain a better understanding of what constitutes good practice both nationally and locally by carrying out a review of those resources which:
 1. Provide effective services
 2. Involve young people and their families
 3. Connect with their local communities
 4. Can reflect on how they manage their work.
- Follow up this research by initiating pilot schemes for different types of area, such as urban/remote/island communities, with sufficient funding to enable them to work effectively and enough time for them to develop. There is a need for a greater focus on remote areas and the effects of rural isolation on children and young people in Scotland.

CONSULTING YOUNG PEOPLE AND FAMILIES

Following discussions with the SNAP Reference Group and a number of agencies and practitioners experienced in consulting children and young people, the members of the Core Group decided that consultation with young people and their parents should be a key part of the SNAP report.



Funding was obtained from the Scottish Executive to allow the commissioning of this report, which was co-ordinated by Julia White of the Scottish Development Centre for Mental Health (SDC). The consultation exercise was carried out between May and September 2002.

The Core Group also agreed that one of the four Regional Consultation Seminars should be allocated to young people. Pat Little, from Penumbra, SNAP Core Group member, managed the event which took place in September 2002. Young people from all over Scotland, including many who had taken part in the SDC consultation, travelled to Dundee for the seminar.

The report on the consultation process and the proceedings of the Dundee seminar are published together, in full, in parallel with this report and copies are available from PHIS. Many of the issues raised are picked up and fed into the report at different points. This summarising comment comes from the consultation report.

"In order for children and young people and their parents to get the sort of services they require, it will be necessary to build in to the system a lot of 'second chances'. If a service or resource does not suit someone or they cannot manage to attend at the time given, then there needs to be an alternative which is readily available. It is also the case, however, that many young people and their parents are not getting to have their first chance: parents and young people have spoken about not getting help when they need it, how things have to become serious before help is offered and how sometimes a referral is made but there is no service available for months.

There are many examples of inspiring resources and provision of services throughout the feedback from the consultation interviews and group discussions. Both young people and parents are quick to acknowledge the right type of support or someone who goes the extra mile for them. The task ahead is to ensure that these good examples become the norm across Scotland."

CHAPTER 5

ENHANCING THE CAPACITY OF THE NETWORK OF SERVICES



It is already clear that we have identified a significant mismatch between the level of mental health need and the capacity to work with that need. There will need to be a sustained commitment to building this capacity.

Capacity is clearly dependent on the available resources and, in particular, the range and level of skill within an agency or team. But it is not solely determined by them. These resources exist in a dynamic balance with a range of contextual and environmental factors, which can operate to enhance or reduce effective capacity. For example, schools with similar resources can vary in their capacity to achieve greater pupil participation, inclusion of high numbers of pupils with additional support needs, low exclusion rates or low output rates to specialist facilities⁶⁸.

An environment which is demanding by virtue of geography, e.g. with a widely scattered population, or by virtue of limited amenities will effectively reduce the capacity of a service.

Drawing on education research, Weare illustrates that the way people work together – with supportive relationships, a high degree of participation, the encouragement of autonomy and clarity about rules, boundaries and expectations² – has a direct bearing on their effectiveness as an agency.



So we suggest that when agencies are working well together, those good collaborative arrangements will contribute to the capacity of each. This attribute of networks is always important, but particularly so when an agency's capacity comes under pressure, as figure 5.a illustrates.



Figure 5.a: A critical network dynamic

Here we see that one agency finds itself under pressure – perhaps a rise in demand for their particular service. This generates a response within the agency who, in an effort to manage the imbalance in capacity, make some changes to the way they work. If they do this without reference to their network partners, they run the risk of losing the support and therefore the added capacity that the previous successful collaboration conferred.

We now discuss three strands which contribute to the capacity across the network of children's services. These are learning opportunities, contexts for consultation and evolving arrangements for joint working and referral.

Running through each of these strands is the issue of time and resources required by workers, often from different professional and theoretical backgrounds, to build relationships which will underpin good collaborative work. The SNAP survey provides evidence of much interest in this but concern that there is, at present, little room to achieve such development.

