Thank you for asking us to respond to the enquiry of the Sport and Health Committee on CAMHS in Scotland. As introduction we would want to point to the large amount of work that has already taken place dealing with your questions, and in particular want to draw the committee’s attention to two key documents: “The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care” (2005) and “Getting the Right Workforce, Getting the Workforce Right” (2006). These policy papers review the available evidence, set out the work that needs to be done to develop a Scottish CAMHS fit for the 21st century and, crucially, have wide inter-agency support. Our response should be regarded as corroborating and further supplementing these policy documents.

A second strand that runs throughout our response is our awareness of the stigmatised nature of mental illness. One way this stigma operates is by people minimising the seriousness of mental disorders in children. Whilst there has undoubtedly been an improvement in the status of children with mental illness and/or learning disability, it remains true that such children are, based on their everyday experiences, rightly fearful of being stigmatised by both their peers and the adults who should be looking after them. Child mental health services are often characterised by a lack of investment and poor real estate. A study of young people’s experiences of mental health services showed that young people are highly sensitive to the poor overall investment in specialised service provision and take that as further evidence of being a person of little value (see “M. van Beinum (2003) Teenage user perspectives of adolescent psychiatry outpatient services. Ph.D. Thesis, Glasgow: University of Glasgow).

1. How children and adolescents potentially at risk of developing mental health problems are identified and how those problems should be prevented

At a population level, the research evidence has identified a number of key risk factors – poverty, harsh and unsympathetic parenting, witnessing or being a victim of violence or abuse, social isolation, drug and alcohol abuse by a child, parental mental illness, maternal smoking or alcohol abuse during pregnancy (for instance, the biggest single preventable risk factor for a child being born with a learning difficulty is maternal alcohol use during the first trimester of pregnancy), parental separation and divorce and parental conflict. However, whilst there is good evidence to suggest that exposure early in life to the above risk factors increases the risk of developing a mental health disorder in children, there is an enormous heterogeneity in children's response to adversity and the relationship between individual risk factors and outcome is non-specific. Furthermore, there is no simple correlation between risk factors and subsequent problems; some children respond to exposure to risk factors by developing mental health problems, but others show no long-term adverse reaction and can be said to be resilient. Factors promoting resilience in children include good genetic endowment, empathetic and supportive parenting, intellectual ability, a positive social outlook and good
social support, including a supportive peer group. However, we would want to make the distinction between the emergence of a major mental disorder such as Depressive Disorder or Psychosis and temporary emotional upset in response to a current stress. The latter can be ameliorated by health promotion strategies, but as yet there is no robust evidence that specific early years interventions will reduce the burden of mental ill-health later in childhood and adulthood, with the exception of parent training, such as Webster-Stratton, on later disruptive behaviour.

At an individual level, early identification and treatment of children developing a mental health problem is very important. The research evidence indicates that early intervention in emerging mental health problems will both diminish the severity of the current episode of illness and significantly reduce the likelihood of subsequent recurrence. Screening of high risk populations, such as children with Learning Disabilities, for early symptoms suggestive of mental disorder is required.

2. What obstacles there are in identifying children and adolescents with mental health problems and how they might be overcome?

It needs to be recognised by all those working with children that impairing and disabling mental health problems in children and young people are common – around 1 in 10 of 5-to-15 year olds at any one time will suffer from a mental health disorder. Despite this, many such children do not have their mental health problems recognised. In part this is to do with stigma, with children and young people reluctant to seek help for fear of being stigmatised, but is also a matter of a lack of recognition of mental health problems in children by adults working with them, including parents, a lack of training of staff working with children and a lack of specialist resources for children who may have mental health disorders. One way that stigma operates is by a lack of a shared understanding among professionals about the nature of mental disorder among those working with children, and that ultimately serves to deny these children a service. Thus a number of professionals still deny the existence of disabling mental health disorders in children, or maintain that mental health disorders are somehow the result of ‘labelling’ of children by psychiatrists – as opposed to understanding that making a careful diagnosis is the basis of any rational and evidence-based intervention. This is most clearly illustrated by the debate that continues over the nosological validity of ADHD, despite the very large amount of evidence supporting the reality of the devastating impact of having severe ADHD on a child and his or her family’s life and the beneficial effect of evidence-based interventions.

To address the obstacles in early identification of mental health problems in children requires a comprehensive multi-agency strategy across all agencies, as detailed in the Framework document referenced in our introduction. Better training in the basics of child mental health is required for all those professional staff who may come into contact with children, including GPs, paediatricians, speech and language therapists, health visitors, public health
nurses, teachers, members of the Children’s Panel, child and family social workers, and workers in the voluntary sector. Ideally all such professionals should have a shared, Scotland-wide, basic training in child mental health to provide them with shared conceptual tools and understanding, aiding later joint work. How this could be undertaken is spelled out in the Framework document referenced under our introduction. In order to provide such training staff from Tier II and III services need to spend more of their working week providing training and consultation to staff working at Tiers 1, but this can only happen with a substantial expansion of Tier II and III staff, as argued in detail in “Getting the Right Workforce”. No Health Board is currently resourced to the level expected to deliver high quality CAMHS, with the average wte staff numbers being around 10 for a population of 100,000, while the Framework has argued for around 20 wte per 100,000 population. Secondly, more work is required to counter the stigma associated with mental health, including building on the excellent work done by the ‘See Me’ campaign and the work in schools on de-stigmatising mental health problems among children and teenagers.

