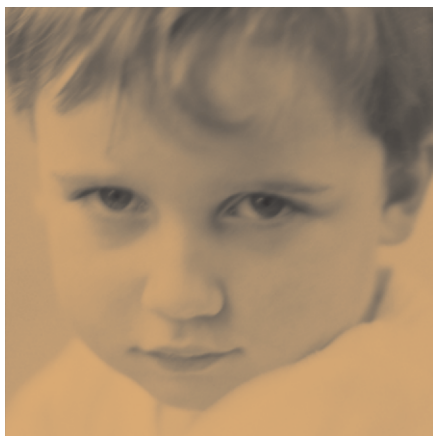
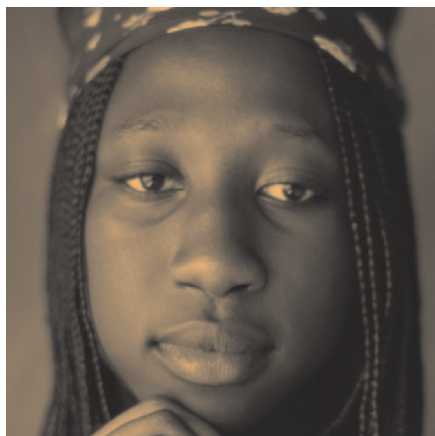
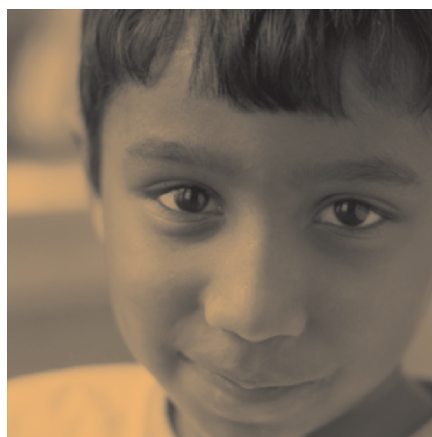
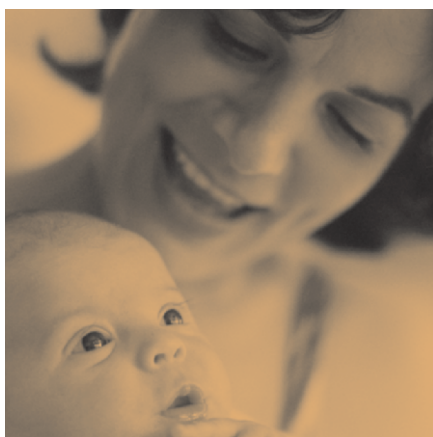


Health Scotland

ONLY CONNECT: ADDRESSING THE EMOTIONAL NEEDS OF SCOTLAND'S CHILDREN AND YOUNG PEOPLE

A report on the SNAP Child and Adolescent Mental Health Phase Two survey

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GLOSSARY

ASD	Autistic Spectrum Disorder (including Asperger's Syndrome)
ADHD	Attention Deficit/Hyperactivity Disorder
Adjustment Disorder	A code used in this report to indicate problems arising from a significant change in a young person's circumstances (e.g. bereavement)
CAMH	Child and Adolescent Mental Health
CAMHS	Child and Adolescent Mental Health Services
CPD	Continuous professional development
CPN	Community psychiatric nurse
Children's Hearings	Scottish system using selected and trained volunteer members of the public to make decisions about children in need – including young offenders
Emotional intelligence	The ability to recognise, understand, handle and appropriately express emotions.
Externalising disorder	A code used in this report to indicate that the child/young person's behaviour is seen as challenging e.g. conduct disorder, oppositional-defiant behaviour, truancy, running away, disruptive behaviour
GP	General practitioner
Looked after children	Children who are subject to formal care or supervision by the local authority. They may still live in their own homes.
Looked after and accommodated children	Children who are cared for by the local authority in some form of residential provision, foster care or care of relatives
NES	NHS Education for Scotland
NHS	National Health Service
ONS	Office of National Statistics
OCD	Obsessive-Compulsive Disorder
Panel member	Person who sits on the decision making panel of a children's hearing
Questionnaire A	A questionnaire distributed to non-CAMHS professionals
Questionnaire B	A questionnaire distributed to CAMHS professionals
Reporter	Person appointed to investigate referrals of children in need and decide if a Children's Hearing is necessary. They are also involved in Children's Hearings but do not take part in the decision making.
SEHD	Scottish Executive Health Department
SNAP	Scottish Needs Assessment Programme

EXECUTIVE SUMMARY



INTRODUCTION AND METHODS

This is the report of the survey of professionals carried out as part of the second phase of the SNAP¹ *Assessment of Child and Adolescent Mental Health Needs in Scotland*¹. Questionnaires were sent to a wide range of professionals who work with children in a variety of settings but whose main training is not in mental health. One thousand and sixty eight completed questionnaires were received. A separate questionnaire was sent to different professionals whose main responsibility is to provide a specific mental health service to children and their families. Two hundred and eighteen completed copies of this questionnaire were received. The responses were analysed using both qualitative and quantitative methods. The quantitative data are presented in detail on the HeadsUpScotland website².

PROBLEMS FACED BY CHILDREN AND YOUNG PEOPLE IN SCOTLAND

Responses to the first questionnaire showed that many people outside the formal child and adolescent mental health services are working regularly with children and young people who are experiencing severe emotional distress and mental health difficulties. The problems described varied from psychotic illness in adolescents to behavioural difficulties in infants. Some of the respondents described transient and relatively simple difficulties that were quickly resolved but many people were working with children and young people who were facing complicated, extensive and disabling problems that were likely to have adverse and in some cases catastrophic outcomes.

The specific problem areas described by respondents were examined quantitatively. Respondents were asked to describe their most recent case, the case causing greatest concern and the case giving greatest satisfaction. The most recent case was described most often, followed by the case causing most concern and the case giving most satisfaction respectively.

¹ Scottish Needs Assessment Programme

² www.headsupscotland.org.uk/SNAP



The number of problem areas described varied across professional groups, especially for descriptions of the most recent case. Community paediatricians and social workers were more likely to describe more than one problem and this might reflect the greater complexity of cases seen by these professionals.

Among the diagnostic categories used most frequently for most recent cases was depression, reflecting high levels of depression amongst children and young people. Among the cases causing greatest concern, drug problems among children or their parents were described frequently, often linked to previous history of abuse, neglect or rejection.

The other problem areas described varied greatly between professional groups reflecting differing caseloads and language used to describe issues. For the case causing greatest concern, self-harm and abuse were featured prominently in the responses from all professional groups.

PROFESSIONAL INVOLVEMENT

The survey reveals a wealth of information about how the emotional needs of Scotland's children and young people are being tackled in a wide range of settings. These include the universal health services, schools, social work agencies, foster placements, residential care settings and specialist health services for children and young people in both the voluntary and NHS sectors.


There is clearly a commitment to helping children, young people and their families in difficulty. This may involve providing a "listening ear" and reassurance but can also require complex input from several agencies. Much effort and flexibility about people's roles are needed to make this work.

Although several professionals may be involved in the care of a child or young person with complex and severe difficulties, those with the least formal mental health training often provide the most contact. Extensive training and ongoing support is needed to enhance the capacity of the children's services network.

HEALTH PROMOTION

A great deal of health promotion work that supports children's emotional well-being is happening. This occurs largely within two organisational foci: health centres/GP surgeries and schools. In the health settings this work is mainly undertaken by practice nurses and health visitors, supported by GPs. Within education, school nurses are frequently involved in health promotion and it is also now commonly part of the curriculum, or a whole-school issue in health promoting schools. In addition, considerable health promotion work is undertaken by residential care workers and foster carers.

Far less health promotion work is done by other agencies, notably specialised mental health services for children and young people, but this may be appropriate as children are already exposed to substantial health promotion through their access to universal services.



All agencies commented on the shortage of good early intervention and prevention work. More work should be undertaken to develop early intervention and prevention strategies.

FRUSTRATIONS

The most frequently expressed source of frustration among professionals was “the system” which they experience as responding too slowly and inflexibly. The main systemic sources of frustration relate to delays in accessing assessment or suitable provision, and the effect of waiting lists was the commonest difficulty cited by all professional groups.

Other sources of frustration are funding difficulties, gaps in services, difficulties professionals experience in working within their organisations and the impact of policies.

Recognition that there might be a limited possibility of making a difference is an important cause of frustration. The reasons given by professionals include: lack of available time; problems which appear intractable; the client/patient moving on; a referral not being taken up; inappropriate parental expectations and difficulties in engagement.

Living in a rural setting can be a significant barrier to being able to access suitable services. Lack of specialist services locally combined with poor public transport for patients and their families are important sources of dissatisfaction.

Professionals can also, however, experience frustration because they are dissatisfied with their own capacities. This can arise from, for example, feelings of inadequacy, lack of access to specialist services or lack of clarity about role boundaries, routes of referral and sources of advice and support. Some of these points are expanded in the next section.

WORKING WITH OTHERS

Respondents from all professional groups emphasised the importance of a co-ordinated, multi-agency approach, particularly for very complex cases.

Although the situation is variable across Scotland, most professionals reported major difficulties in achieving positive collaborative work. Much of this is to do with overload or tension points within the system. This included delays in accessing support because of insufficient resources or cumbersome referral procedures, gaps in or between services and failures of joint planning between agencies. A commonly identified tension point was the relationship between CAMHS and local authority social work agencies. Other problems included misunderstanding of each other's roles and some undervaluing of the knowledge and understanding of those most closely involved with young people, such as teachers, residential workers and foster carers. Although many respondents made a distinction between the attempts of individual professionals to be helpful and the failures of the wider system, a few people reported occasions on which they experienced open discourtesy and lack of interest despite the very serious nature of the problems they described.



An area of particular concern was poor communication and liaison. Although some of this again reflected poor planning and procedures or lack of time and resources, there were other factors that compounded this problem. Respondents from a number of professional groups were frustrated by the differing perspectives on confidentiality that exist between different disciplines. For those most directly involved with children and young people, the refusal of some medical personnel to share information with anyone except other doctors left them disabled in their work with children, particularly in areas such as child protection.

Despite the high level of difficulties reported, many professionals were also able to describe examples of excellent practice facilitated by good team working. Often these positive experiences were the result not only of good planning and communication but also of individual practitioners' co-operation in "putting themselves out" to help. Such willingness to collaborate is highly valued across all professional groups.

Although respondents described frustration at being unable to gain a direct service for children and young people, several would have been happy on many occasions to have been able to access advice or consultancy so that they could provide a better service themselves. This desire was matched within CAMHS with a wish to broaden consultancy services to front-line practitioners.


A few respondents described cases with catastrophic outcomes that they related directly to a failure of joint working, but many were also able to recount examples of young people receiving a co-ordinated and timely service that enabled them to regain their emotional health and happiness.

TRAINING

Twenty percent of the non-specialist CAMHS respondents reported any previous training in relation to mental health of children and young people. The clear majority (78%) of the responses from those 20% who had had any training described experiences which were relevant to child and adolescent mental health, but which were not part of a formal training programme.

The low level of systematic exposure to training in mental health amongst these professionals is striking, as is the high rate (81%) of respondents indicating a wish for further training in this area.

As well as indicating the kinds of training they would want, many respondents indicated a preference for training which was practically focussed and delivered, using interactive learning methods in small multi-agency groups.



More than half of the specialist CAMHS respondents reported a relevant qualification which was additional to their main professional qualification – the majority in the arena of therapeutic skills. One in four of the respondents with an additional qualification reported two or more of these.

Many of the specialist CAMHS respondents from most professional groups reported regular involvement in teaching and training both within their own professional group and with other professional groups.

INNOVATIONS – WHAT ARE PEOPLE DOING WELL AND WHAT WOULD MAKE A BETTER SERVICE

Many respondents were able to describe current good practice or make suggestions for new or improved services.

The importance of dealing with stigma and making services accessible and child friendly was frequently emphasised. Linked to this was the recognition that engaging the whole family was often essential. One frequently suggested way to confront stigma and make children more likely to engage with services was to bring specialist professionals into the child's own environment – for example, schools or residential units – rather than expecting them to attend clinics.

Respondents also wanted quick access to the right service. Many argued for either a “one stop shop”, where all relevant professionals were available under one roof, or some form of triage system which would ensure that children were routed to the correct service quickly.

Several non-specialist CAMHS respondents wanted access themselves to trained specialist CAMHS practitioners to obtain advice and support in their work.

Many of the suggestions fit well into the categories identified in the *SNAP Assessment of Child and Adolescent Mental Health Needs in Scotland*ⁱ – promotion, prevention and care.

Promotion: School was seen as a particularly positive environment in which to focus on mental health promotion. For some respondents, this was through developing “emotional literacy” and for others through incorporating mental health awareness and promotion into the formal curriculum. Other suggestions included ensuring that all children and young people were encouraged to develop positive leisure and sporting interests.

Prevention: Targeted work with at-risk groups was also high on the lists of respondents’ concerns. Many professionals wanted support to be offered not merely early in a child’s life but even before birth. There was enthusiasm for the idea of preventive work in nurseries and primary schools. Parenting groups are in operation in many areas and are seen as a very good way to prevent emotional difficulties. There were also ideas about engaging young people in regular creative or nurturing groups that could prevent mental health difficulties. Some people advocated massage or relaxation techniques for young people at school.



Care: Some respondents argued for a lesser emphasis on verbal therapies and wanted to see diversification into music, art or play therapy, among others. There were also pleas for improved services for some groups of children, in particular, learning disabled children and looked after children. Many respondents wanted an increase in the number of specialised residential resources for looked after children.

RECOMMENDATIONS

Survey respondents suggested many improvements in service provision for children and young people with mental health needs. A high proportion of these suggestions would require the allocation of substantially increased resources. Resource allocation issues are currently being addressed in several ways, and we do not propose to deal with these issues further here.

Scotland may have a small population but we are a very diverse society and the best ways to meet the needs of children and young people in Shetland may be very different from the best ways in inner-city Glasgow. There can be no “one size fits all” solution for the whole of our country. Nevertheless, some general recommendations for good practice flow from the results of our work.

PREVENTING PROBLEMS AND EARLY INTERVENTION

- There is a need for more widely accessible early intervention strategies from before birth and across the age range. The *Framework for Promotion, Prevention and Care*ⁱⁱ envisages wide provision of early intervention. For instance, wider provision of parenting groups, as recommended in the recent Hall 4 report *Health for All Children*ⁱⁱⁱ should be ensured.
- Early intervention requires early identification of problems. In some cases there are clear indicators, but there is a need for further research into identifying at-risk children and young people before they develop problems.
- There is a need for simple care pathways for children and young people in difficulty. All professionals working with children and young people should be able to gain access to the care pathway easily and without delay.
- Simple methods of assessing children and young people causing concern must be made available soon after problems are suspected. Such assessments should allow the direction of children, young people and their families towards the agency most likely to be helpful.
- There is a need for locally provided, low key services for the vast majority of children and young people with emotional and behavioural problems, and these services should be available where children and young people live their lives – for example, schools and residential homes.

MAKING THE SYSTEM WORK

Respondents encountered many frustrations dealing with “the system”. These require imaginative responses from all levels of professionals responsible for the emotional well-being of children in Scotland.

- There should be a strong political commitment to the importance of the mental health of children and young people supported by policy development and implementation strategies by the Scottish Executive in consultation with other key agencies.
- At regional and local level, multi-agency strategies should be in place to identify need and to develop local solutions.
- The importance of individuals and agencies working carefully and constructively together around children and young people with particularly complex needs cannot be overstated. All agencies need to be pro-active in the development and maintenance of shared strategies.

PLUGGING THE GAPS

Several gaps were identified within both the health and social care services.

- There are problems in accessing services in remote rural areas. While some of these difficulties could be tackled by technical innovations such as teleconferencing, creative solutions to service provision and more resources are required.
- There is no consistency in managing the transition between child and adult services. For some young people such as looked after children, transition between services coincides with a time of increased vulnerability as they have to negotiate the difficulties of independent living. There should be a national policy on transition arrangements.
- Some respondents experienced referral criteria as excluding the young people with whom they work. A strategic multi-agency approach to referral criteria should be taken at area or regional level to ensure that gaps in services do not exist (for example, service A sees only “mild” cases, service B sees “severe” cases and no one sees the people falling in between).
- Some groups were less likely than others to have a consistent service throughout Scotland. In particular, learning disabled children and looked after children in some parts of Scotland had difficulties accessing specialist mental health services for children and young people. There should be explicit provision for such vulnerable groups across all areas.
- Agencies should review together the arrangements they have made to ensure the availability of appropriate services for those children and young people with the most complex needs.
- There are serious concerns at the lack of specialised therapeutic residential services for particularly troubled young people. A more strategic approach to identifying need and developing resources is required at national and regional level.



WORKING TOGETHER EFFECTIVELY

- Creative solutions need to be found to the problems in communication between members of different professional cultures. The issues of dialogue and development between organisations can, and should, be informed by ongoing research and evaluation. Identification of the factors which enhance and sustain these relationships is required, as is systematic work between professional bodies to address areas of particular tension such as differing understandings of confidentiality.
- Time spent in feedback to referring agencies by mental health specialists is time well spent, if that feedback is appropriate. This approach should become standard practice and should include clear advice on how to support children in their daily lives.
- All carers and professionals working with deeply distressed children and young people deserve sensitive and thoughtful consultancy and advice. This is a skill and service that should be developed further by specialist mental health services for children and young people. This recommendation emphasises the importance of capacity building within the specialist mental health services.
- Innovative means of linking people together effectively need to be found. Examples might include e-mail discussion groups for professionals dealing with emotional and behavioural problems, sharing resources, arranging meetings etc. These solutions might involve more inter-professional training and resources for administration and technical support for such groups.

TRAINING

Training was identified across all groups as an area for development.

- The different levels of training in specialist mental health services for children and young people should be developed in a coherent way that allows different professional groups to access them instead of each duplicating their own training.
- Teaching and training should be endorsed as a core part of the role of the specialist mental health services for children and young people. These services should be given the capacity to extend and develop their teaching and training roles.
- Professional staff within the specialist services should have the necessary learning and professional development opportunities to allow them to build their knowledge and competence. This involves recognising the vital role played by senior staff within these settings in supporting the learning of their less experienced colleagues.
- A coherent training strategy based on the competencies framework^{iv} should be developed for practitioners within the wider network of services for children and young people. This should address basic knowledge and skills but also allow for progression.
- There should be serious attempts to introduce regular inter-disciplinary training both at qualifying level and in further professional development.
- All training should include a focus on the influence of social factors on mental health as well as the importance of individual experience.

ACCOUNTABILITY TO CHILDREN, YOUNG PEOPLE AND FAMILIES

- The participation of young people and their families should be a fundamental aspect of both service planning and individual care plans.
- Further investigation is required to identify appropriate mechanisms by which agencies can express their accountability to children, young people, their parents and carers.

EVALUATION AND DISSEMINATION OF GOOD PRACTICE

- Innovative ways of sharing good ideas and putting them into practice need to be explored. Possible mechanisms might include: a dedicated website; a directory of services; and regular national conferences to bring service users and professionals together.

The service developments recommended here have arisen from the experiences and views of a broad range of professionals. While each appears logical and sensible, they may have unforeseen consequences. The process of developing new services requires careful consideration of how evidence and experience gained elsewhere can be applied in the new local context. There should be a commitment to evaluate all new service developments rigorously.

CHAPTER 1

INTRODUCTION



The *SNAP Report*ⁱ, a needs assessment of the mental health of Scotland's children and young people, was commissioned in autumn 2000 by the Scottish Executive Health Department. A core group³ drawn from a variety of professions working with children and young people carried out, or commissioned, a series of surveys described here.

THE SNAP PROCESS AND FINDINGS

The initial groundwork for the SNAP report made it clear that the scope and scale of the issue of child and adolescent mental health required an extensive research process.

The aim of this process was to secure wide involvement. In particular, a broadly based description of the current strengths and weaknesses was seen as essential, as was the engagement of those involved in the generation and refinement of proposals about how to improve the situation. The core group wished to conduct the assessment in a way which was inclusive and collaborative. That led to a demanding and fairly lengthy path (Figure 1.1) but one which had the merit of being transparent and accessible.

The “field work” was conducted in two phases. In the **first phase**, the core group looked at the strategic environment and so surveyed Directors of Public Health, Social Work Services planners, managers of NHS health promotion units and leaders of NHS services. This took place at the end of 2001 and the beginning of 2002.

The **second phase** took place from 2002 to 2003. It was supported by funding from the Scottish Executive Health Department and involved surveys in which three main constituencies were approached:

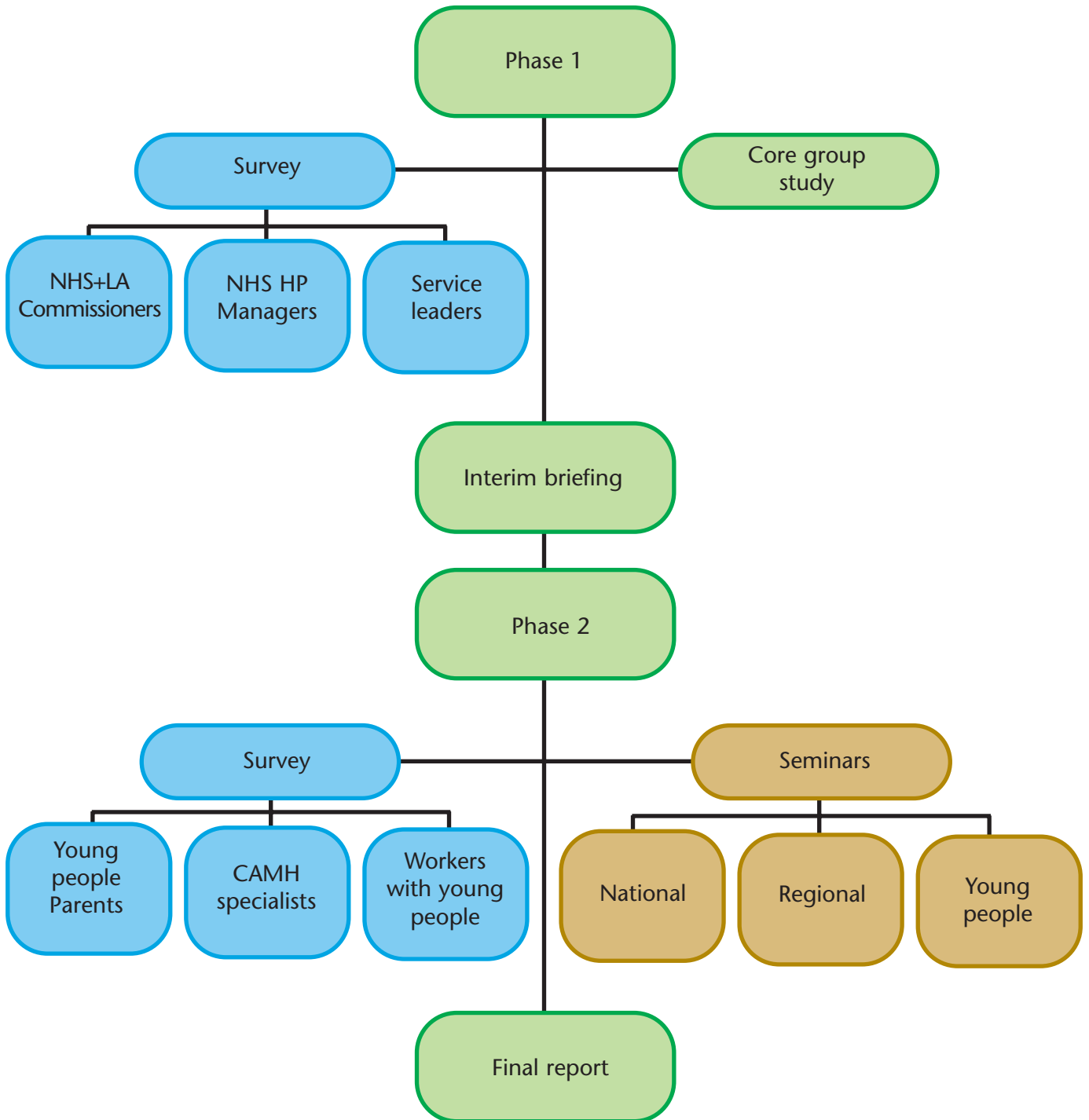
- A. People who work routinely with children and young people;
- B. People who specialise in mental health and work with children and young people;
- C. Young people and parents.

In this document we report on surveys A and B.

³ Graham Bryce (Chair), Child and Adolescent Psychiatrist, Yorkhill NHS Trust; Carolyn Brown, Educational Psychologist, Fife Council; Mary Gallagher, Operations Manager, Social Work, East Renfrewshire Council (formerly Family Support Services Manager, South Lanarkshire Council); Helen Hammond, Consultant Paediatrician, West Lothian Healthcare NHS Trust; Margaret Hannah, Consultant in Public Health Medicine, Fife NHS Board; Leonora Harding, Consultant Clinical Psychologist, Fife Primary Care NHS Trust (formerly Consultant Clinical Psychologist, Borders Primary Care NHS Trust); Emma Hogg, Research Specialist – Mental Health, Health Education Board for Scotland (formerly Health Promotion Specialist – Mental Health, Grampian NHS Board); Patrick Little, Scottish Development Manager, Penumbra; Elaine Lockhart, Child and Adolescent Psychiatrist, Yorkhill NHS Trust; Imogen Stephens, Consultant in Public Health Medicine, Argyll and Clyde NHS Board (until November 2001); Phil Wilson, General Practitioner/Senior Research Fellow, Department of General Practice, University of Glasgow.



Figure 1.1. The SNAP process



CHAPTER 2 METHODS



“The human understanding is no dry light, but receives an infusion from the will and affections; whence proceed sciences which may be called ‘sciences as one would’. For what a man had rather were true he more readily believes ... Numberless in short are the ways, and sometimes imperceptible, in which the affections colour and infect the understanding⁴.”

INTRODUCTION

Bacon's 400-year-old observations are equally relevant today. He offers a striking pointer to the contemporary notion that knowledge is socially constructed and culturally located. As he suggests, the light under which this report has been written has been far from dry; indeed, the difference in backgrounds and approaches amongst the research group has provided a lively reminder of the importance of the professional, cultural and other differences which inform all of the responses. Taking these differences seriously and considering how they “infuse” the accounts given was a continuous discipline for the research group.

The surveys were a core part of the needs assessment process. Their main aims were:

- to develop a picture of what was happening in Scotland in relation to the mental health of children and young people from the perspective of those working with them;
- to generate ideas about how to improve services.

Although the SNAP core group thought that it was important to survey those closely identified with mental health, such as the NHS CAMHS practitioners, the group adopted a broad definition of mental health and consequently considered it equally important to look at ways of tapping into the views of a much wider constituency. The survey offered inclusion in the needs assessment process, in the hope of promoting a sense of ownership. A number of groups emerged. There were those involved formally or informally in the promotion of health and well-being, such as health promotion teams, youth and community workers, teachers and others. There were those who worked routinely with

⁴Francis Bacon. *Novum Organum: Aphorisms concerning the Interpretation of Nature and the Kingdom of Man*, 1620.



children and young people who, while having no specialist mental health role, often made important contributions in terms of preventive initiatives, early intervention, continuing care and so on. This group included health practitioners in primary care and dedicated children's health services, social care professionals in residential and community services and teachers. Finally, there were children, young people and their families.

Rather than attempt to conduct any kind of epidemiological task – good quality studies of that kind had been conducted in the relatively recent past⁵ – this study sought to provide a contemporary description of what was happening in Scotland. The challenge for the group was therefore to do this in a way that would generate useful detail without sacrificing the possibility of wide relevance.

Given the limitations of timescale and resources, a self-administered questionnaire was used to elicit detailed data from large numbers of respondents. This was considered a less appropriate way to approach children, young people and parents so a separate piece of work was commissioned and has been published^v separately.

There were no suitable instruments available and the group therefore developed its own questionnaires. In all cases these were subjected to pilot studies, but these were necessarily limited and the timescale prevented a more comprehensive validation process. The questionnaires have been published in full on the HeadsUpScotland website⁶.

At an early stage in this discussion the members of the core group began to identify two distinct sets of concerns emerging – one was to characterise the circumstances and practice of those with a specialist mental health or psychological role, the second was to enrich the awareness and understanding of the kinds of “mental health related” experiences of those who did not have that specific role. This led, in due course, to the development of two different questionnaires. One of these (known throughout as questionnaire A), designed for the latter group, was orientated towards eliciting descriptions of experiences and attitudes. The second (questionnaire B) was more formally structured and was designed to elicit quantitative data-rich accounts of how specialist mental health practitioners approached their work and delivered their service. While there are similarities between the two questionnaires, the extent to which direct comparisons can be made between the reports of those who work “inside” and “outside” specialist mental health settings is limited by the decision not to incorporate a series of identical questions. Nevertheless, the rich qualitative data elicited via open-ended questions goes some way towards compensating for these shortcomings since it provides valuable contextual detail and opportunities for making comparisons within and across the two datasets.

QUESTIONNAIRE A

Having decided that surveying was the method of choice, the SNAP core group had to identify whom to survey. The processes involved in obtaining the samples are described in Appendix A, and some of the characteristics of respondents are described in Table 2.1 overleaf.

⁵ See main SNAP Report

⁶ www.headsupscotland/SNAP/



Respondents	Sample	Questionnaires returned	Response rate (%)
Social workers	234	107	46
Residential workers	289	104 ⁷	36
Reporters to Children’s Panel	32	22	69
Panel chairs	32	19	59
Teachers	603	353 ⁸	59
General practitioners	280	137	49
Health visitors	142	71	50
Paediatricians	70	54 ⁹	77
School nurses	230	103	45
TOTAL	1912	970	51

Table 2.1. Sample sizes and response rates for the groups asked to complete non-specialist CAMHS questionnaire A. Sample sizes are not available for voluntary sector workers (55 responses received), foster carers (38 responses) and police (five responses). Case descriptions were provided by 80-90% of most professional groups.

Despite the various difficulties in identifying, recruiting and accessing the sample populations, the average response rate across the non-specialist CAMHS groups was 51% (range 36–77).

Questionnaire A incorporated a series of three open-ended questions, each with supplementary questions, asking the respondent to describe their “most recent”, “most worrying” and “most satisfactory” experience of dealing with a child or young person with emotional, behavioural or mental health problems. The number of respondents who provided any answers to these questions ranged from 50 to 93%, with all but two groups scoring 75% or more. Unsurprisingly, the written text responses varied greatly – from single-word responses to brief notes to several paragraphs. Nevertheless, the survey group regard this response rate as particularly high for a free text section of an unsolicited questionnaire.

⁷ 50 Residential care workers, 31 senior residential workers/deputies, 19 team/unit managers, 4 senior managers

⁸ Nursery staff: 27 nursery teachers, 4 nursery nurses, 6 head teachers/managers

Primary school staff: 71 class teachers, 7 deputy/assistant heads, 101 head teachers, 16 behaviour/learning support teachers

Secondary school staff: 10 class teachers, 45 guidance teachers, 12 deputy/assistant heads, 13 head teachers, 14 behaviour/learning support teachers

Special/EBD school staff: 14 class teachers, 7 deputy/assistant heads, 19 head teachers

Teachers working in other settings: 9

⁹ 36 community paediatricians (16 consultant grade), 9 school doctors, 5 combined school doctors/community paediatricians, 4 hospital consultants

QUESTIONNAIRE B

This questionnaire was designed for mental health and psychology practitioners working with children and young people.