Learning opportunities


The SNAP survey clearly indicates that across the network of people who work with children and young people, many practitioners recognise mental health need amongst young people and are looking for ways to develop their own capacity to make a difference. There is a need for learning opportunities which will both support that aspiration and lead to enhanced capacity.

Successive reports have recommended that mental health, in the broad and inclusive sense in which we use the term in this report, should be on the curriculum of every professional training leading to work with children and young people. We add our weight to this consensus.

There are also emerging opportunities, through a variety of post-qualifying routes, to study aspects of mental health work in more detail, for example with training in systemic practice or therapeutic skills with children.

Contexts for consultation

Alongside formal learning opportunities, consultation is an effective method of practice-based learning where practitioners meet with colleagues for discussion about issues and



dilemmas in their own practice. Consultation is a particularly useful way of convening discussion between practitioners from different backgrounds and can be used for a wide range of tasks from developing a health promotion programme to an inter-agency discussion about a young person in difficulty.

Effective consultation takes place in a non-hierarchical atmosphere where the differences in skill and perspective are understood as a strength. These arrangements already exist in many settings, including schools, social work services and health settings, but there is a need to develop and extend this activity.

*For Scotland's Children*¹² recommended that agencies working with children should develop shared assessment and planning in relation to individual children's needs, rather than operate independently. This work, which is already underway in some areas, needs both agreed protocols and good contexts for consultation. Both aspects of this issue should be under discussion in each area.

Evolving arrangements for joint working and referral

In the SNAP survey many practitioners in the wider network reported significant difficulty in accessing specialist services for the young people with whom they work. One clear implication of the discussion about building capacity is that more help will be available to young people "closer to home", i.e. within the universal services. But it is also important that when specialist services are needed, they are readily accessible.

Clarity about what the specialist services should offer is clearly an important element. In reaching for such clarity, numbers of specialist services have adopted, and sometimes published, clear advice about how to get the best out of these services. It is important that where referral criteria are being developed, this is done through discussion between specialist services and the wider network. The indications from those who use these services are that these criteria can compound access problems rather than improve them. Referral processes should be implemented and monitored with a view to ensuring outcomes for children which are socially inclusive.

The proposal here is that services for children and young people operate better as relationship-based or intelligent networks. Any protocols must run against that background and be designed to facilitate rather than govern these arrangements.

We believe that there are now clear opportunities available, and more emerging, to enhance joint working arrangements. The clear direction in Education policy, for example in Section 15 of Standards in Scotland's Schools Act, is towards mainstreaming. Schools already have a clear role in supporting children and co-ordinating the delivery of services. We would propose growth in the number of mental health workers, one of the main aims being to allow mental health services to engage directly with the arrangements in schools for support, assessment and planning. This would fit with the provisions of the Additional Support Needs (Scotland) draft bill which will seek to support such multi-agency coordinating systems including through Co-ordinated Support Plans. There are several initiatives in place and it is likely that more are under discussion. As this moves forward, it will be important to evaluate these developments and share good practice and effective models.



An evaluation of a nationally co-ordinated Australian project to redesign services has been published recently.⁶⁹ The authors set out a number of themes which were important to this task:

Workforce development

- Up-skilling of workforce
- Staff commitment to an early intervention approach
- Reframing current practice to an early intervention approach
- Tailoring early intervention activities to the local context

Organisational development

- Management support for early intervention
- Reference group to guide activities
- An organisational culture that supports an early intervention approach
- Fit of early intervention activities with the policy structure of agency
- Absorption of early intervention into the agency's everyday practices
- Agency's ability to problem solve

Resource allocation

- Dedicated driver of early intervention activities
- Funding to support activities
- Access to information and specialist advice

Partnerships

- Informal links with other agencies
- Formal interagency partnerships
- Interest in activities from other agencies
- Community interest and support for early intervention activities

In their comments, the authors noted that many of the practitioners most closely involved in the re-orientation projects “had backgrounds in mental health but for many of them early intervention and reorientation were new concepts. Therefore, it was essential to work closely with them, to share early intervention information sources, monitor progress and provide assistance with reporting requirements”.

