

Child and adolescent mental health

A guide for healthcare professionals

June 2006



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There were no competing interests with anyone involved in the research and writing of this report. For further information about the editorial secretariat or board members please contact the Science and Education Department which holds a record of all declarations of interest : info.science@bma.org.uk

Abbreviations

ADD	Attention deficit disorder
ADHD	Attention deficit hyperactivity disorder
AMHS	Adult mental health services
ASD	Autistic spectrum disorder
BME	Black and minority ethnic
CAMHS	Child and adolescent mental health services
CORC	CAMHS Outcome Research Consortium
DDA	Disability Discrimination Act
DH	Department of Health
DRC	Disability Rights Commission
ICD	World Health Organisation International Classification of Diseases
LA	Local authority
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NSF	National Service Framework
ONS	Office for National Statistics
PCT	Primary care trust
PHIS	Public Health Institute for Scotland
PSA	Public Service Agreement
SHA	Strategic health authority
SNAP	Scottish Needs Assessment Programme

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Foreword

The British Medical Association has long been concerned with the health of children and young people. The BMA's Board of Science has produced a number of health promotion publications on this group, including *Growing up in Britain (1999)*, *Eating disorders, body image and the media (2000)*, *Adolescent health (2003)* and *Preventing childhood obesity (2005)*.

Mental health problems in children and young people are of great significance to public health. Children and young people make up about 25 per cent of the total population of England.¹ Not only do mental health problems impact on the lives of the individual concerned, limiting their ability to cope with life and fulfil their potential, they also have a considerable effect on their families and carers. Further, psychiatric disorders in childhood may persist, increasing the risk of problems in adult life.² Research has shown that of those with mental health problems at the age of 26, half had met the criteria for a disorder by age 15. It should, however, be noted that a mental health problem in childhood does not necessarily lead to an adult disorder: the majority of children with anxiety or depression will not have mood disorders in adult life.³

Certain groups of children and adolescents are at greater risk of suffering from mental health problems. As this report highlights, socio-economic factors play a significant role, and there is a higher prevalence of mental health problems among children from deprived backgrounds. Looked after children (ie children in the care of local authorities) are at particular risk, as are refugee and asylum seeker children, and young offenders.



Professor Sir Charles George
Chairman, Board of Science

The Board of Science, a standing committee of the BMA, provides an interface between the medical profession, the government and the public. One major aim of the Board is to contribute to the improvement of public health. It has developed policies on a wide range of issues such as alcohol, smoking and eating disorders, and specific groups such as children and the elderly.

Introduction

Mental health problems are difficult to define. The term covers a wide range of problems, from the worries and concerns of everyday life, to severe and debilitating disorders such as depression. These problems become a cause for concern when they severely affect the individual's ability to function on a day-to-day basis. It is often not easy to distinguish between normal and abnormal behaviour; the boundaries are not clear cut, and different social and cultural customs influence what is considered to be unusual.^{4,5} Similarly, different professionals may use different terminology to describe a condition: 'A child psychologist might categorise certain symptoms in a child as "conduct disorder". An education psychologist, seeing the same symptoms in a child in the classroom, may describe them primarily as "emotional and behavioural difficulties".⁶ The following definition is used in the *National service framework for children, young people and maternity services*: 'Mental health problems may be reflected in difficulties and/or disabilities in the realms of personal relationships, psychological development, the capacity for play and learning, and in distress and maladaptive behaviour. They are relatively common, and may or may not be persistent. When these problems are persistent, severe and affect functioning on a day-to-day basis they are defined as mental health disorders.'⁷ The Office for National Statistics (ONS) uses the term mental health disorders as 'implying a clinically recognised set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions'.²

Different levels of severity of mental health problems can be distinguished, as described in the BMA publication *Growing up in Britain*:

- mental health problems: relatively minor conditions such as sleep disorders or excessive temper tantrums
- mental health disorders: a marked deviation from normality, together with impaired personal functioning or development, and significant suffering
- mental illness: severe forms of psychiatric disorder, particularly of the kind also found in adulthood, for example, schizophrenia, depressive disorders and obsessive disorders.⁸

Throughout this report, the term mental health problem will be used generically to include all of the above, except where disorders or illnesses are specifically discussed.

Statistics show that at any one time in the UK, one in ten children under 16 years of age has a clinically diagnosed mental health disorder, and among 11-16 year olds, 13 per cent of boys and 10 per cent of girls are affected.² The government has recognised that mental health problems among children and young people is an important area of concern, and has set out guidelines and targets for provision of care, making resources available to help achieve these targets.

It should be noted that this report will not cover learning disabilities, although this is an important group, and includes particularly vulnerable children and young people. The Royal College of Psychiatrists states that: a general learning difficulty (ie difficulties in learning, understanding and doing things compared to other children of the same age) is not a mental illness. Unlike mental illness, from which people may recover, it is a lifelong condition. Children with learning disabilities, however, are more likely to develop mental health problems than other children.⁹ Approximately 40 per cent of children with learning disabilities will have a significant mental health problem, with emotional and conduct disorders being the most common.¹⁰ Page 17 highlights the need for more mental health services aimed at children and young people with learning disabilities.

Good mental health is not merely the absence of a problem. Those with good mental health are able to develop emotionally, intellectually and creatively, and have the resilience to cope with problems that life might throw at them. They are able to form effective and satisfying relationships, and live life to the full.^{11,12} The key to good mental health in children and young people is an approach that involves the whole person. Life events impact in a variety of ways on the emotional wellbeing of every child and young person. The way that children are parented, their diet and exercise, their school and education, and experimentation with drink, drugs and other substances, along with many other factors will all affect a child's mental wellbeing or mental ill health.

This report is aimed at healthcare professionals and policy makers. It examines the type of problems faced by children and young people aged five to 17 years and the prevalence of mental health problems among this age group. It discusses barriers to the necessary provision of treatment, including stigma and discrimination. It considers the strategies in place to provide care, looking at the situation in England, Scotland, Wales and Northern Ireland, and how effective these strategies are proving in practice. It goes on to look at mental health promotion, and finally makes recommendations for action and lists sources of further information.

Type of problems faced

Many children will suffer symptoms of some of these problems to a certain extent. For example, most children will feel low, moody or sad at some point; this does not mean that they suffer from depression. To be classified as a disorder, symptoms must be sufficiently severe to, in most cases, impair a child's normal functioning and cause distress.^{2,9} The categories broadly follow those used by the ONS in its 2004 survey, *Mental health of children and young people in Great Britain, 2004*, which are based on the World Health Organisation International Classification of Diseases (ICD).² (See appendix 1 on page 44 for a list of categories covered by the ICD) The Royal College of Psychiatrists, the charities Mind and the Mental Health Foundation, and Williams & Kerfoot (ed) *Child and adolescent mental health services (2005)*¹³ all provide more information about different types of child and adolescent mental health problems.

Emotional disorders

Emotional disorders are the most common mental health problems in children, and include anxieties, phobias and depression.

Anxieties and phobias are related to fear, which can be generalised, or specific to a situation or object; for example school or separation from a parent. For a problem to be classified as a disorder, behaviour needs to present as an exaggeration of normal developmental trends.¹⁴ Parents can take action to help allay children's anxieties, for example, by reassuring and supporting them, and talking about worries. If the child is unable to cope with everyday life, more specialist treatment may be necessary to deal with the cause of the anxiety and overcome the problem.

Depression: it is estimated that 1 per cent of children and 3 per cent of adolescents suffer from depression in any one year.¹⁵ Symptoms include sadness, irritability and loss of interest in activities. Associated features include changes in appetite, sleep disturbance and tiredness, difficulty concentrating, feelings of guilt, worthlessness, and suicidal thoughts. Depression can be treated through talking treatments, although it should be noted that these treatments are currently of limited availability in Child and Adolescent Mental Health Services (CAMHS).¹⁶ (See page 22 for further explanation of CAMHS.) Antidepressant drugs can also be used, but must be combined with talking treatments.^{9,17} (See box 1 below for an explanation of talking treatments.) The National Institute for Health and Clinical Excellence (NICE) recommends that children suffering from moderate to severe depression should only be given antidepressants in combination with psychological therapy. Children with mild depression should not be offered antidepressants.¹⁸ There is evidence that diet may have an impact on depression. Research studies have shown that a deficiency in omega-3 fatty acids is associated with symptoms of depression, and supplementation has led to dramatic improvements in some clinical trials. Similarly, an association has been shown between low levels of vitamins and minerals and depression. Studies have found that vitamin and mineral supplementation in combination with existing treatment led to more improved outcomes in depression than the treatment alone. It should be noted that while the evidence base of an association between diet and mental health is growing, more research is needed.¹⁹ More information about the effect of food on mental health can be found at www.foodandmood.org, a project supported by Mind. Further information about diet and exercise in relation to children can be found in the BMA report, *Preventing childhood obesity (2005)*.²⁰

Box 1: Talking treatments

Talking treatments are a means of exploring issues with a professional to gain a better understanding of problems, develop coping mechanisms, and help people change their behaviour. They include counselling, cognitive behaviour therapy, psychoanalysis, psychotherapy and self and group help.

Source: Sane at: www.sane.org.uk/public_html/About_Mental_Illness/Talking_treatments.shtml (Accessed January 2006).

Self-harm and suicide

Self-harm and suicide can be a symptom of underlying unhappiness or emotional disorder. Self-harm can include self-cutting, burning, hair-pulling or self-poisoning. It may be linked to suicidal thoughts, and is a way of coping with problems, a means of taking control, or a form of release from painful feelings.^{17,9} NICE has produced clinical guidance on treating those who self-harm.²¹ Research suggests that the incidence of self-harm is increasing among young people. A survey of school children in England in 2002 found that 6.9 per cent of young people had committed an act of self-harm, and it was more common in girls (11.2 %) than boys (3.2 %).²² The average age of onset of self-harm is 12 years.²³ A two-year national inquiry carried out by the Camelot Foundation and Mental Health Foundation found that self-harm is an issue that is poorly understood, even among professionals and school staff, and treatment is often inappropriate; for example focusing on the self-harm rather than the underlying causes. The report of the inquiry, *Truth hurts* (2006), calls for more comprehensive and targeted research into the issue, and sets out an agenda for change.²³

Suicide rates are very low in children, but start to increase from the age of 11.²⁴ Boys and young men aged 15-24 are most at risk, but there has been a decrease in the number of suicides in this group in the last few years.²⁵ Attempted suicide is more frequent: as many as 2-3 per cent of girls attempt suicide at some point in their teenage years.¹⁷ Attempted suicide is primarily a problem in older adolescents.²⁶ Depression, serious mental health problems and the misuse of drugs are all factors related to suicide attempts. Young people who have already tried to kill themselves, or know someone who has tried to kill themselves, are also at greater risk of attempting suicide.⁹

Eating disorders

During adolescence, young people's bodies change, and they can become more susceptible to external influences such as peer pressure and the media. This can lead to greater awareness of physical appearance. Some young people find it hard to cope with the experience of growing up. These factors can lead to concerns about weight, which in some cases can become problematic. Eating disorders include anorexia nervosa, where the person eats very little, effectively starving themselves, and bulimia nervosa which involves bingeing on food followed by induced vomiting or use of laxatives. The average age of onset of anorexia is 15, and of bulimia, 18.¹⁷

Both conditions can cause severe weight loss, which can lead to other medical conditions including osteoporosis and cardiovascular problems.²⁷ If left untreated, the disorders can result in death, either from the weight loss or from suicide. NICE has produced clinical guidelines on treating those with eating disorders.²⁸ The BMA publication, *Eating disorders, body image and the media* (2000), provides greater detail about both conditions, and discusses the role of modern society in the onset of these disorders.