Response rates from CAMHS services

Thirty services were identified in Scotland as offering NHS based mental health services. Three of those 30 did not respond to the request to participate. Completed questionnaires were, however, received from staff working in one of those three services. One of the 27 services which did agree to participate (by advising on the number of questionnaires required), did not return any questionnaires. The survey team prompted each of these four services by mail, without success. The reasons for their lack of participation are not clear.

There was wide variation in service size, as indicated by the number of questionnaires requested, with five services accounting for more than 50% of the questionnaires sent out. These all offered inpatient and or substantial day services.

606 questionnaires were distributed to the 27 respondent services. 228 completed B questionnaires were received back from those services: a response rate of 38%. The SNAP report was inaccurate when it reported that the response rate was in excess of 50%. The response rate within individual services varied from 0 to 89%. There was no correlation between the response rate and the size of the service: a high response rate was just as likely in a small service as a large one. We received no responses from one large service. Psychology services were no more or less likely than multi-disciplinary services to achieve a high return rate.

One in three “responding services” had a response rate of 50% or more.

Response rate	<25%	25–49%	50–74%	75% +	TOTAL
No of services	6	12	6	3	27

Table 2.2. Questionnaire B response rates among the responding CAMHS services

Respondents	Respondents	Sample	Response rate %
Voluntary sector “B” workers	24	N/A	N/A
Educational psychologists	28	87	32
NHS based CAMHS specialists	228	606	38
TOTAL	280		

Table 2.3. Response rates among the (specialist CAMHS) recipients of questionnaire B in the phase two survey



Figure 2.1 gives a breakdown of the professional disciplines of the respondents to the B questionnaire.

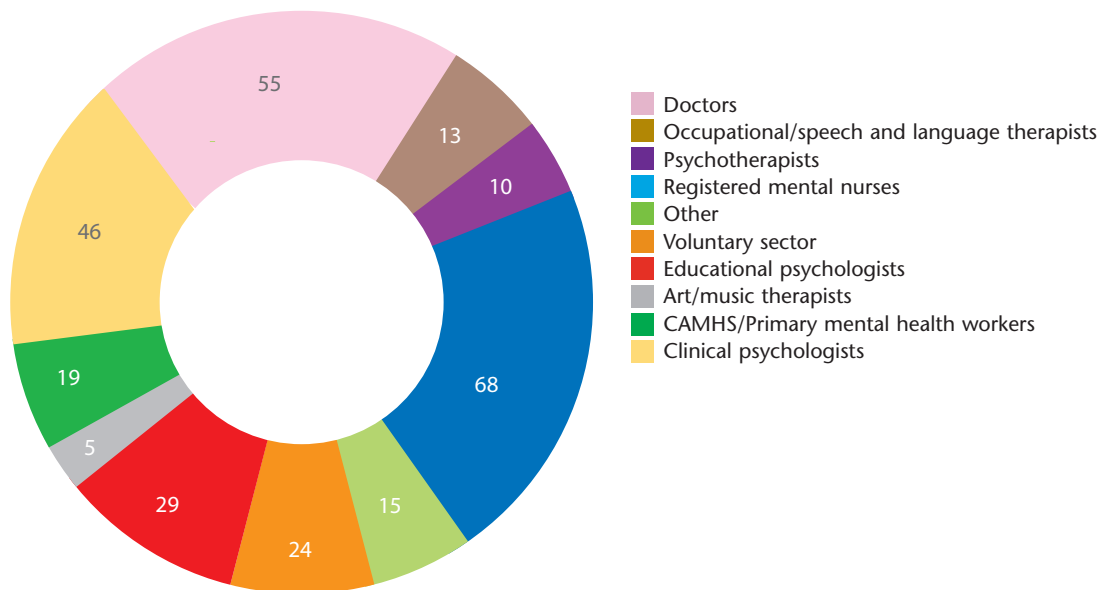


Figure 2.1. CAMHS B survey responses by professional background

Analysis

The survey data were entered into a Microsoft Access database to allow easy retrieval of quantitative data. The free-text responses were analysed using the qualitative software QSR N6, which allowed systematic coding and data retrieval.

Quantitative data

Items were reported in terms of range, frequency, distribution and correlation. Statistical comparisons were limited because of the nature of the sample and only conventional (parametric) methods were used. The quantitative data are presented in full on the HeadsUpScotland website¹⁰.

Qualitative data

A coding frame which reflected the main themes identified in the free-text responses was developed and revised through a series of team meetings. The research team was deliberately constructed to have representatives from a wide range of professionals working with children. This enhanced our ability to bring multiple perspectives to bear on interpreting the data. Thus a rich source of personal knowledge, based on each research team member's own working life, was available to make sense of respondents' answers, and indeed it appeared at times that the different perspectives and understandings contained within the respondents' answers was also very much alive in the debates about the meaning of the data conducted by the research team.

Throughout this report readers should be aware of what Goffman^{vi} called "impression management" – respondents may justify their way of working, and therefore quotations may not actually be an objective assessment of the situation. Quotations need to read in multiple ways, and not be seen as unalloyed portrayals of an objective truth. They are "accounts"^{vi} and the main challenge is to the reader who aims to read these accounts as "objective".

¹⁰ www.headsupscotland/SNAP/

Conclusion

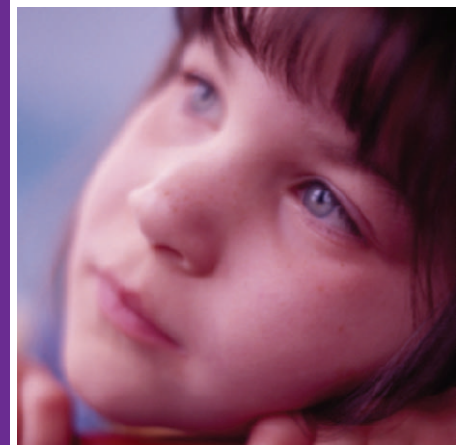
This pragmatic survey differs significantly from a narrowly focussed research project designed to test specific hypotheses. The need for immediacy, relevance and breadth of coverage combined with a short timescale and limited resources has meant that the study inevitably illustrates some of the limitations of a needs assessment exercise.

The resulting database nevertheless provides considerable comparative potential and our qualitative/quantitative mixed methods approach helps illuminate similarities and differences between the perspectives and experiences described by our respondents.

We are not aware of any other such diverse and rich dataset in the field of mental health and therefore believe that it is important to publish these findings not only as a unique piece of research but also as a resource for all those interested in children and young people and their mental health and well-being.

CHAPTER 3

PROBLEMS FACED BY YOUNG PEOPLE



INTRODUCTION

This chapter focuses on the mental health difficulties that young people in Scotland, their families and the professionals providing services to them have to deal with. The material is drawn from an analysis of the responses to questionnaire A. Respondents to questionnaire A were non-CAMHS workers involved with children and young people in a range of settings. As such their answers provide a more complete picture of the whole range of emotional difficulties that children face than the responses of the specialist CAMH workers who replied to questionnaire B. The professionals described the problems in response to the following questions:

15. Thinking about the **last time** you dealt with a child or teenager with mental health, emotional or behavioural problems, what was the problem?
 - 15a. What did you do, if anything, in relation to the problem?
 - 15b. What would you like to have done?
 - 15c. What were the barriers, if any, to achieving the outcome you would have liked?

16. Please think about **the most worrying case** of mental health, emotional or behavioural difficulties in a child or adolescent you have dealt with within the past three years. What was the problem?
 - 16a. What did you do, if anything, in relation to the problem?
 - 16b. What would you like to have done?
 - 16c. What were the barriers, if any, to achieving the outcome you would have liked?

17. Now thinking about the management of a case of mental health, emotional or behavioural difficulties over the past three years which gave you most satisfaction, what was the problem?
 - 17a. What did you do, if anything, in relation to the problem?
 - 17b. What would you like to have done?
 - 17c. Why did you find the management of this case so satisfactory?

Methods and findings

The cases were coded for the number of problems described, formal diagnostic categories, and a more pragmatic code for actual problems described. The responses are described quantitatively below to provide some flavour of their extent and nature. In addition, direct quotations will be used to illustrate particular themes or difficulties. When reporting questions 16 and 17 some data were left out for the sake of clarity¹¹.

The numbers of respondents describing cases in each category are shown in Figure 3.1

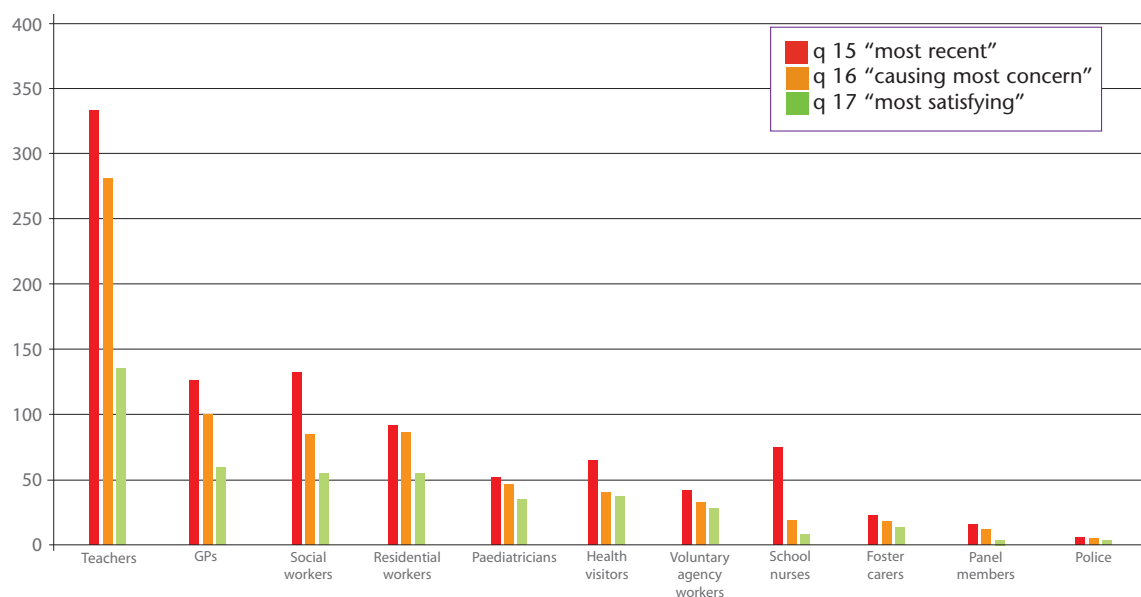


Figure 3.1. Numbers of respondents describing cases in responses to questions 15,16 and 17

Across all professional groups there is a reduction in the number of respondents reporting a most satisfying case. In part this is simple respondent fatigue – faced with the third demanding question in a long questionnaire, some people just stopped answering. This fits with the reduced number of responses to the second of these questions. Further analysis of the data, however, suggests that there are other factors at work. For many respondents their most satisfying case was also the one that had worried them most. Several respondents, however, stated that either they had had no satisfying cases or that they could not remember any. A few expanded on this:

“Although I hadn't thought about it until answering this question I can't think of a case of any kind in recent years which has given me genuine satisfaction. Maybe I need some mental health or emotional support!” (General practitioner, GP157)

“I have racked my brain and I can't think of any. That is pretty sad.” (Primary school head teacher, ED2703)

“I honestly can't think of a case that gave me satisfaction. This would have required a magic wand on my part.” (Special school head teacher, ED1017)

These quotations give a glimpse of the powerful and in some cases very negative impact that working with severely distressed young people can have on professionals. This highlights a theme that recurs throughout this report – the need for more consistent and sensitive support for those professionals and carers who cope with children's emotional pain, sometimes on a daily basis.

¹¹ Where there were a large number of possible variables, when preparing charts showing responses from specific professional groups, if numbers were very small (less than 2% of the total number of responses), those professional groups were excluded. When percentages were used to compare professional groups in a particular category (e.g. number of problem areas described), where there were fewer than 40 responses from a particular group, these were not included. When calculating percentages, the denominators were based on the numbers from each professional group who gave a response.



PROBLEMS FACED BY YOUNG PEOPLE

Many respondents did, however, identify cases that had given them real satisfaction. This teacher describing the work with a young girl with severe anxiety disorder and chronic school refusal was clear that:

“This was a great pupil who through no fault of her own had hit a wall. Emotional/ mental health issues are not always recognised and tackled but this one was so rewarding.”
(Secondary school guidance teacher, ED0216)

For the teacher, seeing a positive result was important but so was the fact that she herself had not given up on the child. In many cases satisfaction for professionals came from being able to achieve a good result for a child, either by themselves or through close co-operation with colleagues or parents.

The number of problem areas described by each professional group may reflect the complexity of cases with which they are involved. This can be seen in Figure 3.2 in which the paediatricians and social workers are less likely to describe one problem only.

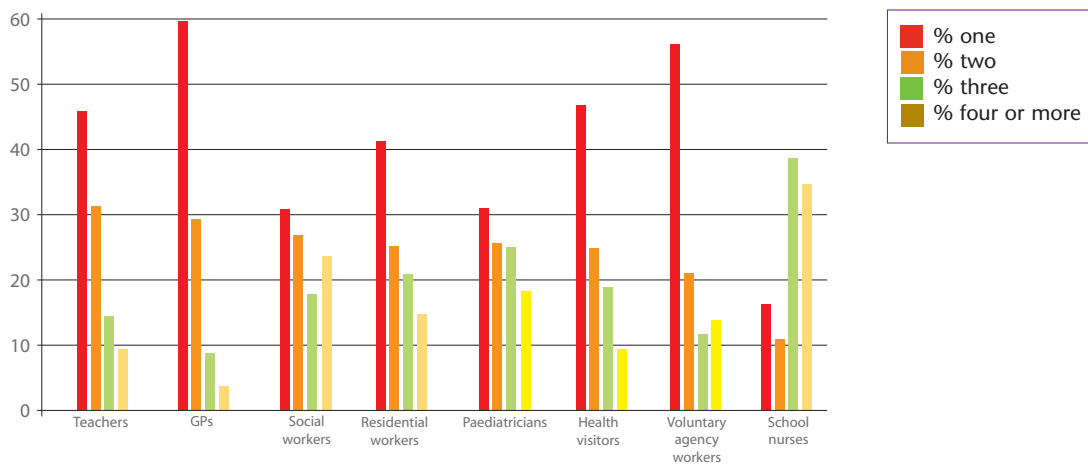


Figure 3.2: Percentage of respondents by professional group describing one or more problems for most recent case

A similar pattern can also be seen for cases causing most concern (Figure 3.3) but is less evident for cases associated with most satisfaction (Figure 3.4)

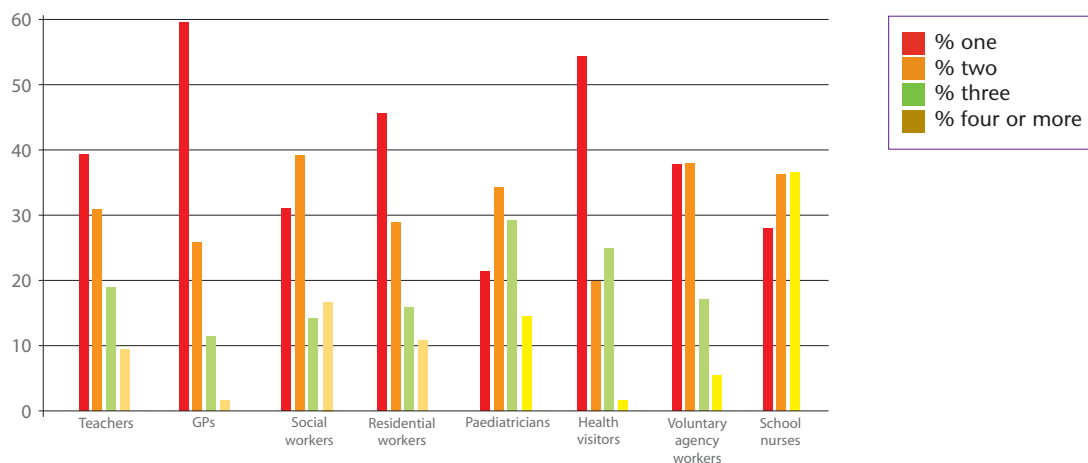


Figure 3.3: Percentage of respondents by professional group describing one or more problems for case causing greatest concern

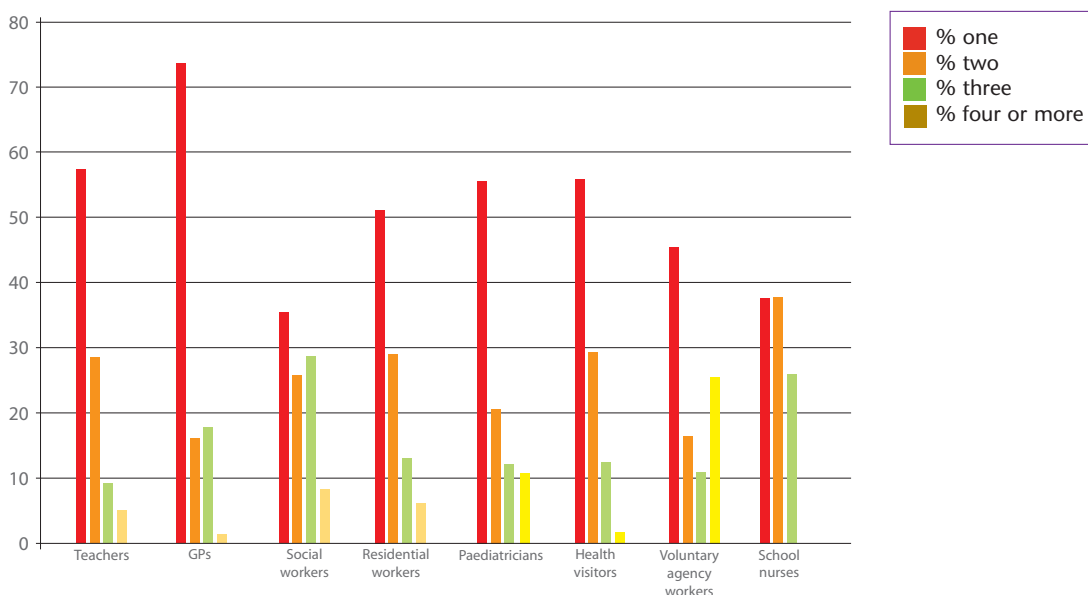


Figure 3.4: Percentage of respondents by professional group describing one or more problems for most satisfying case



PROBLEMS FACED BY YOUNG PEOPLE

Many respondents described problems using terminology derived from diagnostic categories. This was examined in greater detail. The numbers of respondents using these categories for most recent case, case causing most concern and most satisfying case are shown in Figure 3.5. Depression, autistic spectrum disorders and ADHD are important areas, while anxiety is commonly described for the most recent problem but less frequently for cases causing greatest concern. Drug problems are disproportionately represented among cases causing greatest concern. In most cases, drug problems are explicitly connected with a previous history of problems such as abuse, neglect or rejection.

“Serious history of neglect and poor parenting. No interests, low self-esteem, relatives not interested. Whenever free, takes drugs to his serious endangerment (in ITU at one time).” (Community paediatrician, CHD058)

In a few cases, however, the young persons' difficulties appear to be as a result of their drug use:

“A young person who had drug and alcohol induced mental health issues and was very violent and aggressive.” (Residential worker, RW0224)

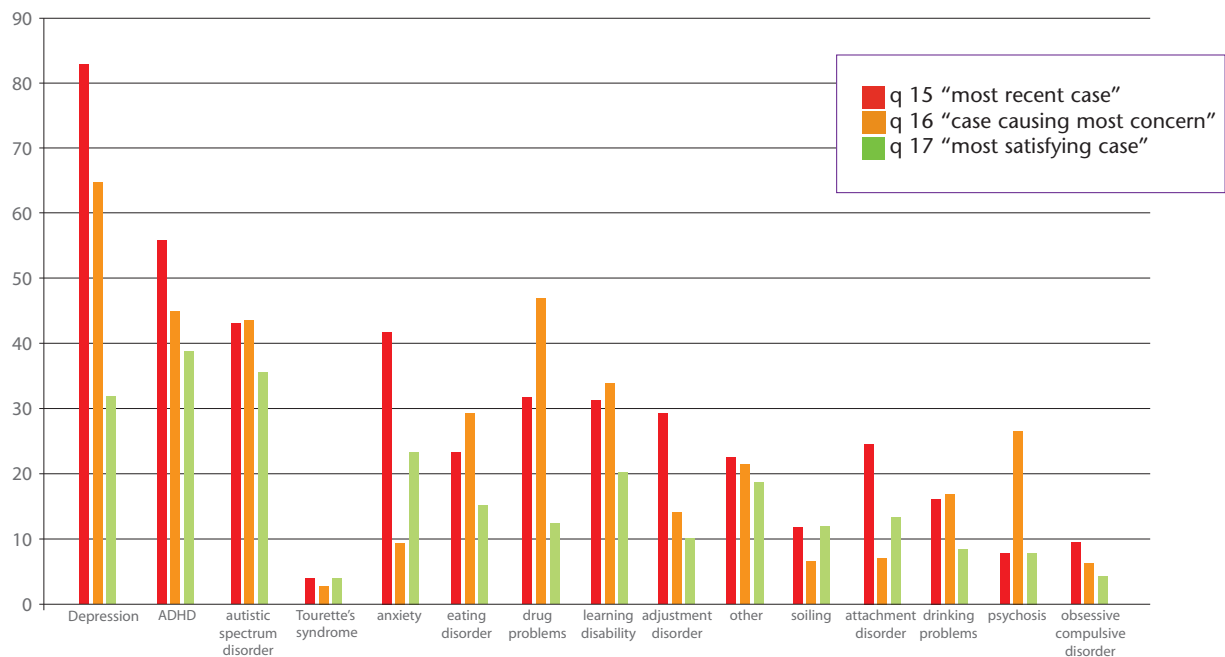


Figure 3.5: Number of respondents describing problem areas in diagnostic categories

Different professional groups varied in terms of whether or not they used diagnostic categories. The percentage of each professional group using diagnostic categories for most recent case, case causing greatest concern and most satisfying case are shown in Figures 3.6, 3.7, and 3.8. Not all groups described problems which could be categorised by diagnosis and where numbers are small, the groups have been excluded for clarity (police, panel members, school nurses and foster carers). Diagnostic categories with small numbers have also been excluded.

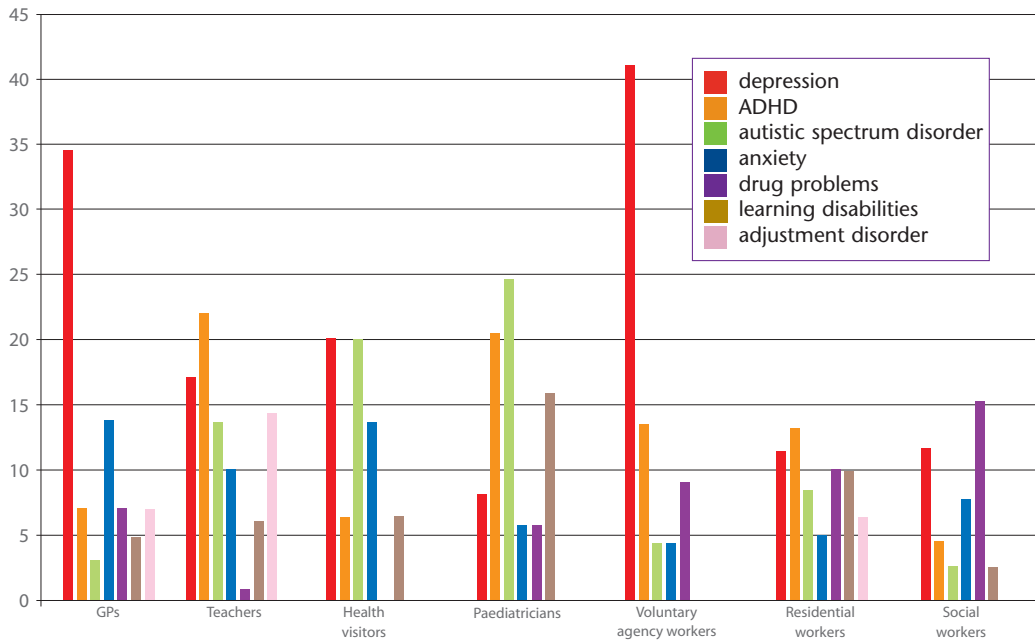


Figure 3.6: Percentage of professional groups describing most recent problem – diagnostic categories

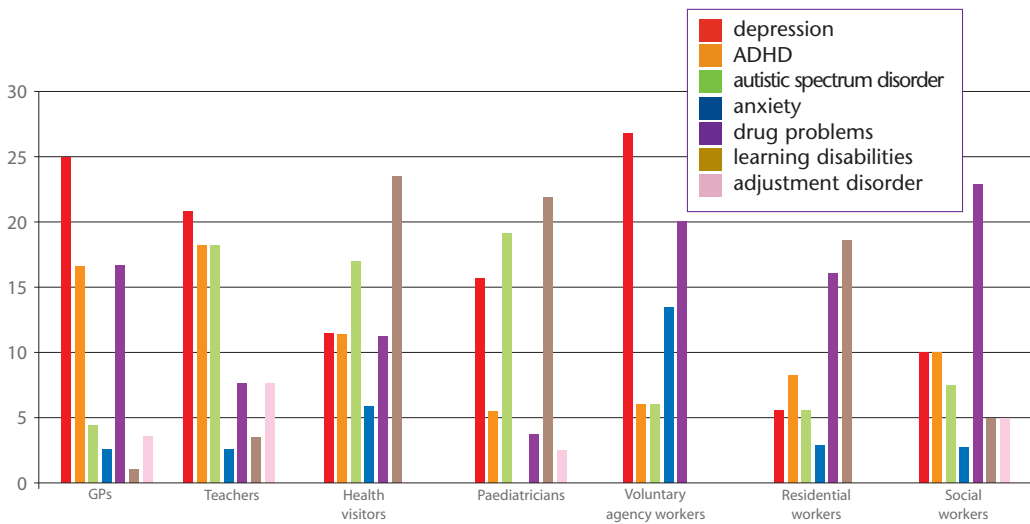


Figure 3.7: Percentage of professional groups describing problem causing greatest concern – diagnostic categories



PROBLEMS FACED BY YOUNG PEOPLE

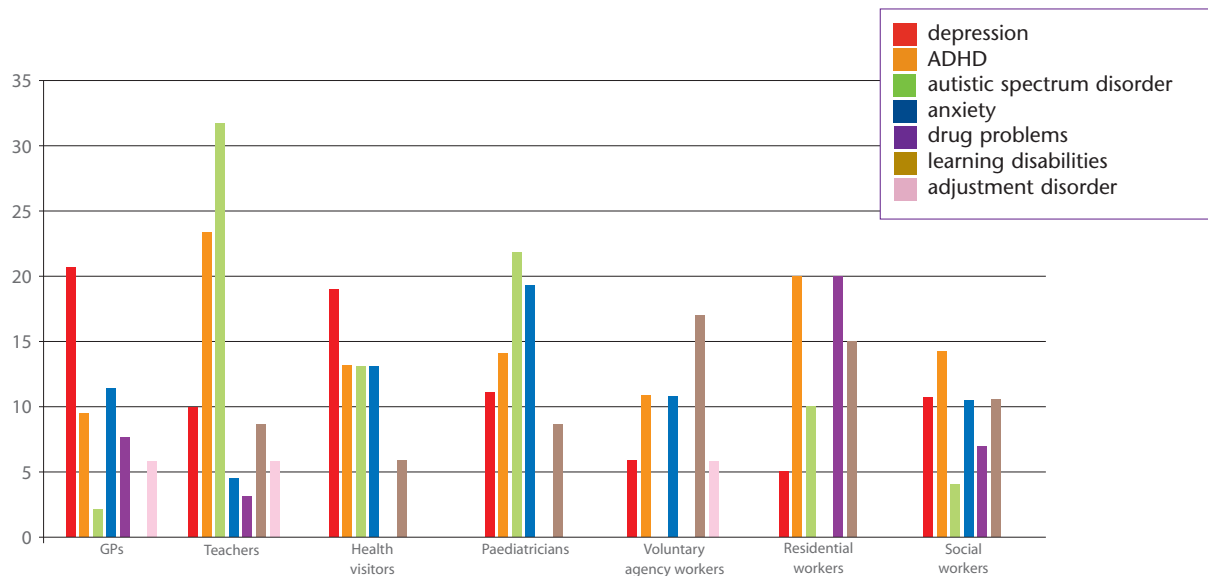


Figure 3.8: Percentage of professional groups describing problem giving greatest satisfaction – diagnostic categories

Problems that did not fall neatly into diagnostic categories were also coded separately under “other problems”, which was broken down into a number of different subcategories based on scrutiny of the responses. The total number of problems described for each of these categories in response to questions about the most recent, most worrying and most satisfying case is shown in Figure 3.9. The three types of case are shown separately in Figures 3.10, 3.11 and 3.12, displaying the percentage of problems reported in each category by each professional group. Externalising behaviour is a higher order category, which would subsume some of the others such as violence. It has been excluded from Figures 3.10 – 3.12 for clarity.

The most prominent problem areas include family problems, violence and aggression, self harm and abuse – the last being particularly important among cases of greatest concern. Some examples of the specific problems which would be coded under each category are given here for illustration. The family problems included parental separation, poor parental management of child, child caring for parent, family disharmony or family dysfunction such as whole family being involved in violent behaviour. In some cases the negative impact of an invalidating or hostile family environment is powerfully described:

“Young woman (18) seen with mother – mother extremely negative, over-anxious and convinced ‘something wrong’ with daughter ‘not normal’.” (General practitioner, GPCHD051)

“Preschool child in family with history of neglect and sexual abuse mocked by siblings because ‘he cannae light he’s ain fag yet’.” (General practitioner, GP0231)

Self harm incorporated a huge range of severity and complexity. Some quite young children were involved – primary school children as well as teenagers. The self harm was sometimes quite superficial but also included serious suicidal behaviour including actual suicides.

“Very self destructive. Self harm putting self at risk. Drug and alcohol abuse. Would like to have avoided his eventual death by drugs overdose. Perhaps some form of compulsory or coercive intervention might have helped.” (Residential worker, RW0073)

Violence also included a wide range of behaviours, from temper tantrums in young children to severe episodes of violence in a context of complex social and family problems.