This is useful information when it comes to thinking about the kind of learning opportunities that will support the development of enhanced networking. In the phase 2 survey, there was much interest in training in relation to child and adolescent mental health. Those who have developed their skills in practice in mental health departments are, perhaps, likely to find that they, too, will want the opportunity to learn new skills and ways of transferring their “old” skills, learned in a different context, to the new environments.

Those environments are, of course, familiar to the others in the network, raising the promising possibility of training events organised as opportunities for shared learning and exchange of skills.

CHAPTER 6

SOME SPECIFIC EXAMPLES OF NETWORK CONNECTIONS



A range of models of relationships between the network partners in the service of “promotion, prevention and care” is now available. Some are established, while others, currently emerging, will require evaluation before they are disseminated. Some illustrations are given here of how these themes might apply in different contexts.

Primary care

There are numbers of well-evaluated models under this heading. One involves a health visitor embarking on a short training course in parent training, then, with consultation from a mental health specialist (this work was pioneered by clinical psychologists⁷⁰), offering a service to the local area.

A second model, now being developed widely across the UK, including Scotland, is that of the “primary care mental health worker” (sometimes “community mental health worker”). In this model, a practitioner with a specialist mental health background is based outwith the specialist CAMHS, sometimes in school, a child health setting or in a primary care setting. They are then well placed to offer consultation, rapid intervention and to facilitate referral on of those children who cannot readily be supported in that context. This system is now gaining a lot of support. One of the strengths of this model is its adaptability. The worker’s base can be negotiated according to what works best in that locality. One of the challenges of the model is to ensure the right kind of support, training and other aspects of professional development are available.

A different model, called the Pedagogic Psychological Service, operates in Norway. Here a team of workers, made up of three main disciplines – social work, psychology and pedagogy (a teacher with additional specific training) provide a second level service, into which school, primary care, parents and others may refer.



As resources and reorientation allow, models, or more likely, principles of best practice may become clearer.

Education

Over recent years, traditional approaches to health education have evolved into the notion of the health promoting school. Here the focus broadened from the curriculum and the individual pupil to the “whole school approach”. This is a very rich area for collaboration between health and education which, in Scotland, is facilitated by a national joint project, the Health Promoting Schools Unit. They will shortly be “mapping” what is going in schools and inviting young people, parents and services to indicate their views about mental health and schools.

One of the opportunities this relationship affords is to develop primary prevention initiatives, using both risk reduction and, increasingly, practices aimed at building resilience.

The role of school nurses is in transition, with indications that they will increasingly develop a role in health promotion and early intervention work⁷¹. One recent study indicated the viability of a drop-in advice service for young people.

There are now projects running, including one in West Lothian, looking at direct involvement of NHS mental health specialists in school teams. This would enhance the feasibility of shared assessment protocols and earlier interventions, delivered in a way which many young people say they would prefer, should they prove successful.

Social work services


Social workers are routinely involved with the most vulnerable and disadvantaged children in the community. Many of these children and their parents and carers have mental health and other problems which impact significantly on their relationships. Close working between social work services and health, including mental health services, should be a cornerstone of children's services and many practitioners from both agencies reported experience of relationships working well. However, the pattern across Scotland is very variable.

There are well described, though few fully evaluated accounts of how social work and mental health can work together. Social workers and mental health practitioners have much to contribute to one another's practice in relation to child protection, child abuse, fostered and adopted children, many of whom have can be thought of as having attachment and post-traumatic disorders.

It seems likely that resource and other “network confounding” variables have meant that much needs to be done to restore these relationships. We suggest that this should be a priority issue wherever it is a problem.