Conduct disorders

All children will occasionally be badly behaved and disobedient. If bad behaviour continues for several months (six months, according to the ICD 10)¹⁴ or beyond the normal age period for misbehaviour, or if it is out of the ordinary and seriously breaks accepted rules, there may be a more acute problem, known as a conduct disorder. Conduct disorders affect a child's development and ability to lead a normal life, and can cause them distress. Typical behaviour includes unusually frequent and severe temper tantrums beyond the age that this is normally seen, severe and persistent disobedience, defiant provocative behaviour, excessive levels of fighting and bullying, cruelty to others or animals, running away from home and some criminal behaviour.^{9,2,14} According to the 2004 ONS survey, children with conduct disorders were more likely to be boys (69 %) and 55 per cent were aged 11-16.²

Hyperkinetic disorders

Hyperkinetic disorder is the official term in the UK for describing children who are consistently over-active and inattentive. Attention-deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) are also commonly used terms.⁹

Signs of hyperkinetic disorder include restlessness and over-activity, inattentiveness and difficulty concentrating, acting impulsively, and disruptive and destructive behaviour. Many young children occasionally behave in this way, but to be diagnosed with hyperkinetic disorder, a child must display both impaired attention and over-activity in more than one situation, such as at home and at school.¹⁴ Children with hyperkinetic disorder may find it difficult to interact with other children. Their inability to concentrate and restlessness at school impacts on their education, and can be extremely disruptive to other pupils. Their behaviour can also put significant strains on family life. These problems can persist into adult life; approximately two fifths of children with hyperkinetic disorder will still have some symptoms at age 18.¹¹ Most children do however settle down by the time they reach their mid-teens, especially if they receive appropriate treatment.⁹

Medication, such as methylphenidate, can help treat hyperkinetic disorder, reducing the hyperactivity, and improving concentration. Although this is only a temporary effect, significant improvements in behaviour are reported in children who are prescribed these medications.⁹ There is however concern about the prescribing of drugs to young children, and the *British National Formulary* advises that methylphenidate is not given to children under six years. Medication should only be used in association with other psychological therapies.¹⁷ The ONS survey found that 43 per cent of children with hyperkinetic disorder were taking some form of medication, most commonly methylphenidate.² The Royal College of Psychiatrists provides further information on the use of medication to treat hyperkinetic disorder.⁹ NICE is currently reviewing its guidance on the use of these medications,²⁹ and is working on guidance for treating those with ADHD, which is due in February 2008.³⁰ There is evidence to suggest that diet can impact on the behaviour of some children, which can improve on a diet low in sugar, artificial colourings and carbonated drinks.^{9, 17} Research trials have shown a link between deficiencies in essential fatty acids and ADHD; lower levels of essential fatty acids in the body correlated with symptoms of ADHD. Supplementation with omega-3 was shown to lead to a decrease in symptoms in some studies. Similar relationships have been found between iron, zinc and magnesium deficiencies and ADHD symptoms. Again, more research into the effects of diet on mental health is needed.¹⁹ See page 4 for references for further information.

Autistic spectrum disorders

The term 'autistic spectrum disorder' (ASD) describes a range of lifelong developmental disorders, which can come under the definition of learning disabilities, and are characterised by difficulties in social interaction, communication and imagination. ASD sufferers may appear indifferent or aloof, insensitive to others' needs and have difficulty cooperating with other people. They may have language problems, both understanding and speaking, as well as non-verbal communication. They can have problems with interpersonal play and imaginative activities, preferring instead familiar routines and resisting change.

There is a spectrum or range of disorders, from those with severe learning disabilities, some of whom may never speak, to those with average or above average intelligence, such as sufferers of Asperger syndrome. Some may be particularly talented in a specific area, such as drawing or mathematics.^{9, 31} For more information, please see the National Autistic Society at www.autism.org.uk.

Psychotic disorders

Psychotic disorders cover a range of conditions where a person suffers from symptoms such as delusions and hallucinations (see box 2 below). These include schizophrenia and bipolar affective disorder (commonly known as manic depression). The causes of psychotic illnesses are not properly understood; they can sometimes be genetic, and in schizophrenia and bipolar affective disorder, abnormalities in the chemistry of the brain are thought to be involved. The use of mind-altering substances, such as drugs, alcohol, glue and aerosols, can also lead to, and be a symptom of psychotic disorders. For more discussion on the links between substance misuse and mental health, see below. The incidence of psychotic illnesses increases in early adulthood. Treatment varies depending on the condition. Medication, sometimes taken over a long period, is usually an important part of treatment. Patients may need to be hospitalised, and talking treatments and support are often also useful.^{9,11} For more information, please see the Royal College of Psychiatrists at www.rcpsych.ac.uk and the Mental Health Foundation at www.mhf.org.uk.

Box 2: Delusions and hallucinations

Delusions: Fixed, unshakeable beliefs which are usually false and out of keeping with a person's educational, cultural and social background. For example: persecution, where a person feels that they are being harassed or harmed; grandiose delusions where a person feels that they have a grandiose identity or power.

Hallucinations: seeing or hearing things that are not real, but with a compelling sense that they are.

There are many more mental health disorders, but this report is not intended to include all of them. Examples include tic disorders, stammering and pica (persistent eating of non-nutritional substances, eg soil, paint). The Royal College of Psychiatrists and the Mental Health Foundation both provide information on these and other mental health disorders.

Co-morbidity

The ONS survey found that one in five children diagnosed with a disorder had more than one disorder, the most common combinations being conduct and emotional disorder, and conduct and hyperkinetic disorder. The majority (72%) of children with multiple disorders were male, reflecting the high proportion of children with conduct disorder in this group. Children suffering from more than one disorder were at greater risk of suffering more serious problems. Sixty-three per cent of those with multiple disorders were behind in their intellectual development, compared to 49 per cent of those with a single disorder. Children with multiple disorders accounted for approximately one third of those using specialist mental health services.²

Alcohol and substance misuse

Alcohol and substance misuse can sometimes be linked to mental health problems, and a significant proportion of young people take alcohol and drugs. The use of alcohol and drugs can both exacerbate and trigger mental health problems: those with mental health problems may be at greater risk of misusing drugs, and the misuse of drugs can cause mental health problems. For example, alcohol can be attractive to those suffering from depression because it increases confidence and may produce a feeling of wellbeing, drowning out problems in the short-term. It is, however, also a depressive, and can worsen the symptoms of depression, such as increasing risk of suicidal thoughts and behaviour.³² A survey of 11-15 year olds in England in 2004 found that while the prevalence of drinking among young people had not changed greatly in recent years (23% had drunk in the previous week in 2004; 25% in 2003), the amount consumed by those who do drink has increased: 10.7 units per week in 2004, compared to 5.3 units in 1990 and 9.9 units in 1998.³³

Young people may be particularly at risk of problems resulting from substance misuse as their brains are still developing.³² For example, some research suggests that young people who use a significant amount of cannabis are more likely to have mental health problems, and develop mental illnesses later in life.³⁴ In 2004, 11 per cent of 11-15 year olds had taken cannabis in the last year. Prevalence increased with age, with 26 per cent of 15 year olds having taken it. The survey also found that 4 per cent of 11-15 year olds had taken Class A drugs in the previous year, a figure that has remained constant since 2001.³³ Some CAMHS work with drug dependency teams, but this is not universal.³⁵ Given the correlations between mental health problems and substance misuse, and the effectiveness of multi-agency working in addressing mental health problems among young people (see page 26), more widespread collaboration between these services would be appropriate. More information about the links between mental health problems and alcohol and drug use can be found at SANE, Mind and the Royal College of Psychiatrists. The BMA report *Adolescent health* (2003) discusses alcohol and drug use by young people and the consequences, including mental health problems.²⁴

Prevalence and risk factors of child and adolescent mental health

There is evidence to suggest that the prevalence of childhood mental health problems is gradually increasing.^{36,37} Studies suggest that 20 per cent of children and adolescents have mental health problems at some point,^{1,12} and one in ten have a clinically recognisable mental health disorder. A prevalence of 10 per cent of one to 15 year olds would suggest that approximately 1.1 million children under the age of 18 would benefit from specialist services. Up to 45,000 young people suffer from a severe mental health disorder at any one time.⁷

The ONS survey carried out in Great Britain in 2004 covered children and young people aged five to 16, and found that 11 per cent of boys had a mental health disorder, compared with 8 per cent of girls.² Conduct and hyperkinetic disorders are much more likely in boys than girls, although girls are slightly more liable to suffer from emotional disorders. Older children and adolescents were found to be more prone to a mental health disorder than younger children. 1.9 per cent of all children had more than one disorder (ie one in five children with a disorder). The sample size for the study was 12,294.

Table 1. Prevalence of mental health disorders in boys and girls in 2004

Age	Boys (%)		Girls (%)		All 5-16 year olds (%)
	5-10 year olds	11-16 year olds	5-10 year olds	11-16 year olds	
Conduct disorder	6.9	8.1	2.8	5.1	5.8
Hyperkinetic disorder	2.7	2.4	0.4	0.4	1.5
Emotional disorder	2.2	4.0	2.5	6.1	3.7
Less common disorders	2.2	1.6	0.4	1.1	1.3
Any disorder	10.2	12.6	5.1	10.3	9.6

SOURCE: Office for National Statistics (2005) *Mental health of children and young people in Great Britain, 2004*. London: HMSO.

The ONS survey found that 54 per cent of children with an emotional disorder were girls and that 62 per cent were aged 11-16. Children with an emotional disorder were more likely to come from a single parent family (31%, compared to 15% children with no emotional disorder), and 54 per cent lived in households with incomes under £300 per week. The survey also found that children with an emotional disorder were more likely to suffer poor physical health (23%, compared to 5% of children with no disorder). There were no significant differences between ethnic groups among those with emotional disorder.² The majority of children (86%) with hyperkinetic disorder were boys, and almost all were white (97%). They were more likely to live in households with low income (52% lived in households with less than £300 per week), and have parents with no educational qualifications (36% compared to 21% of children with no disorder).²

As these figures suggest, research has shown that different factors affect the prevalence of mental health problems in children and young people, with socio-economic situation playing a major part.³⁸ The findings of the 2004 ONS survey were compared to a previous survey conducted in 1999, which showed very similar results. The 2004 survey is discussed here. It found that the prevalence of mental health problems was higher among children in families where neither parent worked (20%) compared to those in which both parents worked (8%), and one parent worked (9%). Sixteen per cent of children from families with a weekly household income of under £100 suffered from mental health

problems, compared to 5 per cent with a weekly household income of more than £600.² Using the National Statistics Socio-economic Classification (NS-SEC), box 3 below, it was shown that 13 per cent of children with parents from semi-routine occupations (group 6) and 15 per cent of those with parents from routine occupations (group 7) suffered from a disorder, compared to 4 per cent of children with parents in higher professional groups.

Box 3: The National Statistics Socio-economic Classification (NS-SEC) Analytic Classes:

1. Higher managerial and professional occupations
 - 1.1 Large employers and higher managerial occupations
 - 1.2 Higher professional occupations
2. Lower managerial and professional occupations
3. Intermediate occupations
4. Small employers and own account workers
5. Lower supervisory and technical occupations
6. Semi-routine occupations
7. Routine occupations
8. Never worked and long-term unemployed

SOURCE: National Statistics at: www.statistics.gov.uk/methods_quality/ns_sec/default.asp

The link between childhood mental health problems and familial affluence is again highlighted by type of accommodation. Children living in rented accommodation, either social sector (17%) or private sector (14%), were twice as likely to suffer from a mental health problem than those in owned accommodation (7%).² Similarly, there is evidence to show that homelessness can lead to poor mental health and lower educational attainment.³⁹ See page 12 for further discussion on the links between mental health problems and deprivation.

Educational qualifications of the parents, especially the mother, have a strong impact on prevalence of mental health problems. The ONS survey showed a rate of 17 per cent among children whose parents had no educational qualification, as opposed to 4 per cent among those with parents educated to degree level.²

Family make-up can also impact on the mental health of children and young people. Prevalence rates of mental health problems were higher in children from single parent families (16%) compared to married couple families (7%). Nearly one fifth (18%) of boys living in single parent families suffered from a mental health problem, as opposed to 13 per cent of girls. Reconstituted families, ie those where stepchildren are present, also increased the prevalence of mental health problems: 14 per cent compared to 9 per cent without stepchildren.²

There are a large number of risk factors that increase the vulnerability of children and adolescents to experiencing mental health problems. As outlined above, deprivation presents an important risk. Other factors that increase risk include poor educational and employment opportunities, enduring poor physical health, poor peer and family relationships, witnessing domestic violence and having a parent that misuses substances or suffers from mental ill health. Children who have been physically and sexually abused are at particular risk. Asylum seeker and refugee children have been shown to have consistently higher levels of mental health problems, including post-traumatic stress, anxiety and depression. This group is discussed further on page 13.

Looked after children (ie those brought up in local authority care) are particularly at risk of poor mental health. An ONS report, *The mental health of young people looked after by local authorities in England* (2003) found that in England, 45 per cent of looked after five to 17 year olds had a mental health disorder, compared to 10 per cent from private households.⁴⁰ In Wales, 49 per cent of five to 17 year olds in care had some form of mental health disorder,⁴¹ and in Scotland, the figure was 45 per cent.⁴² Looked after children are discussed in more detail on page 14. Young people in the youth justice system are another group among whom there is a high incidence of mental health problems. Young offenders are discussed in more detail on page 16.

The ONS survey (2004) found no differences between metropolitan and non-metropolitan areas in England. However, closer examination identify variations between areas of wealth and deprivation, as would be expected. There is no significant variation between England, Scotland and Wales.

