Evidence with illustrative Case Examples to the Scottish Parliament Health and Sports Committee’s Inquiry into Child and Adolescent Mental Health services in Scotland: Dr RM Wrate

Includes reference to the Executive Summary of a 2008 Report: Developing Integrated Stepped Care Pathways for Remote & Rural CAMHS: an Initial Scoping Exercise

Q1: how children and adolescents potentially at risk of developing mental health problems are identified and how these problems should be prevented

Kyle, a depressed 17yr old island teenager, approached his guidance teacher believing on the basis of an internet search, that he was depressed. He talked of feeling low and hopeless, with intermittent suicidal thoughts. These, on further enquiry by the school nurse, included lying awake at night ruminating about death, with increasing thoughts of either hanging or poisoning himself. Lacking confidence in her own skills about mental health, she immediately phoned his GP, who had see Kyle previously for unexplained tiredness and headaches. The GP, who several years before had treated his mother for depression, faxed an urgent referral to the nearest specialist-CAMHS team.

1. there is strong evidence that certain family factors (both genetic and experiential [including psychological trauma]) heighten risk, and that social adversity increases this much further. ‘Looked after’children are amongst those most at risk. Although universal health messages tend to be the most accepted (least stigmatising), public health interventions should particularly focus on higher risk population cohorts, including from pre-school years.

2. measures to lessen social adversity should increase self-esteem and reduce stress, so lessening individual vulnerability to health problems of all kinds. However, here is little evidence that, except for those induced by traumatic events, mental health problems in young people can be prevented from arising (any more than asthma can be prevented). The example of Kyle is typical of many adolescent-onset mental health problems that arise without earlier childhood difficulties, and may often recur in adult life. More realistic goals include substantial reductions in the severity and duration of psychological distress and impaired mental health, the prevention of relapse, and minimising secondary handicap arising from the experience of being unwell.

3. in comparison with those at risk for ADHD, now quite well understood within the community, most teenagers with depression remain unrecognised despite their more frequent GP presentations (they may not understand what’s happening themselves). Since schools are by far the most important universal provider for youngsters, it is now widely agreed that schools-related initiatives are likely to be most effective for the identification of risk of depression, and for most other types of mental health problem. A few CD-ROMS and websites have been developed to support these (eg for depression and for anxiety/stress). Their effectiveness within schools is probably limited by the
multiple other educational challenges schools must undertake, but there is considerable unmet need for similar material for other types of MH problem

**Q2: what obstacles are there in identifying children and adolescents with mental health problems and how might these be overcome**

_Familiar with web-based searches, Kyle had sufficient insight and impulse control to seek appropriate help without acting upon his suicidal ideas, the presence of which he had protected his single-parent mother from. Later, renewed professional concerns about his safety were tempered by the knowledge that he wasn't part of a local drinking culture, where excess alcohol would have quickly disinhibited him. A different temperament and social circumstance might have led to a fatal outcome even before his GP could make the diagnosis._