Hospital and community based child health services

The mental health of children and young people is affected by a number of protective and risk factors and difficulties are frequently seen in children whose primary diagnosis is of illness, abuse or disability. As a result mental health problems may present in any setting in



which we see children. Against a background of rising awareness of mental health problems paediatricians find that there are real shortages in the services available to young people and families. In some areas there are particular difficulties in relation to children with both learning difficulties and mental illness. Whilst paediatricians would always seek specialist CAMH support in these situations they recognise the importance of training in the identification and early management of common emotional and behavioural difficulties.

Community child health staff work in a number of settings such as clinics, health centres, family centres (social service provision), schools and nurseries increasing their accessibility to young people and families and offering invaluable opportunities for close working with other disciplines, particularly teachers and care assistants. The New Community Schools initiative (and health promoting schools) and the public health nursing approach has further increased the opportunities to work more effectively with young people and their families within their communities, to work jointly with other services and to reduce the number of youngsters requiring to be referred on to tertiary mental health services.

The recently published fourth edition of the Hall report⁷² advocates a further move away from universal towards targeted services for preschool and school age children in order to focus our limited resources on those children and families most in need. The potential risk that this will result in less availability of health visitor contact for young children and their families and a loss of opportunity to detect problems at an early stage and intervene effectively must be recognised. Mental health issues are often not as readily identified by professionals, young people or their families and we need to consider how we may enhance our ability to recognise early signs and develop clear clinical pathways and user friendly services to address them.

A number of models of service delivery are evolving in Scotland bringing together the multi-disciplinary first and second tier work in place in the community and the specialist CAMH services into an integrated pathway with clear criteria, management plans and opportunities for regular supervision and support. An example is the ADHD pilot in north west Edinburgh and West Lothian. If successful such service developments will not only improve the cost effectiveness of our services but have a much greater beneficial effect by generalising skills and knowledge of emotional and behavioural problems in our schools and communities.

Child protection

An understanding of mental health issues and their impact on children and families is fundamental to our ability to evaluate significant harm, assess risk and put in place a child protection plan. The effect of postnatal depression, maternal drug and alcohol abuse and separation of the newborn infant and mother on the bonding process are well recognised. Increasingly we are admitting infants to special care baby units with severe symptoms of drug withdrawal not only leading to their separation from their mothers at this important time, but also making them difficult babies to look after. Paediatricians, whether hospital or community based need to be aware of these issues and their implications and communicate them clearly to colleagues in health and other agencies responsible for the child's ongoing care.



The long term emotional difficulties which follow abuse, particularly, but not only, sexual abuse, are well recognised. The recent Child Protection Review⁷³ highlighted the inadequacies of our current response to these children. Unfortunately many cases of chronic abuse are still unreported during childhood and emerge in adult life through contact with the adult mental health services. Even where disclosures are made and the abuse confirmed there are many barriers to accessing appropriate mental health services for the young person, including the legal processes, problems with access to specialist CAMH services and a lack of specialist resources.

There are examples of specialist (multi-disciplinary) services set up on a pilot basis (e.g. the Edinburgh CSA team) offering a rapid response service to the non-abusing parent, a service for the abused child and for young perpetrators. The early evaluation of these services, particularly the rapid response service, indicates that it is effective and may reduce significantly the need for a direct CAMH service for the young person. A number of projects responding to the victims of abuse (particularly sexual abuse) are also in place across the country led by voluntary agencies such as Barnardos and supported by statutory funding to varying degrees. Long term studies will be required to measure the impact of these services on the high level of morbidity currently recognised in the adult population post abuse.


There is a high degree of overlap between children who are victims of abuse and neglect and those 'looked after' by the local authority. The mental health needs of this group of youngsters is very high, particularly of those in residential care⁷⁴, and requires a dedicated service currently only available in some parts of Scotland.

Information systems

A vast amount of data on the health of our children is gathered within our computerised health information systems in general practice, hospital and community child health (national pre-school, school, special needs and immunisation systems). Until recently analysis and feedback of this information for patient care, audit, epidemiology or research was extremely limited. Some progress has been made with the setting up of the child health information team (CHIT) at ISD and a number of Modernising Government (Glasgow, Aberdeen) and Changing Children's services (West Lothian) funded projects exploring the electronic sharing of information.