“Violence – through feeling rejected unwanted unloved – almost killed his teacher!!!” (Foster carer, FP005)

“YP was extremely violent/aggressive on a daily basis. Issues around seeking sexual satisfaction from violence and restraint situations.” (Residential worker, RW0032)

Abuse included sexual and physical abuse and neglect. In many cases, children were suffering multiple types of abuse:

“The child was sexually abused and was forced to abuse his siblings by his parent and their partner they were also physically abused.” (Residential worker, RW0160)

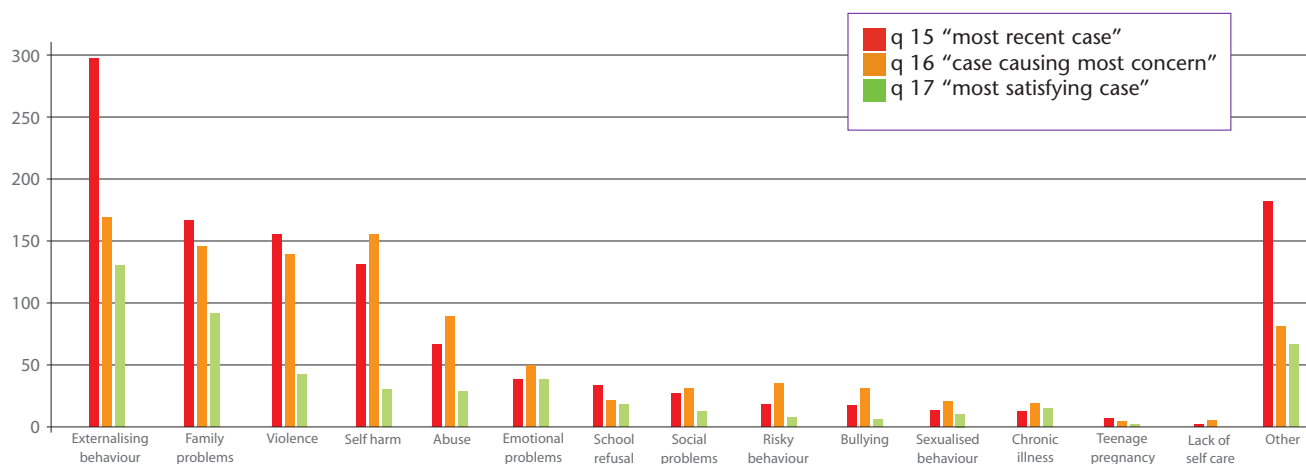


Figure 3.9: Numbers of respondents describing problems classified as “other” – i.e. not falling into clear diagnostic categories

Many respondents used both formal diagnostic terminology and the more descriptive labels particularly when they faced complex cases such as these:

“Suspected sexual abuse of child – child had been physically abused by father. Previously accommodated as seen to be outwith parental control. Low IQ and understanding. Had sexually abused his younger brother. Child unable to work through any of these issues. Had bouts of depression, self harming behaviour (painkillers, cutting arms).” (Residential worker, RW0001)



PROBLEMS FACED BY YOUNG PEOPLE

“F.A.S.? Regression? Schizophrenia? Petit mal? Abuse. Extremely disturbed, learning disabled 13 year old girl. Could be very violent. No academic progress. Epilepsy, refusing medication. Refusing sanitary protection. Running away. Poorly handled by single parent father. Mother alcoholic schizophrenic.” (Community paediatrician, CHD035)

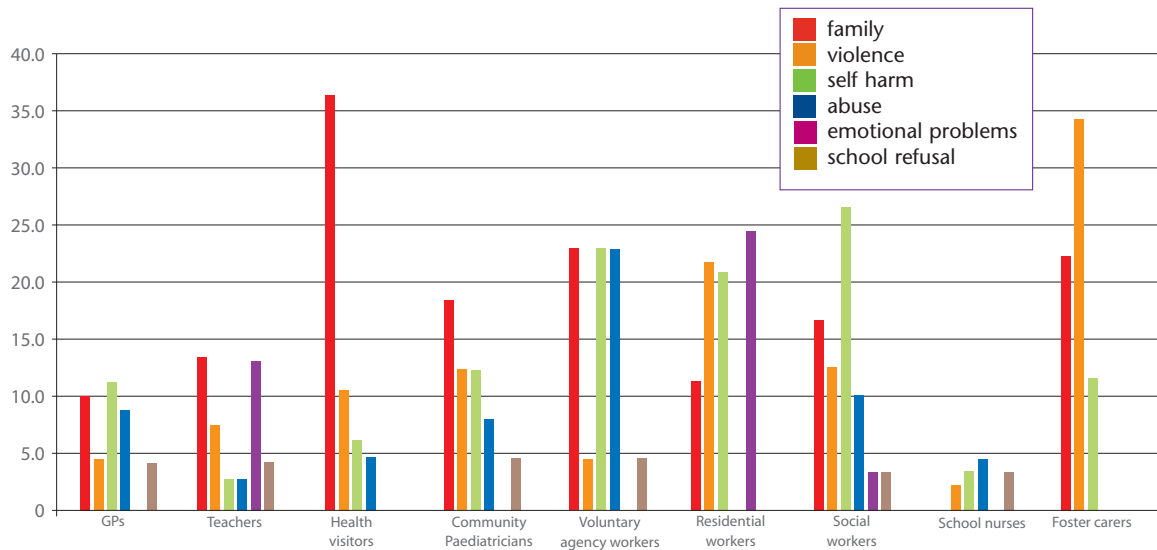


Figure 3.10: Percentage of professional groups describing problems for most recent case

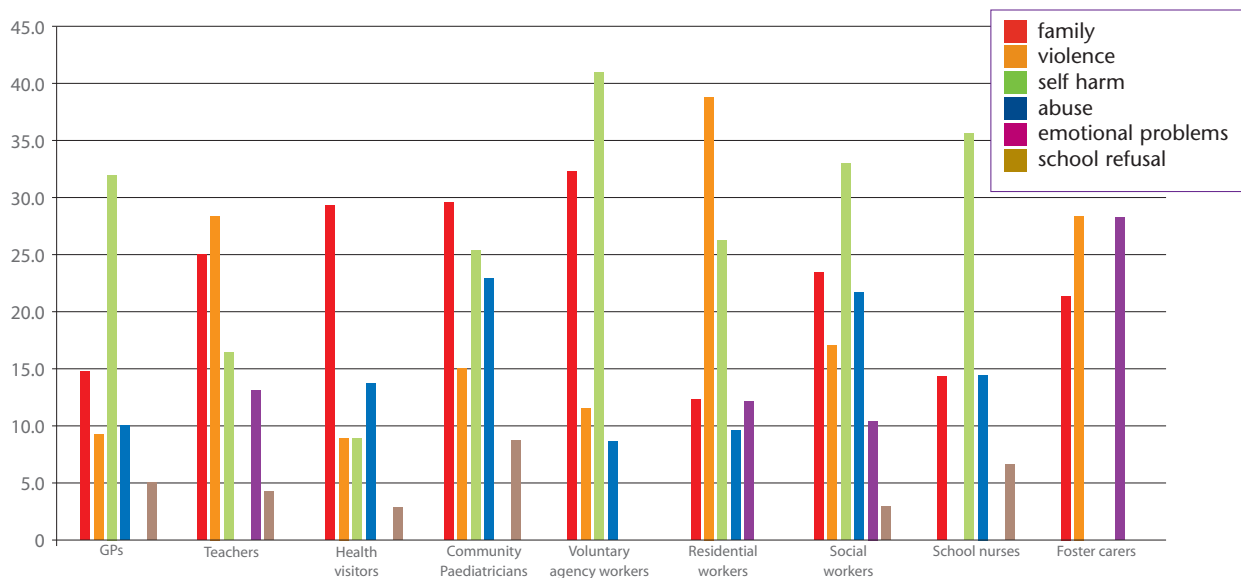


Figure 3.11: Percentage of professional groups describing problems for case causing most concern

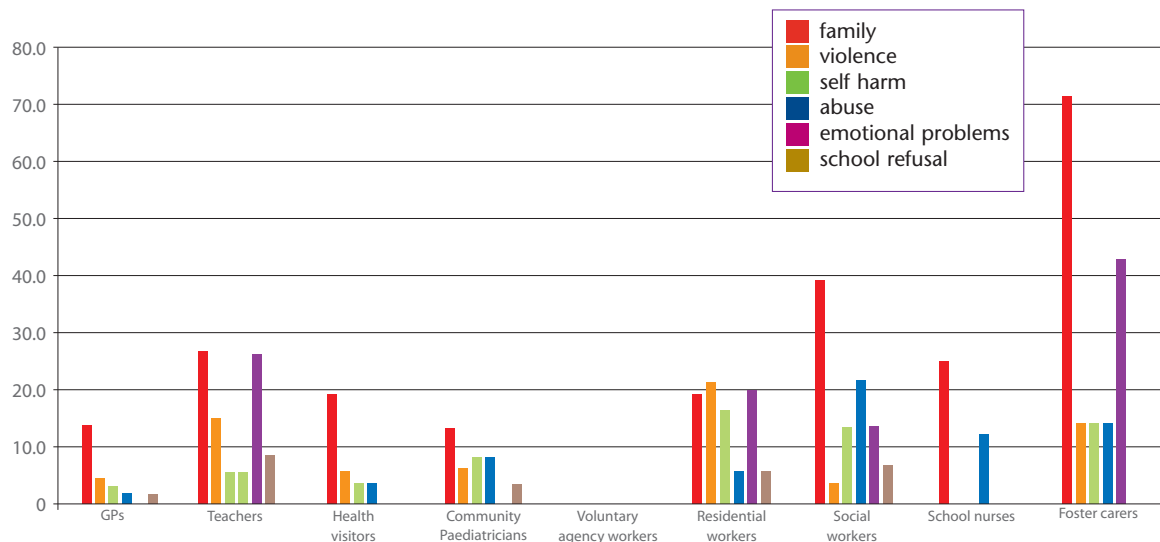


Figure 3.12: Percentage of professional groups describing problems for case which gave most satisfaction

There were many problems which were not coded separately but grouped together as “other”. These included a wide range of issues such as the mental or physical health of parents, communication problems, pressure to achieve at school, feeling unwanted, lack of information provided about a child. Sometimes the issues were described too vaguely to be coded elsewhere – for example, “unusual behaviour”. Problems which appeared in a wider context were also included, such as consequences of homelessness, housing problems, or poverty. This category also included less frequently mentioned problems such as sleep difficulties or sexual/gender identity difficulties.

Conclusion

The analysis of the questionnaires paints a picture of professionals in non-CAMH settings dealing on a regular basis with children who suffer from a wide range of emotional difficulties. This extends from florid cases of psychosis to much simpler and more easily resolved short-term emotional or behavioural problems. There were no professional groups, however, that were not regularly dealing with very complex and serious situations that involved entrenched and damaging family or social experiences. These cases were often the ones that caused professionals the most concern and anxiety.

CHAPTER 4

HOW ARE SERVICES/PROFESSIONALS RESPONDING TO CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH DIFFICULTIES?



INTRODUCTION

This chapter describes how a range of professionals respond to mental health and behavioural challenges in children and young people. They all encounter children and young people in their place of work (or home in the case of foster carers), but their primary tasks vary widely. Teachers are expected to educate all the children in their class as well as deal with children and young people with emotional and behavioural problems. They are supported in this by educational psychologists, school nurses and doctors. There are other non-specialist services who work either specifically with children and young people (e.g. paediatricians) or who work across the age span (e.g. GPs and the police). Some organisations provide discrete services, for example sexual health clinics where mental health issues are presented. There are professionals who work in specialised mental health services either within the NHS or in voluntary organisations. Others look after children and young people in residential settings or in their own homes as foster carers – for them, dealing with mental health issues is only part of the overall care they provide.

MENTAL HEALTH, EMOTIONAL AND BEHAVIOURAL PROBLEMS

Table 4.1 summarises the number and frequency of contacts which respondents to questionnaire A have with young people who have mental health problems. Residential workers, field social workers and others were about twice as likely to have dealt in the past year with more than ten young people with mental health problems, as compared to GPs, health visitors and school workers. Residential workers, field social workers, school management and teachers were most likely to have more than five occasions per week of dealing with such young people. The vast majority of social workers spent at least two hours in a typical week looking after mental health problems in young people.



		GP	Health Visitor	Residential Worker	Field Social Worker	School Management	School Teachers	School Nurse	Other	p-value
In the past year, roughly how many young people with mental health, emotional or behavioural problems have you dealt with?	N: total	133	68	103	103	159	201	96	148	<0.0001
	N: >10	42	24	65	69	67	71	37	112	
	% >10	31.6	35.3	63.1	67.0	42.1	35.3	38.5	75.7	
How many times, in a typical week, do you have to deal with young people with mental health, emotional or behavioural problems?	N: total	135	72	103	102	157	198	93	143	<0.0001
	N: >5	3	5	71	51	82	108	4	44	
	% >5	2.2	6.9	68.9	50.0	52.2	54.5	4.3	30.8	
How much time, in a typical week, do you spend dealing with mental health, emotional or behavioural problems in young people?	N: total	135	70	99	98	153	194	86	140	<0.0001
	N: >2 hours	1	24	91	87	98	128	27	92	
	% >2 hours	0.7	34.3	91.9	88.8	64.1	66.0	31.4	65.7	

Table 4.1. Workload

PROFESSIONALS' RESPONSES IN DIFFERENT SETTINGS

School based services

Teaching staff

Among the teachers surveyed were heads of nursery, primary, secondary and special schools, class teachers and some specialists – guidance and learning support teachers. Their primary task is to provide an education for children and young people, some or all of whom may have complex physical needs or emotional and behavioural problems. In their responses, they described a range of interventions used to manage challenging behaviour and psychological distress. These included working individually with children and young people, e.g. counselling, providing support and information to families and helping other children to accept and support those with difficulties. Some schools provide lunch clubs and after school activities, buddies and a sanctuary within the school. Sometimes children and young people went through the process of exclusion from school in the cases described. It was, however, much more common to read about behaviour management strategies, using the pupil support base and providing a caring environment for their pupils. Establishing a routine and structure for children and young people is often the response to those with behavioural difficulties, with extra support provided in the classroom if required.



HOW ARE SERVICES/PROFESSIONALS RESPONDING TO CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH DIFFICULTIES?

One innovation described involved a weekly support group run by guidance staff for self-esteem building.

Teachers may have an entire class to manage in addition to supporting a child or young person with difficulties, but seeing them every day of the school year increases the benefits of the teacher's input. Many reported becoming deeply involved with children and their families, with one describing a response to a crisis which required taking her own family along to a pupil's home.

Team issues can impact upon how a child or young person with difficulties is managed, for example, in secondary schools the issue of consistency of approach and the need for staff discussion were highlighted.

Educational psychologists

Educational psychologists regularly address the mental health needs of children and young people as part of the school staff complement. In collaboration with other school staff, they facilitate curriculum modification and extra support for children and young people with particular needs. Their approach is encapsulated by this description:

“Consulting with those who have the concern and bring together those best placed to make a change and offer support to the child/family.” (Educational psychologist, EDPSY19)

Assessments were often carried out in collaboration with teachers, using approaches such as curriculum based assessment and classroom observation. Standardised assessment tools like the Wechsler Intelligence Scale for Children and the Conners' rating scales are also used. Some wrote of individual treatment, e.g. behaviour therapy, counselling, solution focussed therapy, cognitive behaviour therapy and stress management. Others worked in a more systemic way, usually through discussion with teachers, and suggested adapting the curriculum, developing schedules of activity, with the emphasis on low key, local and easily available strategies. Many of these respondents described working closely with parents, carrying out home visits and training events for parents and teachers. Covering several schools limits the capacity to provide prolonged individual input.

School nurses

School nurses provide a link between school and other health services, both for children and young people with chronic illness and disability and for those who are otherwise well but present with emotional and behavioural problems. They have a varied remit within schools, from providing pain relief and reassuring about physical problems to supporting children and young people with various mental health issues. Some work with children with chronic illness and complex disability, but most respondents work in mainstream school settings. The majority spoke about their role in dealing with mental health problems as being there to listen and support the child or young person. This was either all that was needed or was used to hold the situation while further input was being arranged. They provided bereavement counselling, had chats about body image, offered behaviour management and worked on anxiety and anger management:

“Listened, tried to reduce anxiety by discussing coping strategies. Liaison with school staff to reduce stress in the school.” (School nurse, SCN151)

Work with families was mentioned frequently – providing emotional and practical support to carers, giving parenting advice and being a “listening ear” for parents. They also described supporting staff in various ways such as giving advice to teachers and assisting class staff. At times school nurses feel they are left with struggling children and young people, stepping in when all other services refused to:

“GP doesn't see a problem. CPNs won't address problems with children as none are trained in this field for under 16s. Adolescent psychiatrist only visits every 3 months & clinic full.” (School nurse, SCN106)

School doctors

School doctors provide services to all public sector schools and are also likely to become involved in managing difficulties that arise at school, e.g. behaviour problems, depression and eating disorders. They often speak about addressing these themselves in conjunction with school staff, again using counselling, recommendations for medication, information sharing and referral to appropriate services. They also worked systemically with families and friends and frequently provide sexual health services. For example, one respondent wrote of providing the following input for a child with aggression, inappropriate sexual behaviour and poor peer relationships:

“Discussed behaviour with parents and child, encourage parents to work together with the school, try to identify how to manage anger, ensure proper sexual education by speaking to child.” (School doctor, CHD052)

The fact that school nurses and school doctors meet young people with difficulties who refuse to go to CAMHS indicates that for some young people school may be a more acceptable place to receive help than clinics:

“Young persons often present with mental health concerns but do not wish referral.” (School nurse, SCN041)

“Young people do not want to be seen accessing mental health services at psychiatric hospital.” (School nurse, SCN151)

See chapter 10 for a further discussion of where help should be provided.

Other services for children and young people in the community

Paediatricians

Community paediatricians work with children, young people and their families with complex disabilities which may include mental health problems. They often identify and address these needs as part of a holistic care package and may be seen by families as a more acceptable option than a referral to CAMHS.



HOW ARE SERVICES/PROFESSIONALS RESPONDING TO CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH DIFFICULTIES?

Paediatricians describe reluctance and embarrassment from parents when a referral to CAMHS is suggested:

“It is extremely difficult to access a child and family clinic because of their ‘priorities’. Even when we get access, parents do not go back because they do not like two-way mirrors or they perceive they are being criticised.” (Community paediatrician/school doctor, CHD052)

Paediatricians described their role in identifying and monitoring developmental disorders, working as part of a multi-disciplinary team and being involved in child protection. There is overlap with CAMHS, with some diagnosing and treating emotional and behavioural disorders such as autism or ADHD. Often they are the first to confirm serious problems and they speak of listening, providing support, discussion with families about long-term support issues, accessing local support groups and giving information to young people, schools and families. They frequently identify or exclude mental health needs and at times address those identified, e.g. through medication, counselling and referral to other agencies. Often their confirmation of a diagnosis facilitates access to resources, e.g. attendance at a special school, transport etc. Many paediatricians provide long-term input to children and young people with complex needs in the absence of accessible CAMHS and following discharge from specialist services. One described providing for a child with severe and complex disability, depression and thoughts of death after surgery:

“Referral to Clinical Psychology – telephone discussion and later letter. Family had already had discussion with me about support which might be necessary at various stages in life.” (Consultant community paediatrician, CHD026)

Paediatricians frequently recognise the scale of need in schools and child development clinics and some describe feeling overwhelmed.

Police

Few responses were received from the police but the commitment to vulnerable children and young people was evident. They spoke of the need to gain trust and take several attempts to interview a young person. They described using special supports to facilitate interviewing the child or young person, e.g. obtaining a psychiatric assessment, using a sign language interpreter and using a video link to allow the child to give evidence in court. An emphasis was placed on the importance of gaining a successful prosecution on behalf of the victim.

“Gaining the trust of the victim which was part of a prosecution that resulted in a sentence for the offender.” (Police sergeant, P0003)

Panel Chairs

Again relatively few panel Chairs responded. Issues raised included identifying mental health needs, pressing for resources and looking for psychiatric assessments. Their role allowed them to use Supervision Orders and place vulnerable children and young people in secure units, although often the resources available curtail their options:

“Supervision order in the only facility available.” (Panel Chair, PAN028)

General practitioners

GPs have long-term relationships with children, young people and their families, often providing input after specialist services have discharged them. One of the core roles mentioned is about assessing and managing physical and psychological difficulties, with the need to address underlying concerns and preventing unnecessary investigations. Although they wrote about dealing with crises, assessing risk and speeding up specialist input if required, they are also in a position to take a long-term view and adopt a “wait and see” approach.

They provide a varied input to children and young people with mental health problems. Respondents described talking, listening, providing advice and reassurance to the child/young person, parents and other family members. Often their role is to monitor physical well-being and address psychological issues which arise. Some described providing psycho-education and giving verbal and written information to families. They frequently provide counselling and reported prescribing medication such as methylphenidate (Ritalin), methadone, anti-depressants and benzodiazepines, occasionally with specialist input:

“Prescribe SSRIs¹² [anti-depressants], refer child and family psychiatry, encourage liaison with school guidance base, regular GP review.” (General practitioner, GP0069)

They usually provide GP services for the whole family and will often describe working with families around particular difficulties and negotiating between family members. Often mental health issues become evident only once the patient has presented with a physical problem:

“Initial consultation was supposedly about a minor physical ailment, I've encouraged her to make another appointment for fuller discussion.” (General practitioner, GP056)

As the above quote suggests, time constraints are a real issue for GPs and they write about working round this for children and young people with mental health difficulties, for example, by stretching consultation times and arranging double appointments. Complex cases often involve a child or young person seeing different people within the practice, with the need to adopt a consistent approach among GP partners.

Health visitors

Health visitors generally provide input to young children and their carers, being closely involved in the first few years of life, but they also occasionally provide input to older children with particular difficulties.

One of their key roles is in monitoring babies' and toddlers' growth and development. They wrote frequently of responding to parental concerns with advice and support, active listening and reassurance. They provide verbal and written information, lend books and videos and supply equipment, e.g. a pushchair, alarm etc. The majority provide parenting advice and use behaviour management strategies with parents, both individually and in groups.

¹²Since this survey was conducted, GPs have been advised against prescribing this class of drugs for treatment of depression in children and young people.



HOW ARE SERVICES/PROFESSIONALS RESPONDING TO CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH DIFFICULTIES?

They frequently link parents with local resources and see their role as encouraging new parents and supporting carers of children with various difficulties. For example, for two boys whose parents had separated and who presented with enuresis and soiling, one health visitor commented:

“Offered parenting and behaviour advice. Support to parents – saw both independently to obtain views/perspectives of children’s behaviour, liaised with school nurse.” (Health visitor, HV0110)

Health visitors spend time in families’ houses where parents can feel isolated and vulnerable. They describe their role in supporting new parents and those with children with complex needs and are well placed to pick up mental health needs of both the adults and children through an acceptable, universal service.

Voluntary and other services


Many of the voluntary services offer something quite different to children and young people, often providing anonymity and instant access. Some of the respondents were available to children and young people through an anonymous phone line, which was being used in a very different way from statutory services. Some people encountered children and young people through sexual health services and provided emergency contraception, pregnancy tests etc. Difficult issues were described, e.g. exploring safe deliberate self-harm, with the time and frequency of contact determined by the child or young person. Flexibility seemed to be a key element of this type of input for children and young people, with contact varying from single drop-in contacts to long-term individual support. The approach to children and young people stood out as being more personal, accessible and child focussed. Difficulties were addressed at the child or young person's pace, with little mention of specific therapies or protocols. At times voluntary agency staff used their own time to see the young person – for example visiting them in hospital when not at work.

Members of this group were distinct in the way that they conceptualised and described the work they undertake. Some of the language suggested that this group were younger and more likely to spell out key elements of relationship building, which others might take as read.

In cases where there were large numbers of professionals and agencies involved with the child or young person, respondents from voluntary agencies often regarded themselves as advocates who voiced the child's view.

Social workers

Social workers carry responsibility for child protection, being involved in making decisions in removing children and young people from their homes, detaining them under the Mental Health Act, nominating alternative caretakers and finding residential care for children and young people with whom they work. They also speak about providing packages of care and at times describe accessing a huge range of resources, whilst at others they highlight the lack of appropriate resources for individual children and young people.



The social worker respondents included those working in child and family teams and residential settings, with some having a management role. Their remit varies from advising families about parenting and providing benefits advice to supporting children and young people in residential placements and playing a key role in child protection procedures. Individual work included bereavement counselling, anger management, life story work and building self-esteem. Some use cognitive behaviour therapy, others provide intensive individual work or regression therapy.

The range of input described for one young person whose mother had died and who was not attending school or engaging with support services demonstrates the breadth of interventions:

“Individual work with the young person, group work and voluntary agency support, offers of bereavement counselling, practical advice and guidance in regard to housing or benefits agency difficulties.” (Social worker, SW0003).

Parental work involved helping parents understand the young person’s needs, reinforcing parental boundaries and carrying out family therapy. Some respondents deal with offending behaviour, assess risk and support young people with court attendance. There were many individual examples of putting in a lot of time with children and young people who are hard to reach. A recurring theme was that of trying to engage other people – either within their own agency or from other services – to recognise and respond to difficulties.

Specialist mental health services

People working in CAMHS were given a different questionnaire but there is comparable information about the type of work they do with children and young people.

Table 4.2 summarises the main job elements. The distribution of time allocated to mental health promotion does not vary significantly across professional group. The educational psychologist and “other” groups devote more time than other professional groups to the prevention of mental health problems. The majority of respondents spend most of their time treating mental health problems, the nursing and medical groups having the highest rates. Compared with other CAMHS staff, the clinical psychology group spends the greatest amount of time in working with people with non-mental health problems. The majority of respondents spend at least some of their time in consultation to other agencies.

Individual work with children and young people includes assessment of mental health disorders, complex neuropsychiatric disorders, physical and learning disabilities. Other areas covered included risk assessment, motivational interviewing regarding drug and alcohol misuse and assessment of attachment and suitability for treatment. Specific professionals carry out assessments relevant to their area of expertise, e.g. speech and language assessment regarding language, voice, communication and swallowing; psychometric assessment; functional analysis of behaviour; assessment of activities of daily living; assessment of movement, sensory skills etc. Other assessments include in-patient and day patient and emergency contacts.



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Table 4.2. Main elements of job

		Nursing	Medical	Clinical psychology	Therapy	Educational psychology	Other	p-value
Mental health promotion	N: total	72	44	41	22	25	36	0.2635
	N: Most of time	4	1	1	0	1	0	
	% Most of time	5.6	2.3	2.4	0.0	4.0	0.0	
	N: Half of time	2	0	0	0	1	0	
	% Half of time	2.8	0.0	0.0	0.0	4.0	0.0	
	N: Some of time	30	11	11	6	12	15	
	% Some of time	41.7	25.0	26.8	27.3	48.0	41.7	
	N: Little/none of time	36	32	29	16	11	21	
	% Little/none of time	50.0	72.7	70.7	72.7	44.0	58.3	
Mental health problem prevention	N: total	71	44	43	22	27	19	<0.0001
	N: Most of time	7	0	2	2	1	1	
	% Most of time	9.9	0.0	4.7	9.1	3.7	5.3	
	N: Half of time	4	0	1	0	6	0	
	% Half of time	5.6	0.0	2.3	0.0	22.2	0.0	
	N: Some of time	34	16	22	12	19	12	
	% Some of time	47.9	36.4	51.2	54.5	70.4	63.2	
	N: Little/none of time	26	28	18	8	1	6	
	% Little/none of time	36.6	63.6	41.9	36.4	3.7	31.6	
Treatment of mental health problems ¹³	N: total	76	47	42	29		21	0.0007
	N: Most of time	61	32	22	15		10	
	% Most of time	80.3	68.1	52.4	51.7		47.6	
	N: Half of time	10	13	13	5		4	
	% Half of time	13.2	27.7	31.0	17.2		19.0	
	N: Some of time	5	2	7	8		7	
	% Some of time	6.6	4.3	16.7	27.6		33.3	
	N: Little/none of time	0	0	0	1		0	
	% Little/none of time	0.0	0.0	0.0	3.4		0.0	

¹³Educational psychologists were not asked these questions.

		Nursing	Medical	Clinical psychology	Therapy	Educational psychology	Other	p-value
Treatment of other health problems ¹³	N: total	66	45	40	21		19	0.0114
	N: Most of total	10	2	6	6		4	
	% Most of time	15.2	4.4	15.0	28.6		21.1	
	N: Half of time	6	6	2	0		0	
	% Half of time	9.1	13.3	5.0	0.0		0.0	
	N: Some of time	22	16	25	5		8	
	% Some of time	33.3	35.6	62.5	23.8		42.1	
	N: Little/none of time	28	21	7	10		7	0.0395
% Little/none of time	42.4	46.7	17.5	47.6		36.8		
Consultation to other agencies	N: total	77	48	45	26	28	40	0.0395
	N: Most of time	3	0	2	0	4	1	
	% Most of time	3.9	0.0	4.4	0.0	14.3	2.5	
	N: Half of time	6	3	4	3	8	6	
	% Half of time	7.8	6.3	8.9	11.5	28.6	15.0	
	N: Some of time	60	42	36	21	15	31	
	% Some of time	77.9	87.5	80.0	80.8	53.6	77.5	
	N: Little/none of time	8	3	3	2	1	2	0.0395
% Little/none of time	10.4	6.3	6.7	7.7	3.6	5.0		

Systemic assessments involve looking at the wider systems around the child, e.g. parenting, family structure and functioning and contributing to decision making about where and with whom children should live. Respondents also described individual work with children and young people, family-based interventions and group work. Individual work included various psychotherapies, e.g. cognitive behaviour therapy, psychodynamic psychotherapy and problem solving therapy. Medication is recommended occasionally by nearly all psychiatrists. Family and systemic therapy is used frequently, as is family work, narrative therapy, individual work with carers and couple work. There are various types of parenting work, e.g. the Triple P (Positive Parenting Programme) and Webster-Stratton



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parenting programmes. Many described group work, often according to a specific therapeutic orientation or to particular disorders, e.g. children's self-esteem group, with some run jointly with other services, e.g. a joint parenting group with health visitors, Dinosaur School with a local nursery. Consultation also featured regularly, e.g. a psychotherapist consulting to a multi-disciplinary team and consultation by CAMHS workers to other agencies, such as social work and health visitors. Teaching and training were often described, e.g. for community project workers and training of social work staff about parenting.

Some therapeutic work is described in terms of either disorders or vulnerable groups, with several services having been set up for children and young people with conditions such as ADHD and autistic spectrum disorder. Vulnerable groups mentioned include those with physical problems, homeless young people, sex offenders and looked after and accommodated children/young people. Professionals in the specialist voluntary sector work in a range of organisations including residential settings, drop-in clinics and psychotherapeutic resources. As with the CAMHS workers, these respondents provide comprehensive mental health assessments and therapies for children, young people and families. There are differences however, with voluntary organisations providing services for children and young people on the fringes of society e.g. services for runaways and work with anti-social families to promote changes in behaviour and sustain tenancies. Individual treatment focuses more on psychotherapeutic approaches, both short- and long-term with children, young people and parents. Groups targeted for interventions include looked after and accommodated children/young people and sexually aggressive young people. Group work is provided – for example for bereaved children. There was evidence of a real wish to establish therapeutic relationships for children and young people using innovative approaches – e.g. some were exploring alternative therapies, others provided outreach services, with arts and activities used to engage young people.