1. the e-material described above is directed to promoting self-identification, including schools’ support of it (e.g. www.depressioninteenagers.co.uk, www.anxiety andstressinteenagers.co.uk, and the www.hansonscotland.co.uk toolkit).
2. The separation of specialist-CAMHS from adult mental health services and from primary care, as well as its low current level of resources in most regions of Scotland, preclude other ‘public health’ interventions for high risk population-cohorts.
3. This circumstance greatly affects remote & rural areas, where service lines are stretched and isolated practitioners common. An SG-funded scoping exercise in 2008 concluded that focus group work would constitute one of the principal ways of exploring the issues involved, but progress on agreed aims and methods proved slow, because of the meagre capacity of the local children’s workforce in many areas. In addition, finding that in these areas the mainstreaming of CAMHS in the community was being undertaken in separate ‘silos’, rather than joint-working (Initial Scoping Exercise: Integrated Stepped Care Pathways for Remote & Rural CAMHS, full report available on request).
4. Child health services re-design has rarely included child mental health, a very important omission that further contributes to reduced specialist-CAMH work.
5. other obstacles include three present in the case of Kyle and his mother; two of these also notably affected the life of Danielle (2nd case example, below):
   - the comparative ‘invisibility’ of psychological distress, and of traumatic damage to youngsters’ mental health compared to traumatic physical injury (burns etc), preventing others’ salient and timely responses
   - stigma about not only mental ill-health but of NHS-mental health services too
   - finally, with the exception perhaps of parents of youngsters with Aspbergers, and perhaps ADHD, the parents of many others are disadvantaged (including by their own depression), so their advocacy as parents can be significantly impaired.
After a long period of being settled by stimulant medication for ADHD, the behaviour of Danielle, a twelve year old girl with mild learning difficulties in long-term foster care, became increasingly difficult in her new school, prompting part-time attendance. This too was now in jeopardy because of her restless disorganised behaviour, likewise her foster placement was under mounting strain. She had an unexpectedly good memory for the rooms, toys, and names of staff she had known in the past; furthermore, ADHD alone could not account for Danielle’s recurrent behaviour problems as intermittently dispersed throughout her restlessness chaotic and immature play she demonstrated a surprising attention to order (e.g. inspecting the cleanliness of the room, finding dust and mislaid papers, tidying things up), giving a running commentary as she rushed about her self-appointed tasks, all of which seemed purposeful, produced results, and were difficult to interrupt. Chaos thus alternated with rigid ordering, but at school she became been excluded after violent outbursts (the trigger uncertain); her foster mother was worn down, and the placement near breakdown.

Danielle was the eldest of several children to different fathers, and had not been in her mother’s care since she was three. During the first three years of Danielle’s life her mother had had a series of cohabiting relationships with abusive men. Many violent assaults on her mother (some to her possible severe injury or life-threatening) were observed by Danielle and her little brother; neighbours were often concerned about their poor care, and both had attended A&E for minor injury incurred whilst inadequately supervised. Over her subsequent first four years in care Danielle had six family placements (including an adoption breakdown); although erratic or aggressive behaviour was sometimes a problem, most of the placements ended because of events or stresses independent of Danielle. In recent years she has had some regular if infrequent contact with her mother and her younger brothers, who are also long-term fostered; on these occasions their mother is reserved if not detached.

5. local authority Social Work departments’ opportunities to introduce at-risk initiatives seem compromised in many areas of Scotland; four particular factors often seem to be responsible (over page)

- by competing demands arising from their dominant Child Protection agenda
- shortages of fully trained staff and by unfilled posts
- an often quite different understanding from specialist-CAMHS on what constitutes mental ill-health, so different priorities prevail
- and because – unlike most of Western Europe- most staff in the majority of Scotland’s residential units for children are neither graduates nor trained professionals.

In many areas of Scotland, specialist psychological assistance to these units (and their children), which could reduce the damage done to youngsters like Danielle before they were received into care, and which might also diminish
costly service-breakdown, is scarce or unavailable. Her difficulties are severe, so twice weekly child psychotherapy would be required, at a 1st year cost of £5,000. Most receive none.

6. the current level of recognition of child sexual/physical abuse probably required at least twenty years’ hard work in the community; that for emotional abuse lags far behind, and it is as poor for other types of mental health-impairment. Only a comparable level of funding support to that provided for the first set of problems will produce a comparable recognition-rate; hopefully that could be achieved far more quickly as much has been learnt since on how best to achieve this, now perhaps including by e-learning (providing this is also supportedguided).

Q3: what action is being taken to facilitate early intervention and what else can be done

The first part of this question is best addressed at NHS Board level. Much can be done that is not being done, there is no shortage of professional evidence on what else can be done, a few examples of ‘good practice’ in Scotland and many outwith it. Most actions will require additional funding.