Clearly to support our young people and develop our services in an evidence based way we need to improve our information technology. There are however some very difficult questions ahead in relation to confidentiality and also terminology, particularly in relation to mental health problems. Currently we have no agreed universal terms, definitions and indices of severity for use across disciplines and agencies for conditions such as autistic spectrum disorder, depression, specific learning difficulties. The social standards data project at ISD has begun to make some progress in this area of work, and a number of parallel initiatives on single shared assessment will contribute to the process and offer an opportunity to test new systems and approaches.

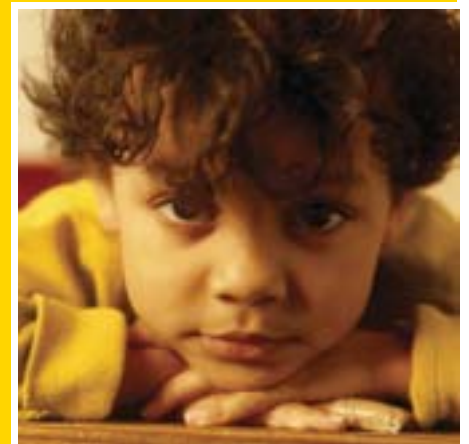
Sharing information about children 'looked after' and those at risk of abuse is an even greater challenge both in terms of practical difficulties in keeping the information up to



date on this frequently mobile population and also in terms of confidentiality and data protection. However they are the most vulnerable children in our society and the need to rapidly improve our ability to share information was highlighted in the recent Child Protection Review⁷³. An understanding of the background of health and social concerns as well as the current situation of the child is vital to the successful planning of the way forward. The ability to draw together key and up to date information from health, social services and education systems is vital to that process.

Huge technical advances have been made in the last few years which mean that our vision of real time sharing of key information (in reality a very small amount of data on identification, current concerns, involved professionals) is technically possible and would be invaluable in promoting effective working at times of crisis and transition.

CHAPTER 7 RESHAPING AND REFOCUSING NHS SPECIALIST CAMHS



NHS specialist child and adolescent mental health services exist in three main forms: single discipline clinical psychology services, multi-disciplinary services without clinical psychology and multi-disciplinary services which include clinical psychology.

Some services offer a service only to children, some only to adolescents, while most work with both. In almost all instances, services work with young people up to the age of 18.

All services offer community-based assessment and treatment. Residential (inpatient) facilities are, at present, provided for children at one unit, in Glasgow, while there are three units for adolescents, in Dundee, Edinburgh and Glasgow (table 7.1). Two units, one for children and one for adolescents, have closed during the SNAP study period.

	Beds for children	Adolescent beds
1994	58	67
1996	36	55
2003	9	48

Table 7.1: Numbers of child and adolescent “psychiatric” beds in Scotland

The pattern of development of these services is highly variable across Scotland. Most NHS Boards now have a child and adolescent mental health strategy, and numbers of Boards have completed local needs assessment exercises. Although Boards report similar processes in developing their strategies, the outcomes in terms of investment in specialist child and adolescent mental health services vary widely. The data SNAP collected cannot account for these differences.

Capacity

This is a potentially serious problem, with some areas reporting great difficulty in sustaining clinical services, as reported by the Child Health Support Group from their visits in 2001 and 2002. It seems possible, if not likely, that these capacity issues may become more pronounced as clinical governance risk assessment procedures begin to examine the adequacy of service infrastructure.

It seems clear from our evidence, that there is a lack of capacity in the specialist sector. This will require attention over a period of time, since problems in recruitment and retention, as well as problems in resourcing, contribute to this state of affairs.