ONS analysis of the survey data on prevalence of mental health problems among children from black and minority ethnic (BME) groups was difficult. The sample sizes for these groups in the survey were small, and there were also language barriers where English was not a first language. The survey found that Indian children had a low reported rate of mental health problems (3% compared with 7-10 % for other groups), and that all non-white groups had a low rate of hyperkinetic disorder.² Other evidence shows that BME groups are more likely to suffer inequalities in accessing, using and achieving positive outcomes in mental healthcare.³⁶ This is discussed further on page 12.

The ONS surveys do not extend to Northern Ireland, and there has been little in the way of examination of the prevalence of mental health problems there. However, Northern Ireland has a higher proportion of children (27% of the population are under 18, compared to 25% in England), and higher levels of socio-economic deprivation. It has also been subjected to 30 years of civil conflict, and there is a higher prevalence of adult mental health problems than in the rest of the UK. It is, therefore, probable that the prevalence of childhood problems will be as great, if not greater than, the rest of Britain.⁴³

Health inequalities

As discussed in the previous chapter, certain groups of children and young people are at greater risk of suffering from a mental health problem. In 2003, the Department of Health (DH) published the strategy document *Tackling health inequalities: a programme for action*.⁴⁴ It includes strategies for children and young people, as well as at-risk groups, such as looked after children, BME groups, asylum seekers and homeless people. Standard 1 of the *National service framework for children, young people and maternity services* (children's NSF) addresses the need to reduce health inequalities and increase access to services among those where take-up tends to be lower, such as looked after children.⁴⁵ See page 21 for further information on the national service frameworks. There should be systematic assessment by primary care trusts (PCTs) to identify risk factors, such as deprivation. Multi-component programmes using a range of strategies are most likely to be effective.⁴⁶ The government white papers *Choosing health* and *Every child matters* (see pages 21-22) also highlight the importance of focusing on improving service availability and take-up for children and adolescents who are at a greater risk.

Deprivation

Deprivation is a major risk factor and is highlighted by the ONS 2004 survey, as discussed on page 9. Evidence shows that there is a high prevalence of mental health problems among the homeless, including homeless children, and that homelessness is a risk factor.^{8,47} The BMA report, *Housing and health: building the future* (2003) provides more information about the effects of accommodation on health, including mental health.³⁹ The government has set a target of halving child poverty by 2010, and eradicating it by 2020. The 2004 Child Poverty Review, carried out by the government, examined the reforms necessary to achieve this, and includes initiatives to increase investment in early years services for disadvantaged children, delivering more decent homes and supporting parents.⁴⁸ Given the impact of deprivation on child and adolescent mental health, achieving these goals could play a significant role in improving the mental health of vulnerable children.

The Sure Start programme is a key component in the government's aims to tackle inequalities among children. It was launched in 1999 and aims to improve outcomes for children, parents and communities by supporting parents, increasing childcare and improving the health and emotional development of young children. It generally focuses on children from birth to age 14, and up to 16 for children with special educational needs and disabilities. It works to combat childhood deprivation and support the emotional development of children, especially those from disadvantaged backgrounds. Further information can be found at www.surestart.gov.uk.

Black and minority ethnic groups

Evidence reveals that the rates of mental health problems tend to be higher among people from BME groups, as they are more likely to experience risk factors associated with poor mental health, such as deprivation, discrimination and poor educational and employment opportunities.^{17, 49, 50} However, people from black and ethnic minorities, including children, are not receiving appropriate treatment. The charity YoungMinds published a survey, *Minority voices*, in 2005 on the availability of mental health services to young people aged 12-25 from BME backgrounds. These young people face a variety of specific barriers to accessing services, including:⁵¹

- Cultural barriers. There is often a lack of understanding of different cultural and religious needs among health professionals, and there is a shortage of mental health professionals from BME backgrounds. Staff need to be trained in race equality and cultural competences; such training must be standard, and across the board.
- People from different cultures may have different understandings of what mental health is. For example, the survey found that the stigma of mental health problems is particularly strong among people from certain backgrounds. Such attitudes can impact on how children seek and access treatment.

- Language barriers. English may not be the first language for these children, especially asylum seeking and refugee children, and translation services are not always available.
- There is evidence of racism within mental health services. This presents as racist attitudes, practices and procedures that are discriminatory in outcome, if not in intent.⁴⁹
- The YoungMinds survey found that a number of services, and particularly those targeted at young people from BME backgrounds, had either recently closed or were under threat of doing so. There is a lack of funding for such specialised services, which must be addressed.

Various actions are being taken to improve race equality within mental healthcare generally. (It should be noted that these policies are not specifically focused on CAMHS.) A report from the National Institute of Mental Health in England (NIMHE), *Inside outside – improving mental health services for black and ethnic minority ethnic communities in England* (2003) outlined the major disparities between care for people from white and BME communities in England. It highlights the fact that strategies for mental health do not sufficiently tackle these inequalities, and sets out a framework for addressing them.⁴⁹ The DH has established a *Black and Minority Ethnic Mental Health Programme* to take forward work in this area. This is part of the government's wider programme for race equality in the NHS. *Delivering race equality* (2005) is a five-year action plan for improving equality in mental health services. It focuses on developing more responsive and appropriate services, community engagement, and the provision of better information, monitoring ethnicity, and sharing good practice.⁵² The first census of inpatients in mental healthcare, which collected data on ethnicity, was released in December 2005.⁵⁰ The children's NSF does address the poor provision of mental health services to children and young people from BME backgrounds, and makes recommendations for improving care.⁷ In March 2005, the DH announced funding of £1.5 million over two years for mental healthcare projects targeted at BME children and young people. These will be evaluated with the aim of providing examples of best practice.⁵³ Evidence from the YoungMinds survey suggests that provision is currently insufficient. While there are examples of good practice, these are not widespread, and there are parts of the country where there is a severe shortage of such services.⁵¹

Refugees and asylum seekers

Refugee and asylum seeker children are at high risk of mental health problems. They have often suffered traumatic experiences prior to reaching the UK, and can face discrimination once here. They are likely to have come from countries with poor human rights records, may have witnessed acts of violence, and will need to cope with new social and cultural experiences in the UK.⁵⁴ Practical problems of living in the UK are particularly difficult for refugee and asylum seeking families, and they are more likely to be living in deprivation and poor conditions.⁵⁵ Their lack of understanding of the UK health and welfare services may hamper access to treatment, as can poor knowledge of other British systems. The legal status of asylum seekers can be uncertain, and this in itself can present an obstacle to receiving help. There are language and cultural barriers, and such children may be reticent about discussing their situation following previous experiences where either they or their parents may have been persecuted for their views. CAMHS staff may also find the experiences these children have been through difficult to cope with, and may need support and training in working with them.^{17, 51} The BMA report, *Asylum seekers: meeting their healthcare needs* (2002), discusses the specific healthcare needs of asylum seekers, including psychological wellbeing and the needs of children.⁵⁶ The DH is funding research into the emotional wellbeing and social functioning of unaccompanied asylum seeker children and young people. The intention is to increase understanding of the health and social care interventions that would meet the needs of this group.⁵⁷

Looked after children

As highlighted in the previous chapter, page 11, looked after children (children in the care of local authorities) are at particular risk of mental health problems, with around 45 per cent of looked after children in the UK suffering from some form of mental health problem.⁴⁰ These children are likely to have been through a traumatic experience, may have come from socially and economically deprived backgrounds, or have parents with marital problems, and the majority are in care as a result of abuse or neglect.^{58, 59} There were 60,900 children in care in England on 31 March 2005;⁶¹ in 2004, there were 45,000 children continually looked after for over one year.⁶⁰ Sixty-eight per cent of looked after children are placed in foster care.⁶¹ The experience of care may further exacerbate mental health problems that developed prior to entering care, and in some cases create new difficulties. The ONS study (2003) of the mental health of looked after children in England in 2002 found that 37 per cent of five to 17 year olds had conduct disorders, 12 per cent had emotional disorders and 7 per cent were diagnosed with hyperkinetic disorders. This was significantly higher than children from private households.⁴⁰ A mapping exercise of CAMHS found that 8 per cent of the total CAMHS caseload in 2004 was looked after children.⁶² See page 23 for further information on CAMHS mapping.

Table 2: Mental health disorders among children looked after by the local authority compared to children living in a private household (England, 2002)

Disorder	5-10 year olds (%)		11-15 year olds (%)	
	Looked after children	Private household	Looked after children	Private household
Emotional disorders	11	3	12	6
Conduct disorders	36	5	40	6
Hyperkinetic disorder	11	2	7	1
Any disorder	42	8	49	11

SOURCE: Office for National Statistics (2003) *The mental health of young people looked after by local authorities in England*. London: HMSO.

The ONS report placed children into four categories: residential care, foster care, living with their natural parents (subject to care orders), and living independently. It found that two thirds of children and young people living in residential care, two fifths of those in foster care or living with their natural parents, and one half of those living independently suffered some form of mental health disorder.⁴⁰

Table 3: Prevalence of mental health disorder among looked after children by type of placement (England, 2002)

Type of disorder	Residential care (%)	Foster care (%)	Living with natural parents (%)	Living independently (%)	All placements (%)
Emotional disorders	17.7	8.6	20.3	15.4	11.7
Conduct disorders	56.2	32.9	28.1	46.2	37.0
Hyperkinetic disorder	7.9	7.4	7.1	2.3	7.3
Less common disorders	11.1	2.2	1.8	2.6	3.7
Any disorder	68.0	38.8	41.9	51.3	44.8

SOURCE: Office for National Statistics (2003) *The mental health of young people looked after by local authorities in England*. London: HMSO.

Looked after children and young people are more likely to experience poor life outcomes than those living in private households. This is often linked to mental health problems, and can be both a cause and a result of problems. For example, children in care are more likely to under-perform at school. The ONS survey found that about 60 per cent of all looked after children had some difficulty with reading, mathematics or spelling. Those with mental health problems were twice as likely to experience problems: in reading, 37 per cent of children with mental health problems experienced difficulties, compared to 19 per cent of children with no mental health problem. In mathematics, the figures were 35 per cent compared to 20 per cent, and for spelling, 41 per cent compared to 24 per cent. Similarly, there was a high level of young people in care who had been in trouble with the police in the previous year (14%). There appears to be a link between mental health problems and offending: 26 per cent of young people with mental health problems had been in trouble with the police, compared to 5 per cent with no such problem.⁴⁰

It is vital that looked after children and young people have access to high quality care and support, and that this is targeted appropriately, both generally and in terms of mental health services. While CAMHS for looked after children have improved in recent years, more needs to be done to ensure that all children and young people with a mental health problem are able to access treatment effectively and quickly.^{59, 63} In developing practices and policies, it is important that there is an understanding of the effects of state care on children, and the specific needs that these children may have.⁶³ CAMHS professionals working with this group need relevant training and information to allow them to tackle the particular problems that they may face. Similarly, carers should be aware of the particular needs of these children, and their vulnerability to mental health problems and should receive appropriate support.⁶⁴ Children and young people should also be consulted about their wishes. It is important that looked after children have access to high-quality education, leisure and social care, as these can impact on a child's emotional wellbeing and their resilience in a positive way. This is especially pertinent, given that looked after children are more likely to experience poor life outcomes. Secure placements are also an important factor in children's mental health; children need stability and the opportunity to develop attachments to primary carers.⁶³ Being constantly moved around placements will disrupt not only their home-life and education, but also the continuity of any healthcare, including mental healthcare, that they may be receiving.

