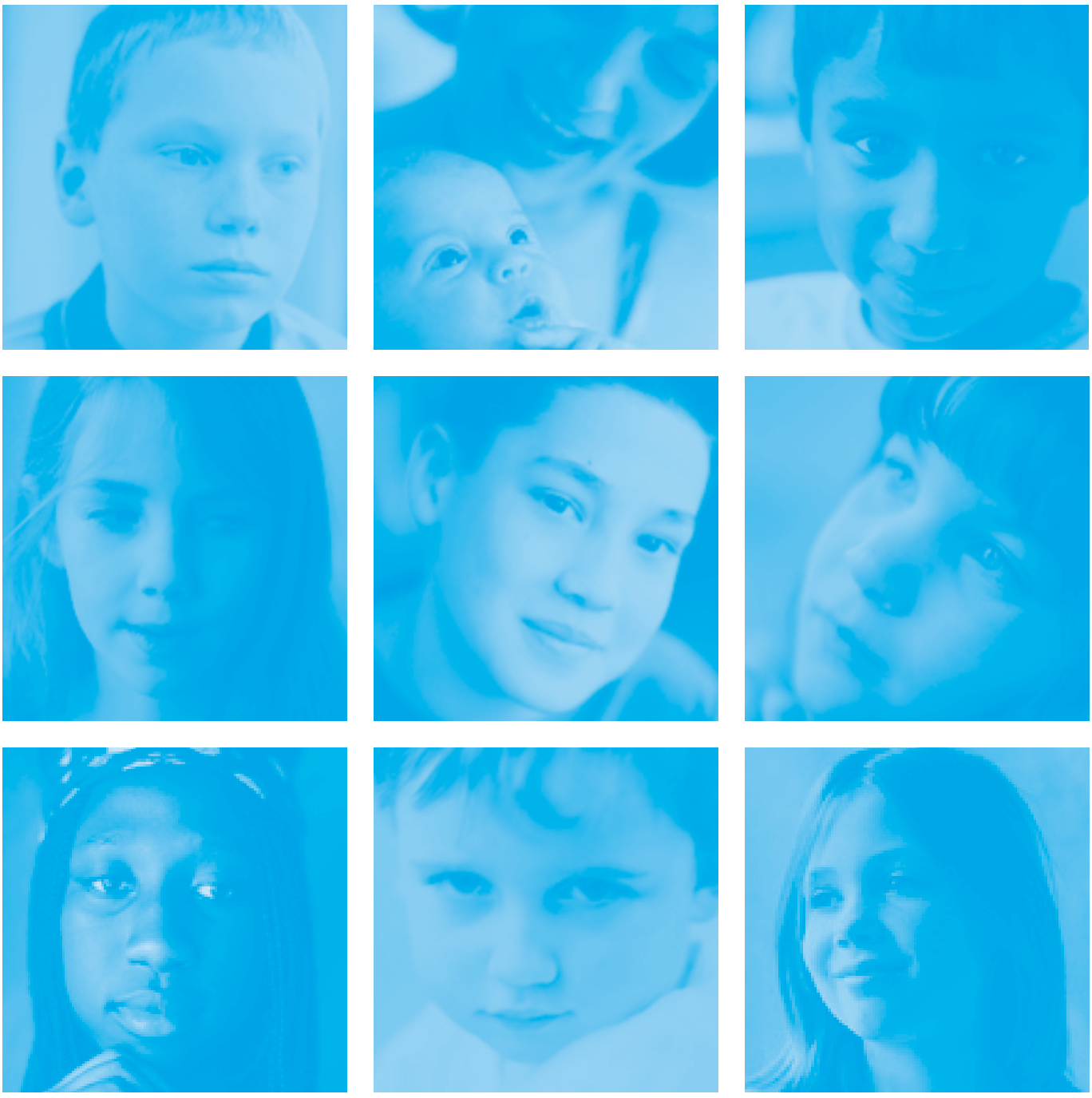
Public Health Institute of Scotland

NHS SCOTLAND

Needs Assessment Report on Child and Adolescent Mental Health

An interim briefing – May 2002



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May 2002

Introduction

About a quarter of Scotland's population is under the age of 19[1]. At any one time, about 10% of them, that's 125,000 young people, have mental health problems which are severe enough to interfere with their day to day life[2].