Their approach was encapsulated by this respondent who aims:

“to improve the mental health of individuals who may choose not to access traditional clinic settings” (Psychology senior support worker VOB158).

Their services work hard to be accessible and flexible, for example by meeting young people in the setting of their choice.

Residential workers

Residential care workers work in various residential establishments, including children's homes and residential schools, with some children and young people who have severe and complex difficulties. The intensive nature of this work is emphasised, e.g. one respondent described working “24/7 with 5 young people”. Complete care is required from providing a place to live, eat, relax and in some instances receive education. Often, the children or young people require specific medical or psychological care. There may be prolonged contact with a small group of children or young people, often with emotions running high. Residential workers often speak of working very hard to establish positive relationships with these children and young people in the face of aggression, unbearable distress and disturbing backgrounds. For example, work with a boy with a history of being sexually abused who was also forced to abuse his siblings, was described as follows:

“Built up a relationship with the young person, worked closely with him on various issues to help him deal with past experiences and provide good quality experiences for him.”
(Residential worker, RW0160)

Some of the work described involved helping children and young people (with backgrounds of neglect, abuse and family breakdown) cope with a residential setting and develop relationships with staff and peers. The need to establish basic trust and develop positive relationships was stated frequently, as was work on increasing self-confidence and building self-esteem. Some children and young people required specific strategies, such as behaviour management, establishing boundaries and consistency and occasionally management of violence and restraint. Holistic care of this group is required with specific physical as well as mental health problems being tackled, including bowel disorders, complex medication regimes, or management of deliberate self-harm through maintaining safety. Problem drug use features frequently. Many workers see themselves as advocates working to obtain appropriate help for their clients and encouraging the young person to accept specialist help. Some work goes beyond individual input – family and systemic work was sometimes described, as well as parenting work – with the stated aim of returning the child or young person home and/or back into mainstream education.

Much of this group's work was described in terms of spending a lot of time with individual children and young people. Some of this is focussed on a short-term aim, for example, returning the child to mainstream school as soon as possible, whereas others spoke about work over a few years. Frequently, however, workers described maintaining contact after the child or young person has moved on from their placement, regarding continuity of care as being particularly important for their client group.

Team issues were raised as being very important. On the one hand, the potential for residential workers to feel unsupported by management and other agencies was highlighted. On the other hand, the capacity for the difficulties of children and young people to split the team was raised. Help was frequently requested from their managers and CAMHS, both to manage problems directly and to support staff when young people refused specialist help.

Foster carers

Foster carers were sent a variant of questionnaire A appropriate to their particular involvement with children and young people. The difficulties they encounter happen in their own homes, where the children and young people in their care can wreak havoc at times. Much of the role of foster carers is in providing day-to-day care, including giving medication and bringing children to school. Additional issues for them lie in relationships with biological parents and with social work. Social work departments are their main source of help and they play a significant role in decisions about placements. Tremendous effort was described by this group in establishing relationships with the children and young people placed in their care. They write repeatedly about spending time talking to children, keeping them safe, providing love and reassurance, making them feel cared for, and letting them know that “this is home”.

“Built up trust in the relationship and tried to help develop strategies for the young person to be able to cope.” (Foster carer, FP034)



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THE BIGGER PICTURE – HOW SERVICES WORK TOGETHER

It is clear that very many different people working in different settings are wrestling with the mental health difficulties of children and young people. Although different language is used at times to describe these difficulties and their responses, there are also interesting similarities¹⁴. For example, almost all groups used terms associated with psychiatric diagnostic categories.


The same problems are faced in a variety of settings, for example, a child with ADHD may receive input from school services, a GP, a paediatrician and/or CAMHS. Additional difficulties may cause social work, the police, the Children's Hearing system and residential placements to become involved. Although there is some consistency of approach, different agencies tend to focus on different aspects of the child's life – the need for education, physical monitoring of medication, or family support. At times, it seems to be that only those living with the child hold the full picture, yet they have the least formal training and professional support.

Many of the respondents provide seemingly similar interventions such as counselling or family support, with the nature of the relationship dictating where this happens, for instance, at school by a guidance teacher or in the family home by a health visitor. Children, young people and their families may accept input from some agencies and not others. Those agencies that provide universal and voluntary services are seen as more acceptable but they are overwhelmed at times. Often, the setting in which help is received appears arbitrary and relates more to patterns of professional relationships than children's needs. GPs, for example, usually refer children to other health services while children and young people with similar difficulties who do not visit their GP may be more likely to receive help from school-based services.

Although many people are working on their own with children and young people with mental health difficulties, a great deal was written about liaising with others, joint working and referring on to other agencies. The 'tiered' paradigm¹⁵ of mental health services involves children and young people being seen by increasingly specialised services according to the increased severity and complexity of their needs. For example, a child with sleep problems might be seen by a health visitor at home, whereas a young person with a severe eating disorder may require admission to an adolescent in-patient psychiatry unit. Children and young people with complex difficulties, however, will access a range of services, e.g. school, GP, community paediatrics, social work and their local CAMHS. The complexity of their difficulties becomes reflected in the complexity of service involvement, and it is a major task for all to work together and co-ordinate their input.

¹⁴ But note, for example, that the word 'depression' can mean something very different to a psychiatrist and to someone without medical training.

¹⁵ A commonly used model for understanding child and adolescent mental health services uses a wedding-cake-like hierarchy of 'tiers'. **Tier 1** is provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers, voluntary agencies. **Tier 2** involves practitioners who tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services). This can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. **Tier 3** is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists. **Tier 4** consists of tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (for children who have been sexually abused, for example), usually serving more than one district or region.



Children and young people with severe and complex difficulties provoke strong feelings, which often enter the relationships of those involved in their care. Many of the respondents, particularly in the non-specialist services, described feeling overwhelmed and expressed the need for others with expertise to become involved, for instance, the previously quoted school nurse who managed a young person with anxiety:

“Lack of knowledge about mental health, lack of confidence in personal skills.” (School nurse, SCN151)

The challenges of working collaboratively are covered in chapter 7. A picture emerges of people working with others, not only within their own agency, but with myriad other services. For example, within schools, teachers often sought help from senior staff, behavioural support or guidance teachers and educational psychologists, and they participated in pre-school planning meetings and joint support groups. They also liaised with medical services, voluntary organisations, the police and the Children's Hearing system.

Educational psychologists relate primarily to teachers but they are also regular participants at school reviews and multi-agency meetings, and refer to health, social work and voluntary agencies. Paediatricians based both in schools and child development centres refer regularly to clinical psychology and psychiatry services and use GPs at times to prescribe and facilitate referrals. They also access social work, post-abuse counselling and local voluntary agencies. They described their role frequently in terms of shared care and joint management, usually with other paediatric services, CAMHS and school staff, and they play a key role in the difficult field of child protection.

GPs refer to a wide variety of health and other agencies, relating primarily to other health professionals. These include CAMHS, clinical psychology, paediatricians, health visitors, adult psychiatry, dieticians and speech therapists. However, they also refer on to several educational, social work and voluntary resources. Health visitors liaise with a wide network of resources including nurseries, schools, psychiatry services, social work services and disability provision. They regularly attend meetings, often seeing their role as an advocate for the child and/or family. Some carry out joint work, for example, a parenting group with a CAMHS worker. One health visitor described her work with an 11-year-old girl with anxiety based difficulties:

“Home visit to offer support and advice to parent on several occasions, referral to GP, Child and Family unit and follow up visits. Liaison between agencies including school doctor and Child and Family unit.” (Health visitor, HV0117)

Throughout the responses, there was an awareness of the many services available within the community for children and young people. Referring on in many cases reflected the benefit to families of accessing more expertise and resources, while maintaining the original contact throughout. At times, the difficulties experienced by the child or young person were seen as being beyond people's abilities and other services were seen as possessing the required expertise. Sometimes however, lack of clarity about other people's roles and remits can lead to their response being viewed as unhelpful.



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Many social worker responses involved liaison and joint work with education, CAMHS, other health and social work services. Social workers routinely attend meetings, e.g. Children's Hearings, school meetings and case conferences. They frequently described joint work with schools, clinical psychology and CAMHS around, for example, getting a young person to school. They also liaise with voluntary organisations, drug and alcohol agencies, residential care staff, disability teams, GPs and adult psychiatry.

Social workers regularly refer on within social services in order, for example, to access home help resources or residential placements. They also wrote about referring children and young people to GPs, CAMHS, psychotherapy services, educational psychology, the police and the hearing system. For some, the issue of power is salient, that is, the ability to make things happen. The more specialist services have their own criteria for accepting referrals, which have rarely been agreed with other agencies. Residential care workers and foster carers describe living with children and young people with significant difficulties, but they often have to rely on others to make referrals and follow them up if help is not forthcoming. Trying to find the right help is frequently mentioned as a challenge and reflects not only the difficulties faced by children and young people, but also the variation, gaps, duplication and overlap in the services available.

Conclusion

The overall impression given by the respondents is of tremendous commitment to children and young people and the will to make things better for those with mental health problems. Each group surveyed described a range of responses to these difficulties, with more commonalities in their approach than differences. The vast majority of respondents were child-centred and their interventions focussed on enhancing coping and resilience. Almost all respondents see family support and joint working as relevant to their input. There were many examples of people "going the extra mile" to help children and young people. Although joint work and liaison works more easily within the same agencies, e.g. health or social work, many of the respondents wrote about good working relationships with several different services, to the benefit of children and young people. Professional relationships seem to thrive where people work "under the same roof" or meet each other in the course of their work, even if employed by different agencies, for example, school-based professionals frequently wrote positively about joint work and collaborative ventures. Some groups appear to straddle different services, which can work well for children and young people – examples include school nurses providing psychotherapy at school for young people who refuse to attend CAMHS.

Many professionals described pushing the boundaries of their roles to offer care to children, young people and their families who have found difficulty in attending specialist services. This can result in professionals feeling overwhelmed and poorly qualified to carry out this work, consistently highlighting the need for training and support. Voluntary organisations can respond more flexibly and creatively than the larger statutory agencies to specific needs of children and young people, but there are opportunities for both to collaborate more in the development and delivery of services.

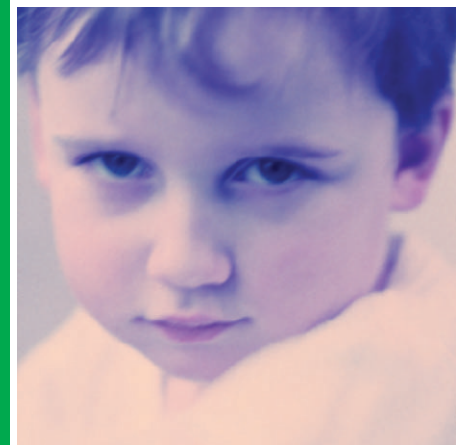


Foster carers and residential care workers spend most time with the most vulnerable children and young people, but often have the least training and professional support. Their accounts make it clear that they are often closely involved in sustained, intense work with young people with complex difficulties. It also seems clear that access to and input from specialised mental health services are frequently constrained by the availability of resources and frequently shaped by the quality of relationships between individual professionals. So while CAMHS and voluntary sector specialised professionals have particular training and experience of providing assessment and treatment to children and young people with the most complex and severe mental health difficulties, the respondents described the ways in which they, too, make important contributions to their well-being, often in the absence of support from specialist services.

There are frequent calls, throughout the survey, for recognition of the mental health needs of children and young people and increased investment to improve their lot. And while many respondents talk of the importance of more direct input from the specialist services, there are also clear statements about the importance and value of investing in the support and training of those who work every day with these children and young people.

CHAPTER 5

HEALTH PROMOTION/PREVENTION



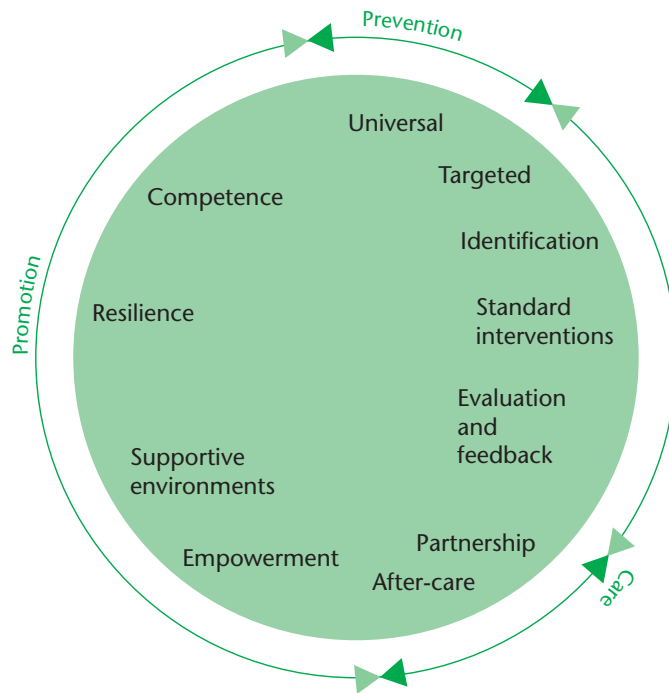
INTRODUCTION

This chapter considers respondents' reports of their work in the areas of health promotion, prevention and early intervention. These are areas with considerable overlap and, consequently, some potential confusion. To quote the SNAP report on Child and Adolescent Mental Health:

"Some reserve the term mental health promotion solely for activities on the mental health continuum which involve improving mental health as opposed to preventing mental health problems i.e. "activities which enhance competence, self-esteem and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders."^{viii} These authors add that "the focus on health, rather than illness, is what distinguishes it from enhancement of protective factors within a risk reduction model for prevention interventions". However, for others mental health promotion covers both the promotion of mental health and the prevention of problems as they are viewed as one and the same - efforts to promote mental health will prevent mental illness and vice versa and measurements of mental illness and mental health actually overlap considerably as do the intervention methods. In a major meta-analysis of prevention and promotion efforts for children and adolescents, Durlak and Wells^{ix} highlight that programmes designed to promote mental health also tend to reduce problems, while those that seek to prevent mental health disorder usually also enhance competence and resilience."

The Intervention Spectrum

Adapted from Mrazek and Haggerty^{viii} (1994), via Barry (2001)



Health promotion¹⁶, focussing on health rather than illness, involves initiatives to create and sustain supportive environments that enable a young person to deal with adversity – in other words, the development of resilience. These initiatives include activities that enhance competence, self-esteem and a sense of well-being. Prevention and early intervention strategies, on the other hand, utilise a risk reduction model and aim to prevent or minimise the risk factors known to lead to later mental health problems.

The chapter will first outline the analytic strategy used, and then describe the services provided, attempting, as far as is possible, to separate the early intervention and health promotion work of each professional group. This will lead into an analysis of how there appear to be different understandings by each professional group of their roles and remits, followed by an analysis of the perceived shortcomings of services in this area and the barriers to providing better work. The chapter will end with a number of overarching conclusions.

Analysis

Different questionnaires were used for different professional groups, making direct comparisons between some groups on specific problematical questions. For instance, most respondents were asked “Do you offer any sort of health promotion?” CAMHS staff, however, were not asked specifically about health promotion, but were instead asked about how much time they spent on promoting health and well-being and preventing problems, as well as details about what kinds of therapies or interventions they used. Consequently it is difficult to comment with confidence on the understanding that CAMHS staff have of health promotion. Similarly, foster carers were not asked what kinds of health promotion or preventive work they did. They were asked instead to discuss their most recent experience of working with a child with emotional and/or behavioural difficulties, and whether they would like training on mental health promotion. The types of answers provided by different groups may, therefore, be in part a reflection of the differences in the questions they were asked, as well as of any underlying differences in approach to health promotion and prevention/early intervention.

The analysis was conducted by browsing all the free text of each occupational group, and making an interpretative analysis. This had the advantage of reading those text segments that related to health promotion and early intervention in context. The analysis was first

¹⁶ It should be noted that traditional health education – the provision of advice, leaflets and posters, for example, is only one small part of health promotion.



done for all occupational groups individually, and subsequently overarching patterns and commonalities were identified across groups.

Services provided

Whilst virtually all groups surveyed indicated that there were significant health promotion or early intervention aspects to their work, the services they described varied both in content and in terms of the vocabulary used (reflecting differing assumptions underpinning professional practice). The police officers were the only group who did not appear to consider that their work involved a health promotion or early intervention component. These officers all worked in child abuse units, and all were involved in specialist interviewing of children where sexual abuse had been alleged. There were, however, very few police respondents, so we can infer little from this finding. In addition, there were virtually no references to health promotion work in forms completed by panel members and Reporters. Indeed it could be argued that Reporters did not regard it as their task to consider early intervention and health promotion strategies. In marked contrast to other respondents, foster carers did not classify their interventions into specific types of interventions, such as health promotion or “therapy”, but instead wrote of working with the child in question in any way possible. For example, one foster carer described her involvement with a child placed with her as *“the joys and worries of growing up, making friends, coping in public”* (Foster carer, FP015).

Unlike any of the other workers, foster carers work and live with a child 24 hours a day, seven days a week. This made any distinction between work time and living time impossible, and in many respects their work is similar to that of any parent with a child rather than that of a professional worker identified by a series of specified tasks. Thus, even though much of their input with children contains aspects of health promotion or early intervention, it would be inappropriate to analyse their work under 'services offered' apart from stating that they work intensively and in a holistic way with all aspects of a child growing up.

Early intervention and prevention work

CAMHS staff tended not to refer explicitly to early intervention or prevention work, but a great deal of the work described under “therapies offered” could be regarded as forms of early intervention, including cognitive behaviour therapy, family therapy, parent training and under-fives services. For instance, one said that her work included:

“Group work e.g. social skills, parent training, anxiety management, parenting guidance, individual sessions – self-esteem.” (Mental health nurse, DMMD16)

In particular, parent training, such as the Webster-Stratton programme, was frequently mentioned. Whilst quite a lot of work that was carried out by CAMHS staff could be described as early intervention, this was almost always provided only for those young people and children coming to the clinics, and was nearly always described as “therapy” or “treatment”, rather than as “early intervention”.

Several specialist CAMHS workers specifically mentioned early intervention projects, focussed on parenting, based at their local health centre and working in conjunction with health visitors. In addition, most specialist CAMHS respondents wrote of inter-agency consultation and education.

For instance, one respondent wrote:

“we provided teaching session on DSH [deliberate self harm] to the school” (Consultant child psychiatrist, BBMD01).

The educational psychology questionnaire returns gave little indication of the range of potential early intervention and prevention strategies that educational psychologists might be engaged in, perhaps partly as a result of the way questions were framed, and only one psychologist specifically identified their work as having an early intervention and prevention component. From the responses given, however, it was evident that this group was involved in early intervention and prevention work. In particular, many said they were involved in developing services for autistic spectrum disorder, including parent education and educational support. Other early intervention work mentioned included providing pupil support strategies, intensive educational support for children presenting with dyslexia, and playground anti-bullying initiatives. The overall impression gained, however, was summed up by one educational psychologist:

“Training and preventive approaches have too low a priority within our service.” (Educational psychologist, EP0002)

Although there were few direct references to health promotion or early intervention in the responses given by general practitioners, they appeared to regard such work as an integral part of their remit. For instance, one wrote about having “Open dialogue at any attendance e.g. acne” (General practitioner, GP031), while another said his strategies included: “opportunistic discussion” (General practitioner, GP032).

Many GPs ran antenatal and parenting classes from their premises, and some mentioned child health surveillance programmes as part of their everyday work. Sexual health screening for teenagers was also frequently mentioned. In addition, many GPs appeared to see their work in early intervention, as well as health promotion, as part of a larger team effort, notably with health visitors and practice nurses. There were many references to the health promotion and early intervention work of these staff groups including “advised discussion with health visitor re: local parenting groups” (General practitioner, GP030), “health visitors run parenting classes to help parents tackle challenging behaviour” (General practitioner, GP0036) and “teenage health clinics run by our HV” (General practitioner, GP0002).

Health visitors themselves reported that they undertook a wide range of early intervention work. This included co-ordinating a lot of inter-agency work, such as arranging bereavement counselling from CRUSE. For instance, one wrote:

“[I] sought other agencies who could advise offered support and counselling. Referral to family mediation and the Department of Child and Family Psychiatry. Basic behaviour advice to parents.” (Health visitor, HV0110)



The reports from teachers, although recognising the great deal of early intervention and prevention work being done by school nurses, indicated that they themselves engaged in little early intervention and prevention work. Many teachers, however, indicated that they wanted to see far more early intervention work being undertaken.

Community paediatricians, normally working closely with schools, delivered a fair amount of preventive and early intervention work. Many wrote that they were involved in the early detection and management of autistic spectrum disorders and ADHD. Paediatricians also reported that they routinely provided screening of children for neuro-developmental problems which could facilitate earlier intervention.

It proved difficult to estimate the extent of social workers' involvement in both health promotion and prevention, but many appeared to view such work as an integral – though possibly not explicitly identified – aspect of their jobs. For instance, a number of social workers made the point that Looked After Children (LAC) materials really provided a form of early intervention. Thus one senior social worker said that she did undertake early intervention work, but:

“Albeit indirectly, I promote this via the LAC system of reviews I currently chair.” (Social worker, SW0104)

Others argued that their work in child protection was a form of early intervention, and indeed much of the direct work with children and families could be regarded as, in part, aimed at ameliorating the environmental risk factors for developing serious mental health difficulties in both childhood and later adult life. Residential workers rarely regarded their work as having an early intervention component, although, like many staff groups, frequently stated the need for far more early intervention and prevention work to be undertaken.

Workers in the voluntary sector reported that early intervention and the prevention of more serious difficulties was a core aspect of their work. For instance, one wrote:

“I see myself at the enabling end of emotional health – maybe enabling some children and young people to regain emotional health rather than becoming emotionally ill.” (Support worker VOA102)

Health promotion

There was no specific mention of health promotion work as such by CAMHS staff, but many staff gave, under the heading of therapies offered, examples of innovative work with other agencies that could be regarded as health promotion. For example, one psychologist wrote of her work in starting self-esteem workshops in a local secondary school to help sixth-year pupils with their stress. An awareness and involvement with health promotion projects was by no means universal, however, and some specialist CAMHS staff appeared to regard health promotion as work for other agencies.

Educational psychologists said they were involved in a number of health promotion strategies, notably in “promoting emotional intelligence” of young people in school settings. In addition, they were involved in numerous other activities in the health promotion field, such as pupil peer support projects to promote social and emotional development and “empowerment of service users”.

GPs described themselves as pursuing a number of general health promotion strategies, often in close cooperation with the practice health visitors and practice nurses; many mentioned providing leaflets and having displays put up in their waiting room by health visitors.

As would be expected, health visitors undertook a great deal of health promotion work. This encompassed a wide range of interventions including: “Family planning advice, alcohol consumption, and sexual health” (Health visitor, HV0054). They also highlighted their involvement in dealing with social problems: “Drugs/alcohol misuse, low self-esteem, financial and social problems” (Health visitor, HV0025).

School nurses also regarded health promotion and prevention as a core component of their work, undertaking a wide range of activities such as:

“Sexual health workshops (primary and secondary), breast awareness contraception workshops (secondary) testicular self examination, STDs, changes at puberty, feeling yes/feeling no, 'senses', healthy eating, drugs, alcohol, share, hygiene, healthy heart, exercise and any other related topic in 5–14 curriculum.” (School nurse, SCN128)

Such services were provided in a wide variety of ways, including a drop-in service at high school for teenagers, or drop-in service at primary school for pupils and parents. Often there was a strong mental health component to such work, which included self-esteem group work, dealing with stress, drugs and alcohol education and trying to reduce the stigma associated with mental health problems. Where they felt they lacked the necessary expertise themselves some would engage other professionals, for instance:

“As a team we access other professionals and have presented on topics in-house, i.e. self harming, anger management, adolescence mental health.” (School nurse, SCN190)

Teachers, and in particular those working in the new community schools and health promoting schools, were engaged in a wide range of health promotion activities. For instance, one wrote that:

“We are linked to C*** Health Food Project offering fresh fruit to nursery – health eating promoted, also offer adult fitness classes for our parents, fitness classes for our children at local sport centre, promote physical exercise indoors and outdoors, liaison with health visitor – well-being classes workshops – diet – herbs.” (Nursery teacher, ED0014)

Most teachers noted that their school was involved in numerous health promotion strategies, often as a central part of the school curriculum.



For instance, one teacher wrote that her school offered:

“5–14 health ed programme, s3-s6 health ed programme, topics include hygiene-safety-healthy eating, emotions/ relationships – drugs ed, sexual health.” (Special school class teacher, ED0017)

Another wrote:

“Health promoting school – healthy eating and exercise, brain gym.” (Primary school head teacher, ED0204)

Many different strategies were described, including working on a child's personal health, dealing with growing up, sexual health, relationship issues, social development, eating and exercise, and personal hygiene. Many mentioned mental health improvement as part of their health promotion strategy.

Community paediatricians worked closely with schools, but although some did state that they undertook health promotion work such as giving talks on sexual health or contraception, they were very much the exception. As the following quote indicated, this was often done in an opportunistic, rather than a planned, way:

“Nothing organised. One-to-one advice to parent and/or child, depending on nature of question or problem. Encouraging parents to quit smoking.” (Community paediatrician, CHD035)

There was considerable variation in the level and content of health promotion activities carried out by social workers. For some social workers, health promotion work was seen as a limited and essentially passive role, such as ensuring that leaflets on health subjects were available at centres where they worked.

Most social workers, however, provided individual tailored information (most commonly on sex or substance abuse, including alcohol) and some reported they were involved in group work – for example:

“Group work to address/promote positive mental health. individual work to promote self-esteem, provide social skills training.” (Social worker, SW0303)

A few social workers reported they were involved in health promotion as part of a team approach in schools, where a wide range of activities and initiatives was happening:

“I work in conjunction with the School Educational and Behavioural Disorders staff within the school who offer a wide range of activities linked to health promotion i.e. breakfast club and the provision of healthy snacks and water. There are many other activities within the school – sex education, drug awareness and small groups are also run by youth workers on specific areas i.e. 'Crying Wolf'.” (Social worker, SW0406)

Residential care staff dealt with all aspects of a child or young person's growing up in a healthy way. This included a great deal of health promotion, often supported by a care planning approach.

As one wrote:

“We try to maintain high standards in care by offering a good balanced diet, staff who talk to and support the young people with their personal hygiene. Provide chances for socialising with their peers etc.” (Residential worker, RW0202)

Another wrote that she dealt with:

“All aspects of general health e.g. sexual, dental, opticians.” (Residential worker, RW0284)

Staff also frequently mentioned that boosting the self-esteem and self-confidence of a young person was an integral part of their work.

Interestingly, despite the fact that much of their work could be seen as falling within the sphere of health promotion, only some voluntary work staff identified it as such. Much of the work described by voluntary workers had a health promotion aspect. For instance, staff providing services for homosexual or transsexual young people routinely offered sexual health counselling. Support was also provided for foster carers, providing counselling services for young homeless people, or providing a supportive service for special needs children and their carers. In addition many workers provided more general counselling to improve self-esteem and a greater sense of self-confidence. For instance, one wrote:

“Support young people, talk to them, help them overcome social attitudes, give them a listening ear, be a positive role model.” (Voluntary worker, VOA368)

Promoting a child or young person's self-esteem and helping them to access mainstream services more easily was a recurrent theme in voluntary workers' descriptions of what they did.

Roles and remits

There were marked inter-professional differences in the way different professional staff groups described their work in health promotion and early intervention. This could be best understood as staff forming informal multi-agency teams; one such team occurred within the school setting, and comprised school nurses, teachers, social workers, educational psychologists and community paediatricians. A second team was found in the health centre or surgery, and comprised health visitors, practice nurses and general practitioners. Within each team there appeared to be a natural division of labour; for instance, school nurses appeared to take the lead in schools on health promotion, while educational psychologists rarely reported that they undertook that kind of work.

Health visitors were the group who most strongly identified health promotion and early intervention – such as parenting work and behaviour interventions, and offering general health advice – as a core component of their work. In addition, as part of their surveillance work with very young children, health visitors were often in a position to offer pro-active advice and support to families regarding other children who might be developing problems.



For instance, one wrote:

“Child seen while visiting other pre-5 child in house. He is approx 15yrs and has been described as having social phobia. Discussed with GP, phoned social work. Advised mum to make GP appointment.” (Health visitor, V0101)

Other forms of indirect early intervention work by health visitors commonly concerned recognising a depressive disorder in a new mother and arranging appropriate psychiatric help, with consequent benefit for the child:

“I witnessed measurable improvement in the condition and saw the mother/child attachment progress as the depressive condition improved.” (Health visitor, HV0054)

School nurses also identified general health promotion and prevention as a core component of their role, as did social workers although for social workers, there was considerable variation in how they viewed their role. For educational psychologists the most common form of health promotion work identified was “promotion of emotional intelligence”, with about a fifth of educational psychologist respondents including this as part of their work. This was notable as this was not a phrase employed by any other professional group and reflects a unique conceptual perspective.

Other professional groups, such as those working in the voluntary sector, social workers, residential care workers and specialist CAMHS staff, tended to work more in isolation. All stated that they provided early intervention and health promotion, but even between these different groups there were marked differences of emphasis. Thus voluntary sector workers were predominantly engaged in health promotion strategies, while specialist CAMHS staff placed more emphasis on early intervention strategies. Where voluntary sector workers stated that they were engaged in early intervention work this was rarely informed by an explicit, recognised and evaluated strategy targeted at specific mental health problems, while the parenting programmes described by CAMHS staff were often strongly evidence based.

In contrast to voluntary sector workers many specialist CAMHS staff appeared to regard health promotion as work for other agencies. For instance, one respondent wrote:

“I wanted to say that there is an urgent need for effective anti-bullying policy. Too much variation within schools as to the quality of response to this problem.” (Consultant child and adolescent psychiatrist, BBMD01)

In other words, this respondent thought it was the responsibility of schools to develop an effective anti-bullying strategy, and did not see it as a joint task between CAMHS staff and education.

There were also marked intra-CAMHS staff differences, with consultant psychiatrists, despite often having advanced psychotherapy or family therapy training, describing their work as predominantly based around assessments and prescribing medication, and often noting frustration at not being able to do more direct intervention work with children and families.

Nursing staff, on the other hand, were normally the group undertaking parenting programmes and individual self-esteem programmes, while psychologists undertook most cognitive-behaviour therapy and solution-focussed work.

Paediatricians, both hospital and community-based, appeared to be mainly concerned with the detection, diagnosis and treatment of medical conditions. Many, however, were involved in the early detection of autistic spectrum disorders and ADHD, but thereafter saw their task as referring the child and family on to more specialist services, such as to clinical psychology services for a child who had been sexually abused. For example, one wrote that her work with one young person included:

“Difficulty behaving in school and truanting – diagnosis Asperger's and ADHD. Spoke to school staff about management and arranged multi agency meeting. Directed mum to local support groups.” (School/hospital paediatrician CDD017)

Even when paediatricians wrote about situations where there was a clear opportunity for health promotion work, this was not specifically mentioned. For instance, one wrote about a particular case in response to a question about the nature of work with young people:

“Absconding from children's home, prostitution, possible substance misuse, previous child sexual abuse.”