The DH has produced guidelines, *Promoting the health of looked after children* (2002), which provides a framework for the delivery of services to looked after children by health and social services. It provides guidance on assessing the health of every child on entering care, and creating and implementing individual health plans. This includes mental as well as physical health, and health promotion. It states that all LAs should have CAMHS strategies in place, which should make specific reference to looked after children. It also emphasises the necessity of strong links between looked after children's services and mainstream CAMHS.⁶⁵ The National Children's Bureau and DfES have together developed *Healthy Care*, which aims to promote the health and wellbeing of children in care, and take forward *Promoting the health of looked after children*.⁶⁶ *Every child matters*, *Choosing health* and the children's NSF all address the general needs of looked after children, though in very broad terms. The charity YoungMinds, in collaboration with the DH, has set up a Looked After Children Learning Network to support professionals working with these children and young people. More information is available at www.youngminds.org.uk/lac/.⁶⁷ YoungMinds is also working with HeadsUpScotland (a project to improve the mental health of children and young people in Scotland) to develop training courses to enable those working with looked after children to provide appropriate mental health support.⁶⁸

Young offenders

Young offenders are at high risk of suffering mental health problems; 40 per cent have a diagnosable disorder.⁷ Of the total caseload of CAMHS, 5 per cent were young offenders. (This figure does not include those in secure provision in the independent sector.)⁶² There is also a high rate of suicide among those in young offenders' institutions: 13 young people killed themselves while in prison in 2003, 16 in 2002 and 15 in 2001.¹⁷ Youth offending teams have been set up to prevent offending by children and young people. They are comprised of a range of professionals, including health practitioners, and one of their functions is to try to prevent crime by addressing the causes of it. They also work with young people once they are in the justice system.⁶⁹ The Youth Justice Board has released guidance on working with young offenders with mental health needs,⁷⁰ and YoungMinds runs a Young Offenders Mental Health Network to support practitioners.⁷¹ The NSF states that PCTs should work with LAs and the Prison Service to ensure that young offenders have access to improved healthcare.⁴⁶

Although not a precursor to criminal behaviour in later years, there is a positive correlation between time lost from education and crime, with half of all male prisoners having been excluded from school.⁷² Many of these children suffer from conduct disorders and there is evidence that they may also exhibit problems with social understanding, and disorders on the autistic spectrum. However, these disorders often remain undetected: one research programme found that a significant minority of children with disruptive behaviour have significant, previously unidentified, social communication difficulties.⁷³ These children are therefore not receiving the necessary treatment, which could perhaps in turn help to prevent behaviour that would lead to exclusion. There needs to be better provision of integrated services to support such children, including mental health assessments and care.

16 and 17 year olds

Young people aged 16 and 17 often fall into a gap between child and adult services, and therefore do not receive adequate help and support. Many CAMHS do not currently provide services for those aged over 16, although the children's NSF sets out a requirement for CAMHS provision to the age of 18.⁷⁴ There needs to be recognition that young people of this age may be at different levels of maturity: while some 16 and 17 year olds may be mature enough to receive treatment from adult services, this would be inappropriate for many.⁷ A 2005 study of young people found that for this age group, the provision of appropriate care was a major concern.⁵¹ Those who had experienced treatment through adult services had often found it daunting. Some young people in the survey had received inpatient

care on adult wards and found themselves on mixed-sex wards; they highlighted how uncomfortable this made them feel. Young people should be allowed some choice about the services that feel most appropriate to them. There is clearly a need to extend the age range of CAMHS at a local level to ensure that the needs of 16 and 17 year olds are met.⁷

The transition from child to adult mental health services (AMHS) can be difficult, and these problems can further compound a young person's mental health problems.¹⁶ Services are not always effective at meeting the needs of young adults. While CAMHS tend to have a fairly broad remit, AMHS are more focused on severe and enduring disorders; thus many young people may be ineligible for treatment through AMHS. CAMHS also routinely work with a young person's family, which is not necessarily the case with AMHS. A YoungMinds mapping exercise of services for 16-25 year olds found that while there are examples of effective services in England and Scotland, a comparatively low level of services are commissioned by PCTs, and the needs of this age group are not being met effectively. Only 16 per cent of CAMHS commissioners had initiatives in place to provide age-specific services to 16-25 year olds, and only 9 per cent had policies to improve access and services for this age group.¹⁶ A need for more formal transition protocols was also highlighted in the survey.¹⁶ It is important that there is a smooth transition from CAMHS to AMHS, and that child and adult services work together to guarantee adequate support for all. The children's and mental health national service frameworks require LAs and health services to ensure there is no gap in provision, something that is stressed in the 2005 consultation, *Youth matters*.⁷⁴ See page 21 for more information on *Youth matters* and the national service frameworks. The DH is currently funding a two-year project which aims to improve access to age appropriate services and transition to AMHS, as well as reducing age-related inequalities.⁷⁵

Children with learning disabilities

Please see page 2 for a definition of learning disabilities. Children with learning disabilities are more likely to suffer from mental health problems: 40 per cent suffer from some form of mental health disorder, and the incidence is even higher among those suffering from severe learning disabilities. The existing services are insufficient to provide adequate support for this group. Only one third of specialist CAMHS provide specific services for those with learning disabilities.⁷ A service mapping exercise carried out by the charity YoungMinds also found gaps in services aimed at this group of children and young people.¹⁶ The children's NSF outlines means of rectifying this shortfall.

Recommendations

- The reforms outlined in the Child Poverty Review must be implemented to end child deprivation and therefore reduce risk factors for mental health problems.
- Current inequalities experienced by BME groups must be tackled:
 - initiatives set out by NIMHE and DH must be properly implemented
 - healthcare professionals and providers of CAMHS should receive training in cultural values and beliefs, to enable them to care for children and young people from BME backgrounds more effectively
 - language translation services must be available
 - racism within mental health services must be tackled and eliminated.
- Barriers to receiving care faced by asylum seeker and refugee children must be addressed.
- The provision of mental health services to looked after children and young people must be improved. CAMHS professionals and registered carers need training in order to support these groups in their particular needs.
- Actions must be taken to improve access to mental health services in young offender institutions, and to tackle the high rate of suicide among young offenders.
- The provision of appropriate mental health services to 16 and 17 year olds must be improved. Young people should not be receiving adult care when they are not mature enough to do so. CAMHS should be extended to encompass this age group in all areas.
- Collaboration between CAMHS and AMHS must continue and improve to ensure a smooth transition to adult services.
- The current inadequacy of services for children and young people with learning disabilities must be addressed.

Barriers to receiving treatment

Children and young people face a number of barriers to receiving appropriate mental healthcare. These can be practical. The location of services may make them inaccessible to young people, and opening times may be inconvenient, for example, only during school hours. Service provision needs to be flexible and innovative in order to reach young people, with a diverse range of venues and styles of service that reflect the different needs of individuals. An holistic approach, supporting the young person and their family beyond their mental health problems can also be effective.⁷⁶ It can be helpful to combine CAMHS with other services aimed at young people, such as general medical and sexual healthcare. This could disguise the reason for attending services, and thus reduce stigma attached to mental health services.⁷⁴ Further, young people often access healthcare for a reason other than the main problem, which may then become clear later.⁷⁷ There are also problems with long waiting times for appointments, which can discourage young people from attending.⁵¹ (See page 25).

Barriers can also be social and psychological. Evidence suggests that there is a lack of understanding among young people as to what mental health is: they view it as a serious illness or 'madness', and as such, not applicable to them.⁵¹ More focused information needs to be provided, targeted specifically at young people, explaining what mental health is and how and where to find help. Parents also need information and support to help their child receive treatment. There is stigma attached to mental health problems, which can result in an unwillingness to admit a problem or ask for help from peers, parents or professionals. Young people may have difficulty building up the courage to seek treatment. They can be wary of mental health professionals, and it can take time for a sufficient level of trust to grow to allow the patient to relax and open up. Young people need to feel respected and listened to by health professionals, not judged. They also strongly value confidentiality, and there needs to be support available to help them through treatment.⁷⁶ It is also important that they receive consistency of care and do not have to repeat their story to different professionals, and that there is after-care support where necessary.⁵¹ The children's NSF has recognised some of these problems, and has made recommendations to address some of them.⁷ CAMHS need to take account of what young people say they want, and balance this with what they can realistically provide.⁷⁸

Many of the health inequalities discussed in the previous chapter (page 25) can act as barriers to receiving care, such as the difficulties faced by young people from BME groups, refugees and asylum seekers, and looked after children.

Stigma and discrimination

Stigma arises from the socially constructed negative stereotypes associated with mental health problems. Discrimination is the unfair treatment of an individual, which limits or denies opportunities. Discrimination can arise from attributed rather than actual characteristics.^{79, 80} Research has shown that those with mental health problems often face stigmatisation and discrimination by society, and that this is a key barrier to social inclusion. Indeed, 83 per cent of respondents to the Social Exclusion Unit consultation, *Mental health and social exclusion* (2004), identified stigma as a major concern.⁷⁹ The report outlined the major issues surrounding discrimination on the basis of mental health. Further, discrimination can exacerbate mental health problems, leading to poor self-esteem, depression, anxiety and isolation.⁸¹ Discrimination for other reasons, such as race, can also lead to mental health problems. Discrimination can result in barriers to accessing mental health services; the fear of stigmatisation may lead people to be reluctant to seek treatment, and hide diagnoses from friends and family. Evidence also reveals that discrimination is ever-present among health professionals. A survey of psychiatrists, community psychiatric nurses and primary care specialists found that 55 per cent of their clients had faced discrimination when accessing services.⁸²

One of the major causes of stigmatisation and discrimination is a lack of understanding of mental health by society. The media has an important role to play in this. Much of the British media portrays people with mental health problems in a negative or deprecating manner, especially in linking mental

health problems with violence. A study of British tabloid newspapers found that 40 per cent of daily tabloid articles about poor mental health used derogatory terms such as 'nutter' or 'loony'.⁸³ The media could, alternatively, be a major way of educating the public about the reality of mental health issues. The National Institute of Mental Health in England sets out in its five-year strategic plan (2004-09), *From here to equality*, how it plans to work with different forms of media to redress the imbalance and promote more accurate reporting.⁸⁰ The NIMHE is also working with the independent regulator of communications in the UK, Ofcom, to monitor complaints about the portrayal of mental health problems received by its committee on Older and Disabled Persons. Promoting mental health and educating the public in this area is discussed in the chapter on mental health promotion, page 33.

There are various programmes in place to tackle discrimination against those with poor mental health. It is important that for any action to be effective, it is well funded, and planned over the long term;⁸⁰ it takes time to change peoples' attitudes, and short-term initiatives may be ineffective. In 2001, the DH launched *Mind out for mental health*, a campaign aimed at tackling mental health discrimination, focusing on young people, the media and employers.⁸⁴ The Royal College of Psychiatrists has also run an anti-stigma campaign, *Changing minds*.⁸⁵ The NIMHE is taking forward the government's work in this area in England, and launched *From here to equality* in 2004 to tackle stigma and discrimination on mental health grounds. SHIFT, which is a part of the NIMHE, was set up to carry out this work.⁸⁶ The Disability Discrimination Act 2005 (DDA) has already outlawed discrimination against people with disabilities in various areas of life. A substantial number of people with mental health problems in Britain are covered by this legislation,⁷⁹ although people with mental health problems may not view themselves as disabled, and as such may be unaware of their rights. The Disability Rights Commission (DRC) was set up in 2000 to work towards eliminating discrimination against disabled people and promote equality of opportunity. The NIMHE and DRC have agreed to work collaboratively together on mental health discrimination.⁸⁰ In 2004, the DRC launched an 18-month formal investigation into inequalities in healthcare provision to people with long-term mental health problems and learning disabilities. This investigation considers people of all ages, and focuses on physical health, as evidence shows that these groups often have worse physical health than the general population. The investigation aims to identify measures to facilitate access to healthcare, and examine the adequacy of steps already undertaken by PCTs and government to reduce inequalities.⁸⁷

Young people tend to have more discriminatory attitudes to mental health problems than adults. A survey in 2001 found that 61 per cent of young people aged 16-24 admitted to using derogatory language in relation to those with mental health problems, and 55 per cent would not want others to know if they had such a problem.⁸⁴ Initiatives are therefore being undertaken to change these attitudes, including educating young people about mental health. The NIMHE has identified this as one of the priorities of *From here to equality*. It will work with the DfES to address mental health in the school curriculum and produce guidelines offering advice to professionals working in schools. The DH Healthy Schools Programme will support schools in promoting emotional wellbeing and reducing prejudice and discriminatory behaviour.⁸⁰

Recommendations

- Innovative services are needed to meet the needs of young people, and access to such services must be improved. Examples include a range of venues that differ from the traditional clinical setting, and easy access to a mixture of services.
- The media should be encouraged to portray those with mental health problems in a positive light, including children and young people.
- Current strategies to address stigma and discrimination against those with mental health problems must be fully implemented. They should be monitored to ensure that they are adequate and effective.

Strategies for improving care (England)

The government has stated that it intends to ensure that every child is able to be healthy, have enjoyment, be able to achieve, and make a positive contribution.⁸⁸ A reform of children's services has been undertaken to achieve these aims. The Children Act, which received royal assent in November 2004, provides the legislative foundation for these reforms. *Every child matters: Change for children* (2004) sets out a national framework for local change programmes. The reforms focus on all aspects of children's lives, many of which will impact on mental wellbeing. For example, deprivation can affect the mental health of children, as can poor diet and lack of exercise.³⁶ See page 12 for the effects of deprivation, and page 4 for a more detailed discussion on diet, exercise and mental health. In July 2005, the government released *Youth matters*, a consultation document on proposals to improve services and opportunities for teenagers.⁸⁹ The DH has published a series of national service frameworks for different aspects of healthcare. The *National service framework for mental health* (1999) (mental health NSF) covers the mental wellbeing of the entire population and includes recommendations for children and young people.⁹⁰ The *National service framework for children, young people and maternity services* (children's NSF)⁹¹ sets out national standards for high-quality health and social care. It is a 10-year programme, launched in September 2004, which forms an integral part of *Every child matters*. Standard 9 refers specifically to the mental health and psychological wellbeing of children and young people. See appendix 2 on page 46 for the full list of standards included in the children's NSF.