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 work on that report is nearing its final stages. The full report will be published later this year. This "briefing" paper tells you about the work by illustrating emerging findings, outlining the next steps and indicating opportunities for contributing to the remaining stages.

The main aim of this work is 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 emotional well-being, how to help build resilience, particularly amongst those at risk of developing mental health problems, and at when and how to help those children and young people who are experiencing mental health problems.

The final report will discuss a wide network of activities, from specialist child and adolescent mental health services to the wide range of agencies who work with children and young people, resilient or struggling, wherever they are. In preparing the report, we also have to find out what children, young people and those who care for them have to say about mental health and mental health initiatives and services, to ensure that their experiences help to shape the emerging conclusions.

The CAMH SNAP process

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. This led to a renegotiation of the timescale for this needs assessment exercise, which now falls into three main parts.

The **first phase** involves surveying the agencies involved in the planning and delivery of mental health services in health and local authorities. This phase is almost complete and some findings will be described here.

The **second phase**, now underway, involves extensive surveying of those who work day to day with young people – for example, in mental health services, children's units, schools, clinics, children's hearings. Children, young people and parents are also being consulted during this phase.

The **third phase** is ushered in by a national conference on June 14th, at Strathclyde University, and followed up in a number of regional seminars after the summer. At these events the SNAP group will meet with people concerned with and involved in child and adolescent mental health. Working group members will present emerging findings and will invite participation in interpreting these and developing conclusions.

By the time the final report is produced, later this year, much of the evidence will, therefore, already be known and the conclusions, which are reported to the Scottish Executive Health Department and to the Scottish NHS Boards, will have already been discussed widely.

Talking about mental health

Language and culture are central considerations in discussions about mental health[3]. Although a relative newcomer to the health service, the phrase "mental health" is now used very widely. This development both reflects and promotes change in the way these matters are discussed. Across the network of services for young people different terms are used to denote mental health difficulty. 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 so the report promotes the importance of recognising and working constructively with such differences of language and culture.

The term "mental health" is therefore a practical convention, whose use here indicates that health service culture provides the major context for this report. This term is not, however, universally acceptable. For young people, for example, the term can have negative connotations[4,5] or little meaning[6].

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 as well as 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[7], 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[8]. 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.

While the full report will discuss trends in risk and protective factors, the relationship between such trends 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[9]. They found that 9.5% had what they called a mental health 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%).

Other studies of younger children[10] and older teenagers[11] 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. This is powerfully illustrated by a recent Scottish study of children who had become looked after and accommodated by the local authority[12]. 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.

In summary, the ONS study shows that significant numbers of children and young people in every community experience mental health problems and these rates are substantially increased by factors, many of which are now referred to as the components of social exclusion[13].

Numerous reports suggest that mental health problems amongst children and young people are on the increase[8]. 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[14], given the differences in methodologies which have been used in different studies. So, for example, a 1998 review of 52 prevalence studies[15] concluded "there appears to be no trend for increasing prevalence among studies carried out since the early 1950's". By contrast Rutter and Smith concluded[16] that there had been a significant rise in the prevalence of psychosocial disorders during the same period. This will be discussed further in the full report. In these circumstances, the publication of a recently completed longitudinal Scottish study designed to address the question of changing prevalence over time is keenly anticipated.

There is, however, clear evidence in NHS data of increasing demand for mental health services for children and young people. These changes can reflect changing prevalence, increased recognition as a result of changing awareness and attitude, and even increasing availability of services. The significance of these changes will be discussed in the full report.

Two Scottish studies suggest that children and young people with mental health problems, even when those difficulties are marked, are often not recognised as being in difficulty. Teachers in one study[17] and general practitioners in another[18] identified only a minority of such young people.