These capacity issues were thrown into sharp relief by a very sharp rise in demand, across Scotland, in the late 90's, for consultation on the subject of attention deficit hyperactivity disorder. It appears that this has had a significant and persisting impact on service organisation and culture – with greatly increased rates of prescribing medication – and, in many cases, on the functioning of local networks. Associated with this, among other factors, many child and adolescent mental health services now have relatively substantial (by previous standards) cohorts of young people attending their clinics for prolonged periods. This has implications for resources within these teams and for relationships with adult services at the time for transition.

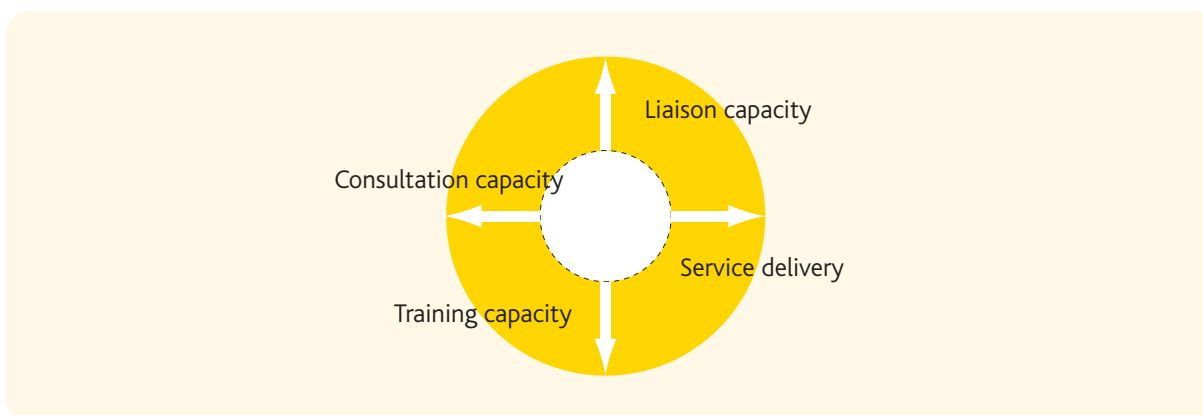


Figure 7a: Specialist CAMHS: post SNAP

Reshaping the services

When it proves possible to enhance the capacity of this sector, it will be important to reshape and refocus. As discussed earlier, practitioners from these specialist services will have an important part to play in enhancing the wider network. The SNAP survey makes clear that they are already involved in liaison, consultation and training, but this will occupy a larger percentage of their time and will increasingly lead to joint working with colleagues in schools, primary care, social services, child health teams and others.

The effect of this will be to move the centre of gravity for specialist CAMH input increasingly towards the universal services, enhancing the capacity of that network for earlier intervention. This also has the potential to change the pattern of demand on the specialist services, allowing them to develop their role more fully for children with more complex and severe mental health problems.



This specialist service role can be conceptualised as a node in the network – non-hierarchical, with multiple connections. We contrast this with the earlier notion of specialist CAMHS as occupying the upper “tiers” or apex of a pyramid, popularised in *Together We Stand*. Although not proposed in these terms by the authors, some had taken this to suggest a hierarchical model of service relationships.

Specific challenges

There will continue to be residential or inpatient units for young people with severe mental health difficulties provided by the NHS, crucially supported by local authority education and social work staff. Current indications are that investment in and expansion of that highly specialised sector is urgently needed. Young people should be treated in the kind of developmentally appropriate settings which the specialist child and adolescent units offer, but they are often unable to access them at present, because of limited bed numbers. It is not appropriate to locate them in wards designed for working age adults, unless very specific arrangements have been made to adapt that environment to meet the young person's needs. This cannot be said to be the case for the majority of adolescent admissions to adult wards.

This is one of a number of issues that cannot be addressed adequately by single NHS Boards. In the medium term, regional planning may be appropriate, but in the short term, it appears that a national framework for addressing the issue of child and adolescent mental health beds will be necessary to prevent continuing attrition of this resource. There is also the need for the development of links between specialist mental health teams and the work done by social work and education services with very vulnerable groups of young people, such as those who are looked after and accommodated and those who have been abused. There are now examples emerging across Scotland, some of them described in the Good Practice Summary, to be found on the Mental Health and Well-being Support Group's website⁷⁵.