The children's NSF makes the point that supporting children and young people with mental health problems should happen across all services and is not solely the responsibility of dedicated child and adolescent mental health services. Health, education and social services, along with housing, local amenities and the voluntary sector all have a role to play.⁹² One of the aims of the reforms is to shift the focus from dealing with the consequences of problems to preventing problems occurring in the first place. There is evidence to confirm that preventive measures are effective, as they reduce risk factors, strengthen protective factors and decrease the symptoms and onset of some disorders, especially when targeted at high-risk groups.⁹³ The importance of intervention at the earliest stage possible has also been recognised.⁹² For example, the *Mental health policy implementation guide* sets out guidelines for early intervention in psychosis for 14-35 year olds. Early intervention in psychosis can prevent initial problems, reduces the risk of suicide (one in ten of those with psychosis commit suicide, two thirds of those within the first five years of illness), and improves long-term outcomes. All those aged 14-35 with first presentation of symptoms, or within the first three years of illness, should be treated by early intervention psychosis services.⁹⁴ As part of *Every child matters*, a common assessment framework has been developed for use by all practitioners working with children. It is a nationally standardised approach to assessing the needs of a child, with the aim of early intervention to prevent problems. It is currently being trialled in selected local areas,⁹⁵ and all LAs are expected to have implemented common assessment frameworks between April 2006 and the end of 2008.⁹⁶ See appendix 3 on page 47 for details of the common assessment framework.

The Children Act 2004 sets a requirement for LAs to develop and put in place a children and young people's plan by April 2006.⁸⁸ This will replace a number of existing statutory plans and should cover all local authority services for children, young people and their families. However, plans should also involve health services, youth justice, private, voluntary and community organisations.

The children's NSF follows on from *Improvement, expansion and reform – the next 3 years: priorities and planning framework 2003-06*, which sets out national requirements for local planning.⁹⁷ It includes an expectation that comprehensive mental health services for children and young people should be available in all areas by 2006. Further, CAMHS should be increased by 10 per cent each year according to agreed local priorities.

The government set out a range of initiatives aimed at improving the health of the population in *Choosing health: making healthy choices easier* (2004).³⁶ Many of the policies aimed at improving the health of children and young people will impact on their mental as well as physical health; indeed, the paper highlights the fact that good physical health is dependent on emotional wellbeing. It acknowledges the need to provide adequate information to children, taking into account what they want, and developing the competence of those working with them. Examples of initiatives include the *National Healthy Schools Programme*, which aims to improve pupils' health through both the school environment and education curriculum. See page 33 for more information about healthy schools. From 2006, the DH will pilot health services dedicated to young people and designed around their needs. It has pledged to build on *Every child matters* to ensure that all young people have access to expert advice and relevant support. The 2005 consultation, *Youth matters*, expands on developments aimed at improving the health, including emotional wellbeing, of young people.

The UK government is reviewing current mental health legislation, and has announced its intention to publish a new mental health bill based largely on the amendment of the 1983 Mental Health Act. It has stated that it would address safeguards for children treated on the basis of parental consent in the Children Act 1989 and confirmed that children under the Mental Health Act will continue to receive the same safeguards as adults. The European Commission has launched a green paper, *Promoting the mental health of the population*, which it consulted on in early 2006. It outlines the relevance of mental health for some of the EU's strategic policy objectives, proposes the development of a strategy on mental health at community level and identifies possible priorities. It considers children and young people as part of the general population.⁹⁸

Many strategies, including the Children Act 2004 and Children's Trusts (see page 26), emphasise the importance of developing the participation of children and young people in the health, education and social care services they receive. The value of involving young people in CAMHS is mentioned in the chapter on barriers, page 19, as a means of addressing some of the obstacles young people face in accessing care. For example, it allows young people's views to be heard, and helps them to feel respected by professionals. YoungMinds has produced *Putting participation into practice* (2005), which provides guidance for CAMHS practitioners on involving children and young people in service development.⁹⁹

Child and Adolescent Mental Health Services (CAMHS)

The term 'CAMHS' can be used in two different ways. It can be used to describe all services that contribute to the mental healthcare of children and young people, including health, social care, education and other agencies. The primary function of these services may not be mental healthcare. The term is also used to describe specialist mental health services. The primary function of these services is the delivery of mental healthcare, and such delivery generally occurs through multidisciplinary teams.^{7,100}

CAMHS are often described as being organised into four tiers:

- Tier 1: Primary level of care. Includes: GPs; school nurses; teachers; social workers; youth justice workers; and voluntary agencies.
- Tier 2: Services provided by specialist individual professionals relating to workers in primary care. Includes: child and adolescent mental health workers; clinical child psychologists; paediatricians; educational psychologists; child and adolescent psychiatrists; child and adolescent psychotherapists; community nurses; and family therapists.
- Tier 3: Specialist services for more severe, complex or persistent disorders.
- Tier 4: Essential tertiary level services such as day units, highly specialist outpatient teams and inpatient teams.

Tiers 3 and 4 include: child and adolescent psychiatrists; clinical child psychologists; nurses (community or inpatient); child psychotherapists; occupational therapists; speech and language therapists; art, music and drama therapists; and family therapists.^{7,101}

This model provides a framework which describes fully comprehensive services. It can however be misleading, as people and services may not fall neatly into one tier. It also implies that the higher up the tier, the more severe the problem, although this is not necessarily the case. Although most children are likely to be seen at tiers 1 and 2, some may enter the system at any point, and will not necessarily move up through the tiers. Services are also commonly described as universal (anyone can access them, ie tier 1), targeted (tiers 2 and 3) and specialist (tier 4).

The provision of comprehensive CAMHS by December 2006 has been set out as a Public Service Agreement (PSA), one of the government's key priorities.⁹⁵ It should, however, be noted that the children's NSF defines comprehensive CAMHS as: 'in any locality, there is clarity about how the full range of users' needs are to be met... This will not necessarily mean that all services will be in their final configuration or available in every locality by 2006.' As such, comprehensive services may not be offered in every area, although there is also a requirement to have arrangements in place to ensure a pathway of care, provided through other services.⁷ In reality this may mean difficult to reach services, with patients having to travel some distance to receive treatment.

The recent policy developments will result in the expansion of CAMHS at a local level, and the government has committed approximately £300 million additional funding to PCTs and LAs for CAMHS development from 2003/04 to 2005/06.³⁶ It is vital that PCTs use this money and any future funding for CAMHS; it should not be channelled into other services. A team of 12 CAMHS regional development workers has been established to facilitate change in this area.⁸⁸ To ensure that the PSA target will be met, delivery of CAMHS is being monitored in three key areas:

- 24 hours a day, seven days a week cover
- services for children and young people with learning difficulties
- services for 16 and 17 year olds.⁹⁵

The outcome of CAMH services must be suitably monitored and evaluated, and it is the responsibility of individual services to ensure that necessary data is collected. The CAMHS Outcome Research Consortium (CORC) is a collaboration between various CAMH services in the UK which has worked to develop a common model for routine evaluation of outcomes from services, and analysis of the resulting data.¹⁰² This information can then be used in developing best practice, and informing service providers, commissioners and users. CORC's approach has been cited as an example of service-based outcome evaluation in the children's NSF.^{7,103} A National CAMHS Dataset has been developed, which can be used as a basis for developing service databases for evaluation purposes. This represents current best practice, and allows data to be compatible with national standards and comparable across services.¹⁰⁴ More information, including guidance on outcome evaluation, can be found on the CORC website, at www.camhoutcomeresearch.org.uk.

Since 2002, a national mapping exercise of CAMHS tier 2 to tier 4 has been carried out for the DH. This allows the provision and expansion of services to be monitored and analysed. It also provides information for the Healthcare Commission to assess performance against targets. Detailed information about individual services should therefore be available to inform and support further development of services and the implementation of the children's NSF. The exercise aims to compile an inventory of all specialist CAMHS (tiers 2-4) in the UK, and the investment that they receive. It also contains commissioning data at PCT and strategic health authority (SHA) level, although it does not currently include services in the private sector.⁶² The information is collected online, and annual reports can be accessed at: www.camhsmapping.org.uk.

In 2004, a total of 139 services were mapped giving details of 989 CAMHS teams. The total caseload of services in 2004 was 104,744, which represented an increase of 21 per cent on 2003. Nationally, however, there was considerable variation in provision, and some localities showed negative growth. This is emphasised by ratings awarded by the Healthcare Commission to mental health trusts for increase of CAMHS in 2004-05 compared to 2004-03: 31 per cent of trusts were awarded top marks, but 17 per cent were awarded poor the lowest rating. This is a relatively high proportion, given that 25 per cent of trusts were not rated due to inapplicable data.¹⁰⁵ The Healthcare Commission has also published star ratings for PCTs and NHS trusts, which showed that approximately 70 per cent of PCTs scored top marks for CAMHS provision in 2004. This is based on an assessment of their increase in investment and the existence of well developed and current needs assessment.¹⁰⁶

CAMHS mapping showed that the total spend in 2003/04 was £340 million, which increased by 23 per cent in 2004-05.^{1,62} There were variations in the budgetary increase between SHAs of 11 per cent to 45 per cent. Mainstream funding accounted for 95 per cent of the total CAMHS budget for 2003-04. Other significant sources of revenue came from Sure Start, children's centres (see page 26), the Children's Fund, and drugs and alcohol, and youth offending funding.

Box 4: The Children's Fund

The Children's Fund aims to tackle disadvantage among children and young people by identifying those at risk at an early stage and intervening to support them. It encourages voluntary organisations, local statutory agencies and the community to work in partnership with children, young people and their families, to deliver high-quality preventative services to meet the needs of communities. More information can be found at www.everychildmatters.gov.uk/strategy/childrensfund/.

CAMHS mapping also highlights national variations in the CAMHS workforce. The data are measured as workforce per 100,000 population of 0-17 year olds. While the workforce increased by 15 per cent in 2004 compared to 2003, it varied between an increase of 40 per cent and a decrease of up to 5 per cent in different localities. (See appendix 4 on page 49 for a list of healthcare professionals included.) The mapping also highlighted a high vacancy rate, which was similar for all professions, but again varied nationally. Vacancy is defined as a funded post which a service is actively seeking to fill. For example, the average vacancy rates for clinical psychologists was 14.8 per cent in 2004.⁶²

Anecdotal evidence highlights the shortage of specialists in childhood mental health:

'Within the recent past, there has been a tendency for community paediatric services to see substantial numbers of children of school age with ADHD, Tourette's syndrome and other neurodevelopmental conditions. These are often managed outside a multidisciplinary framework, primarily by medication. Very recently, advertisements have started appearing to recruit paediatricians with a focus specifically on behavioural paediatrics. There is no formal training in this field in the UK – the pressure that leads to the formation of such posts is no doubt the excessive waiting lists of many CAMHS services, and the lengthy assessments necessarily conducted by such services which exacerbate that problem.'

SOURCE: Correspondence with Professor David Skuse, March 2006.

'Paediatricians are being recruited to do this work. I am working as a paediatrician in our CAMHS and one of my community paediatric colleagues (a staff doctor) had already done so. There are training issues, but it is all hands to the pumps of a sinking ship...'

SOURCE: BMA member

CAMHS mapping has shown that the number of services available and cases dealt with have increased from 2002. However, the demand for services has grown even faster, evidenced by an increasing number of people waiting for treatment. The mapping found that at the end of the study period in 2004, there were 30,716 cases waiting to be seen, compared to 28,880 in 2003 and 21,329 in 2002. As a proportion of active caseloads, these figures represent 29 per cent in 2004, 34 per cent in 2003 and 27 per cent in 2002. The length of wait also increased between 2003 and 2004.⁶² A survey published in March 2006 found that many GPs were forced to prescribe antidepressants, against NICE guidelines, as alternative treatment was not available, or waiting lists for psychological therapies were so long. The survey of 1,300 GPs found that the problem was particularly serious in children's services, with waits of five months for child psychiatrists. The survey also found that the length of wait, and services available vary across different regions.¹⁰⁷ It is clear that while funding and capacity of CAMHS is increasing, in certain areas if not nationally, this increase is insufficient to meet a growing demand for mental health services among children and young people.