Discussing the limited recognition of mental health of children and young people, West and Sweeting[19] suggest that "the biggest obstacle of all" is a widespread and, as they demonstrate in successive studies[20], misplaced assumption that youth and health "go hand in hand". The extent to which the need for mental health services for children and young people is recognised is discussed later.

What helps?

"Real improvements in public health will only be effected by tackling the variations in heath status between the social groups and between different parts of Scotland". This quote from Designed to Care – Renewing the National Health Service in Scotland[21] 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 a major part in determining the mental health of children and young people.

Against that background, the full report will consider evidence about the role and value of specific initiatives and interventions and will look at how this picture compares with current practice. The report will approach this under the headings "promotion, prevention and care".

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[22]. Carefully designed and implemented preventive programmes can reduce the rate of subsequent mental health and other problems in "high risk" populations. There is less evidence about preventing mental health problems in "low risk" groups. There is clearly room for initiatives to prevent children being at risk. For example, the early recognition and successful treatment of women with postnatal depression can reduce the risk of behavioural and relationship problems for the child.

There are many kinds of treatment which have been shown to be effective, mainly in research settings, with children and young people. Here are some examples:

- Carefully structured parenting programmes are an effective way of intervening with children under 8 years of age who have established behaviour problems[23].
- For older children with behaviour problems, programmes incorporating skills training for children together with parent training have proved effective[24].
- Multi-systemic therapy, an intensive form of intervention which closely involves families, can reduce delinquent behaviour[25].
- Cognitive behavioural therapy is an effective treatment for generalised anxiety, phobias and depression[24].
- Stimulant medication is an effective treatment for the core features of attention deficit hyperactivity disorder[26].

However, the evidence about effectiveness of treatments for those with established problems, while accumulating steadily, is still patchy. 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 (CAMHS) have several co-existing mental health problems[27]. 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. There is, therefore, a pressing need for continuing research in this area.

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. There is also evidence to indicate that cultural competence and the full involvement of families have an important influence on effectiveness[28]. It is, therefore, important to evaluate services. Treatment specific outcome indicators and the views and experiences of children, young people and carers who use the service should be part of service evaluation.

The monitoring and evaluation of 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, with children and young people's services as one of the pilot areas.

Planning and delivering CAMH services

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"[29] and the First Minister's declaration, in his recent 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".[30] 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, hold the NHS strategic overview of child and adolescent mental health. The more recently established Child Health Support Group has also taken an interest in child and adolescent mental health services. These two groups conduct visits to NHS Board areas to look at relevant services. Both have reported widespread concern that CAMHS are under enormous pressure and, in many cases, simply do not have resources to meet the demands they face.

The 1995 HAS Report, Together We Stand,[31] 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[32] confirmed that this was also the case in Scotland. It is 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. The report will discuss levels of expenditure appropriate to the mental health needs of this youngest quarter of the Scottish population.

In responses to the first phase of the SNAP study, the majority of NHS Boards report that they have introduced a CAMH strategy in the last two years. Half of the strategies include health promotion and prevention measures. Most include early intervention and assessment and treatment services. In almost all cases, local authority social work departments and NHS Boards now participate in one another's children's planning arrangements.

All NHS Boards who responded (11/15) report rising rates of mental health problems, with ADHD and, particularly, autistic spectrum disorders mentioned. The majority report that they have identified "vulnerable" groups and half have developed targeted initiatives. 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 CAMHS (psychology only and multi-disciplinary) 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 are limited, with associated delays in referrals and access. The specialist CAMHS teams (tier 3) were reported as under very heavy pressure and the highly specialised (tier 4) 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[31], 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.

The mental health network

This first phase of the SNAP study particularly highlights the work of the specialist CAMHS. However, it is clear that professionals working across the "multi-agency CAMHS" do a vast amount of work to develop, sustain and improve the mental health of children and young people. This is being studied in detail in the second phase. The final report will consider how multi-agency CAMHS can be developed as "intelligent networks" – in other words, services engaged with one another in ways that encourage development and adaptation to changing need, circumstance and evidence.