In response to the question “What did you do?” she replied:

“Undertook medical assessments as requested – treated STDs etc worked with legal agencies, social work etc. to try and obtain secure placement with therapy.” (Consultant community paediatrician, CHD026)

It is, of course, possible that some health promotion work, such as sexual counselling, was actually undertaken by the paediatrician on this occasion, but the paediatricians, as a group, were remarkable for making virtually no references to such potential work activity.

Many paediatricians appeared to regard much of the health promotion and early intervention work as the province of other agencies. For instance, one wrote:

“Early intervention service from clinical psychologists working from Child Development Centres in this area is excellent.” (Consultant community paediatrician, CHD037)

Lack of time and resources were identified by paediatricians as important factors precluding more preventive work.

Answers given by foster carers differed qualitatively from those of other workers, with the exception of residential care staff, in that they were not just “working with” a child, but were very active and passionate advocates for the child. In addition they do not “clock off” and are always working with the child. The approach of foster carers is thus “holistic” in that they work on all aspects of a child's development, not just a specific clinical problem.



For instance, one described the role as:

“Trying to build trust but giving clear boundaries. As much praise as possible. Encouragement to talk about his feeling without pushing.” (Foster carer, FP018)

Shortcomings and barriers

Every professional group identified major shortcomings in current service provision.

The need for more health promotion work was frequently noted by CAMHS staff when describing gaps in services. For instance, one respondent wrote that what was missing were:

“Non-stigmatising holistic user-friendly resources for young people's provision of mental health support and life-style issues.” (Consultant adolescent psychiatrist, BBMD05)

Most specialist CAMHS respondents also noted the need for more preventive work and early intervention strategies. This issue was also frequently raised by educational psychologists; for instance, one noted:

“The lack of pro-active rather than reactive work.” (Educational psychologist EP0502)

Although they had less opportunity to be involved themselves in preventive work, panel members also expressed frustration in the face of problems escalating due to the delay in getting services for children:

“Many of the cases we hear through the hearing system are very worrying and primarily involve children whose needs have not been met and who subsequently present with very challenging behaviour [and] emotional difficulties for all concerned. Early effective intervention still does not happen - the agencies involved are frequently overwhelmed.” (Panel member, PAN019)


Most of the panel members complained about what they regarded as a lack of resources, often resulting in very lengthy waiting times before a child could be seen for a specialist assessment. In addition, they noted that different professional services often did not co-ordinate their activities. Thus a typical response was:

“Panel members are particularly aware of the lack of child psychiatric services locally ... waiting lists are slow and time available for ongoing treatment necessarily limited. This is a serious gap in our provision for young people.” (Panel member, PAN021)

A lack of adequate resources across all agencies was identified by virtually all panel members as the major barrier to more effective early intervention. These problems were particularly acute for more rural services, where a shortage of specialist resources was often compounded by very long travelling distances.

All panel members pleaded for:

“A service available to children and young people when a problem is first identified – not years later when it is perhaps too late to make any meaningful progress.” (Panel member, PAN002)



Many teachers and some paediatricians also drew attention to shortcomings in relation to provision of early intervention. Teachers recognised the severe constraints placed on other services that made a quicker response difficult:

“Time is a major factor, it can take months, even years, to get a child seen by educational psychologist as we always have to prioritise. If parents are reluctant they miss appointments and child is discharged.” (Primary school head teacher, ED0204)

In contrast to the teachers (who generally described health promotion and prevention as underpinning all the activities covered by their schools), many of the educational psychologists were deeply frustrated with current health promotion and early intervention strategies and recognised the need to embed such strategies within the curriculum, rather than dealing with these issues as they arose on a one-to-one basis. One considered that what was needed was:

[A] “population based strategy required in mainstream schools to promote personal resilience...we need to raise the profile of promoting mental health in schools. This should be for all young people not just high risk groups.” (Educational psychologist, EP0601)

School nurses, however, stood out as not making a strong case for more health promotion and early intervention work, and only rarely mentioned a shortage of specialist service provision, perhaps in part because they regarded themselves as the primary agency providing health promotion and early intervention work, rather than needing to refer children on to others.

Social workers, like most professional groups, reported that a major barrier to better health promotion and early intervention was the lack of current specialist resources. For instance, one respondent wrote of not having enough resources to provide a basic service:

“Social worker has too many cases and her time is diverted into dealing with the current crisis. My time is similarly affected.” (Senior social worker, SW1402)

A number of social workers also highlighted the need for more preventive work, but indicated that this would be difficult to achieve with current staffing levels. Many social workers said they would have liked a quicker response from specialist services before placements broke down. Better inter-agency co-ordination was seen as likely to result in better and more preventative services for children and young people with mental health problems:

“I would merely wish to re-affirm a need for more mental health services and a need for these services to adopt a more pro-active approach than the traditional in order that young people can get the help they need.” (Social worker, SW0303)



Foster carers echoed this general sentiment and frequently stated that there had been a notable lack of early intervention by professional services. A typical response was given by a young girl's carer:

"If she had been younger and others had helped her earlier she would have had a better chance." (Foster carer, FP017)

Residential care workers also recognised the need for better early intervention and the danger of problems escalating and, like other service providers, they consistently identified the shortage of appropriate specialist services as one of the main reasons that made early intervention more difficult:

"Prevention and early intervention can make all the difference, there is nothing worse than watching a young person suffering and be unable to help due to lack of provision." (Residential worker, RW0153)

In addition, residential workers frequently mentioned the perceived stigma of specialist mental health services as a barrier to getting help sooner.

Residential care staff frequently noted that they were unable to provide as much help as they would have liked. However, their concerns were somewhat different from those of other professional groups, and reflected constraints which prevented their optimum involvement. For instance, one worker wrote:

"By the time young people come to my workplace they are too emotionally detached and unmotivated. It is near impossible to build professional relationship i.e. trust to do work needed." (Residential worker RW0074)

This could leave staff feeling exhausted and emotionally drained. Staff also recognised that young people had often been inappropriately placed with them, making it even more difficult to work with them. As indicated above, in some cases staff felt a child might be so damaged that it might not be possible to do any kind of work. Thus one worker wrote, concerning a particularly difficult child:

"I believe the child is too damaged for meaningful work to be done at this stage." (Residential worker, RW0074)

Residential workers also frequently mentioned lack of enough time to work with a child. For instance, one worker, when asked what else he would have liked to have done in a particular case, wrote about the frustration felt on having contact with the child in question come to an abrupt end. Other residential staff noted that they would have liked more training to equip them to deal with emotional and behavioural issues before they got out of hand.

For instance, one wrote:

“Mental health issues are now at forefront of all young people being looked after. More knowledge with help and support would be beneficial.” (Residential worker, RW284)

Conclusion

A great deal of health promotion and early intervention work was being undertaken and all groups of workers (with the exception of the police and Children's Panel Chairs) regarded this as an important part of their work with children and families.

In addition, all groups said that a shortage of resources was a major barrier to better service provision, including better early intervention, and many workers expressed great concern at having to watch a child's emotional state becoming worse as a result of shortage of specialist help. “Too little too late” was a common refrain. All workers reported that more early intervention work, as well as easier access to specialist services, was required.

On the health promotion front, schools provided a clear locus of work, with school nurses, social workers, educational psychologists and teachers co-ordinating health promotion activities. This had resulted in a great deal of intensive, wide ranging and population-based health promotion work delivered in schools. Similarly, general practitioners and health visitors had formed another sort of team, with health visitors taking on the bulk of early intervention and health promotion work. Much of the health promotion activity described by primary care services seems to be in the form of health education – the giving of advice and provision of leaflets and posters. Foster carers, on the other hand, came across as more isolated, often struggling to co-ordinate the input of other services for their children. Social workers and voluntary sector workers, too, appeared more isolated, with little sense of an easy integration with other agencies on health promotion and early intervention.

Those agencies providing specialist therapeutic input to children with emotional or behavioural problems, such as CAMHS staff and paediatricians, offered occasional health promotion services, but nearly always only to those children that attended their clinic as clients, and rarely on a group or population basis. These specialist workers, however, provided a great deal of early intervention work.

The relative neglect of health promotion work by specialist services contrasted with the reports provided by health visitors, school nurses, teachers, and to a certain extent social workers, who saw health promotion as a core part of their work. There appeared to be some division of labour between agencies, with health visitors and school nurses in particular being regarded as the professions that “did health promotion”, and there was the suspicion that specialist services did not regard health promotion as a core part of their task. One explanation may be that health promotion work was seen as “low status” work, defining the professional identities of “associate staff”, while “professionals” did more direct clinical work with children and their families.



Another explanation of the pattern of health promotion work by agency might be that it was a result of the targeted activities by health promotion departments in local Health Boards. *The SNAP Report on Child and Adolescent Mental Health (2003)* noted that all Health Boards stated that health promotion units in their area worked with formal education, notably in the formation of health promoting schools. In addition most health promotion staff had input into residential care, but in only three out of the 15 Health Boards was a health promotion worker involved in the development of a local CAMHS strategy. It was therefore no surprise that the same report noted that a very high percentage of teachers and school nurses were involved in health promotion work with young people, but that over half of specialist CAMHS staff reported that they spent little or no time on mental health promotion work (SNAP 2003, p48). A similar pattern has been found in this study, with a wide range of health promotion work being undertaken by schools and health visitors, but very little by specialist CAMHS. These latter services, however, were engaged in a great deal of early intervention work, notably parent training. Despite the difference in focus between agencies, however, all stated that there was a great need for much more early intervention and prevention work to be undertaken.

Finally, on an encouraging note, several respondents described local innovative approaches to health promotion, prevention and early intervention: their experiences are described in more detail in chapter 9.

CHAPTER 6 FRUSTRATIONS



INTRODUCTION

Professionals' expressions of frustration in their direct work with young people and in making suitable arrangements on their behalf emerged as important themes in the analysis of the questionnaire data. This chapter provides an account of the frustrations voiced by the different professional groups and therefore provides a picture of a range of barriers to obtaining good outcomes for children and young people presenting with behavioural and emotional difficulties and more serious mental health problems. Frustrations which impede professionals' effective management of young people's care are discussed under four sub-headings which represent the main codes used to organise the data. These are, in order of frequency of responses coded for all professional groups, "the system", problems in collaboration, limited possibility of making a difference and problems of rurality. The chapter ends with a discussion of professionals' experiences of frustrations which have their source in dissatisfaction with their own interventions.

THE SYSTEM

The most frequently expressed source of frustration was "the system", by which respondents appear to mean the institutional channels which provide the organisational frameworks governing service delivery and collaboration between professional groups. Professionals typically expressed frustrations with a system which they experience as responding too slowly and inflexibly. Thus children are caught up in a system which does not adequately meet their needs, a situation described by a school doctor who wrote about a child "...being 'failed' by system – I fear [he] will end up in judicial system post 16 yrs" (School doctor, CHD013). Similar sentiments were expressed, with more apparent exasperation, by a social worker who described an intrusive bureaucracy which interfered with effective intervention.



“The system – there are so many political obstacles and sometimes unnecessary 'hoops' a worker has to overcome in order to receive a holistic assessment for the child. The problem increases due to the time it takes for identified work to begin.” (Social worker, SW0704)

The main systemic sources of frustration expressed by professionals in their responses relate to delays in accessing assessment or suitable provision, funding difficulties, gaps in services, difficulties in working within their own organisations and the impact of policies. The system causes frustration where difficulties are experienced in interfacing with the bureaucracies which manage services, but also important is a feeling of dissatisfaction through not being able to provide a service which matches professionals' own expectations. The latter aspect is examined later in this chapter.

Delays following referrals to other services or in accessing advice are major concerns for professionals. Generally the delays are perceived as being caused by long waiting lists, in particular for specialist health services, as a result of pressure on resources or high demands on staff time, described simply by one respondent as a “rise in referral rate with no parallel rise in staffing” (Consultant Child & Adolescent Psychiatrist DMMD13). Sometimes respondents referred to organisational difficulties within their own service or with another agency as being responsible for delays:

“Crisis management instead of prevention due to lack of response by another agency – child was placed in an inordinate amount of placements over the next few months” (Primary school head teacher, ED0806).

CAMHS professionals frequently represented the delays experienced rather bluntly in terms of waiting times and long waiting lists. These factors impede provision of a good service and damage morale: “time wasted trying to make scant staff complement stretch to do the impossible” (Registrar, Child & Family Psychiatry, BVMD25). General practitioners and teachers are also groups which articulate strong concerns about delays, perhaps unsurprisingly since they are in the front line in assessing problems and seeking referrals. What are perceived as poor response times are particularly problematic in families whose circumstances are changing or are unstable. This effect was summed up in an illustration provided by a GP who in reflecting on what would have been a better outcome for a patient said that quicker access to psychiatric services would have been preferred. The result was that the patient “moved from the practice area to live with father and failed to attend appointment” (General practitioner, GP0006). General practitioners also complain about difficulties in accessing particular specialist services: “no easy access to counselling, YPU Consultant/team, CPN” (General practitioner, GPO226); and help appropriate to the needs of individual patients.

What would you like to have done? “Had her seen rapidly at home by a skilled nurse counsellor – at home because her life is chaotic and she finds it difficult to attend facilities especially if remote...” (General practitioner, GPO238)

What would you like to have done? “Faster assessment from in-house child psychiatry co-ordinator which was previously available with fund-holding.” (General practitioner, GPO268)

Teachers describe very similar difficulties in gaining access to suitable support services.

What barriers? "So much time passed – a year before anything was done for this vulnerable girl." (Secondary school principal teacher of guidance) (ED0902)

What barriers? "After 14 months this pupil still soils himself and has yet to be seen by any support agency ... not seen as a priority." (Secondary school principal teacher of guidance ED1018)

For teachers, problems with the system are not always unambiguously related to dealings with another agency. The sources of these problems can be multiple and complex, such as a combination of perceptions of lack of clarity about the process of referral, lack of training and need for clearer guidelines.

What barriers? "Time it took to call a meeting of all concerned. Lack of specialist advice to name the problem quickly. Lack of clear guidelines about additional support needs in education and how to support effectively." (Primary school senior teacher ED1102)

What would you like to have done? "Got all of the outside agencies on board immediately – training for my staff – someone available to discuss and help me through the major issues." (Primary school head teacher ED0802)

The perception of insufficient funding to provide adequate staffing, administrative support, technical and other resources, suitable accommodation and training is another frequently mentioned systemic problem. Professionals' concerns in this respect were often expressed briefly and with feeling: "understaffed!!!!!" (Specialist registrar – child & adolescent psychiatry BVMD05); "time restraints and funding" (Voluntary sector worker VOA124); "finance to pay for extra personnel" (Primary school head teacher ED1218h). Lack of funds was seen not only as a barrier to accessing services, but apparently could affect provision which had already begun: "assessment not completed due to lack of funds – would have liked to have liaised with psychologist following assessment" (Voluntary sector worker, VOARWO161).

Another feature was the view that a service or resource which would help could not be accessed as a result of lack of funding.

"funding for residential respite" (Autism unit senior teacher, ED1102); "lack of resources and barriers to referral, e.g. [centre named] only took a limited number of referrals then "closed their books" on an annual basis" (General practitioner, GPO161); "I wonder if school put off parents requesting educational psychology due to lack of resources and volume of referrals and volume of referrals they have for Psychology" (Health visitor, HV0068).

Suggestions that financial restrictions were not solely responsible for referral difficulties were also present in some responses:

What would you like to have done? "Found assistance years ago to prevent the problem escalating at vast cost to all." (Children's panel chair, PAN016)



What barriers? "Cost is frequently quoted but attitudes to thorough assessment are probably the underlying cause." (Hospital paediatrician, CHD043)

Frustrations caused by experiencing gaps in services were commonly related to the apparent lack of specialised support for a child with a particular diagnosis, e.g. lack of play therapy; or no dedicated service for ADHD or learning difficulties. Four sub-codes were used to summarise the perceived gaps in services: the acceptability of services, including perceptions of prejudice on the part of service providers; differential access to services; referral restrictions and the non-availability of appropriate services. These different aspects of gaps are illustrated in Table 6.1.

Gap in service	Illustration
Acceptability	"Sometimes I feel child psychiatry is disinterested or does not take problems on board actively enough." (General practitioner, GP0031)
Differential access	"I would have welcomed more community supports such as CPN but this not available because the boy was 15/16 and dealt with by adolescent psychiatry. Also no voluntary agency willing to get involved re befriending support." (Social worker, SW1305)
Referral restrictions	"Young person was pregnant recently having moved back to the community from a secure setting. Concern re level of violence exhibited precluded access to many resources." (Social worker, SW0301A)
Non-availability	"Could not locate a suitable class." (Secondary school principal teacher of guidance, ED1401).

Table 6.1. Illustrative examples of gaps in service

Administrative boundaries provide a considerable source of frustration for professionals when clients do not exactly fit entitlement criteria, either for geographical reasons or because of the defined role and remit of the agency or practitioner.

What would you like to have done? "Access to help for this child has been difficult as she comes from another authority. Due to a cross-authority agreement child must be seen by their Ed[ucational] Psych[ologist].

Very slow response. Just getting response now after three months of phoning etc. Would like to have given this child more specialist support much sooner." (Head Teacher, primary school, ED1501B).

What barriers? "Nurses unable to get suitable restraint training therefore claimed vulnerability and liability and withdrew service concerned for their safety. In effect outreach ceased because they withdrew co-working. This seemed to be acceptable to the department." (Residential care worker, RW0042)

Expressions of frustration as a result of features of their employing organisations were particularly evident in the responses of CAMHS professionals. The problems identified ranged from complaints about incompetent managers, poor leadership, office politics and lack of administrative support to problems which seem more particular to young people's services or mental health issues.

"One cannot help feeling that the mental health of children and young people [does] not impact on health planners in a way that can inform them in providing resources where they can make a difference now and in the future." (Nurse specialist, Family therapy, BVMD08)

"Having to defend Clinical Psychology from predatory psychiatrists." (Consultant Clinical Psychologist DHMD07)

"Rejection of the notion of employing a psychotherapist or more occupational therapists or music/art/drama therapists – very conservative approach here." (Senior occupational therapist, BVMD04)

A related source of frustration is the feeling of powerlessness which results from the belief that one's direct knowledge of the young person may carry less weight than the opinions of other, typically more specialised, professionals. Asked why things had not worked out in a particular case, a foster carer wrote:

"In certain cases social workers think they know the children's needs better than carers – but they only see and talk to them one hour per month. Carers have the children 24 7 and know their needs." (Foster carer, FP005)

A teacher reflecting on a case said direct referral to a psychiatrist would have been the preferred approach, but: "education managers do not allow schools autonomy to access variety of support. Power seems to lie with educational psychologists" (Principal teacher – behaviour support ED0514). This form of frustration is also recognised by professionals who mainly receive referrals from others:

"Ideally the health visitor should have had access to clinical psychology, not had to wait for me." (Consultant community paediatrician CHD014)

Perceptions of the impact (or lack of impact) of government or agency policies were also apparent in the comments of respondents. For some professionals the problems lie in lack of apparent clarity about the service; for others there is policy overload from too many government initiatives, and from others there is antipathy to a policy seen not to be working: "policy is inclusion in mainstream until it's too late" (Foster carer, FP024).



Problems with collaboration

Professionals recognise the importance of effective inter-disciplinary working, and the desire for better collaboration featured prominently in responses to the question

“What would you like to have done?”:

“More integrated care with social work, school, health visitors.” (General Practitioner, GP0097)

“Earlier involvement/liaison with psychology and primary care.” (Hospital paediatrician, CHDVOA303)

However, difficulties associated with working with other professionals and agencies are also major causes of frustration:

“We work on a daily basis with very challenging behaviour and are at times frustrated that we are not contacted when agencies are making decisions re diagnosis. We work with the children on a daily basis and have valuable information to share.” (Special school assistant head teacher, ED0022).

The nature of frustrations associated with inter-disciplinary and inter-agency collaboration is discussed more fully in the following chapter.

Limited possibility of making a difference

Another important cause of frustration for professionals in working with children and young people is the realisation that there might be a limited possibility of making a difference.

“To be honest I feel for the boy but we go through this procedure every time he comes back from weekend leave so the problem is not here.” (Residential care worker, RWO246)

Analysis of the data highlighted six underlying reasons or circumstances in which professionals are frustrated about being unable to improve a child or young person's circumstances. By far the most significant frustration is, unsurprisingly, lack of time available to the professional: “...accumulation of children with ADHD – huge demands on time from excessive caseload” (Consultant Child & Adolescent Psychiatrist BBMD01).

The next most important reason, in order of the number of responses coded against the categories, which is a fair proxy for their relative importance, is a problem which appeared intractable: “Over the years he has had access to an enormous amount of support all of which has been of limited value. He seems to have had an intractable personality/behaviour problem since about age 4” (General practitioner, GPO032).

The other reasons for frustration emerging from the data were: the client had moved on; a referral may not have been taken up; inappropriate parental expectations; and difficulties in engagement.

Problems of rurality

The responses to the questionnaire showed that living in a rural setting is regarded as a significant barrier to being able to access suitable services. Mostly respondents related the difficulties to the effects of geography: the double bind of the lack of specialist services available locally and poor public transport for patients and their families to access provision in a nearby town or, for residents of island communities, a city which cannot be easily reached within a single day. Related difficulties include shortages of staff with particular qualifications or skills, and problems associated with provision, such as having too few people to sustain a specialist service.

Another, less visible, aspect of rural living is the difficulty of maintaining privacy – a particular manifestation of the general lack of understanding or fear associated with mental health issues. In a community where everyone knows everyone else, it might not be possible to get advice or professional services without meeting someone known to your family. Fear of the consequences of disclosure could, as one teacher respondent suggested, lead to serious issues being concealed.

General problems in accessing CAMH services

Quantitative data on the problems non-CAMHS professionals identified in accessing services are provided in Table 6.2. Waiting lists clearly represented the most common difficulty, cited by all the professional groups.

Which of these factors make getting access to a service difficult for a young person?		General Practitioners	Health visitors	Residential workers	Social workers	School management	School teachers	School nurses	Other	p-value
Geography	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	40	32	32	49	24	50	39	57	
	% Yes	29.2	44.4	30.8	46.7	15.1	24.3	38.6	36.8	
Waiting lists	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	124	58	58	93	122	159	80	104	
	% Yes	90.5	80.6	55.8	88.6	76.7	77.2	79.2	67.1	
Stigma	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	31	21	35	40	22	28	39	47	
	% Yes	22.6	29.2	33.7	38.1	13.8	13.6	38.6	30.3	
Communication with services	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	42	20	32	32	64	80	33	44	
	% Yes	30.7	27.8	30.8	30.5	40.3	38.8	32.7	28.4	
Lack of information about services	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	51	26	50	42	56	67	47	61	
	% Yes	37.2	36.1	48.1	40.0	35.2	32.5	46.5	39.4	
Reluctance among young people	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	51	16	55	56	21	37	46	70	
	% Yes	37.2	22.2	52.9	53.3	13.2	18.0	45.5	45.2	
Service style	N: total	137	72	104	105	159	206	101	155	<0.0001
	N: Yes	15	11	27	33	23	23	26	39	
	% Yes	10.9	15.3	26.0	31.4	14.5	11.2	25.7	25.2	
Service criteria	N: total	137	72	104	105	159	206	101	155	<0.0049
	N: Yes	32	27	44	45	64	91	31	59	
	% Yes	23.4	37.5	42.3	42.9	40.3	44.2	30.7	38.1	

Table 6.2 Service access difficulties for young people

Frustrations in direct work with young people

Perhaps unsurprisingly, professionals who work with young people in adversity can experience dissatisfaction with their own actions, and the consequential feelings of frustration were also represented in the responses to the questionnaire. Feelings of inadequacy were most movingly expressed by the school nurse who in response to the invitation to describe the case which gave most satisfaction said: **"I have never felt satisfied – I feel unable to do anything directly with the child or adolescent"** (School nurse, SCN137).

In another case, a voluntary worker recalled being: **"...out of my depth and needed support myself"** (Voluntary sector homeless support worker, VOA150).

Lack of access to other professionals who have the necessary skills or are better qualified to assess and respond to situations causes uncertainty and frustration: **"I would have preferred to tackle the problem in-house with the help of experts and in-house training"** (Residential care worker, RWO131).

One emerging theme which may help to illuminate frustrations experienced in working with young people is uncertainty in respect of the professional role. For example, a teacher describing a case of a pupil with ADHD reported: **"...confusion initially re who was responsible for monitoring medication"** (Special school assistant head teacher, ED0016). Lack of clarity about role boundaries, routes of referral and sources of advice and support for the professional are particular matters of concern. A related theme which emerged from the data was uncertainty about appropriate services. A foster carer: **"...did all I felt I could do due to lack of better information"** (Foster carer, FP010). Lack of information about and knowledge of available services was a commonly reported source of frustration.

At the extreme end of the spectrum of professionals' experiences of frustration is the feeling of being completely overwhelmed by either the volume of work or the complexity of cases, an unpleasant experience rather graphically described by the GP who responded thus to the question about the most satisfying case: **"Can't remember my own name by the end of the week far less the most satisfying case"** (General practitioner, GPO087).

"There have been many situations where I have felt unable to cope with extreme behaviours, cases where young people have attempted suicide or attacked others or ransacked the unit. In all these cases emotional and behavioural difficulties are to the forefront of young people's actions." (Residential care worker, RWO251)



Conclusion

This chapter has sought to present a picture of the real frustrations experienced by professionals who work with children and young people with mental health problems. The consequences of professionals feeling uncertain about their role and competence, frustrated and undervalued are serious impediments to their capacity to provide satisfactory support services for children and young people and their families. The problems are complex and the solutions are not easily discerned. However, the picture was not entirely negative and some more positive messages emerging from the data are discussed in later chapters of this report.

CHAPTER 7 WORKING WITH OTHER PROFESSIONALS



INTRODUCTION

This section reports on perceptions of working with other agencies and other professionals, and covers both good and bad experiences. Also included are views about intra-agency team working, and professionals' reflections on how their own agencies are likely to be perceived and experienced by others. In common with other sections of this report, these findings relate to the responses to open-ended questions and do not, therefore, reflect the views of the whole sample.

We have identified patterning in the data in relation to the various professional groups, their roles and remits, the conditions in which they work, and the nature of their responsibilities. We sought to identify constellations of issues raised by particular groups or subgroups. This involved looking at the relationships between codes, and led us to identify overlaps and some discrepancies/contradictions.

Communication and liaison with other agencies

*"Communication between agencies seems to be at heart of problems as well as answers."
(Nursery teacher, ED0205)*

This quote highlights why communication was the most frequently occurring code related to problems that respondents experienced. This was not, however, something uniformly experienced by all professionals as problematic. The three groups citing this concern most often were the teachers, community/school-based paediatricians and social workers. Whilst there were larger numbers of these three groups represented in the sample, the number of their responses identified this as one of the most important issues for each as a group.



Their difficulties related to interactions with a wide variety of other services and their comments demonstrated the impact of this failure on the service provided to families and children:

“Lack of communication, different work styles/priorities, lack of understanding between teams causes problems with communication with family.” (Community paediatrician, CHD041)

For many of these professionals the frustration resulted from receiving no feedback from others working with the child. This was exacerbated in those situations where the professional was in frequent, often stressful, contact with a young person and perceived others as withholding vital information for procedural reasons or because of professional boundaries.

“Red tape which stops outside agencies being able to reveal what they know about a child and lack of co-ordination of the different services.” (Primary school head teacher, ED1608)

Interestingly, the positive power of good communication was also frequently commented upon and this was particularly important for teachers, residential workers and social workers. Many of these comments, however, serve to highlight that good communication comes as a pleasant surprise rather than being the normal expectation of professionals working together.

“In most respects the addition of a small child tended to focus people into communication. It demonstrated that this could be done and should be done as a norm not the exception.” (Social worker, SW1202)

A theme that runs throughout the responses from those most involved with young people on a close and regular basis is that “no one listens”. The importance of being listened to is crucial for parents and carers who must continue to stay engaged with children whatever their difficulties.

“At last we found people who would listen and gave this boy and his mother the help they needed. His mother described a similar struggle for help going on for years before he was accommodated.” (Residential worker, RW0074)

A related code concerned with poor liaison with specific agencies was also appealed to by CAMHS professionals and social workers, who tended to cite each other as being poor at liaising. The difficulties social workers experienced in relation to CAMHS are graphically illustrated by the following quote from a social worker who tried desperately to access an assessment of a young person engaged in life-threatening, self-harming behaviour.

“Refusal to communicate verbally in writing or to attend a meeting arranged to suit children and families adolescent psychiatric service. Resistance to attempt to acknowledge a problem far less resolve it i.e. accessing a service. Refusing to respond to communications.” (Social worker, SW1704B)

The views of CAMHS professionals about social work liaison are generally more measured; talking, for example, about “the lack of a coherent conversation” (Consultant child and adolescent psychiatrist DHMD20) with the social work department and recognising that structural issues contribute to the difficulties of liaison.

CAMHS respondents also commented on poor liaison with education services. The other group who complained of poor liaison were teachers, although they did not single out particular agencies, instead reporting problems across the board. Some teachers felt that they were not included in discussions and decisions:

“I feel outside agencies need to listen more to people who work on a daily basis with these children.” (Nursery school head teacher, ED1311)

School doctors, school nurses and health visitors were critical of the difficulties they encountered in trying to liaise with their CAMHS colleagues. In many cases they were unable to begin a dialogue with CAMHS staff but, once a child was receiving help, they were also unable to gain information about the work being undertaken:

“Mental health team were not keen/didn't communicate ... with professionals already involved with child.” (Consultant community paediatrician, CHD019)

This may suggest there is a hierarchy of influence within the NHS which warrants further exploration.

Referrals to other agencies

The process of seeking help for a young person through referral to another service was one of the commonest ways in which professionals responded to the distress of young people or those who had to deal with their difficult behaviour. When referral worked it is clear that respondents believed this was associated with good outcomes for all involved. This teacher, commenting on referral to a voluntary agency of a young woman who self-harmed, highlights many of the factors that lead to satisfaction:

“Contact with ... was easy, quick referral, open communication - dealt with issue and continual support offered for me [and] pupil.” (Secondary school head teacher, ED1803)

Speed of response was highlighted as particularly important by health professionals and teachers. The same groups were frustrated when referrals were very delayed: This GP, for example, contrasts the relative speed with which physical tests were completed on a 10 year old child displaying dangerous “bizarre behaviour” and weight loss, compared with an assessment from the educational psychology service.

“Consultant paediatrician seen after three months. Educational psychology took 18 months. The educational support service was woefully inadequate and the child at major risk from leaving the school and being out on the roads etc.” (General practitioner, GP0131)



These professionals remain acutely aware of the potentially catastrophic outcomes of a delay in response and know that they will have to deal with these:

“Referred to ... project but overdosed and died before seen.” (General practitioner, GP0005)

Referrals could also highlight the differing perspectives and priorities of professionals:

“Autism in an adolescent. The child psychiatrist disagreed with teacher, me, and psychologist. Our CAMO refused to allow us to refer to the NAS [National Autistic Society].” (General practitioner, GP02550)

This could leave professionals angry when they observed the adverse outcomes for young people:

“Psychiatrist said child didn't need individual help. Child now in secondary, constantly suspended. Parents have washed hands of child.” (Primary school head teacher, ED1923)

In most cases, problems in referral were commented on by professionals attempting to refer children to CAMH professionals. CAMHS professionals, in turn, highlighted the difficulties that they experienced in trying to get other agencies to understand what constituted an appropriate referral:

“Referrers and other services are not yet familiar with our 'target groups', clinical priorities and referral criteria despite circulation of operational policy and meetings!” (Clinical psychologist, BBCP01)

Although this clearly illustrates a tension point between particular groups of professionals, the focus on CAMHS professionals as “the problem” in this instance may be a construct of the language used. Later in this chapter similar difficulties will emerge between different professional groups describing tension or disagreement but not using the language of referrals.