As with the rest of the network, consultation, joint working and models of joint service delivery should be explored as ways of making the best interventions available to these most vulnerable young people.

Where there are effective treatments and evidence of the benefits of early intervention – as in early intervention in psychosis – development of strategies to promote early identification and protocols to guide rapid intervention is encouraged.

This is a proposal for continuous service evolution, informed by rolling needs assessment, which seeks excluded groups and unmet need. In this respect it is important to acknowledge that there are groups of children and young people who have not been well served by these services: in particular those with a learning disability, those who are looked after and accommodated, those involved in substance abuse and those who are offending.

It is also important to note the challenges to service delivery associated with rural and island communities. There have, however, been important developments in models of service delivery, in a variety of Board areas, including Dumfries and Galloway, Borders and Highland. Evaluation of these developments will be important in the process of

CHAPTER 8

ENHANCING THE CAPACITY FOR ENQUIRY



There are many opportunities for participating in research relating to child and adolescent mental health. Much important research is going on, for example, in mental health epidemiology, basic sciences and social sciences, as well as clinical research in child and adolescent mental health.

Nonetheless the cohort of clinical academic child and adolescent mental health specialists remains modest and almost entirely confined to psychiatry. It seems important, as this capacity is developed, that it also diversifies to include other professional groups, such as clinical psychologists and nurses.

There is already collaborative work going on, for example, between mental health specialists and social scientists and social work academics. In this domain, too, such partnerships often generate significant synergy, and enhance the capacity of each party.

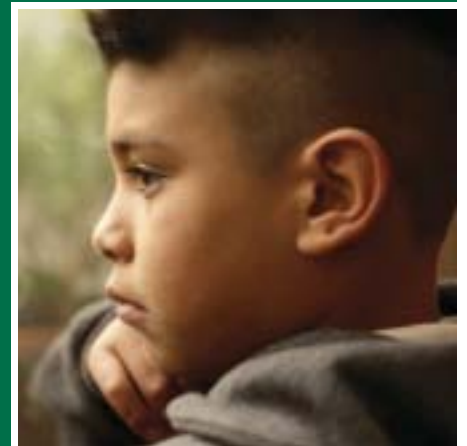
This report talks about integrating promotion, prevention and care. This development, as well as the proposals for service development and reform, will provide opportunities for further research, as well as the need for evaluation.

There are, therefore, opportunities for primary research and for service research – evaluating the most effective methods of delivering interventions of known effectiveness. Both are important.

The SNAP survey found that few of the NHS specialist mental health services were involved in any service research. It was also reported that few were involving young people or parents in formal evaluations of their experience of these services. These are matters for early attention.

CHAPTER 9

LEARNING AND TRAINING OPPORTUNITIES




As well as those opportunities for learning made available through professional supervision and consultation, there is a need for formal learning opportunities.

NHS Education Scotland has now begun work on the “educational needs of child and adolescent mental health services”, and is considering course content and also the contexts in which any child and adolescent mental health training opportunities could be offered.

In the “narrow” domain of NHS specialist CAMHS, there is evidence, from across the country, of problems with recruitment and retention. Approaches to training have not enjoyed a strategic infrastructure and the indications are that they are often piecemeal and reactive. Few services have a training strategy and most indicate that staff interests and available training opportunities have a particular influence on the use of training budgets.

There are sources of training for specialist CAMHS, from basic post-qualifying training, with introduction and orientation to child and adolescent mental health work, through to specialised training in psychological therapies, e.g. cognitive behaviour therapy, family therapy and child (analytical) psychotherapy. Many of these resources, on which the NHS relies for the development of its skilled workforce, exist at or beyond the edge of the NHS and operate with tenuous infrastructure jeopardising their capacity and reliability.

