A large amount of work 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 21\textsuperscript{st} 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).

We have provided both a reasoned argument in response to your questions and given a clinical vignette to give a real life perspective for your inquiry.

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 there is, as yet, no convincing 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-to15 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 Tier 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”. Here in NHS Borders, with a population of around 107,000, the specialist CAMHS workforce currently stands at 10.8 WTE clinicians and 3.1 WTE admin staff in specialist CAMHS with a further 2 WTE community mental health workers, but according to the recommendations set out in the Framework should be around 21wte for a service from age 0 to 16th birthday. If services are to be provided to age 18, an additional 7 wte staff will be required (excluding Learning Disability, Dug and Alcohol and Forensic services). 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).

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 2010 now looks in serious doubt, 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 (See ‘the Matrix’ referenced above), be provided by staff
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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 including Autistic Spectrum Disorders and 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. Alternatively, 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 the Borders are as well-placed as they would like to be to provide high quality mental health services for adolescents undergoing this transition.

**Case Example**

J was first referred to the CAMHS team at age 7 by the Educational Psychologist following concerns about his behaviour at primary school. He was falling behind at school with his academic work because of difficulties with attention and concentration, was reported to be restless and fidgety and was always in trouble because of impulsive behaviour.
A developmental history taken at assessment by the CAMHS team showed that J was born at full term weighing 7lb 3oz following a normal delivery. His mother had an uneventful pregnancy and there were no complications with his birth. The first concerns arose before J was a year old when his mother spoke to her Health Visitor about difficulties she was having breast-feeding and generally bonding with her baby. Following this the Health Visitor had brought the case for discussion at one of the monthly consultation sessions held with the CAMHS team. At that time J’s mother was a single parent. She and J’s father had never been in a relationship together and he lived in another part of Scotland. They got on well together, however, and her father had expressed an interest in helping out with J’s upbringing in whatever way he could. J’s mother had had a poor experience of parenting herself in and had been brought up in care. J’s father came from a similar background. Advice was given at that time to help promote the early attachment relationship between mother and child and extra support via parenting classes at the local family centre was arranged through the social work department.

A diagnosis of Attention Deficit – Hyperactivity Disorder (ADHD) was made, and following limited successes with behavioural, social and environmental approaches, he was started on stimulant medication. This balanced package of interventions worked with good effect and J’s behaviour became more settled and his academic performance returned to what would be expected of a child of his age. J was subsequently followed up by the CAMHS team and his treatment package monitored evaluated and adjusted accordingly.

As J progressed in to adolescence, however, new symptoms began to appear. J began presenting with tics and developed obsessive patterns of thoughts. His tics included involuntary swearing and facial twitching. J found this very difficult to cope with and his self-esteem was badly affected. He became depressed and started to report hearing voices. He began to cut himself with a razor as he had read on the internet that harming yourself could help get rid of voices in your head. J’s condition was reassessed by the CAMHS team and a joint appointment arranged with the paediatrician to rule out any other underlying physical cause of his presentation. A new diagnosis of Tourette’s syndrome was made and he was prescribed alternative medication and given further treatment of his mood related difficulties using Cognitive Behaviour Therapy with good effect.

At the age of 16 the CAMHS team met with adult mental health colleagues to discuss his difficulties and subsequently management of his mental health difficulties was transferred to adult services.

J is now 29 and is in employment. His symptoms are relatively well maintained on medication and he still requires therapeutic help and support with his moods. He still occasionally has facial twitching and the odd involuntary outburst of swearing, but his work colleagues are used to this and are quite accepting of J’s difficulties. J has been happily married now for nine years and has a family of his own. One of his children has ADHD and the family are receiving input from the CAMHS team in relation to his difficulties.

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