When referrals were accepted and the referring professional listened to, the outcomes were perceived as good and the level of satisfaction was high, as this quote from a teacher about another primary aged child illustrates:

“Help was received, special residential school placement was organised – educ[atational] psy[chology] soc[ial] work and other agencies all worked with child (and family). Child at P4 was unable to remain in mainstream. Now secondary age. Is at a mainstream school.” (Primary school head teacher, ED1109)

Co-ordination and joint planning

Difficulties in co-ordination and joint planning were issues highlighted by representatives of each of the professions included in the survey. Some of the frustrations expressed related to boundaries between services, both geographical and in terms of client groups served. The most frequent complaint related to the division between child and adult services, which caused problems – particularly for those professionals with responsibilities for both adults

and children and those with a long-term involvement with regard to individuals, such as teachers and GPs:

“[He fell] between two stools – too old for child mental health – but knew him before [so] new referral to adult = not seamless.” (General practitioner, GP0266)

“Referred to child and adolescent. But because 16th birthday occurred while waiting assessment was told to re-refer to adult psych...” (General practitioner, GP030)

Some respondents referred to their frustration with other types of gaps in services:

“Neither took case on – too severe for [voluntary agency][and] not appropriate to psychiatry!!!” (General practitioner, GP0161)

Although several of the teachers cited attendance at Joint Assessment Team Meetings as a source of advice, others pointed out that there were limits to what such joint meetings could offer:

“A major route is discussion of problems at our joint assessment team. However, this can cope with only the most dramatic of the mental health issues, and often is dealing with cases which are quite far down the line, rather than early interventions.” (Secondary school guidance teacher, ED1915)

Again this highlights the somewhat different remits of the agencies/professionals, with some providing a crisis or acute service, whilst others had more of a preventive role. GPs shared this frustration:

“[It's] often difficult finding someone in acute situation(s). Sometimes I feel child psychiatry is disinterested or doesn't take problems on board actively enough.” (General practitioner, GP0038)

The importance and effectiveness of having appropriate planning processes in place is illustrated by this teacher describing the work with a child with Asperger's Syndrome.

“Lots of planning and discussion in a multi-disciplinary forum then joint implementation.”

This was seen as satisfactory because:

“All the agencies and the parents worked co-operatively in prevention of problems rather than fire fighting later.” (Secondary school behaviour support teacher, ED0522)

Inter-agency work

It was clear that most professionals believed that the young people they worked with required the co-ordinated services of more than one group of professionals. When this worked the outcomes tended to be good and those involved felt positive and satisfied.



“We used a very structured way of working, all agencies concerned knew their role. Good communication.” (Social worker, SW1704D)

The most common code in the section on cooperating with others was team work. Although some of this related to intra-agency work it is also clear that for many practitioners the experience of being part of an effective team that worked across professional boundaries was rewarding. Social care and educational professionals particularly emphasised the importance of team work but paediatricians, CAMHS professionals and voluntary workers all rated this as highly satisfactory and likely to promote positive outcomes for young people and their families.

“Young boy – soiling in class ...[abuse in family]... case discussion – multi-disciplinary health/education/housing/social work, referred to paediatrician and health visitor and family support – re behavioural charts/counselling and community services – re clubs, organisations etc and guidance/consultation with CAMHS ... all agencies pulling in the same direction, showing tenacity and perseverance. Positive outcomes for child and parent.” (Social worker, SW1004)

For many respondents, however, this type of system was not in place. Lack of a framework for joint working was most important for teachers and social workers. Social workers talked about integrated working and working alongside others, but considered that they were not currently working as a multi-disciplinary team, identifying the interface with health – most commonly with psychiatry – as being problematic. Teachers highlighted the lack of support they received and their perception that they are often left to work in isolation, with other agencies assuming that “schools themselves can offer solutions to deep-seated problems” (Secondary school class teacher, ED2014). Their accounts reflect what they see as missed opportunities for combined interventions at an earlier stage in the development of children's problems. Some comments suggested that teachers may feel that their expertise is not valued:

“Other professionals don't have the time/resources to bring to child, time passes, little done, and other professionals don't want 'amateurs' to deal with case.” (Primary school class teacher, ED2007)

There were, however, indications that recently systems have begun to be developed that can address some of these issues in ways that recognise the different roles and skills of professionals.

“Few situations ever resolve themselves fully, but over the last few years the extended team that I can contact has been developed so that as happens in most cases when we need to go to the next level then the stepping stones are there. Being in the position where I manage every case with the school and also have [contact] with all the agencies outwith.” (Primary school head teacher, ED1604)

Many respondents, however, were realistic about difficulties involved in putting joint working into practice, recognising that this is an ambitious goal. In addition to the problems discussed above, practical barriers were also described. Many of these comments show an understanding of the constraints – such as resources, staffing, short-term funding, procedural requirements – under which other agencies work. Several respondents recognised, as did this social worker, that all professionals were, to some extent, at the mercy of the system:

[The barriers are] “usually time scales, emergencies, roles, responsibilities, inter-agency barriers, referral problems.” (Social worker, SW2101)

There were, however, many examples of apparently unnecessary barriers to joint working raised by certain agencies. Most commonly cited were excessively demanding referral processes:

“Referral to local attendance council can take more than 10 weeks due to the number of warning letters that must be sent, and after a SAT meeting has taken place the process of reversing non-attendance takes too long. It is a paper exercise.” (Secondary school class teacher, ED1018)

“...adolescent who had tried to self refer but had been unable to return questionnaire” (Community paediatrician, CHD049)

Other codes which gave some indication of the extent of more informal joint working were “seeking advice” and “consultancy/support for me/us”. Teachers were the group who sought advice from the widest range of agencies/professionals, spanning health and social care, and including educational psychologists, perhaps reflecting their feelings of being left on their own to deal with difficult situations. Social workers, residential workers, paediatricians and GPs were also fairly active with regard to seeking advice, mentioning child psychiatrists and clinical psychologists; social workers and GPs also sought advice from each other. For some professionals this was seen as a more appropriate way of ensuring a young person's needs were met than was referral for a direct service.

'What did you do?' “Request that someone from CAMHS speak to staff [as] regards this type of behaviour as the YP refused to take advantage of this service.” (Residential worker, RW0081)

For others this kind of support helped them to develop their own professional skill base for working with young people in the future:

“Support from outside agencies is crucial to success. We are always learning as teachers as well.” (Primary school class teacher, ED2211)



Although good examples of receiving appropriate advice, consultancy and support were described, many respondents were left managing difficulties with no access to such help. This is reflected in the answers they provided when asked what they would have liked to do:

“I would have liked a link person to call for advice.” (Health visitor, HV0101)

“Dealt with it more myself with help.” (School doctor, CHD038)

“Have gained help/input from other professionals to tackle the problems.” (Residential worker, RW0032)

Several CAMHS professionals saw part of their role as providing exactly this type of advice and consultancy. Providing or developing this service was one of the most frequently mentioned when CAMHS professionals were reporting on their strengths or innovative work, for example:

“Offering regular consultation to staff in residential units and fieldwork social workers.” (CAMHS team social worker, MBMD05)

This type of consultancy, that would enable practitioners to intervene effectively to prevent the deterioration of the mental health of young people or to avert inappropriate referrals to CAMHS specialists, seems to be an area for development. Frontline practitioners are desperate for such help and many CAMHS professionals appear eager to provide it.

Understanding of each other's roles

One of the blocks to good interagency work cited by several respondents was the belief that others did not fully understand or value their role. This issue was raised by virtually every group:

“... our views in school based on many hours contact [are] usually disregarded.” (Secondary school head teacher, ED0515)

This lack of understanding was, however, of particular concern to teachers, with some concerns also raised by CAMHS and social workers. This is illustrated by the earlier quote about the lack of appreciation of teachers' daily involvement with pupils. One of the issues identified for this professional group was that other agencies did not acknowledge their expertise in dealing with children. Some of the CAMHS representatives bemoaned the stigma which could still be attached to their service. Although most complaints related to what this group termed “inappropriate referrals” there were some suggestions that this was likely to arise due to misconceptions of their role. Few, however, were explicit about this, although one CAMHS professional expanded:

“[A] distinction needs to be made between child psychotherapy as a treatment modality/intervention and child psychotherapy as a profession which undertakes a range of interventions, using an application of psychoanalytic/attachment/development theories in conjunction with behaviour management.” (Occupational therapist/psychotherapist, BVMD16)

Although relatively little text was assigned to this code, there were suggestions elsewhere throughout open-ended responses that representatives of agencies did not always take into account the somewhat different way in which other members of the multi-disciplinary team viewed their own roles and remits. Much of this material has been coded under the heading “different mindsets”.

Different mindsets

Several of the quotes hinted at underlying expectations of other agencies/professionals, which were often not articulated, but are evidenced by unspecified feelings of being let down or not being fully supported. For example, many of the teachers complained about what could be termed “empty reassurance”. For example, one teacher commented:

“The psychologist said we had such positive strategies in place, therefore little advice could be offered.” (Special school class teacher, ED0701d)

Although the teacher may have been looking for reassurance, it seems that she also wanted more information and advice about possible alternative ways of proceeding.

Whilst one of the CAMHS professionals stated that he “can’t work solely as a therapist [because I] have to be [a] ‘jack of all trades’” (Occupational therapist/psychotherapist, BVMD17), another was concerned about the expectations of social work with regard to attending hearings for young people “who don’t have mental health difficulties” and the expectation to provide “statutory/intervention alongside therapeutic input” (Social worker/therapist, BSMD05). This clearly demonstrates different views about statutory requirements.

The same conflict is apparent in the comments of a social worker regarding client confidentiality:

“[A barrier is] Issues of patient confidentiality, even though it is explicit in guidance that child protection matters override this, [there’s a] lack of information/understanding of the role of police/social work in child protection enquiries by health care professionals.” (Social worker, SW0401)

The various agencies tended to process cases differently, which could even result in conflicting diagnoses or approaches:

“No two people agreed on anything, or could give an explanation.” (Foster carer, FP013)

Part of the fundamental tension that appears to exist between many CAMHS professionals and their social work colleagues is highlighted by one respondent reflecting on his/her perception of the changed ethos in social work:

“Over 15 years I have seen huge advances in NHS provision but a serious decline in SW commitment to mental health issues. This is linked to the loss of specialist ‘psychiatric SW’ training and an ethos of care management rather than support or therapy in SWDs.” (Consultant child and adolescent psychiatrist, DHMD20)



Although this is the view of only one person it hints at some of the different perspectives and value bases that can impede multi-disciplinary work if they are not understood.

Working as part of a team

Working as part of a team seemed to be particularly important for those professionals whose setting meant that working closely with others was a necessary part of their everyday work. Residential workers and teachers gained enormous satisfaction from effective team work whether this was within their own staff teams or across professions:

“Talking with all staff members, calibration of all necessary information and trying to stick to the plan that has been identified. As a staff team it gave us the feeling of success.”
(Residential worker, RW0188)

The other codes related to satisfaction in working with others that emerged most frequently for both teachers and residential workers are those that lead to good teamwork – good communication and consultancy/support for us.

These workers frequently highlight the importance of agreed aims and a positive attitude:

“There [were] clear objectives from the start and everyone involved worked to make it a success. This was true working in partnership.” (Residential worker, RW0057)

Quality of care

The ultimate purpose of collaboration between professionals is to achieve a good quality of care for children and their families. Respondents emphasised the importance of this. For example, this paediatrician, commented on the involvement of a child psychiatrist with a child with Asperger's and Tourette's:

“Clear diagnosis led to appropriate management and therefore positive response from education and social work which supported the adolescent and family after many years of distress and loss of school time.” (Community paediatrician, CHD027)

The professional groups that commented most frequently on these aspects were GPs, paediatricians, school nurses and teachers. They described children whose symptoms resolved or where appropriate support had enabled families to understand and manage their children's difficulties:

“Young person gained in confidence after sessions with a CPN. Left school a happy self assured person.” (School nurse, SCN151)

“Pre-school child referred to me by health visitor. Provisional diagnosis of Asperger's confirmed by cons psychiatrist, parents counselled. Appropriate support in school. Doing well.” (School doctor, CHD045)

The relative infrequency of comment by other professionals on good outcomes as a result of collaboration may reflect the more entrenched and intractable difficulties they face in the children with whom they work. Several residential workers, however, did recognise the importance of support for young people and carers that could be offered by outside agencies.

“In some cases the YP who display behavioural difficulties can be supported through this period by a combination of stability from the unit and good services outwith. This was the case recently when YP fully engaged with professionals whilst being given support within the unit.” (Residential worker, RWSW1505)

A frequently occurring code related to the poor involvement of certain agencies, which was highlighted by all groups. There were interesting patterns in the data with regard to the agencies singled out for criticism. For health professionals their inability to access a service from their CAMHS colleagues was mentioned most frequently, though some were also critical of the lack of response from the social work department. The lack of service meant that these professionals were left to manage difficult situations alone. For example, this GP working with a girl with anorexia was told she was not ill enough for a service:

“Sought help from YPU, psychiatrists and CPNs but in the end had to try and support her and her family myself.” (General practitioner, GP0237)

For foster carers, residential workers and teachers, although their frustration in accessing a service from psychiatry was evident, social work was the agency whose service was most often seen as sub-optimal. The comments demonstrated the frustration experienced when workers had to rely on the response of others to do their own work well. This residential worker was very concerned about the dangerous behaviour of a young woman who was absconding and getting involved in prostitution. Despite her close and careful work with the young woman, she depended on others to ensure the child's safety. One of the main barriers was:

“Length of time social workers take to get things done” (Residential worker, RW0247)

The accounts provided highlight the gate-keeping role of social work and emphasise the problems that develop if a response is delayed or not forthcoming. In some cases there was a clear lack of understanding of the importance of early intervention:

“The twins have no awareness of danger and do not understand 'no'. One of the twins climbs on everything and could climb out of his cot over 30 times until I stayed with him. I asked for help in January from OT who came in April. Sent a joiner to review in June. I tied one fireguard on top of the other and did various other temporary measures to keep them safe.” (Foster carer, FP025)



There were a few comments critical of education but the main foci of dissatisfaction were these two services. CAMHS and social workers themselves each identified the other as the agency causing them the most difficulties. CAMHS professionals comment frequently on the lack of front line social work provision, and in some cases are scathing about the quality of services when they are available. One CAMHS professional for example stated that one of their difficulties was the fact that the

“social work service is in disarray” (Consultant clinical psychologist, DHMD07)

The view from some social workers about their involvement with CAMHS was equally negative – criticising both the lack of accessibility and the service when it was finally accessed:

“We have no direct access to child & family psychiatry. The amount of time and effort we spend trying to get children seen is disproportionate to the value of the service received. The psychiatrists are not approachable and do not view social workers as equal partners.” (Social worker, SW17038)

A particular problem that emerged frequently was the lack of clear leadership and control. One GP wanted to be able to refer to

“one person who could link all agencies involved - someone with experience” (General practitioner, GP0278)

A similar complaint came from a foster carer living with and caring for a child with serious family difficulties and having to manage a complicated pattern of living arrangements:


“Problems of past are not easily swept away – lack of co-ordinated approach from social work and lack of control by any [one] party.” (Foster carer, FP034)

Although many respondents were critical of the poor support or involvement of other agencies in providing an adequate quality of care for young people, there was some understanding of the pressures other professionals faced. One GP recognised the lack of priority and consequent lack of resources for CAMH services:

“The mental health service in Scotland is struggling at present, and the services for young people are the 'Cinderella' of the mental health services.” (General practitioner, GP0268)

This school doctor made an important distinction between individuals and agencies:

“Most people involved are very good and helpful individually but services are grossly overloaded.” (School doctor, CHD004)



The most critical comment was reserved for other professionals who were unco-operative, unforthcoming or who appeared uninterested in the child or their difficulties. This social worker working with a sexually aggressive young person was able to understand the pressures but still felt a lack of interest and support from other professionals. For her, the barriers were:

“Finances/waiting list/appeared lack of concern from others professionally involved.” (Social worker, SW2302)

In contrast, fellow professionals who were prepared to co-operate were very highly valued:

“A collaborative psychiatrist is worth their weight in gold” (Consultant clinical psychologist, clinical psychology service, HECP01)

One social worker highlighted the difference between the positive and negative experience of working in a multi-disciplinary way:

“Best outcomes have taken place when DCFP have an investment in working with young person and are prepared to work collaboratively with all agencies owning their responsibilities and not frequent response that social circumstances are too unstable to begin to work with young person and passing buck completely back to social work.” (Social worker, SW1506)



Conclusion

Explaining the patterns, similarities and differences between groups

Core components of their professional roles clearly shaped the statements made by respondents. For example, the referral of problems on to other services is clearly a core element of the work of GPs (referral was mentioned by virtually all of them), whereas the foster carers mentioned referring on only twice. Health visitors and school nurses talked about referring on – mostly to GPs, social work or voluntary agencies – but they frequently expressed frustration at restrictions on their ability to refer to certain services (particularly community psychiatric nurses, clinical and educational psychology).


Foster carers, followed by residential workers, expressed the greatest frustration with regard to the difficulty of getting other agencies to engage with clients' problems. Several foster carers complained that “no one listened” to them. Foster carers and residential workers not only had the least recourse to referral channels, but also had the most protracted contact with young people with behaviour problems, so this is, perhaps, not surprising:

“[The] problem remains. We cannot walk away the way that medical personnel can.”
(Residential worker, RWSW0308)

Other professionals did, however, sometimes report feeling “disempowered” in dealing with specific cases. Professionals working with whole families reported their frustration that other agencies did not seem to appreciate the impact of the referred child's problems on the family as a whole:

“[The problem] affected the whole family. Mother was depressed. Sisters (aged 16 and 18) left home and therefore less support for mother.” (General practitioner, GP0161)

Regardless of the issues being discussed it was apparent that some interfaces were consistently reported as giving rise to problems, and the interface between social work and CAMHS is particularly noteworthy in this respect. There are also particular problems associated with a structure in which some professional groups, such as teachers, residential workers and foster carers, do not have the capacity to refer directly, but are reliant on social work to refer on to other agencies and thus gain access to support and services. Similar issues were highlighted by school doctors and nurses who may have to refer to services via the patient's GP.



A recurrent theme related to the capacity of some professional groups – in stark contrast to others – to decline referrals or to re-define the problem as meriting attention from another professional group/agency. The groups who raised this issue were mainly residential workers, voluntary agency workers, and teachers:

“No one agency would take responsibility. SP/Lang therapy, educational psychology, [Children's hospital]. Each said there were problems, but the main underlying problem was not theirs.” (Special school guidance teacher, ED0016)

One of the teachers labelled this “the non-accountability syndrome” (Specialist unit head teacher, ED2424). Although social workers and GPs were sometimes cited by others as having a gate-keeping role, they could themselves experience similar frustrations with regard to their dealings with child and adolescent psychiatrists and adult psychiatrists, and, on occasion, with each other. School doctors also experienced problems with regard to getting their colleagues in psychiatry to accept referrals.

Finally, we must exercise caution in interpreting the comments of respondents about difficulties in collaboration. We cannot assume that absence of complaints means that this joint working is problem-free. Individuals who do not collaborate may not see problems that those trying to work with them can see very clearly. Similarly, the negative comments about other professionals may not mean that this is an objective assessment of the service – they may be a result of misunderstanding, frustration or problems in the respondents' own services. Nevertheless, the accounts of the professionals who took part in the survey can teach us a great deal about structural tension points, inter-professional communication challenges, and the impact of inadequate resources. The respondents also had strong ideas about what constituted good and co-ordinated provision for young people and their families and there were clear pointers about how this might be achieved.

CHAPTER 8 TRAINING



INTRODUCTION

The importance of appropriate training in relation to the mental health of children and young people might be regarded as being beyond question. However, the findings of the survey suggest that little can be taken as read in relation to what training is appropriate, what training is available, and what training is taken up.

There have been developments in this area since May 2003 when the Scottish Needs Assessment Report was published. First of all, the Scottish Executive Health Department (SEHD) has published *The Mental Health of Children and Young People*ⁱⁱ. This document has a bearing on this discussion, in that it addresses itself to the purpose of training in this arena. The Framework proposes training as being integral to securing the “outputs” needed to improve the mental health and well-being of children and young people. Secondly, NHS Education for Scotland (NES) have developed and published the document *Promoting the Well-being and Meeting the Mental Health Needs of Children and Young People*^v. Based on an explicit set of foundational attitudes, values and principles, this development framework describes the competencies which are required to achieve many of these outputs. Finally, the SEHD has commissioned work to draw together these strands into a coherent picture of the kind of workforce needed to deliver this.

The SNAP survey is a rich source of information in relation to training. For example it includes comments made by people working in roles or settings which required that they had particular skills in relation to mental health. It also features comments from those who work day-to-day with children and young people, supporting them, often through very difficult times, who have no formal role or training in relation to mental health.

This chapter considers how the data were gathered, the main themes which emerged and some of the exceptions and variations which appeared. It concludes with some discussion of the possible explanations for these findings.



How the data were gathered

Some of the data were elicited in response to explicit questions about training. As well as the answers given to these specific questions, all respondent references to training, much of it given in the form of free text, were noted and are considered here.

Some of the data were amenable to quantitative analysis and some of the more interesting and important findings are reported. The free text responses were studied, coded and analysed for themes.

Questionnaire A: Specific training in child and adolescent mental health

PQA 13. Have you had any specific training in child and adolescent mental health?

Of the 1,071 respondents to questionnaire A, 217 (20%) replied “yes” when asked whether they had had specific training in child and adolescent mental health. There was wide variation between groups, from teachers, where 10% reported specific training, to paediatricians, of whom 40% reported specific training (Table 8.1).

(The high rate amongst the police group is based on very small numbers; and while it is interestingly high, it is worth noting that all the respondents came from Women and Children's Units.)

Respondent group	Number responding to question	Number yes	Percentage
Social workers	105	22	21
Residential workers	103	24	23
Foster carers	38	8	21
Reporters	22	5	22
Panel Chairs	18	3	17
Police	5	3	60
Teachers ¹⁷	353	36	10
GPs	137	31	23
Health visitors	71	18	25
Paediatricians	54	22	40
School nurses	100	27	27
Voluntary sector	55	18	32
TOTAL	1061	217	20

Table 8.1. Frequency of respondents reporting “yes” to PQA 13, reported by professional groups

¹⁷Positive responses from 14/159 (9%) school management and 22/203 (11%) class teachers



PQA 13a. If yes, what training have you had?

Although 217 people reported responded “yes” to question 13, some 232 respondents answered this question. The answers given generated four main themes:

1. *Responses (26/232) which indicated that the experience referred to had taken place as part of a general professional training.*

This response was particularly associated with health professionals, for example, health visitors, school nurses and general practitioners reporting that an aspect of their training had been of relevance to child and adolescent mental health.

There were also responses in this group from respondents in the voluntary sector and one teacher, indicating that they had a psychology degree. It was not clear whether this was obtained in relation to their present post.

The references to qualifications under this theme were sometimes further qualified, e.g.

*“Not in depth – child development, psychology, family dynamics during BSc course.”
(Health visitor, HV0047)*

There were also numbers of doctors who answered “yes” to question 13, who indicated that they were referring to undergraduate experience. One doctor answered “no” to question 13, before writing under 13a:

*“Unless you count very small amount during psychiatric module as a medical student.”
(School doctor, CHD049)*

2. *Responses reporting experiences which were clearly relevant to child and adolescent mental health, but which were not part of a formal training programme.*

78% of the responses to question 13a fell into this theme and included references to:

- **short courses** on a wide range of themes from what constitutes good mental health, through problems, to interventions
- **in-house workshops and consultations** with professional colleagues, particularly from education (educational psychologists) and NHS CAMH services. School nurses again mentioned these
- **personal initiatives** through CPD and seeking further information.

It would be inappropriate to generalise from this small sample. Were the **lack of pattern** evident in these responses representative of these groups as a whole, it would suggest a striking lack of coherence about what training experience these groups of practitioners should have in relation to child and adolescent mental health.

Another sub-theme – of perceived lack of training – is suggested by responses such as these:

“Panel member training (monthly meetings) mostly. Training in specific mental health minimal, although I have been to lots of meetings concerning children with mental health problems.” (Panel Chair, PAN010)

“Not enough. Attended post grad meetings on a couple subjects with talks from local child and adolescent team.” (General practitioner, GP0066)

“Come to think of it – no, I have not. The training I have had has been as a by-product of other adversities i.e. drug misuse, living with parents who have mental health difficulties etc.” (Social worker, SW0704)

3. Responses describing some formal postgraduate training, specific to emotional well-being or mental health.

This was accounted for in three ways. In one group were those GPs who reported spending time in general psychiatry during their general professional training. In a second group were those social workers who had trained as mental health officers. A third group consisted of a small number of people who had undertaken postgraduate training in counselling.

4. Responses reporting a formal postgraduate training in child and adolescent mental health.

The majority of this group of 17 respondents was made up of doctors (both GPs and paediatricians) who had spent time working in child and adolescent psychiatry as part of their postgraduate training. However, four respondents described themselves as being involved in a postgraduate training course in a therapeutic skill: family therapy, play therapy or psychotherapy.

PQA 26 Would you wish to have any further training in dealing with emotional, mental health or behavioural problems, or in mental health promotion for young people?

Of the respondents to the questionnaire A, the majority within each respondent group indicated that they would wish further training (Table 8.2). The average rate across all respondents – 81% – gives a clear indication that this is a widely shared view.

Respondent group	Number in sample	Number agreeing	Percentage
Social workers	107	94	88
Residential workers	104	101	97
Foster carers	38	26	68
Reporters	22	18	82
Panel Chairs	19	14	74
Police	5	5	100
Teachers	353	302	86
GPs	137	66	48
Health visitors	71	59	83
Paediatricians	54	40	74
School nurses	103	91	88
Voluntary sector	55	47	85
TOTAL	1068	863	81

Table 8.2. Number of respondents to PQA 26 indicating “yes”, reported by professional groups



PQA 26a. If you ticked “yes”, what sort of training would you like?

The main discussion in this section will consider the themes which emerged in the free text response. But there are some important general considerations. First, it is worth noting that amongst the responses in the free text area, there were more than 1,000 which touched on the theme of training. This lends further weight to the earlier evidence of significant interest in this theme. Secondly, there were numbers of particularly succinct statements of some of the reasons for this interest:

“I would have liked to have had the knowledge and skills to have dealt with this boy as I am conscious that I am not trained to properly deal with this behaviour.” (Residential worker, RW0171)

“My lack of knowledge about this field was a barrier to the support and advice I could give the family while waiting on referral to [the] appropriate agency.” (Health visitor, HV0019)

Main themes

Questionnaire A

Five themes which emerged particularly clearly in questionnaire A:

1. Basic knowledge

Against the background information that most of those working in this area had had no specific training in relation to mental health, there were many suggestions about the value of some basic knowledge. Suggestions from one respondent for a “course on common problems and best treatment” and another respondent proposing training that was “not too detailed – a pointer system with practical advice” were echoed widely across the range of backgrounds.

There were specific requests for training on different life stages including “infant mental health”, “pre-5 mental health”, “dealing with young people” and “working with parents”.

The response from one residential worker indicated a notion of developing skills over a period of time:

“Initially a good grounding on basic issues from which we could choose more in depth training relevant to our service users.” (Residential worker, RW0123)

There were some important pragmatic twists offered by some respondents. For example, these two clinicians connected their comments about training to remarks about waiting times:

“Any kind as no one seems to be available to see these people quickly and they appear to have had horrendous lives and had no help in coping with any of this.” (Health visitor, HV0004)
“... basic advice to give e.g. dealing with anxiety, so that a family can work on something

¹⁷Positive responses from 14/159 (9%) school management and 22/203 (11%) class teachers

before they eventually might be seen at psychology/psychiatry.” (Community paediatrician, CHD003)

This teacher indicated a view that attention to mental health and well-being was not only important for young people when asking for:

“Strategies for supporting pupils and staff.” (Primary school depute head teacher, ED0009)

2. Basic skills

There were many comments about the value of having basic skills in relation to the mental health of children and young people. For example, these teachers commented on their own experience:

“I have a feeling that in all cases we could do more but we have had no training.” (Primary school head teacher, ED2509)

“Often I handle situations from instinct and personal experience. Maybe I don't always approach from the right angle.” (Primary school head teacher, ED1312)

There were many suggestions about the kinds of skills that would be helpful:

“Training in how to deal with simple problems [avoiding the need for referral].” (General practitioner, GP0197)

“For managing specific situations – self-harm, anger, bereavement.” (Foster carer, FP017)

“Skills to support parents deal with their young people.” (School nurse, SCN218)

But there were also numbers of comments which indicated a concern to match skills to role and task, for example:

“Need the skills to make an informed assessment and then refer to appropriate agency i.e. community psychiatric nurses, and work with them and the child.” (School nurse, SCN137)

“Residential staff locally don't appear to be qualified or equipped to deal with very challenging behaviour – requires sustained training/support input to develop service and employment of skilled and qualified workers.” (Social worker, SW2205)

“excluded high risk suicide – counselled but felt out of my depth – agreed referral to CAMHS but without guardians' consent. They would not see her without guardians.” (School doctor, CHD002)

These are important comments, suggesting the importance of consensus between agencies about who deals with what problems.



3. Signs and symptoms

The responses here generated a comprehensive list of themes, including problems such as:

- autistic spectrum disorder (ASD)
- attention deficit hyperactivity disorder (ADHD)
- depression
- psychosis
- eating disorder
- post traumatic stress
- self harm.

There were numbers of comments which suggested that knowing about these problems had to be complemented by skills in recognising their presence. So there were references to the possible use of “screening tools” and training in “how to spot serious problems”, “recognising the less obvious MH problems”.

There was consideration of the issues which might lead to this complexity, such as references to “understanding co-morbidity” (i.e. when two or more problems coincide) and a variety of specific examples:

“clearer identification of possible different presentations of severe mental health problems in adolescence.” (Social worker, SW1103)

“Some basic training on recognising or screening children/YP with learning disabilities for mental health problems so that appropriately referred.” (Community paediatrician, CHD011)

“[Training] linked to communication disorders/learning difficulty and associated mental health, emotional and behavioural problems.” (Special school head teacher, ED2618)

There were also requests for training in relation to helping promote well-being and coping strategies, including “stress”, “anger management”, “attachment”, “self-esteem” and “resilience”.

4. Counselling

Of all the specific skills mentioned in response to question 26a, counselling was the most common, by a considerable margin, being mentioned by 74 respondents, of almost all backgrounds.