'In most cases in the UK, the desirable aims stated for CAMHS are: 24-hour cover, treatment of those with learning difficulties, and treating 16 and 17 year olds. This is a long way from reality. Most CAMHS are struggling to meet their office hour commitments with mental health problems in children from birth to 16 years of normal intelligence. This is partly due to lack of funds, but recruitment is a huge problem. There should be four child psychiatrists in our district, and there is half of one (part time).'

SOURCE: BMA member

Recommendations

- Government policies and strategies that are currently being implemented, such as *Every child matters*, *Choosing health* and the national service frameworks must be fully monitored and data collected and analysed to ensure that they are effective in addressing need. This information should be made publicly available.
- The government must, as a priority, address the current shortage of mental healthcare professionals.
- There must be adequate funding for CAMHS to ensure that they are properly resourced and staffed.

Multi-agency working

One of the major themes running through the Children Act 2004 and subsequent initiatives is the need for effective partnership working across different agencies, including health and social care, to ensure competent, coordinated support for children and young people. CAMHS, by their very nature, are supplied by a wide variety of different practitioners, including GPs, practice and school nurses, teachers and youth justice workers, as well as mental health specialists. The range of agencies involved makes the provision of CAMHS complex, and successful cross-agency working is vital. The Children Act 2004 placed a duty on LAs to make arrangements to promote cooperation between agencies, and a duty on key players to participate in this cooperation.⁸⁸ The children's NSF highlights the importance of collaborative working, and points to ways of achieving this. There is a need for effective, multi-agency strategies for commissioning and delivering mental health services. Multi-agency agreements clarifying the level and scope of service provision are also necessary. It is the responsibility of PCTs and LAs to develop and oversee the commissioning strategy, and all appropriate parties should fully participate in this process.⁹¹ It is also important that there are sufficient resources available; effective inter-agency working is currently being impeded by competition for resources.⁵¹

In order to ensure that the needs of children are met, the government aims to integrate key children's services through Children's Trusts.¹⁰⁸ These are located within LAs, and it is planned that every area should have a Children's Trust by 2008. Thirty-five Children's Trust pathfinders were set up when the scheme was announced in 2003, and will be independently evaluated over a three-year period to inform policy and best practice guidance. The final evaluation report is due in April 2007. Children's Trusts include children's health services, children's social services and local education authorities, and should potentially include youth offending teams, and services such as Sure Start and Connexions. Connexion is an advice and information service aimed at 13-19 year olds, which covers topics including education, careers, money and health. More information can be found at www.connexions-direct.com. Children's Trusts ensure that planning and commissioning of services is carried out by a single body with agreed strategies and a pooled budget. This integration aims to ensure effective cooperation between all the different services involved, and multidisciplinary working will be a key feature. There should also be opportunities for children, young people and their families to participate in the trusts, although early evaluation has shown that the effectiveness of this varies greatly across different areas.¹⁰⁹ Children's centres are being set up to integrate the delivery of services to children, bringing together in one place non-acute health services, child health preventive services and family support. The government has set a target of establishing 2,500 children's centres by March 2008, with the eventual aim of a children's centre in every community.³⁶

For different agencies to work effectively together to achieve the best outcomes for patients, it is important that they are able to share information about each patient. *The children's and maternity services information strategy* (2004) was published alongside the children's NSF, and sets out necessary action at a national level to facilitate recommendations made in the children's NSF. It addresses ways in which information is shared within the NHS and with and between other agencies. It also comprises information to support cross-agency working and for the direct care of children and young people, as well as access to knowledge, training and development.¹¹⁰

The development and roll out of effective information systems is a key priority: CAMHS mapping in 2003 found that only 24 per cent of services had access to electronic databases to support their work.¹ Cross-government guidance on information sharing on children and young people was published in April 2006. This outlines when, why and how professionals should share information, and can be accessed at www.everychildmatters.gov.uk/informationsharing. The aim is to provide practitioners with the necessary knowledge to decide when and how information should be shared with other professionals.¹¹¹ The DH, through the *NHS Connecting for Health* project, is looking to modernise the healthcare information technology system.¹¹² This would allow health professionals greater access to

shared information, including patient records, prescription information, appointment details and up-to-date research on illnesses and treatment. This is currently in the early stages of development, and has the potential to greatly facilitate joint working. This system must be implemented in a way that is practical and efficient for both practitioners and patients. There are many concerns with sharing information, including issues about confidentiality, and any new system must be introduced gradually to allow not only effectiveness, but confidence among health professionals and patients.

In order to implement the proposed changes in children's care, those working with children need to adopt different approaches to how they work.⁷⁶ Cultural barriers, which can be deeply entrenched within traditional children's services, need to be broken down. Early evaluation of Children's Trusts found that inter-agency relationships were most effective where there was a shared vision, agreed terms of reference, trust, and a willingness to cooperate between partners. An inability to establish working arrangements at a strategic level inhibited effective working.¹⁰⁹ The DfES' Children's Workforce Unit has proposed a variety of strategies, including a children's workforce strategy to ensure that the workforce is capable of delivering change.¹¹³ *The common core of skills and knowledge for the children's workforce* has been produced by the DfES, in conjunction with stakeholders, to enable effective team-working across disciplines, and set out the areas of expertise that everyone working with children should have. The aim is that over time, all practitioners who come into contact with children and young people will be able to demonstrate the basic skills covered by this programme, and that it will eventually form part of the requisite qualifications for working with children, young people and families.

Box 5: The common core of skills and knowledge for the children's workforce

The essential skills and knowledge set out in *The common core of skills and knowledge for the children's workforce* are described under the following areas:

- effective communication and engagement with children, young people and families
- child and young person development
- safeguarding and promoting the welfare of the child
- supporting transitions
- multi-agency working
- sharing information.

SOURCE: National CAMHS Support Service (2005) *The NSF – One year on*

www.camhs.org.uk/SearchResults.asp?txtSearch=nsf+one+year+on&myReso=0 (Accessed November 2005)

The *Every child matters* website provides a variety of resources to promote effective multidisciplinary working.¹⁰⁰ Initial evaluation of Children's Trusts has emphasised the urgent need for training to support new ways of working and ensure that frontline staff understand different roles across professions. This is especially pertinent as the restructuring is causing concern among frontline staff, and new roles are being developed.¹⁰⁹ It is also important that professionals who are not specialists in mental health receive training to enable them to identify and support children and young people with mental health needs. For example, professionals such as those in accident and emergency and general practice should be able to see beyond the physical injuries of self-harm and recognise it as a mental health problem that requires further help. (See page 5 for more information about self-harm.) The Royal College of Paediatrics and Child Health in association with the Royal College of Psychiatry is developing courses on mental health for paediatric and GP trainees, in recognition that there are behavioural and psychosocial aspects of paediatrics that are not covered by current training.¹¹⁴ It is particularly important that GPs receive training on early identification of mental health disorders in children and young people.

'The multidisciplinary team, which is characteristic of the CAMHS set-up in most services, should allow the provision of comprehensive evaluation and treatment for clients. In many cases this is so, especially for vulnerable groups such as looked-after children, and refugees. However, there is still a tendency in some clinics for the term to imply a lack of division of expertise, with similar roles being taken by different experts within the clinic. This is often unhelpful, and has led in the past to a jaundiced view of CAMHS services by many doctors working in primary care.'

SOURCE: Correspondence with Professor David Skuse, March 2006.

Recommendation

- It is essential that all professionals providing CAMHS receive adequate training and support enabling them to work effectively together. Measures that have already been taken to implement multi-agency working must be continued and extended. Governments need to ensure that the resources, including training in the healthcare information technology system,¹¹² are available to allow this to happen.

Strategies for improving care (Scotland)

The Scottish Executive's plan to reform the NHS, *Our national health: A plan for action, a plan for change* (2001), identified mental health as one of three key priorities. It commits to accelerating implementation of the Mental Health Framework, and sets out planned investment in mental health care.¹¹⁵ The health white paper, *Partnership for care* (2003), builds on *Our national health*, but focuses on key priorities. It sees patients and national standards as the drivers for change.¹¹⁶

The Scottish Parliament has recently passed legislation to reform mental health law; most sections of the Mental Health (Care and Treatment) (Scotland) Act 2003 became law in October 2005.¹¹⁷ The Act defines the nature, duties and powers of organisations involved in the administration of mental health law, sets out circumstances under which a person with mental health problems may receive treatment and/or be detained on a compulsory basis, describes how people in the criminal justice system with mental health problems should be treated, and states the rights and safeguards of those with a mental health problem. *A framework for mental health services in Scotland* (1997) outlines mental health policy, and has been updated regularly since its publication. It sets out principles that should inform comprehensive mental health services, and general guidance for NHS boards, LAs and other agencies on developing joint strategies for planning, commissioning and providing services.¹¹⁷ The *National programme for improving mental health and well-being* was launched in 2001 to raise the profile of improving mental health, both through promotion and prevention, encourage recovery from mental health problems, address the stigma of mental health, and reduce suicide. It provides guidance for national and local work. Two of the key priorities are improving infant mental health, and improving the mental health of children and young people.¹¹⁸

The Scottish Executive set out its plans for improving and promoting the integration of children's services in its report *For Scotland's children* (2001).¹¹⁹ This recommends ways in which the NHS, local government and voluntary sectors can work together more effectively to meet children's needs. It particularly focuses on disadvantaged children, and provides good practice examples of joint working.

The 2004 ONS survey of child and adolescent mental health in Great Britain found that the prevalence of mental health problems among children and young people in Scotland was very similar to those in Great Britain as a whole.² In 2003, the Public Health Institute of Scotland (PHIS) published a Scottish Needs Assessment Programme (SNAP) report on child and adolescent mental health.⁵⁴ This provides a way forward for NHS boards in the planning and delivery of services. It identifies three core themes in addressing mental health problems among children and young people in Scotland:

- recognising the right of children and young people to be heard, and their right to input into new approaches to mental healthcare
- mainstreaming mental health, as those with mental health problems are often marginalised
- the need to integrate promotion, prevention and treatment in dealing with mental health problems.

The report made recommendations on developing CAMHS, including mental health promotion, early intervention, training and joint working between different professions. It also provides examples of different models of service provision, and discusses lack of capacity in provision.

The Child Health Support Group is an expert advisory group which works with NHS boards to drive forward improvements to children's health services. It is a multidisciplinary group, with representatives from areas including healthcare, social work and education. One of its priorities is child and adolescent mental health.¹²⁰

Following the SNAP report, the Scottish Executive, in conjunction with the Child Health Support Group, produced *Children and young people's mental health: a framework for promotion, prevention*

and care, which was launched in October 2005.¹²¹ This is intended for use by local health, education and social services as a planning and audit tool, and provides recommendations for pushing forward integrated services and identifying means of future improvement in service delivery.

The Health Promoting Schools Unit is a national joint project between health and education, highlighting the important effect schools can have on promoting health among children. The Scottish Executive set a target of 2007 for all schools to be health promoting schools. (See page 33 for information on the *National Healthy Schools Programme* in England.) One of the key aims is to promote the mental and emotional wellbeing of pupils.¹²²

Strategies for improving care (Wales)

The National Assembly for Wales has identified mental health as one of three key health priorities, and has allocated substantial funding to this area. In 2001 it published the *Child and adolescent mental health services, everybody's business* strategy document which sets out a 10-year programme aimed at establishing effective services for children and young people across Wales.¹²³ It is a guidance document, against which services are measured. A major element of this guidance is effective joint working across professions, as is promotion and prevention.

The strategy includes a four tier model of care, similar to that described in the English children's NSF (see page 22):

- Tier 1: Primary or direct contact service
- Tier 2: Services provided by individual specialist CAMHS professionals
- Tier 3: Services provided by teams of staff from specialist CAMHS
- Tier 4: Very specialised interventions and care.¹²³

In September 2005, the Welsh Assembly published the *National service framework for children, young people and maternity services in Wales*.¹²⁴ This outlines 21 standards which are in line with the principles embedded in Healthcare Standards for Wales (see box 6), and also fit into other Assembly priorities, such as the *10-year strategy for health and social care; designed for life*, and *Making the connections: delivering better services for Wales*. The NSF is a 10-year programme with reviews every three years to ensure that the standards remain relevant. It has a chapter specifically on child and adolescent mental health, which covers areas including: access to services; the four tier service model; quality of services; and comprehensive and coordinated services.

Box 6: Healthcare Standards for Wales

The Healthcare Standards for Wales came into force in June 2005. They aim to ensure a high quality of care across all healthcare settings, establish foundations for continuous improvement in the delivery of all NHS funded care, and provide a framework both for self-assessment by healthcare organisations and for external review and investigation by Healthcare Inspectorate Wales.

