Note: I have already completed this form along with my colleagues Helen Minnis and Graham Bryce from the perspective of academic CAMHS. These few additional comments are written from the perspective of a general practitioner. Most of my comments relate to the under-five age group because this is the group for which primary care teams are the sole health care provider in the vast majority of cases. For most under-threes there is no involvement of any other health, social care or educational service. Very few under-fives currently have any involvement with CAMHS although a fair proportion (variable across Scotland) do consult with community paediatric teams. It is important that you elicit responses from these teams because they do a great deal of work in relation to early diagnosis and treatment of autism, ADHD and other neurodevelopmental problems.

On a more general note I am slightly concerned about the circulation of this document. It reached me by the most circuitous route via the Principal of the University of Glasgow. Have CAMHS teams, child development teams and primary care providers been consulted?

The following questions have been broken into two parts

Q1 How children and adolescents potentially at risk of developing mental health problems are identified and how those problems should be prevented?
Part a) How are children and adolescents potentially at risk of developing mental health problems identified?
Response:

The child’s parents are usually the people who first suspect problems and parental concern should trigger a systematic approach to case identification. Recent Glasgow research on the role of health visitors and school nurses\(^1\)\(^,\)\(^2\) in the identification and management of psychological, emotional and behavioural problems confirmed that this work accounts for a substantial proportion of their total workload. Other UK researchers have also found that, for example, autism diagnoses are most commonly first suspected by health visitors.

The approach to early identification is undoubtedly very variable and there are no systematic approaches to case finding taken anywhere in Scotland as far as I know.

Once mental health or neurodevelopmental problems in early childhood are first suspected by a parent or health visitor, the GP tends to be the next port of call. In many cases referrals are then made to the paediatric-led child development team. Few of my colleagues would normally consider referral of a pre-five child to CAMHS – the general perception is that this is the domain of community paediatricians.

Part b) How should the problems identified in question 1a be prevented?
Response:

A greater focus on the potential of the primary health care team is central to the solution of this problem. Insufficient attention is paid to sensitive periods for social and emotional development during which intervention is most likely to succeed – and this particularly applies to the under threes for whom the primary care team is usually the only health care provider.

Promoting healthy parent-child interaction is likely to be the most effective preventative strategy and provision is largely the domain of health improvement staff and health visitors. The HeadsUpScotland Infant Mental Health Report summarises the main evidence-based
elements of primary prevention and the new Parenting Support Framework in Glasgow has embraced these recommendations.

Once there is a suspicion that a child is at risk of developing mental health problems, for example when behaviour management difficulties have been identified, disruptive behaviour disorders can be prevented by targeted interventions which can be delivered by appropriately trained and supervised primary care staff\textsuperscript{3,4}.

**Q2 What obstacles there are in identifying children and adolescents with mental health problems and how they might be overcome?**

Part a) What are the obstacles in identifying children and adolescents with mental health problems?

Response:

The Glasgow health visitor research identified major issues with lack of formal training of health visitors in identification of problems in the parent-child relationship and this is clearly an important area for development. I have, for example, been quite shocked that most early years staff do not appreciate the significance of indiscriminate friendliness in young children – a highly sensitive indicator of severe attachment problems.

The level of training of my profession is also rather disappointing – basic medical education now rarely includes more than a day or two of child psychiatry and general practice professional training might include half a day. We do of course have access to CPD and journal articles but I think that a more systematic means of encouraging GPs to attain a degree of competence in early identification of mental health problems in young children would pay great dividends. Perhaps the most effective strategy might be to offer a consultation service to discuss cases in the first instance.

Recent developments in child surveillance policy seem to pose great dangers to child mental health. There is an increasing view that universal child health surveillance should stop at 2-4 months of age and this will probably miss the majority of the children most vulnerable to mental health problems\textsuperscript{5}.

Few people making policy seem to understand the incredibly close relationship between language delay and mental health problems\textsuperscript{6} and failing to pay attention to language delay in the community risks delaying the offer of effective services to these children and their families. Even now the situation is far from ideal. Many children with language delay are referred to speech and language therapists who do not have access to appropriate neurodevelopmental assessment expertise.

Even worse is the potential impact of the Review of Nursing in the Community. This advocates the abolition of the health visiting role so there would be no specialist universal community nursing service for children. In its place the focus of the new Community Nurse would be on providing services for the ageing population with multiple morbidity.

Conduct disorder presents a specific problem in relation to identification of MH problems. A very high proportion of children and young people with conduct disorder either have or go on to develop other significant psychiatric disorders including psychosis\textsuperscript{7}. Many CAMHS teams across Scotland elect to exclude children (particularly children with conduct disorder) and such restrictive practices in terms of referral criteria by some CAMHS teams (a recent SG documents suggests that this practice may become official policy) close the door to early identification. Making a referral to a service which takes weeks to decide that the case is “not suitable” both humiliates the referrer in the eyes of the family and introduces a
completely unnecessary delay. This has a profound negative impact on a potential referrer’s motivation to identify problems.

**Part b) How might the obstacles be overcome?**

The Glasgow Parenting Support framework provides a structured approach – universal services (including mental health promotion, staff training, public information campaigns etc), “active filtering” – a relationship between parents and professionals (usually the health visitor for young children), good quality assessments of problems and provision of services to those who need them.

A good place to start at the universal level would be Solihull Approach training – which will be adopted in Glasgow soon. This approach simply gives a broad conceptual framework and a common language to describe the mental health of young children. More importantly, the Approach requires the provision of expert supervision. More generally, communication between professions when problems are suspected is undoubtedly an important problem and much work needs to be done in this case. 

In terms of the “active filtering” I advocate specific training of primary care staff in the use of structured tools for identification of psychiatric disorders in children – for example the SDQ, Behaviour Screening Questionnaire, M-CHAT and perhaps even the DAWBA, though this last would need to be for selected staff and be used in collaboration with CAMHS teams.

I think it would be very useful to have one or two triage staff, probably nurses, for each 10,000 under fives who could use these tools and others (eg the HOME Inventory). They would provide a rapid access service for clinicians who suspect mental health problems in children. They would make referrals to appropriate services in paediatrics, CAMHS, speech and language therapy, parenting groups etc. They could also teach use of some of the tools to frontline staff.

**Q3 What action is being taken to facilitate early intervention and what else can be done?**

**Part a) What action is being taken to facilitate early intervention?**

Response:

See above.

**Part b) What else can be done?**

**Q4 How can access to services and ongoing support be improved?**

Response:

See above

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

**Part a) What problems are there around transition from CAMHS to adult mental health services?**

Response:

**Part b) How might a smoother transition be achieved?**

Response:
Other comments:

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15 January 2009

Reference List