Here are some examples of the kind of applications mentioned:

“Further training in counselling to work with pupils who have problems with their mental health.” (Secondary school guidance teacher, ED2203)

“Counselling strategies for children with emotional problems, e.g. coping with bereavement, coping with parents separating.” (Primary school head teacher, ED1604)

“Counselling or cognitive type treatment for mild depression/self harm.” (School doctor, CHD049)

These comments seem to echo earlier comments about the importance of training:

“Possibly some counselling type training would help as you can open up a 'can of worms' that as a teacher you are not trained to deal with.” (Primary school special education teacher, ED2407)

There were also comments about the kind of counselling training available:

“Although I have had training I wonder whether school nurses should be encouraged to undertake the certificate of counselling or whether a module should be developed around adolescent health and this would include mental health.” (School nurse. SCN129)

5. Methods of training

There were frequent comments about the way that training should be made available. The predominant interest was in small, multi-agency groups, and interactive, practically focussed activities. For example, one foster carer asked for “case histories rather than theoretical categorisations”, while a school nurse asked for “skills based workshops”. The following quote, from a teacher, summed up the tone of many of the comments:

“training delivered by good, practical, hands-on practitioners – practical task and scenario orientated – supportive but also able to challenge our skills, philosophies.” (Primary school head teacher, ED1801)

Final remarks

A number of respondents made comments about the importance of resources and time to implement training. This did not fall into any of the main themes, but these seemed to make important contributions to the discussion about training:

“Relevant! But training without resources is only frustrating.” (Primary school head teacher, ED1501F)

“to be more confident in offering strategies to help young people – and more time to work individually with them.” (Secondary school guidance teacher, ED2512)



Questionnaire B

The CAMH SNAP Reportⁱ and the subsequent *Framework for Promotion, Prevention and Care*ⁱⁱ both highlighted the role of those with specialist mental health or psychological training in supporting the development of the “mental health capacity” of the wider network of children’s services through liaison, training and consultation. These documents highlighted that continuous professional learning was integral to that extended role.

There were 280 respondents to questionnaire B, from a range of professional groups in the NHS, psychologists from local authorities and specialist practitioners in the voluntary sector. The questionnaire sought to inform this discussion by gathering data about the qualifications held by members of these groups, about their continuing professional development and about their (then) current training and teaching activity.

Qualifications

The primary qualifications held by those providing these specialist services mainly reflect the professional role they occupy. So, for example, those working as applied psychology roles (educational and clinical psychology) will usually hold an undergraduate degree and a postgraduate qualification in psychology, relevant to their field of practice; those working in psychiatry will hold a medical degree, have completed a prescribed post-graduate training and are registered with the GMC as specialists. Accounts of these qualifications are available in the public domain and no purpose would be served by reiterating these here.

There is, however, no current information about the extent to which those who provide these services have gained additional qualifications relevant to their role, and so the findings in relation to this issue are reported here.

Additional qualifications

PQB6 Do you have any additional professional qualification relevant to your CAMHS role?

261 of the 280 respondents to questionnaire B, answered PQB 6, with 137 (52.4%) reporting that they had an “additional professional qualification relevant to (their) CAMHS role”. While there was a range of responses between professional groups, none of the differences was statistically significant.

	Nursing	Medical	Clinical psychology	Therapy	Educational psychology	Other	Total
N: total	76	47	44	26	25	43	261
N: Yes	41	24	16	16	13	27	137
% Yes	53.9	51.1	36.4	61.5	52.0	62.8	52.4

Table 8.3. “Additional professional qualifications relevant to CAMHS role” by professional group

About 1 in 4 of those reporting an additional qualification reported more than one additional qualification.

There were three main themes amongst the further details provided by those responding yes to PQB6.

1. The largest group comprised those who described some form of qualification in relation to *therapeutic skills*, including:

- family therapy (42)
- child psychotherapy (35)
- cognitive behaviour therapy (17)
- group therapy (13).

Qualifications related to other forms of therapeutic work, including counselling, play therapy, brief/solution focussed therapy and interpersonal therapy, were each reported by fewer than five respondents.

These qualifications were reported by the range of professional groups. Eighteen respondents reported an additional qualification at a standard which was equivalent to, and in several cases associated with, a second professional registration. Nine of these were in child and adolescent psychotherapy, eight in family/systemic therapy and one in cognitive behavioural therapy. Three of these 18, one from each group, were working in a specialist role within the voluntary sector.

2. There were 13 who reported that they had undertaken some form of academic qualification, over and above their core professional training. Twelve of these had achieved their award, mainly at PhD level.

3. Finally there were those who reported additional practice-orientated professional qualifications. This included qualifications in forensic psychology, additional educational qualifications amongst educational psychologists and CAMHS based teachers. The most common additional qualification of this kind was some form of post-registration training in child and adolescent mental health, which was reported by 16 of the 79 nursing respondents.

Professional development

The extent to which those working in specialist CAMHS report additional relevant qualifications might be a useful indicator of the extent to which they are engaged in professional development. In an attempt to gain other indicators of this activity, questionnaire B asked "*How many days did you spend in professional training in 2001–2002?*" (PBQ4). Table 8.4 summarises the responses to that question.



Nursing	Medical	Clinical psychology	Therapy	Educational psychology	Other
median 10 [IQR 6 to 20] (range 0 to 60)	median 10 [IQR 6 to 18] (range 0 to 365)	median 8 [IQR 5 to 10] (range 0 to 40)	median 7 [IQR 3 to 14] (range 0 to 40)	median 10 [IQR 6 to 16] (range 5 to 365)	median 6 [IQR 4 to 16] (range 1 to 35)

Table 8.4. Days spent in professional training 2002–2002, reported by professional group

The first finding was the very wide range of number of days of training, with most respondents reporting 10 days or fewer, but some reporting very high numbers indeed. The median¹⁸, used here to indicate the average, varied across the professional groups from 6 to 10 days per year. Looking at the interquartile range (IQR)¹⁹, we see that at least 75% of every professional group had spent 3 or more days in training in the previous year (Table 8.3). The differences between groups were not statistically significant.

Teaching and training

The question *How often do you take part in teaching and training others?* (PQB16) was designed to elicit the pattern of teaching and training activity. Participants were asked to indicate whether they were involved “regularly” or “occasionally” and to indicate with which groups they were involved. The responses to that question are summarised in table 8.5:

		Nursing	Medical	Clinical psychology	Therapy	Educational psychology	Other
Regularly teaches own professional group	N: total	79	50	46	30	28	47
	N: Yes	18	15	11	8	3	9
	% Yes	22.8	30.0	23.9	26.7	10.7	19.1
Regularly teaches other professional groups	N: total	79	50	46	30	28	47
	N: Yes	14	14	17	8	0	6
	% Yes	17.7	28.0	37.0	26.7	0	12.8

Table 8.5. Those indicating “regular” involvement in teaching responding to PQB16

Neither “regularly” nor “occasionally” was defined in the questionnaire and so some caution is required in interpreting these responses – this question does not tell us what percentage of the working week is spent on these activities. It does, however, tell us that, for most professional groups responding to this question, members were about as likely to be regularly involved in teaching different professional groups as teaching their own. In other

¹⁸The median is the middle of a distribution: half the scores are above the median and half are below the median. The median is less sensitive to extreme scores than the mean and this makes it a better measure than the mean for highly skewed distributions.

¹⁹The interquartile range is a measure of the spread of data. 25% of the data are less than or equal to the first quartile and 25% are greater than or equal to the third quartile: the interquartile range accounts for the 50% in the middle. It is a useful measure in very skewed samples.

words, cross-discipline teaching appears to be an established activity within the NHS groups. The CAMH *SNAP Report* recommended that these services develop their training activity to support the capacity of the wider children's network. The report indicated that a number of elements would need to be in place to allow this development, including an increase in capacity. Willingness to work in this way is in any case likely to be an important element, and so this is an encouraging finding.

Conclusions

Mental health problems in children and young people are common, a fact that is recognised by the respondents to this survey. Despite this, training in child and adolescent mental health is uncommon, with only 20% of those responding to the questionnaire A able to report any training. Amongst those who had experienced training, the common experiences were of short courses and workshops, taken electively as post-qualifying experiences.

Equally striking was the high level of reported interest in further training. While this cannot be taken to represent a universal attitude, it seems reasonable to suggest that such interest is widespread within those working with children and young people. The comments about areas of interest and methods of training provide useful information for those responsible for developing training opportunities.

It seems likely that substantive change in current approaches to training will be required to achieve appropriate levels of knowledge and competence in relation to mental health and well-being, such as is envisaged in the NHS Education for Scotland Development Framework. This holds implications for every stage in the education and training of those who will meet and deal with children and young people as part of their work.

The promotion of a learning culture in relation to mental health within this workforce is one of the clear recommendations of the CAMH *SNAP Report*. This holds implications for all of the agencies involved, as they consider how best to establish and sustain appropriate learning opportunities. It holds particular implications for those with particular knowledge and experience in relation to mental health and well-being – typically those who work in specialist CAMHS, in local authority psychological services and in some of the voluntary and independent sector services. These implications are likely to be considered further in the CAMH Workforce report, which will need to consider how to ensure:

- that acting in a teaching and training capacity is endorsed as a core part of the role of these agencies, and is validated at organisational level
- that these agencies have the opportunity to build the capacity to extend and develop their roles in this way
- that professional staff within these agencies have the necessary learning and professional development opportunities themselves to allow them to build their knowledge and competence. This, of course, involves recognising the vital role played by senior staff within these settings in supporting the learning of their less experienced colleagues
- that professional staff within these agencies learn constructive and effective methods of teaching and training.

CHAPTER 9

INNOVATIONS – WHAT ARE PEOPLE DOING WELL AND WHAT WOULD MAKE A BETTER SERVICE?



INTRODUCTION

This section analyses responses that make suggestions for improved services. Inevitably, some of these are generated from respondents' frustrations and problems and as a result some themes from previous chapters will be revisited. Replies to the following questions from questionnaire A were the main source of information for this chapter:

Q25. If you could have access to a new sort of service for children with mental health, emotional or behavioural problems, or an improved version of a service which already exists, what would it be?

Q27. How might services be changed to allow (involvement in planning) to happen?

Q28. Is there anything else you would like to say about services...?

The chapter also draws on some of the suggestions that these professionals made when they were asked what could have been done differently in the cases they described. In addition, information from specialist mental health professionals will be discussed in relation to their views regarding the strength, weaknesses and gaps in their services.

A number of themes emerged from the data: the requirement to develop services that were more acceptable to young people and their families; suggestions specific to the respondent's own service and ideas to make the system as a whole work better. Codes were developed to incorporate these themes and analysed in relation to respondent groups. The analysis demonstrates a shared perspective across the different professional groupings for many of these issues. The responses emphasise the need for services to fit within the context of the child, their family and the "frontline worker". They also highlight the importance of integrated practice by professionals across all service components, and demonstrate the readiness of non-specialist workers to be involved in the development of mental health services for children and young people. Finally, respondents identified specific developments that could enhance the emotional health of children at various intervention levels and in different settings.



Chapter 6 discussed the barriers that people face when accessing services for children and young people. As illustrated by one social worker:

“Barriers often [as] a result of a lack of confidence in other prof[essional]s, difficult thresholds for intervention, different backgrounds, training etc ... these factors need to be taken into account before we can begin to consider delivering services ... furthermore, young people and their families need to be involved.” (Social worker, SW0404)

Resolution of these frustrations would, in turn, improve services and many of the suggestions for innovation are designed to remove such barriers.

Accessible services for children and young people

Several respondents suggested the development of services to suit young people but also stressed the importance of being responsive to the needs of the family system as a whole. They raised issues of stigma, confidentiality, self-referral and friendly ease of access.

A social worker in local community team wrote of stigma:

“In respect of adolescents – the 'stigma' prevents take up of services. Need to create more flexible services via schools, community resources, rather than formal health settings such as GP surgery, hospitals and clinic environments – important getting them over the door.” (Social worker, SW0004).

Many respondents stated that the process of accessing specialist help is itself a barrier for young people and families. They emphasised that services should be more child-friendly and that locations and buildings should be appropriate. One practitioner suggested they “not have a sign saying mental health” (Residential worker, RW0135). School nurses stressed the need for facilities which are “not seen as ‘mental’ but holistic” (School nurse, SCN171). Privacy was seen to be important and one respondent suggested a “service that comes to you, quietly, discreetly [with] no long waiting list” (Voluntary worker, VOA152).

A number of GPs talked of the difficulty in engaging children with emotional needs. Young people are often reluctant to see doctors and find the appointments systems unhelpful. One practitioner stated that “young people often need immediate help and if left on a waiting list then decline to attend” (General practitioner, GP0105). Another respondent pointed out that young people “have no desire to wait for a service and can quickly become hostile towards them, they need to feel valued and cared for” (Voluntary worker, VOA183).

For CAMH services to improve they must be user friendly and approachable. GPs often refer to direct “walk in” access. This was also highlighted by a residential worker involved with very distressed children who advocated a “less formal arrangement where young people feel they could pop into a centre and discuss their problems” (Residential worker, RW0135). Responses also illustrated the need for flexible services meeting the requirements for young people in their own environments that are seen as in a “safe, comfortable and informal setting” (Special school head teacher, ED0018).



Many of these respondents wanted a specialist CAMH service that was flexible and responsive to the needs of children and young people. There was also a strong emphasis on the need for agencies to work together and with better continuity of care. After working with a child who had experienced sexual and emotional abuse, one respondent commented:

“I would like to have experienced better communication between agencies involved to have enabled the abused adolescent/child to have gained greater confidence in the agencies that were helping.” (Health visitor, HVCHD044)

It was also highlighted that more regular multi-agency contact helps families feel that all involved are working together:

“Good to see that support can make a difference and improve quality of life for child and family, good to see agencies communicating and working collaboratively.” (Residential worker, RW0042)

In addition, CAMH professionals who have close links to other services have more opportunity to build trusting relationships with young people. This notion of specialists being brought to the “coal face” will be discussed in detail later.

A few respondents pointed out that service user involvement is an important way to facilitate change in services. They described a range of methods to achieve this, including listening to the views of children in assessments, consultation through questionnaires or forums and in some cases the involvement of young people in service design and “control over their own service provision” (Social worker, SW2709). One worker explained how inclusion of young people in meetings has proved positive:

“We have regular meetings where all agencies, parents, teachers and the young people are invited to attend. This allows all to put forward views, ideas etc and to assist the young people to move on in a structured way and they have been actively involved in planning their own future.” (Voluntary worker, VOA224)

Services for families

This report has already highlighted the difficulty for services in engaging the families of young people²⁰. The barriers that were identified included stigma, lack of co-operation and chaotic family lifestyles. One worker stated “success requires parental commitment” (CAMH staff nurse, LCMD05) and many respondents, in their work with young people, perceived lack of parental support as a barrier to achieving successful outcomes and to accessing services. One CAMH social worker based in a voluntary service stated:

“I believe that some of the more medical and often very hierarchical structures in place for dealing with mental health problems can be intimidating for some young people and their families.” (Senior social worker, VOB201)

Another respondent noted she had been unable to provide appropriate help because of the “parent’s perception of parenting groups as ‘not for people like them’” (Health visitor, HVSCN194).

²⁰ Chapter 6 see “Limited possibility of making a difference”.

Parental attitudes, resistance and reluctance to work with professionals are therefore factors to be considered when improving services. Family stressors, parental mental health problems and relationship difficulties need to be recognised as impinging on the well-being of the child. Many school nurses and teachers comment on the necessity of a “whole family” approach:

“Again, bearing my experience in mind, I would like to see more support for parents. I am not sure if support is even right. I see children with behavioural problems at 5 and 6 whose parents need taught parenting skills, need taught how to love their child. But how do we do that?” (School nurse, SCN11e)

Suggestions for tackling this included more positive parenting programmes, family counselling and interventions focussing on the entire family. One teacher described how a comprehensive support service might appear:

“One service unit with a multi-disciplinary team consisting of health/psychologists/home link teachers/support staff for parents etc. Crèche facilities are vitally important – offering parent opportunity to attend classes or workshops.” (Nursery head teacher, ED0014)

This notion of a single, dedicated service is complemented by requests for outreach work including support within the community and home. Teachers frequently commented on the need for well-resourced links between home and school:

“A service which would offer intensive support for parents as well as liaising with school staff in order to develop a consistent support for the young person.” (Special school head teacher, ED0521)

Residential workers, social workers and health visitors suggest that there is not just a need for more general awareness raising and programmes that help parents with the skills and confidence to cope with their children. They also emphasise that some families need respite services to manage the stress involved in caring for their children:

“An expert team of interagency workers with respite in an appropriate venue suitable for young people.” (Health visitor, HV0077)

The importance of infant mental health was acknowledged with suggestions that adolescents could be provided with parenting classes. One social worker urged:

“consideration to support young mothers prior to birth, to enable both therapeutic support and intensive assessment re parenting capacity.” (Senior social worker, SW0301A)

A few professionals described their work with families in the context of need for better housing, protected employment opportunities and the awareness of the need for services to be accessible to “troubled families who are hostile to social work, ambivalent to their children, but fall outside the compulsory care bracket” (Community paediatrician, CHD035). CAMH professionals, who discussed their work with families, noted their strengths as being non-judgemental, working in true partnership with young people and their families, and services which build upon families’ resources.



Services to fit within the worker's context

In dealing with children and young people, professionals require resources that assist them in their day-to-day work. Respondents identified their need for training and the opportunity to acquire new skills.²¹ Many workers feel that they lack experience in dealing with children and young people with mental health issues. They suggest that there is a need for more specialist provision at the “coal face”. They also identify their need to access advice and consultancy to prevent them feeling “*out of our depth*” (School doctor, CHD013). Most workers are willing to assist children with additional needs, however, a few people feel overwhelmed by such responsibilities and would prefer a distinct separation of roles:

“All work to be completed by outside agencies, leaving care staff to focus on care and surviving the residential experience.” (Residential worker, RW0074)

Professionals across all agencies argued for CAMH services to be involved in more outreach work and community based projects. GPs, health visitors and school nurses favour the idea of drop-in centres dealing with health related issues and support at a community level. Suggestions include “*more school-based workers promoting general well-being*” (School nurse, SCN131) and “*support at a community level for children of separated parents*” (Health visitor, HV0054). One school nurse even went as far as to state that “*at present, counselling with the medical service is a medieval model*” (School nurse, SCN129).

Residential workers stress the importance of CAMH professionals being involved in outreach work, offering practical examples such as staff representation at inter-agency meetings, arranging programmes of partnership with psychological services and service delivery at more appropriate hours.

“A service that could come to assist or assess outside of normal working hours. Most Y/P are in school these times.” (Residential worker, RW0199)

One residential worker suggested a “*community psychologist who was known to staff and young people in a similar way to our community police who pop in at strategic times*” (Residential worker, RW0115).

Like many respondents, teachers favour the idea of on-site provision with specialist workers attached to the school. This teacher brings together a number of ideas that appear throughout the teachers' responses:

“Mental health nursing team offering advice and a link in schools. More psychologist time in schools. Qualified counsellor in school with a drop-in office.” (Secondary school behaviour support teacher, ED0215)

Some felt that by working “on the ground”, practitioners could share the experiences of teaching, gaining a better understanding of their everyday work.

²¹ See Chapter 10 for a detailed discussion of training needs.

Access to trained professionals

As well as the need for more appropriate provision for young people, respondents also identified the need for access to mental health professionals for their own support. The need for consultancy and advice is highlighted across all agencies.

A variety of methods for accessing advice were suggested including help lines for staff, more regular liaison, access to a named link person or having a co-ordinator who could then access the relevant agencies for support. One respondent also suggested a CPN drop-in service for staff (School nurse, SCN007). Social workers favour consultancy services to *“consult immediately re worries and concerns”* (Youth justice social worker, SW0303). Another respondent suggested a joint consultancy group.

Teachers in particular require urgent access to advice and help in order to be able to continue their commitment to troubled and sometimes disruptive children. One teacher felt that there was a need for:

“Effective access to trained support to help teachers deal inclusively with all children experiencing difficulty.” (Primary school head teacher, ED0508)

Workers not only required assistance during crisis or when feeling uncertain – there is a real sense that people wish to improve their strategies, with specialist workers supplementing their skills and sharing good practice. One teacher recognised the impossibility of specialists being able to see each individual, however, *“by giving advice to 'front-line' workers it can often make a huge difference and often filters or reduces the eventual referral list”* (Primary school class teacher, ED2210).

Residential workers require assistance that will increase their understanding of the difficulties young people face and help them to generate strategies to work more effectively with them. One respondent stated a need for a professional to *“assist us on a weekly visit, to help us understand, to try other ways to work with the young person, to enlighten us on what they are going through”* (Residential worker, RW0254).

Referral pathways, rapid access, staffing and resources

The vast majority of GPs simply wanted rapid access to services, stating the need for much shorter waiting lists and reasonable response times for any benefit to be gained from a service. School nurses talk of fast track referrals and quicker feedback from services, Teachers seem to wish to improve access to service by receiving help straight away, with more time from specialists on a regular and ongoing basis. Paediatricians tend to look at the wider picture with regard to what services they would like, focussing predominantly on increased staffing of non-specialist services, clinical psychologists and community (primary) mental health workers. Many social workers commend existing services but nevertheless state the need for an increase in workforce capacity to provide more immediate contact for young people, reduce waiting lists and lessen workload for specialist workers.



One respondent stated there must be a “greater awareness at a primary care stage in all agencies” (Community paediatrician CHD027) and all respondents require the development of adequate referral pathways:

“Routine referral service for GPs.” (General practitioner, GP0217)

“Who can we refer to other than the community paediatrician?” (School nurse, SCN197)

Some people are more specific regarding requirement:

“A quick and efficient referral route through new community schools with access to mental health workers/psychologists/psychiatrists when child first needs help – not when it is too late.” (Teacher, ED1606)

There is a general consensus that easier access to specialist mental health services and quicker response times from mental health professionals are needed. There is also an overwhelming sense that people are positive about existing structures, however, in building upon current services, increased staffing and resources for more services are essential. One paediatrician recognising the lack of trained professionals across the mental health and child care services urged a serious attempt to improve recruitment and workforce planning:

“Make links with local career advice services to try and influence local young people to consider training for these jobs. I'd consider what sort of skill mix was required in each locality and build teams.” (School doctor, CHD014)

Building upon services	Illustration
Early intervention	“A resource that could be used when early intervention is a priority, too often we see children when it is too late.” (Children’s panel member, PAN032)
Assessment	“A move towards multi-disciplinary care planning, integrating services at point of assessment.” (Residential worker, RW0092) “There needs to be a more uniform assessment process.” (Social worker, VOB114)
Bridging gaps	(person receives) prompt intervention.” (School doctor, CHD024) “Age barriers re assessed.” (Senior nurse, VOA165) “Sufficient input from clinical psychology and DCFP in order that every looked after child/ young
Locality of services	“Rural area provision.” (School nurse, SCNHV0059) “Local unit that combines health and social work, that can work with adolescents with severe mental health problems.” (Mental health officer, SW1103)

Table 9.1: Further examples of improving existing services

Integrated working/improved liaison

In developing new or improved services the importance of integrated working and planning was a powerful theme across all respondent groups. Good liaison, improved communication and a sense of involvement were all seen as essential.

One GP described interagency working as “ensuring communication is open and that all agencies are consulted so people are not isolated or duplicating work” (General practitioner, GP0282). Some respondents wanted more local interagency meetings to ensure their inclusion in planning. One respondent described their own service as so isolated “it might as well be on the moon” (Residential worker, RW0019). Services are quite often described as fragmented, with not only workers but also families feeling “isolated and floundering” (Health visitor, HV0117). Interdisciplinary discussions help ensure that needs are being met, in partnership with children and parents. The following ways to facilitate change in services were suggested:

- joint clinics and shadowing
- interagency meetings with adult mental health services
- linking with Education and Social Work at early stages
- demystifying processes by engaging in joint training.

Many people want clearer links to mental health services and actively seek more liaison. Several respondents would like to see more joint assessments, joint group work and interagency training. School nurses stress the need for more sharing of resources, ideas and information in addition to involvement in multi-disciplinary meetings. Teachers wish for a “greater dialogue” (Primary school head teacher, ED0505) between educational psychologists and class teachers to share approaches and strategies.

More direct contact and collaboration can provide an opportunity to gain a greater understanding of the roles of workers and services available. A social worker commented on the “more involvement with health services and CPNs – the less obstructive boundaries between child and adult psychiatric service” (Social worker, SW1305). Some people also discuss the need for single, integrated children's services encompassing social work, education and health care. Voluntary sector workers stressed the need for more joint health projects and more direct work. They also emphasised the importance of being “taken seriously by health and social services” (National development worker, VOA266). Voluntary workers also want to be more involved in health and management structures, emphasising the importance of good communication at organisational levels. Respondents identified the need for early consultation before structures are put in place, in particular, “there requires to be more consultation with coal face workers when planning services” (Social worker, SW2004). The importance of service user involvement was also recognised by some respondents who pointed out that we

“need involvement of young people at an early age. Statutory agencies need to learn to be facilitators.” (Health visitor, HV0121)

The need for structural change at organisational and planning levels was emphasised if attitudes and working patterns are to be improved.



New services

A wide range of other new or improved services were suggested by respondents – these include descriptions of current good practice that could be more widely applied. The suggestions include changes in the delivery of specialist CAMH services but there are also a number of proposals that could improve services provided by other agencies. In exploring these it is useful to draw on the *SNAP Report's* categorisation of promotion, prevention and care.

Promotion

There are not as many suggestions that are clearly designed to promote mental health as there are those that focus on prevention or care. Unsurprisingly, they come predominantly from the respondents involved in universal services such as GPs, health visitors and professionals working in schools. Several GPs reported how they were able to respond opportunistically to introduce a health promotion component to their work by raising these issues during routine consultations. Others organised these opportunities more systematically by using mechanisms such as sending cards to all teenagers on their thirteenth birthday or arranging other age triggered strategies such as the clinic described below.

“[We] arranged clinic within health centre for all youngsters on their 16th birthday to discuss health concerns contraception, drug issues, appropriate use of health service, acne, smoking, alcohol.” (General practitioner, GP0049)

Other professionals argued for a number of changes that would promote the health and emotional well-being of children and young people in Scotland. One health visitor for example made a plea for “more community based initiatives ... to assist young people in using their free time positively. Encouraging sport and physical fitness seems like a good place to start” (Health visitor, HV 0054). Some respondents suggested the introduction of massage and relaxation techniques for school children.

Teachers and school nurses saw the school setting as a good place in which to develop strategies for mental health promotion. One school nurse has her own plans:

“Emotional intelligence training. I am presently reading up on this and enquiring about emotional literacy development to use with children of all ages.” (School nurse, SCN227)

Teachers stressed the importance of including emotional and mental health issues in the core teaching programme. One teacher explained that in his school “awareness raising of mental health and use of outside speakers will be built into new personal development course in S5.” (Secondary school guidance teacher, ED1704).

Prevention and early intervention

Most respondent groups from questionnaire A mentioned informal drop-in centres for practical advice for children and young people, and the availability of peer support and befrienders. Specialist CAMHS staff also gave many examples of innovative work, often in conjunction with other agencies. For example, one clinical psychologist wrote of her work in starting a self-esteem workshop in a local secondary school to help 6th-year pupils with their stress. Another spoke of an early intervention workshop for schoolchildren aimed at mental health. She regarded this as important not only because

it might help these teenagers to look after their own mental health but also because it might help them with parenting issues when they themselves became parents in due time. Several specialist CAMHS workers mentioned early intervention projects, focussed on parenting, based at their local health care co-operatives and working in conjunction with health visitors. The importance of preventive work aimed at parents is a common theme among respondents with several people suggesting that this should start even before children are born:

“I think it would be good to have a pre-school (or even pre birth) service to help parenting skills.” (Primary school behaviour support teacher, ED1814)

There was a strong argument in favour of much earlier targeted work to prevent the onset of mental health difficulties or their deterioration. Several teachers wanted services to be available for very young children in school or nursery:

“A service which could respond more immediately at an earlier stage (e.g. pre-school early stages).” (Primary school head teacher, ED1109)

Other respondents wanted services to help particular at risk groups such as children and young people who have experienced sexual abuse; are bereaved; homeless; at risk of offending; and one GP mentioned a service for obese children.

Social workers too wanted sufficient resources to be able to work in a more effective way earlier in children’s lives:

“More staff so that a pro-active approach could be established. It is currently mostly reactive.” (Social worker, SW1202)

Teachers recognised that for some young people the normal school experience contributed to their emotional distress. One argued for “massive investment in alternative certificated flexible curricular provision” (Secondary school deputy head teacher, ED2420).

Respondents also wanted services developed that could increase the resilience of vulnerable young people:

“Monthly groups where children could go led by an expert specialist in music, art, drama, computing, sport. Could be accompanied by [a learning support worker] who could assist and then follow up in house. Children acquire new skills and have something extra to help raise self-esteem. Existing specialists could be timetabled to deliver this.” (Primary school class teacher, ED0701G)

Care

A strong theme across respondents is the need for a service that brings agencies together at one central point. There are, however, slight variations across professional groups:

“A ‘one door’ approach to the problems, offering the client all agencies under ‘one roof’.” (Police sergeant, P0004)

“A single point of entry into all existing services, with appropriate assessment to direct child towards appropriate management.” (General practitioner, GP0157)



“A fast track assessment centre which would take nurse referrals, almost like triage.” (School nurse, SCN161)

“Co-ordinator who could quickly assess needs and identify the best placed agencies/specialists, cut down the guess work.” (Primary school head teacher, ED2805)k

There is no doubt that respondents feel an urgent need for some form of rapid assessment that can be simply and reliably accessed. This is by far the most frequent suggestion made for improving specialist services for children and young people.

There are, however, other suggestions for new services. A number of respondents suggest help-lines or email support providing 24-hour advice and guidance for professionals and parents. GPs and health visitors identified a need for community psychiatric nurses, specialising in child and adolescent psychiatry. Community paediatricians propose an increase in trained school nurses to fulfil a liaison role, and another paediatrician requested input from “psychology as part of paediatric care” (Hospital paediatrician, CHDVOA303). One respondent argued for a national strategy to deal with sexually aggressive children.

Respondents also want a move away from traditional methods of intervention and some urged increased use of creative therapies such as music therapy.

“Increase in therapeutic services. Less emphasis on talking therapies. More variety. Genuine multi-disciplinary approach. Specialists working in the community, not only in clinics.” (Social worker, SW2905)

“More groups run for children with difficulties – art therapy, play + drama therapy for children with mild/ moderate difficulties.” (School nurse, SCN186)

Paediatricians wanted to see new and improved services for young people with learning disabilities of various kinds. This group of young people was seen as sometimes being neglected by specialist CAMH services and unable to access services as easily as their peers.

“Service for children with learning difficulties who also have emotional or behavioural problems.” (Hospital paediatrician, CHD016)

Another particular area of concern was the provision of services for looked after and accommodated children. One residential worker wanted a child-centred CAMH service that provided stability:

“Someone linked to a child who was involved on a long-term basis to make ongoing assessments and provide advice.” (Residential worker, RW0063)

Residential workers and social workers also wanted CAMH services that could provide crisis help when they were dealing with very difficult or distressed young people.