3. What action is being taken to facilitate early intervention and what else can be done?

Early intervention can be understood in two ways: intervention in the first few years of life and intervention early in the course of a child’s mental disorder. Both need to be based on sound and evidence-based interventions (See “The Matrix”: A Guide to delivering evidence-based Psychological Therapies in Scotland, December 2008). With respect to the first, there are several well-researched parent training programmes, notably the Incredible Early Years and Webster-Stratton. These have been shown to reduce the later prevalence of conduct problems in children. However, research by Scott et al in London has demonstrated that absolute fidelity to the treatment model is required for such programmes to be effective, and therefore they should only be delivered by trained staff working in organisational settings with rigorous supervision arrangements, excellent clinical governance procedures and frequent audit of outcomes. Unfortunately this is not always the case and therefore the cost-effectiveness of a number of well-meaning parent training programmes, even when they are available, is questionable. Furthermore, it is often the most vulnerable families who have the greatest difficulties in making use of such programmes.

There is increasing evidence of the effectiveness of early and vigorous intervention programmes in emerging mental health disorders. The best researched of these is the Early Psychosis Intervention Service (EPIS), first developed in Australia, and now increasingly adopted in parts of Scotland. To date it is only provided in the larger urban centres, despite the very good evidence base demonstrating both a reduction in morbidity and a much reduced rate of subsequent psychosis later in adulthood. There is also a developing evidence base indicating that similar programmes of early recognition and vigorous treatment of other mental illnesses, such as Depressive Disorders, in children and young people has a similar positive
impact on long term mental health. Of note is the impact of unrecognised neuro-developmental disorders, including Learning Disabilities and cognitive disabilities, on the subsequent development of impairing mental health disorders in children. Early recognition of and intervention with such developmental problems can substantially improve a child’s life. To deliver such programmes requires a substantial expansion of the specialist CAMHS workforce and better access to Tier II and III services (including a substantial expansion of primary mental health workers and community paediatric services that act as referring agents).

Lastly, there is an extremely worrying decline in academic child and adolescent mental health in Scotland, leading to both a dearth of good outcome research in child mental health, particularly applied research indicating what sorts of service provisions in Scotland have the greatest impact on child morbidity and that could guide service design, and on high quality training provision. Thus the only chair in child psychiatry in Scotland has remained vacant since the death of Prof Parry-Jones nearly 10 years ago, and Edinburgh University will not replace the recently retired senior lecturer in child psychiatry.

4. How access to services and ongoing support can be improved

Specialist CAMHS are often provided in poor quality, over-crowded and inappropriate premises that young people (and staff) regard as stigmatising and that may significantly impede the clinical encounter. For instance, in NHS Borders CAMH clinics are often run in local GP surgeries (in part to make them geographically easier for users to access), but this is frequently far from ideal; for instance, it is not unknown for a teenager seeking psychological help following sexual abuse to be seen in a clinical room that also contains an examination couch and prominently displayed boxes of needles and rubber gloves, giving the unintended message that a physical examination might take place. Such an interview room is equally unsuitable for assessing a child who presents with hyperactivity, but often it is all that is available. There is an urgent need for Health Boards to invest in their real estate to make specialist CAMHS clinics easier to reach and more attractive to children and their families. Greater involvement of children, young people and their families in the location and design of their local CAMHS clinics would make a real difference.

There is an urgent need to substantially expand specialist CAMHS provision, as argued earlier, including the need to expand the provision of adolescent psychiatry inpatient beds to approach the European standard of 20 beds per million population. The much-promised expansion of available adolescent beds to 56 across Scotland by 2008 has not happened, and this means that very ill teenagers are either being admitted to unsuitable – and often traumatising - adult mental health wards or being kept, to their detriment, in the community. This disregards all available expert opinion.
The voluntary sector has an important role to play, but services provided by the voluntary sector should be subjected to the same standards of professionalism expected of statutory services. Unfortunately, service provision for children with mental health problems is often piecemeal, not integrated strategically across agencies, plagued by short-term funding that makes staff development highly problematical, inadequately resourced and sometimes provided by staff with little specific training or professional support. Services to children with mental health problems, irrespective of who provides them, must be based on best available evidence of effectiveness, be provided by staff with high levels of professional training, be supported by sound and rigorous organisational systems of supervision and clinical governance, provide evidence of effectiveness by regular audit and be coherent with other service provision for this population.

5. What problems there are around transition from CAMHS to adult mental health services and how a smoother transition may be achieved.

There are significant problems of transition from CAMHS to adult mental health services, but some apparent problems of transition are in reality problems of adequate resourcing. For instance, several CAMHS in Scotland only provide services up to a young person’s 16th birthday, largely because their local Health Board has not invested adequate resources into their local CAMHS to allow it to extend services to age 18. This not infrequently creates difficulties as adult services in these Boards may, as a result of their own poor resourcing, be reluctant to provide services to young people under the age of 18.

The Royal College of Psychiatrists paper “Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults.”(2008) (available on the College website) provides detailed guidance on how best to manage transitions for young people moving from CAMHS to adult mental health services. It is important to stress that flexibility is required, as children develop at different rates. Some conditions, such as neuro-developmental disorders such as Autistic Spectrum Disorders or ADHD, are better understood by CAMHS than adult services and this would argue for young people with these conditions to be seen for longer by CAMHS, while other conditions, such as Bi-polar Disorder, are better managed by adult mental health services and therefore it would make sense for a young person presenting with a first episode of such a life-long illness at, say, age 17 to be seen by adult mental health services and not to have to manage a transition the following year. There are good arguments for the development of ‘transition-specific’ mental health services, covering an age range from age 16 to age 25. Such services have been developed, for instance, in the Netherlands and in the USA and are able to address the impact of the transition from adolescence to adulthood, including finding a work identity, leaving home and developing long-term sexual relationships, on mental health. Currently, neither CAMHS nor adult mental health services in
Scotland are well –placed to provide high quality mental health services for adolescents undergoing this transition.

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