The following questions have been broken into two parts

<table>
<thead>
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<th>Q1</th>
<th>How children and adolescents potentially at risk of developing mental health problems are identified and how those problems should be prevented?</th>
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<td>Part a)</td>
<td>How are children and adolescents potentially at risk of developing mental health problems identified?</td>
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<td>Response:</td>
<td>The entirely appropriate focus on health inequalities in Scotland has led some authorities to apparent confusion about this matter. All children are at some risk of developing mental health (MH) problems and so public health approaches to promoting the mental health of children and to preventing mental health problems have to start there. The fact that some children are at increased risk should mean that we are particularly exercised about them, but not at the expense of those who, though at lower risk, are at still at risk. There is also a danger that, in our entirely reasonably attempts to address social inequalities, we equate the risk factors for social exclusion with the risk factors for MH: while they overlap, they are not the same. The factors which increase the risk of developing MH problems are well documented (see SNAP report (2003)). They include dynamic aspects of risk, such as personal experience, including living with parents who are in conflict, being exposed to any form of abuse, being cared for by a parent with a mental illness, and personal factors, such as poor physical health or having a learning disability, among others. They also include fixed aspects of risk, such as the inherited risk of developing a mental illness. As far as I am aware, we are not yet able to predict reliably which of those children who are at increased risk of developing MH problems will actually go on to develop MH problems. Therefore the potential for targeted effective preventive intervention is currently limited and requires further research. The evidence does, however, suggest that risk accumulates and so those with the highest number of risk factors are those at greatest risk of developing mental health problems.</td>
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<td>Part b)</td>
<td>How should the problems identified in question 1a be prevented?</td>
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<td>Response:</td>
<td>A most important step in addressing preventable MH problems in children involves supporting and promoting the quality of the parent-child relationship, from the very earliest stage. As such, efforts to inform parents of the importance of this relationship, to support them in building this relationship and to move quickly to address problems that may interfere with this (such as post-natal depression) are vital. There is good evidence that some mental health problems, such as disruptive behaviour disorders, can be prevented by targeted interventions with children who are known to be at risk. There is also some evidence to suggest that targeted work on coping skills in vulnerable families and on promoting the resilience of children who are at risk of developing mental health problems can reduce the risk of those children going on to develop mental health problems. But there is, so far, little or no convincing evidence that more severe forms of mental health problems, such as eating disorder or psychosis, can be prevented. There is some evidence of the value of preventive approaches, good reason to persist with these and every reason to invest in further research into prevention. But the current state of</td>
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evidence provides more robust support for early detection and intensive intervention at the earliest point in the problem course as key to the mental health and wellbeing of children.

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:

Scotland’s children pay the price for the historical lack of attention to mental health in the training and in the practice of professionals of all disciplines. The knowledge about the nature and course of MH problems has increased steadily in recent years; but this translates only slowly into the training programmes of those who work with children and families or into their day to day work. Education policy is an example of an area where there has been a shift in recent years, and in keeping with the general trend, this is mainly in relation to mental health improvement.

Accordingly, limited awareness of the characteristics or significance of MH problems in children is an important obstacle. Interestingly, the SNAP research indicated that those who work day to day with children often recorded that they were aware of a MH problem in a child or young person in their care but reported a lack of knowledge, experience and support in how to approach these problems.

Those who set public sector priorities for investment have been slow to recognise the importance and scale of mental health problems. This is reflected in the time taken for the well articulated development agenda around children’s mental health, first signalled in the SNAP report and then crystallised in the 2005 policy document, to gain support for investment.

The historic lack of investment in specialist MH services for children, which was the rule across Scotland, rather than the exception, remains an important obstacle, with the limited availability of services seriously constraining the capacity to identify and address MH problems. The associated long waiting lists for specialist services, compounded sometimes by restrictions on access, serve to maintain a situation where we identify only a proportion of children with MH problems, we identify them later than we could and we then struggle to provide adequate interventions, sometimes because of lack of knowledge or evidence, but more often because of a lack of investment in services.

Part b) How might the obstacles be overcome?
Response:

Enabling and encouraging those who work in universal services for children and young people (e.g. health visitors, nursery workers, teachers) to embed mental health improvement, or promoting resilience, in their day to day work is likely to be rewarding. There are signs of this happening in some places.