For example

- the specialist psychological assistance required to understand and respond to Danielle’s mental health needs would require several years of intensive development, albeit at a cost likely to be substantially less than the cost to local authorities of not providing that assistance
- the developments costs of CD-ROM & websites for each specific type of CAMH problem for which no material is currently available is likely to be at least £30,000-£50,000 (not including their dissemination/promotion), particularly if a piece-meal approach to commissioning them continues.
Q4: how access to services and ongoing support can be improved

Living on a Scottish island, Kyle’s treatment was complicated by geographical distance, the lack of any local CAMHS staff to closely monitor his wellbeing and risk, and – during his recovery, when a medication side-effect temporarily much heightened the risk to his safety until the source of it was recognised and dealt with.

The only specialised psychological support to him was off-island, which it was possible for him to access by text messaging and e-mail; after a few very worrying weeks, these measures (together with telephone liaison between the professionals involved), proved sufficient to discount the need for hospital admission on the mainland.

1. Similar resources would not be sufficient for others; Kyle’s own initiative was an important factor in recognising his needs. In some of Scotland’s rural areas, and in all of its remote & rural areas, service lines are stretched and isolated practitioners common, posing a particular problem where risks to safety are present, or intensive treatment is required. Unlike Norway for example (see Appendix), the intensive treatment needs of youngsters living in remote & rural areas are currently very difficult to meet.

For exactly similar cases that occur in urban populations (providing these are recognised), local multi-disciplinary specialist-CAMHS team can quickly introduce intensive interventions (undertaken by staff with a shared understanding of need and how to meet it), and – unlike rural & remote – can do so without crossing several service boundaries to gather in sufficient capacity to support and care for the youngster.

2. Even then, multi-agency working is widely required to support/resolve CAMH-problems, so the development of integrated care-pathways is essential. These would help to delineate the steps that should or may be taken to resolve a problem, and should be developed from the end-user perspective i.e. providing transparency for parents, youngsters, teachers, GPs etc on the steps service-providers have agreed, on their behalf, on the timing and nature of interventions that might be necessary to resolve the most concerning CAMH-problems. The development of these for each geographical area will require ‘local champions’ with the necessary time & authority to undertake their task.

Heather, who lived on a mainland farm and a locally well-known junior horse-riding champion, was taken by her mother to the GP at the insistence of an aunt because of weight loss (15% over the previous nine months). Her mother reported Heather was over-exercising when unsupervised and her suspicions about possible laxative abuse or self-induced vomiting. The local health visitor then saw Heather with her mother weekly but found that she couldn’t a relationship with Heather, who continued to deny any difficulty but continued to lose weight. A visiting dietician was brought in by the GP, to see if a
relationship can be built upon and an agreed diet reached, but because of increasing conflict at home and the agreed diet not being followed (with further weight loss), the CHP’s primary care mental health worker was involved. First, to support the family and advise on school attendance, then to liaise with the local specialist CAMHS team and seek their assessment, anticipating that a hospital admission might be recommended rather than outpatient treatment.

3. although a clear progression of help is evident in the above case, the steps undertaken were not necessarily those other areas might undertake; variation tends to depend on individual confidence and professional skills availability. In particular, the absence of a local intensive ‘home treatment’ team would substantially hasten the perceived requirement to hospitalise, likewise if there were not any local expertise specifically related to the care of youngsters with eating disorders.

Both the geographical distance of the hospital unit, and the length of the anticipated delay before a bed became available, are also likely to influence decision-making in many areas, yet hospitalisation is far from the ‘gold standard’ for the treatment of anorexia nervosa. Guided self-help at an early stage, and omitting steps of unproven effectiveness (e.g. few health visitors and dieticians have expertise in MH problems), would much improve local responding providing specialist-CAMHS capacity to provide timely skilled outpatient work was present. Currently too many urban teams feel beleaguered by other demands of them, and few rural teams are sufficiently resourced.

In short, there is sufficient evidence to develop stepped care pathways that would integrate the various possible resources in a planned way, helping service-users understand what will/can happen at each stage of their journey, explaining and smoothing transitions and, not least, highlighting all significant gaps in local resource provision. Telehealth investment, for example, would facilitate shared expertise across Scotland, and some very obvious complete absences of a necessary resource would emerge.