A more common response, however, among residential workers, social workers, panel members and reporters was to suggest some form of specialised residential resource.

The following quotation demonstrates some of the factors that respondents think are important in such a service:

“more intensive treatment on a residential placement for the young person where the needs could have been met within a living environment offering a nurturing environment combined with mental health treatment.” (Residential worker, RWSW1505).

In addition, residential resources for children with particular difficulties are mentioned:

“Specialised units with trained staff. Units for young people with drug abuse. Unit for young people [with] alcohol abuse. Unit for young people who have been sexually abused etc.” (Residential worker, RW0247)

Panel Chairs and Reporters want services that will provide them with decent assessments to support their decision making:

“Residential facility for assessing the degree of difficulties faced by the young person. This would include a psychiatric assessment. On the basis of the results appropriate treatment and placements could be identified and commenced.” (Panel Chair, PAN005)

They also want more locally based close support units to prevent admission to secure accommodation.

“A locally based service a specialised unit for the young people we deal with who are deemed to be at risk to themselves and others to avoid the use of secure accommodation.” (Reporter, REP007)

The final suggestion in this section is to develop residential provision for whole families:

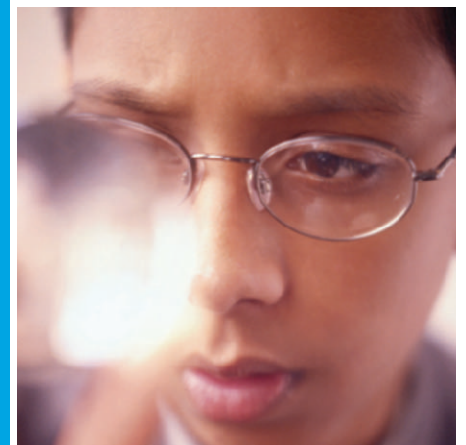
“Local fully furnished fully resourced residential assessment centre for child/young person and their families.” (Social worker, SW0301C)

Conclusion

For many practitioners, the most important change in services would be to make the current system work better. Frustration at delays in accessing a service and failures of joint working lie behind the strongly expressed wish for the introduction of a “triage” or “one stop shop” system. In addition, however, respondents demonstrated their wish to place families and children at the centre of service delivery with a number of people arguing for user involvement in planning services. Professionals also recognised their own need for support and advice in dealing with children in turmoil.

There is an understanding of the powerful effect (both positive and negative) that schools can have on children’s emotional well-being. Many professionals wanted schools to be places where children could access a wide range of mental health services. Several respondents believe that help was provided too late for many young people and they strongly advocated very early intervention for children at risk, often citing parenting groups as a useful way of achieving this. Finally, a clear need was also identified for more therapeutic and specialised residential services for looked after children.

CHAPTER 10 CONCLUSIONS AND RECOMMENDATIONS



“Glad that a change looks like coming. Greater need for all to work for the benefit of the individual without too much red tape and interagency misunderstandings.” (Primary school class teacher, ED0503)

Although this report draws on the views of almost 1,300 professionals from a variety of backgrounds, we should remind ourselves that the findings may not fully represent the experience of all those who work with children and young people in Scotland²².

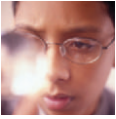
Respondents to surveys tend to be those with the most strongly held views, and the authors certainly read many passionate accounts. Nevertheless, the rich data and the analytical approach give a broad and deep perspective on the work of professionals with children and young people. The authors therefore regard the report as offering an account of many of the strengths and weaknesses of current arrangements for addressing the mental health needs of Scotland's children and young people. As such, it can, perhaps, be viewed as a source of feedback to all concerned in planning and delivering the initiatives and services represented by the respondents. Despite the great diversity that respondents experience in terms of geographical location, economic environment, client groups and professional role, clear themes and shared concerns consistently emerge.

Complexity and inter-relatedness of problems

Some respondents described simple problems responding rapidly to interventions. All the professional groups, however, deal regularly with complicated and entrenched difficulties affecting not only young people but also their families and communities.

Among the most worrying cases described by non-CAMHS respondents, many involve drug misuse, abuse and family-based difficulties which require a comprehensive response from multiple services. The problems of children and young people may not only be complicated in themselves but may sometimes be compounded by the responses of peers, families and other agencies. Similar themes emerged in the SNAP Consultation with Children, Young People and Parents^v

²² See appendix A for a description of how the sample of respondents was obtained.



“It affects his self-esteem and confidence. He also had Perthe’s disease when he was five and was in a wheelchair for three years. These health issues made his behavioural problem more difficult to deal with. It was most difficult for him to cope in school because of the pressures on him, there were more demands on him to concentrate and to control his behaviour. For a whole year my son was made to sit in the corridor at primary school because of his behaviour. Children are told they are bad and they begin to believe that.”
(Parent of child with ADHD)

‘Too little, too late’

“Prevention and early intervention can make all the difference. There is nothing worse than watching a young person suffering and be unable to help due to lack of provision.”
(Residential worker, RW0153)

All professional groups made the point that it was the rule rather than the exception that opportunities for early intervention were missed. It is noteworthy that this point was repeatedly made, irrespective of the age of the client and the severity of his or her difficulties. Again, the *SNAP Consultation with Children, Young People and Parents’* highlighted identical issues:

“ I’ve been aware of problems since he was two but I could not get the problem recognised between the ages of 2-9.” (Parent)

Children keep growing and developing and problems can become entrenched. Furthermore, unresolved problems at key developmental stages can have enormous knock-on effects on learning and relationships which can be difficult or impossible to reverse.

All non-CAMHS professional groups (more than three quarters of respondents) highlighted delays in accessing services as a major barrier to optimal care for children and young people. On the other hand, several CAMHS respondents emphasised the problem of “inappropriate referrals” causing logjams and wasted resources. These perspectives from opposite sides of the boundary between agencies merit specific attention - they point to a need for creative ways to assess problems rapidly and direct children and their families towards the best service to meet their needs.

Stigma

Again, the findings of this survey of professionals resonate with those of the *SNAP Consultation with Children, Young People and Parents’*. Stigma was repeatedly mentioned by young people at the consultation event as a major barrier to approaching professionals for help. Mental health problems are still seen as socially excluding. Respondents often report that young people are unwilling to be seen to access services. School nurses in particular wrote that they were aware of serious emotional difficulties experienced by young people who refused onward referral. Over a third of non-CAMHS respondents identified reluctance among young people as a barrier to accessing services. Professionals who have most contact with children in difficulty such as residential workers or social workers appeared to be most aware of this reluctance.



Resources

People frequently highlight lack of resources in both time and money to deal with all aspects of service, i.e. promotion, prevention and care. This confirms the message of the *SNAP Assessment of Child and Adolescent Mental Health Needs in Scotland*ⁱ that there is a serious problem about capacity both in the specialist CAMH services and in the wider network of CAMH provision in Scotland. The Scottish Executive through the Child Health Support Group has published a framework documentⁱⁱ which is designed to assist local services in planning and delivering improvement in children's and young people's mental health. At the same time a Child and Adolescent Mental Health Workforce Group has been set up to consider ways of building capacity across a range of agencies.

Working together

Key issues in the relationships between services are highlighted in the *SNAP Consultation with Children, Young People and Parents*^v.

“Parents of younger children identified the need for integrated care, with the different elements co-ordinated so that the child and family are at the centre of the care that is being provided for them by family centres, school nurseries and primary schools. Transitions between services provided by different agencies, especially for young children, are currently almost incomprehensible to people outside of the services ‘system’. There is often little explanation of who provides what service or why. Parents who have to try to work with the system fail to see why these services are not already co-ordinated with each other for the benefit of the child and their family members.”

There was a high degree of concordance among respondents that optimum care requires effective collaboration between agencies and individual professionals. There was, however, an equally strong degree of agreement that this is often not achieved and many respondents described experiences of not being listened to or understood by other professions. The accounts suggest a number of strands to this difficulty. One is that barriers to working together effectively can result from structural and planning failures. A second is that professionals with different backgrounds, trainings and tasks bring different discourses to bear on their work, reflected in their values, their use of language, and their practice. Differing understandings of confidentiality, for example, could prevent professionals working together well. A third strand reflects the emotional task which is involved in supporting children and young people in distress, with respondents' accounts suggesting that this sometimes finds expression in heightened tension between the adults and agencies involved. These statements were most commonly made by people whose role made it more difficult to define and restrict the boundaries of their work with children and young people in distress²³.

Specific interfaces were consistently reported as giving rise to problems, and the interface between social work and CAMHS is particularly noteworthy in this respect. Particular problems resulted from some professional groups being unable to refer directly, instead having to rely on social work or GPs to refer on to other agencies and thus gain access to support and services. Transitions between services for children and young people and adult

²³ For example, the head teacher explaining on page 81 that his views, based on many hours of contact with a child, are usually ignored.

services were frequently identified as problematic. Other “boundary” problems occurred when relevant agencies were geographically separated – as often occurs for children placed away from their own local authority. Finally, some children had problems for which no service would take responsibility. These particular accounts led to considerable discussion amongst the members of the research group, best distilled in the question “how can we ensure that those children or young people with the most complex difficulties gain access to services?” Recalling that the phenomenon of exclusion of such children and young people was described clearly in *For Scotland's Children*²⁴, the research team considered how agencies experience and express their accountability, particularly to these children and young people, and to those who care for them and work with them.

Many good examples of “joined up working” were given by respondents. There were excellent examples of liaison work and consultancy, and of services “pulling together” and working in intelligent networks. These good examples²⁴ were often characterised by a combination of effective structures for joint working and flexibility and commitment from individual practitioners.

Support and training

All groups wrote of the distressing nature of this work and the need for ongoing support and training. Support and training are necessary for everyone working with children and young people. The type of distress described, however, differs markedly between groups. Several CAMHS professionals talked about being overwhelmed by numbers and feeling burnt out as a result. GPs experienced stress at being unable to access a service fast enough to help families and children. Those who worked more intimately with children such as foster carers, residential workers or teachers described a different quality of fear for themselves, the child or others and were desperate for direct help, advice or support in containing and managing the young people with whom they work. Those who had had access to consultancy from CAMHS professionals were very positive about its impact – mirrored by a number of CAMHS workers who saw this as a strength in their particular service

Most of the non-specialist CAMHS respondents wanted access to more formal training to help develop basic knowledge and skills and many suggested that interagency training would be helpful. *The SNAP Consultation with Children, Young People and Parents*²⁴ identified certain areas where practitioners could be offered training beneficial to young people:

“[Emotional health is] not talked about in school and dealt with. We do get some stuff on drugs, sex, but there is no mention of everyday life. Are the teachers qualified to?”

Some young people also did not believe that professionals always had the right skills to work with them.

“Training for all professionals (including psychiatrists) in people skills”

²⁴ See for example, the description of effective inter-agency working on page 78/79



NHS Education for Scotland has recently published a competencies framework^{iv} which addresses some of these concerns. It focuses on developing the knowledge and skills of people involved in the three key areas of working with children who may have mental health problems – promotion, prevention and care.

Other issues

Although a few people mentioned the importance of the social context within which children live, it received very little emphasis as a factor in children's emotional difficulties. Most of the issues highlighted were individual experiences of trauma, abuse or family difficulties. There is considerable evidence that social factors contribute substantially to the likelihood of a child or young person having a significant mental health problem. For example, in the most recent Office for National Statistics (ONS) survey^{xi}, children with significant mental health problems were more likely to be living in poverty than other children. They were also more likely to have parents with no educational qualifications and to live in lone parent households. Likewise there were virtually no references to children's cultural or ethnic backgrounds as being important to their emotional well-being. This in part reflects the fact that Scotland is still predominantly a white community (98.8% of the population in the 2001 census²⁵) and is confirmed by the ONS data on the Scottish scene.

Since the data reported here were collected, however, many more refugees and asylum seekers have been accommodated in Scotland. It seems likely that many young people in these groups have had a series of experiences that might have compromised their mental health and they may need a greater focus within the network of CAMH services. We considered the absence of these social contexts from respondents' accounts to be an important finding. It may be an artefact of the data collection method, for example, respondents assuming that the survey group was more interested in the specific 'clinical' problems they were dealing with than the social context of the children and young people with whom they were working. This finding may, however, indicate that the connections between the problems described and the social contexts in which they arise are not well established in the thinking and practice of the respondents. It is therefore worth recalling that the description of mental health adopted in the CAMH SNAP report was "both personal and social" (p30) and emphasised the importance of "due reference to wider contextual issues" (p32).

Although a number of respondents argued strongly for the inclusion of young people at various different levels in planning services, this was not one of the major themes to be identified. This is in stark contrast to the importance accorded to this in the SNAP consultation^v. This reported that young people wanted to be involved earlier, more frequently and crucially to see some effect on services of the views they express.

"What's the point of having consultation if people don't act?"

²⁵ www.scotland.gov.uk/library5/social/aescr-02.asp

Variability across Scotland

The picture that emerged from the data was of enormous variability in services across Scotland. Some areas had no CAMH services for particular vulnerable groups such as learning disabled children or looked after children whereas others had teams specialising in these groups. Similarly there were pockets of innovative thinking and creative practice that had transformed the quality of services in particular areas. What did not emerge was that this variation was based on responding logically to different identified needs. There seems to be considerable difficulty in sharing good practice more widely and moving good ideas into mainstream services.

In conclusion

It is important to recognise the enormous commitment, compassion, and creativity that characterised the majority of respondents in this survey. There was a real determination to provide the best support they could to the young people with whom they worked and an ardent desire for change and improvement throughout the services. Respondents spoke of a lack of resources and a pervading sense of the emotional well-being of children being undervalued. Nevertheless, there is enormous goodwill, desire and potential to develop a much more effective response to the emotional needs of all our children.

RECOMMENDATIONS

Many improvements in service provision for children and young people with mental health needs were suggested by survey respondents. A high proportion of these suggestions would require the allocation of substantially increased resources. Resource allocation issues are currently being addressed in several ways, and we do not propose to deal with these issues further here.

Scotland may have a small population but we are a very diverse society and the best ways to meet the needs of children and young people in Shetland may be very different from the best ways in inner-city Glasgow. There can be no “one size fits all” solution for the whole of our country. Nevertheless, some general recommendations for good practice flow from the results of our work.



Preventing problems and early intervention

- There is a need for more widely accessible early intervention strategies from before birth and across the age range. The framework for promotion, prevention and careⁱⁱ envisages wide provision of early intervention. For instance wider provision of parenting groups, as recommended in the recent Hall 4 report *Health for All Children*ⁱⁱⁱ should be ensured.
- Early intervention requires early identification of problems. In some cases there are clear indicators, but there is a need for further research into identifying at-risk children and young people before they develop problems.
- There is a need for simple care pathways for children and young people in difficulty. All professionals working with children and young people should be able to gain access to the care pathway easily and without delay.
- Simple methods of assessing children and young people causing concern must be made available soon after problems are suspected. Such assessments should allow the direction of children, young people and their families towards the agency most likely to be helpful.
- There is a need for locally provided, low key services for the vast majority of children and young people with emotional and behavioural problems, and these services should be available where children and young people live their lives – for example, schools and residential homes.

Making the system work

Respondents encountered many frustrations dealing with “the system”. These require imaginative responses from all levels of professionals responsible for the emotional well-being of children in Scotland.

- There should be a strong political commitment to the importance of the mental health of children and young people supported by policy development and implementation strategies by the Scottish Executive in consultation with other key agencies.
- At regional and local level, multi-agency strategies should be in place to identify need and to develop local solutions.
- The importance of individuals and agencies working carefully and constructively together around children and young people with particularly complex needs cannot be overstated. All agencies need to be pro-active in the development and maintenance of shared strategies.

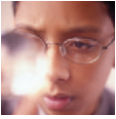
Plugging the gaps

Several gaps were identified within both the health and social care services.

- There are problems in accessing services in remote rural areas. While some of these difficulties could be tackled by technical innovations such as teleconferencing, creative solutions to service provision and more resources are required.
- There is no consistency in managing the transition between child and adult services. For some young people such as looked after children transition between services coincides with a time of increased vulnerability as they have to negotiate the difficulties of independent living. There should be a national policy on transition arrangements.
- Some respondents experienced referral criteria as excluding the young people with whom they work. A strategic multi-agency approach to referral criteria should be taken at area or regional level to ensure that gaps in services do not exist (for example, service A only sees “mild” cases, service B sees “severe” cases and no one sees the people falling in between).
- Some groups were less likely than others to have a consistent service throughout Scotland. In particular, learning disabled children and looked after children in some parts of Scotland had difficulties accessing specialist mental health services for children and young people. There should be explicit provision for such vulnerable groups across all areas.
- Agencies should review together the arrangements they have made to ensure the availability of appropriate services for those children and young people with the most complex needs.
- There are serious concerns at the lack of specialised therapeutic residential services for particularly troubled young people. A more strategic approach to identifying need and developing resources is required at national and regional level.

Working together effectively

- Creative solutions need to be found to the problems in communication between members of different professional cultures. The issues of dialogue and development between organisations can, and should, be informed by ongoing research and evaluation. Identification of the factors which enhance and sustain these relationships is required, as is systematic work between professional bodies to address areas of particular tension such as differing understandings of confidentiality.
- Time spent in feedback to referring agencies by mental health specialists is time well spent, if that feedback is appropriate. This approach should become standard practice and should include clear advice on how to support children in their daily lives.



- All carers and professionals working with deeply distressed children and young people deserve sensitive and thoughtful consultancy and advice. This is a skill and service that should be developed further by specialist mental health services for children and young people. This recommendation emphasises the importance of capacity building within the specialist mental health services.
- Innovative means of linking people together effectively need to be found. Examples might include e-mail discussion groups for professionals dealing with emotional and behavioural problems, sharing resources, arranging meetings etc. These solutions might involve more inter-professional training and resources for administration and technical support for such groups.

Training

Training was identified across all groups as an area for development.

- The different levels of training in specialist mental health services for children and young people should be developed in a coherent way that allows different professional groups to access them instead of each duplicating their own training.
- Teaching and training should be endorsed as a core part of the role of the specialist mental health services for children and young people. These services should be given the capacity to extend and develop their teaching and training roles.
- Professional staff within the specialist services should have the necessary learning and professional development opportunities to allow them to build their knowledge and competence. This involves recognising the vital role played by senior staff within these settings in supporting the learning of their less experienced colleagues.
- A coherent training strategy based on the competencies framework^{iv} should be developed for practitioners within the wider network of services for children and young people. This should address basic knowledge and skills but also allow for progression.
- There should be serious attempts to introduce regular inter-disciplinary training both at qualifying level and in further professional development.
- All training should include a focus on the influence of social factors on mental health as well as the importance of individual experience.

Accountability to children, young people and families

- The participation of young people and their families should be a fundamental aspect of both service planning and individual care plans.
- Further investigation is required to identify appropriate mechanisms by which agencies can express their accountability to children, young people, their parents and carers.

Evaluation and dissemination of good practice

- Innovative ways of sharing good ideas and putting them into practice need to be explored. Possible mechanisms might include: a dedicated website; a directory of services; and regular national conferences to bring service users and professionals together.
- The service developments recommended here have arisen from the experiences and views of a broad range of professionals. While each appears logical and sensible, they may have unforeseen consequences. The process of developing new services requires careful consideration of how evidence and experience gained elsewhere can be applied in the new local context. There should be a commitment to evaluate all new service developments rigorously.

INTRODUCTION

Having decided that surveying was the method of choice, the SNAP core group had to identify whom to survey. The main issue in this respect was whether to survey whole populations or (more or less) representative samples. A decision was taken to survey whole populations, where this was feasible. The particular implications for each stage of the survey will be discussed later.

Phase one

There were two main phases in the survey, designed to complement each other. In the first phase, the aim was to survey those who commissioned, organised and led initiatives and services for children and young people. The aim here was to have a “view from the top down” of what was happening. Therefore during Phase One:

- All NHS Boards in Scotland were asked, through their Directors of Public Health, to describe their commissioning role and activities.
- All NHS Boards in Scotland were asked, through their health promotion unit managers, to describe their approaches to promoting mental health for children and young people.
- All NHS Trusts in Scotland identified as providing a mental health or psychology service for children and/or young people were approached; the clinician identified as leading that service was asked to describe their activities.
- All Scotland's local authorities were approached and a senior figure responsible for organising and/or delivering children's services was asked to describe their activities
- 39 voluntary sector organisations (listed in appendix B) were contacted²⁶ via their director or chief executive and invited to describe their activities.

During Phase One, all relevant informants were contacted. In other words, whole populations were surveyed. Reminders were issued as were invitations to discuss any difficulties with completing the survey forms. The response rates are shown in table A1.

Respondents	Number	Sample	Response rate (%)
Directors of Public Health	12	15	80
Health promotion unit managers	15	15	100
Leaders of NHS CAMHS	27	30	90
Social work leaders	19	32	59
Voluntary sector leaders	14	39	36

Table A1. Response rates in the Phase One survey

²⁶The survey of voluntary sector leaders was conducted simultaneously with the Phase Two surveys.

The Phase One data were elicited mainly as quantitative accounts of activities and populations. The results of the Phase One questionnaires, with the exception of the voluntary sector leaders, have already been reported¹.

Phase Two

The second phase of the survey was designed to elicit “views from the ground”. This was to be achieved by surveying widely amongst those who worked closely with children and young people. At an early stage in this discussion, the members of the core group began to identify two distinct sets of concerns emerging – one was to characterise the circumstances and practice of those with a specialist mental health or psychological role, the second was to enrich the awareness and understanding of the kinds of “mental health related” experiences of those who did not have that specific role.

Questionnaire A

The approach to sampling followed standard principles, but was governed by a primary (pragmatic) concern: how can a small team with limited resources achieve wide penetration with these questionnaires and achieve a good response rate? Therefore early attention turned to identifying paths for distribution and collection of questionnaires.

Who was surveyed?

Table A2 shows the groups identified for surveying:

	INCLUDING	EXCLUDING
SOCIAL SERVICES	Social workers Residential workers Foster carers	
YOUTH JUSTICE	Reporters to Children’s Panel Panel Chairs Police	
EDUCATION SECTOR	Teachers	Educational psychologists (questionnaire B)
HEALTH SECTOR	General practitioners Health visitors Paediatricians School nurses	CAMHS workers (questionnaire B)
VOLUNTARY SECTOR	Trained workforce, working with children and young people, or in mental health	Trained mental health workers (questionnaire B)

Table A2. Groups identified for surveying

Sampling arrangements

This amounted to some 12 groups in all. Balancing three considerations – keeping the total amount of data collected manageable, achieving representative samples and a design which could be implemented – the survey team adopted the initial aim of recruiting between 250 and 300 respondents in each case.

In almost every case the total population of the group was considerably in excess of this number. Samples therefore had to be identified and recruited, using a variety of strategies. These are described here, followed by a summary of the eventual sample sizes and response rates.

Having identified the size of sample required in each category, the next task was to determine the structure of the sample. We chose geographical “units”, with the local authority serving as the “unit” for social services, youth justice and education, and the health board serving as the “unit” for all health services.

In each instance, the sample from each “unit” reflected the size of that population, as a proportion of that the total Scottish population. The formula:

$$\text{Sample from area } X \div \text{Total sample} = \text{Population of area } X \div \text{Total population}$$

The single exception to this approach to building samples was within education services, where the sample was constructed in relation to the population of teachers in that geographical “unit”, i.e.

$$\text{Education sample from area } Y \div \text{Total education sample} = \text{Numbers of teachers in area } Y \div \text{Numbers of teachers in Scotland}$$

That figure was then rounded up to the nearest multiple of 5. This rounding up allowed us to over-sample the smallest areas – such as the local authority of Clackmannan and the health board areas of Orkney or Shetland – and also afforded easier to follow instructions, an important consideration given the distribution arrangements which had to be made.

Social services

Social workers

The social work sample was made up of child and family social workers, based in local authority social services departments.

They were approached via the local authority contact identified in Phase One. Because the Phase One response rate was just under 60%, contact was made to confirm that the access arrangements were still suitable.

Residential workers

The structure of this sample was decided in close consultation with the Scottish Institute of Residential Child Care. The overall number of respondents sought in each area was determined in the same way as before, but that overall number was sub-divided to ensure that a representative mix was achieved of the different kinds of workers: residential worker, senior residential worker, unit manager, head of care, night worker.

Foster carers

It did not prove possible to access a representative sample of foster carers. Instead questionnaire A was distributed through a voluntary support network for foster carers.

In practice it proved impossible to track the number of questionnaires distributed. Completed responses were received from thirty-eight respondents and are included in the analysis of questionnaire A.

Education sector

With the help of the Association of Directors of Education in Scotland, approaches were made to all 32 Directors of Education. They were invited to arrange the distribution of questionnaires to their staff. The Directors of 'Band 1' local authorities received batches of 9 SNAP A questionnaires and one SNAP B questionnaire. 'Band 2' directors received 20, 'Band 3', 30 and 'Band 4', 40.

BAND 1	Fewer than 500 teachers
BAND 2	501 – 1000 teachers
BAND 3	1001 – 2000 teachers
BAND 4	More than 2000 (maximum: 4617)

Table A4. Local authority banding for education sample

The nine A questionnaires were distributed as follows: four to primary head teachers, one each to a nursery head teacher, a secondary head teacher, a special school head teacher, a guidance teacher and a teacher in a school for young people with emotional and behavioural difficulties (EBD). The B questionnaire was sent to an educational psychologist within the authority.

This pattern was designed in consultation with education colleagues to gather a breadth of educational perspectives. The choice of which individual teachers to sample within each authority was made by the education directorate, albeit informed by suggestions about a representative sample. Consequently there is no way of characterising the sample, beyond the kind of teacher and the local authority base. In other words, another methodological "wrinkle".

The anatomy of this sample meant that to achieve adequate "cell" sizes (> 60), the total sample number has to be scaled up. Consequently the education sample for questionnaire A was 603 – chosen to allow adequate sample size within each category.

Health workers

General practitioners

A sample of 280 general practitioners was identified with the help of ISD, the Information and Statistics Division of NHS Scotland. The numbers required from each area having been established (Table A4), a random sample of GPs was then selected within each area.

Health visitors

The core group was not able to identify a nationally held list of health visitors. The decision was made to ask half of the general practitioners who were being surveyed to pass a

questionnaire on to a health visitor colleague. The decision to do this only in half of the cases reflected a concern that additional requests such as this may deter response. We are aware that one consequence of this approach is that we did not sample health visitors who are not attached to general practices.

Paediatricians

The core group was unsuccessful in its attempts to realise the aspiration of surveying all paediatricians in Scotland. Copies of questionnaire A were, however, distributed to all 70 members on the mailing list of the Scottish Association for Community Child Health, which represents doctors working in paediatrics and child health in the community

The absence of hospital paediatric staff is recognised as a gap in this survey which the core group tried unsuccessfully to rectify.

School nurses

The national database of school nursing services was used to identify a senior nurse in each area, who was asked to distribute a specified number of questionnaires to a designated sample of school nurses.

Youth justice

Reporters to Children's Panel

This survey was conducted shortly after the establishment of the Scottish Children's Reporters Administration. Contact with that new organisation led to an arrangement whereby, rather than survey a sample of reporters in each local authority area, the Authority Reporter in each Local Authority area was asked to complete a questionnaire A. Although there are 32 Local Authorities, some Authority Reporters are responsible for more than one area. Accordingly two individuals were surveyed twice, in relation to the experiences in different areas.

Panel Chairs

In each local authority area, Children's Panel members have a Chair, who links with other Panel Chairs across Scotland. The Chair of that national network distributed questionnaire A to the Panel Chairs in each of the 32 LA areas.

Police

Proposals to survey police officers were similarly difficult to bring to fruition. Five completed questionnaires were returned, all from sergeants working in women and children's units.

Voluntary and other agencies

A range of 39 agencies involved with children and young people, mental health or both were approached to participate in the survey (see Appendix B). All were voluntary, except one private sector care organisation and one comprehensive NHS sexual health service. Letters were sent to the Chief Executive, or equivalent, asking that they: arrange the completion of a Phase One type questionnaire describing the agency; identify the number of staff working with children and young people; distribute copies of questionnaire A to all or a proportion (according to size of agency) of those who were not employed as mental health specialists; distribute copies of questionnaire B to all of those employed as mental health specialists; report back what they had done, as part of their own "Phase One" questionnaire. Fourteen out of 39 did so.

Questionnaire B

As already indicated, this was the questionnaire designed for mental health and psychology practitioners working with children and young people. Three main groups of such practitioners were identified: education; health and the voluntary sector.

Education

There were a number of practical difficulties in arriving at the best way to recruit a sample of educational psychologists. On the advice of the Association of Directors of Education in Scotland, the same formula was followed as was adopted for the rest of the education sample. Therefore, each group of nine A questionnaires to be distributed by education authorities was accompanied by one B questionnaire. The total number of B questionnaires distributed to local authorities was 87. 28 were returned, a response rate of 32%. Given the distribution method, it is not possible to identify the causes of attrition.

Health

Phase One information suggested that the total NHS CAMHS workforce was in the region of 500. Given that concern about this particular sector was a significant factor leading to the commissioning of the SNAP report, and the apparent feasibility, a decision was made to survey that whole population.

At the time of the study, 12 of the 15 NHS Boards had local CAMHS. Where there was a service, it was likely that this would be offered from more than one place, e.g. there may be a multi-disciplinary service **and** a uni-disciplinary (clinical psychology) service, or there may be separate services for children and young people. Accordingly, some 30 services were identified across Scotland as offering some kind of dedicated mental health service for children and/or young people.

The team wrote to the leaders of these 30 units, inviting them to participate in Phase Two and inviting them to indicate how many questionnaires they would require to distribute them to all members of professional staff.

Voluntary (and independent) sector

Because of their involvement in delivering dedicated services, the core group knew of the existence of those who work in the voluntary sector in an explicit psychology or mental health role. The group was unable to establish how many there might be. The recruitment method already described did not allow this figure to be established and therefore it is not possible to report a response rate for this group.

APPENDIX B. LIST OF VOLUNTARY SECTOR AND OTHER ORGANISATIONS APPROACHED

1. Aberdeen Foyer
2. Aberlour Child Care Trust
3. Barnardo's
4. Big Step
5. Bridges Project
6. Capability Scotland
7. Care visions
8. Childline
9. Children 1st
10. Children in Scotland
11. Crew 2000
12. Dundee Young Women's Project
13. Edinburgh Youth SIP
14. Enable
15. Facilitate Scotland
16. Glasgow Women's Aid
17. Mental Health Foundation
18. NCH Action for Children
19. Notre Dame Centre
20. NSF Scotland
21. Penumbra
22. Quarrier's
23. Renfrewshire Association of Mental Health
24. Richmond Fellowship
25. Saheliya
26. Sandyford Initiative
27. Scottish Council for Voluntary Organisations
28. Scottish Institute of Human Relations
29. Scottish Throughcare & Aftercare Forum
30. Sense
31. Shelter
32. Speakeasy
33. Stepfamily Scotland
34. Stonewall
35. The Corner
36. Who cares?
37. YoungMinds
38. Young People Speak Out
39. Youthlink

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