Enabling and encouraging children and young people to acknowledge mental health as an important matter is also part of this process and there are good examples, across Scotland, of peer education projects through which young people promote a more ready acknowledgment of mental health issues and problems. These are important steps in addressing the stigmatised nature of experiencing a MH problem. Making information available about what to do about MH problems, e.g. self help, peer support and counselling...
through to accessing specialised services, helps to overcome these obstacles.

Likewise, a focus on how to spot features of MH problems at an early stage in their course should be part and parcel of the role of universal services. Accordingly, education about the nature of MH problems and the range of activities necessary to address them should have a higher profile on the training curriculum for all of the children’s workforce.

Such is the stigma around MH difficulties that it is important that all of these initiatives are underpinned by an understanding of the likely emotional, social and educational benefits for the child of early recognition and early intervention.

There is also a role for the specialist services in overcoming these obstacles. These services can and should be linked into the places the children, young people and families look for help, for example, in schools, in community settings, in primary care. This can be achieved through simple functional steps such as designating a MH professional as a link person to a school – an element set out in Better Health, Better Care Action Plan and already happening in many parts of the country.

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:

The recent policy emphasis on early years and early intervention is welcome. The MH policy in relation to children and young people has also emphasised early intervention, with its focus on the importance of what is referred to as “primary mental health work (PMHW)”. This is work undertaken by those trained in child and adolescent mental health, which has a different emphasis and purpose from clinic-based MH practice. While PMHW does involve some direct clinical work, usually with the less severe and simpler to treat expressions of MH difficulty, it also involves working with others who do not have a training in MH, such as teachers, health visitors, social workers, to help them work more effectively with children with mental health problems. This “capacity building” is an important strand in facilitating early intervention.

Part b) What else can be done?
Response:

There is good evidence that early intervention improves outcome in relation to many significant mental health problems. For example:

- Attachment problems (i.e. difficulties in a child’s capacity to relate well to their primary care-giver) are amenable to intervention, and possibly reversible, if identified at the earliest stage. If, however, they are not detected until school age, there is far less likelihood of achieving a good outcome.

- Disruptive behaviour disorders can be treated at the pre-school stage with relatively simple, often group-based, treatment programmes. The evidence is clear that this reduces the risk of major subsequent health, educational and social problems for those children. But they are commonly not identified and treated until late childhood or adolescence; by that time effective intervention is harder to achieve, as well as being substantially more complicated and expensive.

- The high rate of mental health problems amongst children who are “looked after” by their local authority (4 or 5 times higher than the general population of children) is, first and foremost a reflection of the impact on the child of poor, frequently adverse, sometimes abusive, parental care. There is now evidence available about how to
lessen this impact on children and indications that this translates into better mental health outcomes for those children.

- Psychosis, which most commonly starts during adolescence, cannot, at present, be prevented. But the evidence indicates that appropriate intensive intervention at the earliest stage in this disorder makes a significant difference to the course and outlook.

It is important to note that this is subtly different from the argument which equates early intervention with early years intervention, important as that is. This evidence generally indicates the importance of early intervention in the course of a MH problem at whatever age the problem appears.

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

Capacity of specialist CAMH services has been and remains the major challenge. There is a need to increase the mental health capacity of the wider children’s workforce but that, too, requires improving the capacity of the specialist workforce. This was discussed in the workforce review which accompanied the national policy and there are numbers of suggestions there about how this might be done.

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:

There have been some welcome developments in recent years, such as teams providing services for young people early onset psychosis, which offer alternatives to a “handover” from CAMHS to adult services at a difficult time.

There are, however, often problems in achieving transition for other young people. Two main groups come to mind. There are those with disorders such as ADHD, which have not been well recognised in adulthood and there are those who are difficult to serve and support, particularly young care leavers. Both of these examples illustrate how the different models of care found in CAMHS and in adult services mean that transition can be a very difficult matter.

Part b) How might a smoother transition be achieved?
Response:

Other comments:

All references available on www.headsupscotland.co.uk
Scottish Executive (2005) Mental Health of Children and Young People in Scotland: A Framework for Promotion, Prevention and Care

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<th>Name:</th>
<th>Graham Bryce</th>
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<td>Area/Team:</td>
<td>NHSGGC Looked After Mental Health Team</td>
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