In the wider network, the clear majority of survey respondents indicated a wish for training in relation to mental health. Numerous references were made during the SNAP seminars and surveys to the possibilities of joint training, with the model used in child protection training cited as an example.



There is, therefore, an opportunity for agencies to join together to explore ways of developing and sustaining training opportunities around the broad themes of mental health and of promotion, prevention and care.

*For Scotland's Children*¹³ emphasised capacity to work with families as a core attribute of children's service workers, adding that it was often underdeveloped. We note that the US Surgeon General's report on child and adolescent mental health listed family work and "cultural competence" – the ability to work respectfully and sensitively with people of different backgrounds – as the core skills for effective practice in this area.

Those who take up this task should note that at various points in the consultation with young people, the suggestion was made that they (and we surmise that this would also be true of parents) could make a significant contribution to training.

CHAPTER 10 AN EVOLVING AND DEVELOPING WORKFORCE



*For Scotland's Children*¹³ discussed problems with the workforce and recommended (p. 108) that the Scottish Executive establish “a workforce planning group to take forward plans for the children’s services workforce.” The SNAP work certainly confirms the importance of such a development and our surveying has gathered data which could contribute detail to that process.

The NHS already makes provision for considering some elements of the child and adolescent mental health workforce, e.g. nurses, psychologists and psychiatrists. There are, however, additional groups who will need to be considered in any strategic review of CAMHS workforce: those who offer the “psychological” therapies mentioned above and those who offer “developmental” therapies, in particular speech and language therapists and occupational therapists.

There are specific difficulties in recruitment in relation to some disciplines within the sector, which suggest that staff mix will be substantially affected by supply rather than need. For example, some services are already finding that they have difficulty recruiting psychiatrists, others are having difficulty recruiting psychologists or psychotherapists.

This suggests that, over the coming years, role allocations within services will need to be reviewed and adapted, while steps are taken at workforce planning level to try to re-establish a throughput of appropriately trained staff.

CHAPTER 11

STRATEGIC CONSIDERATIONS



NHS Scotland and its local authority partners need to make clear, effective arrangements for sustaining attention to child and adolescent mental health and ensuring that processes are established to drive change and secure long-term development in this area. These processes must be resilient if they are to endure the changing strategic environment and resist marginalisation of this theme.

The appointment of a Children's Commissioner is currently under consideration at the Scottish Parliament. The outcome is keenly awaited, given the prospect of long-term independent oversight of children's issues.

The National Programme for Improving the Mental Health and Well-being of Scotland's Population will play an important part in keeping issues relating to children and young people at the forefront of the health improvement programme.

The Child Health and Mental Health and Well-being Support Groups have played an important role in drawing attention to child and adolescent mental health. The former group's role in "championing the development of CAMHS", as part of an integrated work programme around children's services, is particularly welcome.

The broad notion of mental health and the integration of promotion, prevention and care need to be reflected in the work of planners at local level: notably child health commissioners at NHS Board level and their partners in local authorities.

Urgent measures, within a Scotland wide framework, are needed to secure the child and adolescent mental health residential (inpatient) sector. Steady progress will be required thereafter to transfer this responsibility to NHS regional commissioning structures. That environment would also be a suitable context for considering other areas of vulnerability



related to child and adolescent mental health, including low volume, high cost clinical services, services amenable to networked delivery and post-qualifying training.

We note that the Scottish Executive is currently considering the need for secure mental health provision for young people.

The SNAP survey attracted many comments about resources. Earlier remarks support the view that investment will be required to redress the capacity problems. However the way funds were introduced also caused repeated comment: there has been a perceived over-reliance on project funding as a way of bringing new resources into child and adolescent mental health work. In particular this was seen, by many service leaders, as a very mixed blessing: they were able to develop a new initiative but not able to afford to sustain a mainstream part of their service. This was one of a number of issues in financing these services which merit further work.

Where successful arrangements for joint planning and joint service delivery exist, they need to be studied and lessons learned to support more extensive joint working, including joint commissioning between NHS and local authority and other partners.

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