There already exist in many places the makings of such networks[33]. The survey has elicited numerous accounts of good working between individual professionals from different agencies. However, it has also gathered accounts of constraints which appear to flow from two main sources. One is the relative lack of arrangements between agencies for joint delivery of services. The second is the apparently widespread lack of adequate resources.

Workforce and training

We already have accounts of welcome developments and initiatives and anticipate gathering a fuller picture of these in phase two. However, there are also indications of significant problems for the CAMHS workforce in Scotland. Service leaders report difficulty in recruitment, particularly in relation to clinical psychologists and psychiatrists. This suggests that any additional resources would need to go hand in hand with a review of workforce, informed by clear notions about the future development of CAMHS.

Implications for training of specialist CAMHS workers will be considered in the full report. Recommendations, described in successive reports[34,35,8] that mental health training be available to all those who work regularly with children and young people, e.g. in primary care, in schools, in children's units and elsewhere, will also be discussed, in light of phase two data.

It will be clear, even in this brief review, that much research and development work is needed in Scottish CAMHS. However, Scotland has only a small academic workforce in child and adolescent mental health, a problem which was compounded by the untimely death of Professor William Parry-Jones. It is no criticism of the present complement of staff to suggest that this needs to be addressed. An academic community vigorously active in research, development and evaluation would almost certainly enhance the quality and standing of CAMH services in Scotland.

What next?

Phase 2 of the study has now begun. This will look at the huge volume of CAMH work undertaken by those working across the multi-agency CAMHS, within and outwith specialist mental health services, in the statutory and the voluntary sector. The study will therefore contact teachers, paediatricians, general practitioners, health visitors, school doctors and nurses, psychologists, psychiatrists, psychotherapists, field and residential social workers, foster

parents, police and children's hearing reporters, among others.

The survey is gathering information on the amount and type of work going on with troubled young people. We hope to find examples of good practice and develop suggestions about how practitioners can work more effectively. The survey will also provide a database to help promote and develop joint working between individual practitioners and between services and agencies.

The Scottish Executive is funding two further important parts of the phase 2 study. In the first of these, children, young people and parents across Scotland will be consulted about the range of issues bearing on mental health and well-being. The second part takes place after the summer when a series of regional seminars will be convened to consult widely about the emerging conclusions and recommendations.

You can follow the progress of the CAMH SNAP report on the PHIS website at **www.show.scot.nhs.uk/phis**

Emerging conclusions

Children in Scotland commonly develop preventable mental health difficulties. Most experience problems which are amenable to treatment and are better treated early. However, they are not recognised soon enough and once problems are recognised, young people often have difficulty getting access to appropriate services.

The mental health of children and young people has suffered from low visibility - this issue now needs careful and sustained attention. While accounts are emerging of numbers of good services and creative initiatives, it is clear that more work is needed to ensure that mental health promotion, prevention and care is achieved for all.

Five areas are emerging for particular attention:

- The need to raise public and professional awareness of mental health as an issue which significantly affects young people.
- The need for concerted efforts in relation to health promotion and the prevention of mental health problems.
- The importance of developing a joined-up multi-agency CAMHS which, as a matter of priority, focuses on early identification and intervention.
- A strategic approach to the resourcing and development of specialist CAMHS.
- The involvement of young people and families in shaping CAMH services.

References

1 Registrar General for Scotland: *Mid-year population estimates for 2000*

2 Meltzer, H et al (2001) *Mental Health of Children and Adolescents in Great Britain*. London, Stationery Office

3 Fernando, S (1995) *Mental Health in a Multi-ethnic Society*. London, Routledge

4 Health Education Board for Scotland (2000) *Young People and Mental Well-being*. Edinburgh. HEBS

5 Commonwealth Department of Health and Family Services (1997) *Research and Consultation Among Young People on Mental Health Issues*. Canberra, Australian Government Publishing Service