SOURCE: Healthcare Standards for Wales at: www.wales.nhs.uk/sites/page.cfm?orgid=465&pid=8970 (Accessed May 2006)

Strategies for improving care (Northern Ireland)

Following the *Minding our health* consultation (2000), the *Promoting mental health strategy and action plan 2003-2008* was published in 2003, with the aims of reducing the incidence and impact of poor mental health and raising awareness of mental and emotional health at public, professional and policy levels.¹²⁵ (See page 33 for more information on mental health promotion.) The implementation of this was reviewed in 2006 and current gaps in provision were identified.¹²⁶ A review of mental health services in relation to social work in 2004 highlighted several good practice initiatives, and made a number of recommendations aimed at raising quality, reducing local variations in practice and promoting greater cooperation between different sectors.¹²⁷

A major review of mental health services was launched in 2002 under the auspices of the Department of Health, Social Services and Public Safety (DHSSPS). The review of child and adolescent services was published in November 2005, and found that there is a serious deficit in CAMHS provision in Northern Ireland.¹²⁸ While there were examples of good practice, the overall quality, consistency and accessibility of services were inadequate, and there was a severe shortfall in investment in services. It highlights the fact that little appears to have happened since the 1998 policy statement on child and adolescent mental health services, which addressed a number of key policy areas. The report provides a summary of the gaps in current services and suggests specific developments needed for reform and modernisation. It also advocates the importance of prevention and promotion of mental health.

To support the review of CAMHS, a consultation of users and carers was carried out in October 2005. This found that while services were valued, users and carers felt that there were huge gaps, and expressed dissatisfaction with some areas of provision. Major areas for development were highlighted. These included increasing capacity at all levels of service provision; developing collaborative working between professionals; establishing structures for user participation in planning and monitoring CAMHS; and increasing public knowledge of childhood mental health.¹²⁹

Recommendation

- CAMHS in Northern Ireland must be reformed and modernised, in line with current policy recommendations, to address gaps in provision.

Mental health promotion

As discussed in the chapter on Strategies for improving care (England), page 21, one of the aims of reforms in CAMHS is to concentrate on preventing mental health problems developing, rather than focusing on the consequences of problems once they have arisen. An important element of prevention is mental health promotion, educating the population in the importance of mental health and the means of enhancing and sustaining good mental wellbeing. Mental health promotion can also play a role in tackling health inequalities. See page 12 for discussion on health inequalities. Core elements of mental health promotion include raising awareness, provision of information and support services. Multi-pronged approaches to promotion of mental health to communities have been shown to be useful, as has promotion tailored to those particularly at risk.^{46, 92}

Many national and local strategies place emphasis on mental health promotion. Standard 1 of the mental health NSF focuses on promotion to improve the mental health of the population and tackle discrimination against those with mental health problems.⁹⁰ The children's NSF highlights the importance of promotion and intervention: relevant initiatives include those to tackle bullying, and providing education about mental health and support for children with particular needs. Children, young people and their parents need information and support in dealing with problems as they occur. Services must ensure that an emphasis is placed on those children who are vulnerable to mental health problems.⁷ The Scottish *National programme for improving mental health and well-being* focuses on promotion and prevention, and tackling discrimination.¹¹⁸ See page 29 for more information. In Northern Ireland, a five-year strategy and action plan for promoting mental health was launched in 2003.¹²⁵ See page 32 for more information.

Standard 1 of the children's NSF is concerned with the promotion of health and wellbeing, including mental health, of children and young people.⁴⁶ It sets out a programme of action to be led by the NHS, in partnership with LAs and other organisations. The *Child health promotion programme* outlines a framework for promoting health and wellbeing and reducing health inequalities. Increasing awareness, information provision and improving access are key to this. Additional funding has been made available to increase NHS capacity, and there is a growing range of staff in schools (eg school nurses) to help achieve the recommendations set out in this programme.

There are many different methods of delivering mental health promotion. Information should be targeted at specific age groups as well as parents and carers, and be available in a variety of formats, including written materials, audio visual, the internet and through the media. CAMHS should consider a variety of settings, such as outreach, schools and community venues to reach a wider number of people.⁵¹ A huge range of factors can affect mental health, for example, a healthy diet, physical exercise, talking about feelings, learning new skills, creative activities, and the environment in which one lives. The importance of such elements should be widely disseminated to the general public.⁵¹ The *Youth matters* green paper includes a variety of proposals to empower young people, increase opportunities for participating in activities, and encourage them to make valuable contributions to society, which can in turn benefit their emotional wellbeing.⁸⁹

Schools have an important role to play in mental health promotion. The *National Healthy Schools Programme* provides support for all health promotion, including mental health. As part of this, the National Healthy Schools Standard provides a model for partnership working between health and education in promoting a healthy lifestyle to children.¹³⁰ The school environment, as well as curriculum content, provide a good opportunity to disseminate information, foster good habits and raise children's awareness of mental health. Initiatives to tackle bullying, provide pastoral support and promote an equal, fair and non-discriminatory environment can all play a part. School nurses have a key role in promoting the health of school children; the Chief Nursing Officer and DfES are working in partnership to modernise school nursing and develop best practice guidance.³⁶ The promotion of emotional

wellbeing is essential for national healthy school status.¹³¹ Government has stated that it expects that half of all schools will be healthy schools by 2006, and all schools should be working towards this status by 2009. The *National Healthy Schools Programme* is currently prioritising schools in the most disadvantaged areas, and evaluation has shown that it is beginning to have a positive effect. For example, young people in healthy secondary schools tend to have higher self-esteem.³⁶

Mental health promotion has a role in strengthening the training and support for professionals working with children, whether these be education, social care or health professionals.¹³¹ Mental health promotion is the responsibility of everyone: all staff working with children should be aware of the role they have to play in children's emotional wellbeing and social development. Staff should be able to access support from specialist CAMHS to help them in this role,⁷ and to receive adequate training on how to identify and help those with mental health problems. Professionals working with children also have a role in promoting good mental health. The DfES' common core skills for all professionals working with children and young people includes an element on promoting good health.¹³² See page 27 for more information on the common core skills.

Promotion must be properly funded and planned over the long term, as must CAMHS. The YoungMinds *Minority voices* survey found examples of services that were not promoting themselves as they did not have the resources to do so, were already running at full capacity and struggling to meet demand, or their funding was unstable and thus there was uncertainty as to how long the service would be available.⁵¹ The Mental Health Foundation has called on the government to recognise the importance of investment in mental health promotion to children and young people, and ensure that this investment is forthcoming.¹³³

Mental health promotion is an important element of tackling health inequalities. Specific services should be targeted at identified risk groups: the children's NSF1 stated that PCTs and LAs should work with other agencies to develop health promotion strategies for children in special circumstances, including looked after and asylum seeker children.⁴⁶ Research has found that many CAMHS were not targeting BME groups for a variety of reasons, including an inability to provide translation services.⁵¹ The fact that fewer BME children and young people access CAMHS, and when they do it tends to be at a crisis point, emphasises the need for more mental health promotion to these groups as a means of addressing health inequalities.

Mental health promotion should not be aimed solely at children and young people, but also at their families and carers; indeed, efforts should be made to actively engage parents in treatment.⁹² Health promotion programmes should focus on the family and environment as well as the individual.¹³¹ Parents can also play a vital role in ensuring that their children have good mental health; children need security and caring surroundings to develop confidence and self esteem to deal with life. Parents and carers need access to appropriate advice and information to support them in this. Parenting classes have been shown to be effective in developing parenting skills and encouraging greater self-awareness among parents. Further information can be found in *Growing up in Britain*.⁸ It is important that families are able to recognise problems as they develop, as early intervention helps to prevent mental health problems becoming serious. Families also need information about the needs of a child with a mental health problem, and support in caring for them. Caring for a child with mental health problems can place a significant burden on the family, while the support of family and friends is important for young people with mental health problems.^{2, 92} Various strategies, including the children's NSF and *Choosing Health*,^{36, 91} acknowledge the necessity of supporting parents. Families should be included in planning services for children to ensure that they are relevant and meet their needs. For example, the Sure Start Unit has been tasked with developing a programme to promote parental involvement in children's early development in disadvantaged areas.³⁶

Recommendations

- There is a need to improve public knowledge and understanding of mental health.
- There should be better provision and dissemination of information about mental health aimed at children and young people, appropriate to different age ranges. This should include information about the different types of mental health disorders and factors that can contribute to them. Information should be presented in a variety of media that appeal to children and young people, and in different languages.
- There is a need for more and better mental health promotion to BME groups in order to address health inequalities.

Conclusion

The government has recognised the importance of mental wellbeing among children and adolescents, and the need to improve services for those with mental health problems. In recent years, a variety of new policies and strategies to address this area have been introduced. Implementation of many of these strategies has only recently begun; as such there is currently insufficient evidence to determine how effective they are or will be in the future. It is vital that implementation is properly monitored and research into the outcomes of the various strategies is carried out. As CAMHS encompasses all services working with children, including health, social care and education, all professionals within these services must work together to ensure an effective multidisciplinary approach is achieved and that individuals do not slip through gaps in provision. This is equally important in the transition from CAMHS to AMHS; these services must work together to ensure that all young adults receive the care and treatment they need.

Current government policies are well intentioned; these must now be put into practice. The recommendations from the BMA follow on page 37.

Recommendations

- **Government policies and strategies that are currently being implemented, such as *Every child matters*, *Choosing health* and the national service frameworks, must be fully monitored, and data collected and analysed to ensure that they are effective and addressing need.** This information should be made publicly available and accessible.

Child and adolescent mental health services

- **The government must address the current shortage of mental healthcare professionals.**
- **There must be adequate funding for CAMHS to ensure that they are properly resourced and staffed.**
- **Innovative services are needed to meet the needs of young people, and access to such services must be improved.** Examples include a range of venues that differ from the traditional clinical setting, and easy access to a mixture of services.

Multi-agency working

- **It is essential that all professionals providing CAMHS receive adequate training and support enabling them to work effectively together.** Measures that have already been taken to implement multi-agency working must be continued and extended. Governments need to ensure that the resources, including training in the healthcare information technology system, are available to allow this to happen.

Mental health inequalities

- **The provision of appropriate mental health services to 16 and 17 year olds must be improved.** Young people should not be receiving adult care when they are not mature enough to do so. CAMHS should be extended to encompass this age group in all areas.
- **Collaboration between CAMHS and AMHS must continue and improve** to ensure a smooth transition to adult services.
- **The provision of mental health services to looked after children and young people must be improved.** CAMHS professionals and registered carers need training in order to support these groups in their particular needs.
- **The current inadequacy of mental health services for children and young people with learning disabilities must be addressed.**
- **The reforms outlined in the Child Poverty Review must be implemented** to end child deprivation and therefore reduce risk factors for mental health problems.
- **Current inequalities in mental healthcare experienced by BME groups must be tackled:**
 - initiatives set out by NIMHE and DH must be properly implemented
 - healthcare professionals and providers of CAMHS should receive training in cultural values and beliefs, to enable them to care for children and young people from BME backgrounds more effectively
 - language translation services must be available
 - racism within mental health services must be tackled and eliminated.

- **Barriers to receiving healthcare faced by asylum seeker and refugee children must be addressed.**
- **Actions must be taken to improve access to mental health services in young offender institutions, and to tackle the high rate of suicide among young offenders.**
- **In addition to the above, CAMHS in Northern Ireland must be reformed and modernised,** in line with current policy recommendations, to address gaps in provision.

Mental health promotion

- **There is a need to improve public knowledge and understanding of mental health.**
- **There should be better provision and dissemination of information about mental health aimed at children and young people, appropriate to different age ranges.** This should include information about what different mental health problems are, how and where to access help and support, what different mental health professionals do, and what treatments entail. Information should be presented in a variety of media that appeal to children and young people, and in different languages.
- **The media should be encouraged to show those with mental health problems in a positive light, including children and young people.**
- **There is a need for more and better mental health promotion to BME groups in order to address health inequalities.**
- **Current strategies to address stigma and discrimination against those with mental health problems must be fully implemented.** They should be monitored to ensure that they are adequate and effective.

Further information

This listing of organisations and publications is intended for further information only. The BMA is not responsible for the content or accuracy of external websites, nor does it endorse or otherwise guarantee the veracity of statements made in non-BMA publications.

English government

Department of Health

www.dh.gov.uk

- *Choosing health: making healthy choices easier* (2004): sets out initiatives aimed at improving the health of the nation, including mental health and the health of children and young people.
- *Delivering race equality in mental health. A plan for reform inside and outside services and the government's response to the death of David Bennett* (2005).
- *Improvement, expansion and reform – the next three years: priorities and planning framework 2003-2006* (2002).
- National Service Frameworks providing guidance on different aspects of healthcare. Includes the *National service framework for children, young people and maternity services* (2004), and the *National service framework for mental health* (1999).
- *Promoting the health of looked after children* (2000).
- *Tackling health inequalities. A programme for action* (2003).