Pathway-development is likely to be useful for a wide variety of CAMHS problems, for example to speed up the treatment of young people developing psychotic illnesses (see below), and to ensure their health needs are dealt with in a holistic and age-appropriate way. Without funding support significant CAMHSpathway-development does not seem possible.

Q5 : what problems there are around transition from CAMHS to adult mental health services and how a smoother transition may be achieved

Youngsters with three types of CAMH problem are likely to require ‘transfer’

1. those whose ADHD still remains problematic at 18 yrs (or will remain life-long)
2. those with unresolved or recurring depression, where a ‘lifespan’ approach should be adopted (very rarely embedded in UK mental health services)

3. those with early-onset psychotic illness, like the case below, where difficulties are very likely to become chronic and enduring.

The academic performance of Kenneth, a 16yr old with specific learning needs identified in primary school, progressively declined over 4th yr at high school, becoming less socially integrated; reluctant to maintain his attendance at the supported-workplace & youth project Kenneth’s school had introduced in place of 5th year. At home he began to express suspicious ideas, with angry outbursts, overheard to talk to himself in his bedroom, progressively more argumentative with them, refusing to come down for his meals or to meet his youth worker. Muddled talk, up at night, observing that he had plucked his eyebrows, and the discovery of a kitchen knife under his pillow alarmed his parents, who reported their concerns to the GP. After interviewing him on the 2nd attempt to see him, the GP faxes an urgent referral to the local CAMH’s office concerned that his patient might be psychotic. A CAMHS CPN visits the house after telephoning his parents, Kenneth refuses to meet him but a strategy is agreed to help them bring him to the clinic, which succeeds. Kenneth’s guarded responses makes the CAMHS staff uncertain that he will accept any medication, or be reliable about taking it. The (distant) regional adolescent psychiatry inpatient unit indicate no bed-availability within the next 6 weeks, so the local duty general adult psychiatrist is consulted about the likelihood that an early admission will be required. He identifies a ward that offers the least-disturbed environment, with a single room and nursing staff interested in young people.

As the frequency of such early-onset illness is not great, the expertise of CAMHS teams serving small catchment areas is accordingly less. However, their professional associations with adult mental health colleagues may be greater (e.g. sharing the same campus or even the same building, facilitating meeting one another). Throughout Scotland most community resources, and most new investment, for the care of psychotic patients applies to adults ie those beyond their 18th birthday (even for ‘1st episode’ funding), so CAMHS teams’ approach is necessarily rather different (with few exceptions, piece-meal rather than systematic, and limited in scope).

Transitions cannot be adequately undertaken without direct communication, and working together over the transition period; that is an ideal rather than a practical reality in many areas of Scotland.
Appendix: Comparisons with Norwegian CAMHS for Lillehammer region north of Oslo (data from meeting their team on 6th March 2008)

For most of Argyll and its islands less than 3 specialist-CAMHS staff are available. For Moray, with twice the population, around 9 specialist-CAMHS staff are present.

By comparison, the Lillehammer region, quite similar to Moray in both population and physical geography, is served by a staff group more than three times that number (32, excl’ A&C). They also have ready access to specialist beds not far to the south. Six of the 32 are based in Otta, a small town of 7,000 two hours up the valley north of Lillehammer (size c 22,000), which also acts as a hub for six more distant smaller populations (amounting, for that team of six, to a total population of c23,000). Staff for each of these six more distant areas includes a local experienced coordinator for CAMHS (appointed from the well developed and quite high prestige public health system), who liaise with another at the Otta base, ensure timely outpatient care, and organise visiting day-clinics, plus arranging case-consultation sessions that are also open to other agencies in the community. To the best of my knowledge, except for Fife no other rural area of Scotland could conceivably offer vulnerable young people & their families anything like this level of support.

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5th January 2009