6 Armstrong, C, Hill, M, and Secker, J (1998) *Listening to Children*. London, Mental Health Foundation

7 Harden A et al (2001) *Young People and Mental Health: a Systematic Review of Barriers and Facilitators*. EPPI-Centre. (available at www.eppi.ioe.ac.uk)

8 Mental Health Foundation (1999) *Bright Futures*. London, Mental Health Foundation

9 Meltzer, H et al (2001) *Mental Health of Children and Adolescents in Great Britain*. London, Stationery Office

10 Davis, H et al (2000) Child and adolescent mental health needs assessment and service implications in an inner city area *Child Clinical Psychology and Psychiatry* 5, 169-188

11 Parry-Jones, W (1995) The future of adolescent psychiatry *British Journal of Psychiatry* 166, 299-305

12 Dimigen, G et al (1999) Psychiatric disorder among children at time of entering local authority care: questionnaire survey *British Medical Journal* 319:675-675

13 Scottish Executive (1999) Social Inclusion Strategy: *Opening the Door to a Better Scotland*

14 Bird, H (1996) Epidemiology of childhood disorders in a cross-cultural context *Journal of Child Psychology and Psychiatry and Allied Disciplines* 37, 35-49

15 Roberts, R et al (1998) Prevalence of psychopathology among children and adolescents *American Journal of Psychiatry* 155, 715-725

16 Rutter, M and Smith, D (1995) *Psychosocial Disorders in Young People* Chichester, Wiley

17 Blair, C et al (2001) *The recognition of adolescent depression in Scottish schools 1997-2000*. Final research report to Chief Scientist's Office, Scottish Executive

18 Potts, Y et al (2001) Lack of mental well-being in 15 year olds: an undisclosed iceberg? *Family Practice*, 18, 95-100

19 West, P and Sweeting, H (1996) Nae job, nae future: young people and health in a context of unemployment *Health and Social Care* 4, 50-62

20 Sweeting, H and West, P (1998) Health at age 11: reports from schoolchildren and their parents *Archives of Diseases of Childhood* 78:427-434

21 Scottish Executive (1997) *Designed to Care: Renewing the National Health Service in Scotland*.

22 Durlak, J and Wells, A (1997) Primary prevention mental health programs for children and adolescents: a meta-analytic review *American Journal of Community Psychology 25*, 115-151

23 Scott, S et al (2001) Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice *British Medical Journal* 323, 194

24 Carr, A (2000) *What Works with Children and Adolescents? A Critical Review of Psychological Interventions with Children, Adolescents and their Families*. London, Routledge

25 Borduin, C (1999) Multisystemic treatment of criminality and violence in adolescents *Journal of the American Academy of Child and Adolescent Psychiatry* 38, 242-249

26 MTA Cooperative Group (1999) A 14 month randomised clinical trial of treatment strategies for attention deficit/hyperactivity disorder *Archives of General Psychiatry* 56, 1073-1086l

27 Davis, H et al (2000) Child and adolescent mental health needs assessment and service implications in an inner city area *Child Clinical Psychology and Psychiatry* 5, 169-188

28 Dept. of Health and Human Services (2000) *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*.

29 Scottish Executive (2001) *For Scotland's Children: Towards Better Integrated Children's Services* (available at www.scotland.gov.uk/library3/education/fcsr-02.asp)

30 National Assembly for Wales (2001) *Child and Adolescent Mental Health Services for Wales: Everybody's Business* (available at www.wales.gov.uk/subihealth/content/pdf men-health-e.pdf)

31 NHS Health Advisory Service (1995) *Together We Stand: A Thematic Review of the Commissioning, Role and management of Child and Adolescent Mental Health Services*. London, The Stationery Office

32 Parry-Jones, W and Maguire, R (1995) *Mental Health Services for Children and Young People in Scotland: A National Review*. Glasgow, University of Glasgow

33 Scottish Executive (2000) *Walk the Talk: Developing Appropriate and Accessible Health Services for Young People*.

34 Scottish Home and Health Department (1983) *Crossing the Boundaries: New Directions in the Mental Health Services for Children and Young People in Scotland*.

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