Department for Education and Skills

www.dfes.gov.uk

- *Every child matters: change for children* (2004): sets out a national framework focusing on all aspects of children's lives, at www.everychildmatters.org.uk
- *Children looked after in England (including adoptions and care leavers) 2004-05* (2005).
- *Outcome indicators for looked after children: twelve months to September 2004, England* (2005).
- *Youth matters green paper* (2005): The consultation document was published in July 2005, and the government's response to comments was published in March 2006.

Social Exclusion Unit

www.socialexclusion.gov.uk

Scotland

Scottish Executive

www.scotland.gov.uk

- *Children and young people's mental health: A framework for promotion, prevention and care* (2004)
- *For Scotland's children. Better integrated children's services* (2001)
- *National programme for improving mental health and well-being* (2001): provides guidance for raising the profile of mental health through promotion and prevention, and encouraging recovery.
- *Our national health. A plan for action, a plan for change* (2001): the Scottish Executive's plan to reform the NHS, identifying mental health as a key priority.
- *Partnership for care. Scotland's health white paper* (2003).

Health Scotland

www.healthscotland.com

HeadsUpScotland

www.headsupscotland.com

A project working to support the implementation of the recommendations of the SNAP report for Child and Adolescent Mental Health, aiming to improve the mental health and wellbeing of children and young people. It is part of the National Programme for Improving Mental Health and Wellbeing which has identified children and young people as one of six priority areas.

Wales

National Assembly for Wales

www.wales.gov.uk

- *Child and adolescent mental health services. Everybody's business* (2001): a ten-year programme aimed at establishing effective services for children and young people across Wales.
- *National service framework for children, young people and maternity services* (2005): a ten-year strategy, with a chapter focusing in child and adolescent mental health

Northern Ireland

Department of Health, Social Services and Public Safety

www.dhsspsni.gov.uk

- *Promoting mental health. Strategy and action plan 2003-2008* (2003): a strategy which aims to reduce the incidence and risk of mental health problems and raise awareness of mental health.
- *Review of mental health and learning disability (Northern Ireland). Vision of a comprehensive child and adolescent mental health service* (2005): a comprehensive review of CAMHS in Northern Ireland, which found that the overall quality, consistency and accessibility of services is inadequate.

Northern Ireland Association for Mental Health

www.niamh.co.uk

Provides local support in the form of a wide range of services and information for those suffering from poor mental health across Northern Ireland. The website has links to organisations which offer help for mental health problems.

Independent and voluntary organisations

BestTreatments

www.besttreatments.co.uk/btuk/home.jsp

Website produced by the *British Medical Journal (BMJ)* which provides information for patients and doctors based on research about conditions and treatments available.

CAMHS Outcome Research Consortium (CORC)

www.camhoutcomeresearch.org.uk

A collaboration between a number of CAMHS in the UK, CORC is working to develop and pilot a model for routine evaluation of outcomes of CAMHS, to provide high quality information for service providers, commissioners, users and their families.

Institute of Child Health

www.gosh.nhs.uk/gosh/clinicalservices/DCAMH/

A collaboration between University College London and Great Ormond Street Hospital. The Department of Child and Adolescent Mental Health provides highly specialised services.

Mental Health Alliance

www.mentalhealthalliance.org.uk

A coalition of user groups, charities, social workers, psychiatrists, psychologists and other interested parties, which is campaigning for a new mental health act which provides a legal right to assessment and care, reducing the need for compulsory treatment.

Mental Health Foundation

www.mhf.org.uk

A mental health charity which aims to help people survive and recover from mental health problems through the provision of services and information. They also seek to raise public awareness through campaigning and influencing policy, and carry out research. They provide information on a wide range of mental health problems, including publications specifically dealing with children and young people.

www.selfharmuk.org

Website of the national inquiry carried out by the Mental Health Foundation and Camelot Foundation, into self-harm among young people.

Mind

www.mind.org.uk

A mental health charity in England and Wales. They work to influence policy through campaigning and education, promote the development of high quality services, challenge discrimination and promote inclusion. They produce fact sheets providing information on children and young people and mental health for health professionals, children and young people themselves, and carers and parents.

National Children's Bureau

www.ncb.org.uk

An umbrella organisation for the children's sector in England and Northern Ireland, providing information on policy, research and best practice.

National CAMHS Support Service

www.camhs.org.uk

Provides information and examples of good practice to support those working in child and adolescent mental health services. It works strategically in establishing common standards of practice and strengthening procedures in commissioning and provision.

National Institute for Health and Clinical Excellence (NICE)

www.nice.org.uk

An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

National Institute for Mental Health in England

<http://nimhe.csip.org.uk/home>

Organisation responsible for implementing strategies to support positive change in mental health and mental health services, and partly funded by the DH. Its priorities include workforce development, and changes in practice and systems to ensure efficient and effective care.

- SHIFT: programme to tackle stigma and discrimination faced by those with mental health problems.
- *Contact: A directory for mental health 2005* (London: DH). A directory of organisations providing services to those suffering from mental health problems, including organisations aimed specifically at children and young people.

Office for National Statistics

www.statistics.gov.uk

Has produced reports on the prevalence of mental health disorders among children in Great Britain, and among looked after children in England, Wales and Scotland.

Research in Practice: supporting evidence-informed practice with children and families

www.rip.org.uk/index.asp

A project working to implement research findings and promote positive outcomes for children and families. Contains articles on mental health.

Royal College of Paediatrics and Child Health

www.rcpch.ac.uk

The professional and educational body for paediatrics.

Royal College of Psychiatrists

www.rcpsych.ac.uk

The professional and educational body for psychiatrists in the UK and Republic of Ireland. Information on mental health problems in children and young people, and a list of relevant publications is available on the website.

Sainsbury Centre for Mental Health

www.scmh.org.uk

An organisation that carries out research, analysis, training and development to improve practice and influence policy on mental health.

Samaritans

www.samaritans.org

Charity offering advice and support to those with emotional problems and suicidal thoughts. It runs a confidential 24-hour telephone helpline and email service.

SANE

www.sane.org.uk

Charity which works to raise awareness and respect for those with mental health problems, and provide them with information and support. It runs a telephone helpline offering practical information, crisis care and emotional support for those suffering mental health problems.

Together

www.together-uk.org

A charity which provides services to support people with severe and enduring mental health problems. They also work to improve mental health policy and practice.

World Health Organisation

www.who.int/en

YoungMinds

www.youngminds.org.uk

Charity working to improve the mental health of children and young people. It provides information, advice and support to young people, parents and professionals, and campaigns for policies to improve children's mental health.

- YoungMinds has produced a paper which aims to help improve the transition from CAMHS to AMHS: YoungMinds (2006) *Stressed out and struggling. A call to action: commissioning mental health services for 16-25 year-olds*. London: YoungMinds.

Appendix 1

Multiaxial classification of child and adolescent psychiatric disorders¹⁴

The psychiatric sections of the tenth revision of the WHO International Classification of Diseases (ICD-10) are arranged in a multiaxial form, with descriptions grouped into axes that have been chosen to provide unambiguous information of maximum clinical usefulness in the greatest number of cases.

Axis One: Clinical psychiatric syndromes

XX	No psychiatric disorder
F84	Pervasive developmental disorders
F90 – F98	Behavioural and emotional disorders with onset usually occurring in childhood or adolescence
F00 – F09	Organic, including symptomatic, mental disorders
F10 – F19	Mental and behavioural disorders due to psychoactive substance use
F20 – F29	Schizophrenia, schizotypal and delusional disorders
F30 – F39	Mood [affective] disorders
F40 – F48	Neurotic, stress-related and somatoform disorders
F50 – F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60 – F69	Disorders of adult personality and behaviour
F99	Unspecified mental disorder and problems falling short of criteria for any specified mental disorder

Axis Two: Specific disorders of psychological development

XX	No specific disorder of psychological development
F80	Specific developmental disorders of speech and language
F81	Specific developmental disorders of scholastic skills
F82	Specific developmental disorder of motor function
F83	Mixed specific developmental disorders
F88	Other disorders of psychological development
F89	Unspecified disorder of psychological development

Axis Three: Intellectual level

XX	Intellectual level within the normal range
F70	Mild mental retardation
F71	Moderate mental retardation
F72	Severe mental retardation
F73	Profound mental retardation
F78	Other mental retardation
F79	Unspecified mental retardation

Axis Four: Medical conditions from ICD-10 often associated with mental and behavioural disorders

This axis covers other medical conditions that are often found in association with mental health disorders in children and adolescents.

Axis Five: Associated abnormal psychosocial situations

- 00 No significant distortion or inadequacy of the psychosocial environment
- 1 Abnormal intrafamilial relationships
- 2 Mental disorder, deviance or handicap in the child's primary support group
- 3 Inadequate or distorted intrafamilial communication
- 4 Abnormal qualities of upbringing
- 5 Abnormal immediate environment
- 6 Acute life events
- 7 Societal stressor
- 8 Chronic interpersonal stress associated with school/work
- 9 Stressful events/situations resulting from the child's own disorder/disability

Axis Six: Global assessment of psychosocial disability

- 0 Superior/good social functioning
- 1 Moderate social functioning
- 2 Slight social disability
- 3 Moderate social disability
- 4 Serious social disability
- 5 Serious and pervasive social disability
- 6 Unable to function in most areas
- 7 Gross and pervasive social disability
- 8 Profound and pervasive disability

Appendix 2

Standards covered by the National Service Framework for children, young people and maternity services:

- Standard 1 Promoting health and wellbeing, identifying needs and intervening early
- Standard 2 Supporting parents or carers
- Standard 3 Child, young person and family-centred services
- Standard 4 Growing up into adulthood
- Standard 5 Safeguarding and promoting the welfare of children and young people
- Standard 6 Children and young people who are ill
- Standard 7 Children in hospital
- Standard 8 Disabled children and young people and those with complex health needs
- Standard 9 The mental health and psychological wellbeing of children and young people
- Standard 10 Medicines management for children
- Standard 11 Maternity services¹³⁴

Appendix 3

The Common Assessment Framework (CAF)¹³⁵

The CAF combines:

- a simple pre-assessment checklist to help practitioners identify children who would benefit from a common assessment
- a process for undertaking a common assessment, to help practitioners gather and understand information about the needs and strengths of the child, based on discussions with the child, their family and other practitioners as appropriate
- a standard form to help practitioners record and, where appropriate, share with others, the findings from the assessment in terms that are helpful in working with the family to find a response to unmet needs.

The CAF has been developed combining the underlying model of the framework for the assessment of children in need and their families with the main factors used in other assessment frameworks. The elements that form the framework for common assessment are shown below.

Development of child

- Health:
 - general health
 - physical development
 - speech, language and communications development
- Emotional and social development
- Behavioural development
- Identity, including self-esteem, self-image and social presentation
- Family and social relationships
- Self-care skills and independence
- Learning:
 - understanding, reasoning and problem solving
 - progress and achievement in learning
 - participation in learning, education and employment
 - aspirations

Parents and carers

- Basic care, ensuring safety and protection
- Emotional warmth and stability
- Guidance, boundaries and stimulation

Family and environmental

- Family history, functioning and wellbeing
- Wider family
- Housing, employment and financial considerations
- Social and community factors and resources, including education

Assessing the needs of a child requires the systematic, holistic approach of a CAF, which uses the same processes for gathering and analysing information about all children and their families, but discriminates effectively between different types, and levels of need and strengths.

The CAF provides an easy to use assessment that is common across agencies. It will help embed a shared language; support better understanding and communications among practitioners; facilitate early intervention; speed up service delivery and reduce the number and duration of different assessments that historically some children and young people have undergone.

Consultations are under way within the DfES, across government and with the agencies responsible for other assessments to best determine how they should fit with the CAF and how to reduce duplication.

Where a referral to a more specialist assessment is required, use of the CAF should help ensure that the referral is really necessary, that it is the right service and that it is supported by accurate up-to-date information. The information gathered will follow the child and builds up a picture over time rather than a series of partial snapshots.

Appendix 4

Healthcare professionals included in the Child and Adolescent Mental Health Services mapping exercise⁶²

- Nurses
- Doctors
- Clinical psychologists
- Educational psychologists
- Social workers
- Child psychotherapists
- Family therapists
- Non-verbal therapists
- Speech and language therapists
- Primary mental health workers
- Occupational therapists
- Other qualified therapists
- Other qualified staff
- Other unqualified staff

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