

SPICe Briefing

Child and Adolescent Mental Health – Trends and Key Issues

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This briefing provides an overview of mental health services for children and young people in Scotland and examines current challenges for service delivery. It outlines recent trends and key issues relating to the mental health of children and young people from infancy to adolescence. Another SPICe briefing looking at the policies and legislation underpinning child and adolescent mental health services is also available.



(Location of Scottish NHS Inpatient CAMHS units)



The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

EXECUTIVE SUMMARY	3
INTRODUCTION	4
TERMS USED	5
PREVALENCE AND TRENDS.....	6
INEQUALITIES.....	6
REFERRALS TO SPECIALIST CAMHS	7
HOW MENTAL HEALTH SERVICES ARE PROVIDED FOR CHILDREN AND YOUNG PEOPLE	8
CAMHS PRACTITIONERS	8
TIERS OF CARE	9
<i>Pathways to Treatment</i>	<i>10</i>
<i>Service Provision by NHS Board</i>	<i>11</i>
CAMHS WORKFORCE.....	12
<i>Balance of CAMHS Workforce.....</i>	<i>13</i>
CAMHS WORKFORCE BY HEALTH BOARD.....	14
<i>Educational Psychologists</i>	<i>15</i>
ELIGIBILITY AND PROVISION BY AGE	16
CAMH INPATIENT UNITS	17
<i>CAMH Admissions to Non-Specialist Units.....</i>	<i>19</i>
<i>Specialist Forensic and Learning Disability Inpatient Provision.....</i>	<i>20</i>
WAITING TIMES	20
KEY ISSUES	24
PARENTAL MENTAL HEALTH AND INFANT MENTAL HEALTH.....	24
<i>Perinatal Mental Health.....</i>	<i>24</i>
INFANT MENTAL HEALTH.....	25
ADVERSE CHILDHOOD EXPERIENCES	27
EFFECT OF COMPULSORY MEASURES ON PARENT-CHILD RELATIONSHIPS	28
MENTAL HEALTH AND SCHOOLS	28
<i>Additional Support for Learning: Policy and Provision.....</i>	<i>29</i>
<i>Curriculum for Excellence</i>	<i>30</i>
SELF-HARM.....	31
MENTAL HEALTH AND GENDER IDENTITY	32
TRANSITIONS FROM CAMHS.....	33
<i>College and University Counselling Services</i>	<i>34</i>
ANNEXE A: TERMS USED – MENTAL HEALTH PROBLEMS, CARE AND TREATMENT.....	35
SOURCES	38
RELATED BRIEFINGS	48

EXECUTIVE SUMMARY

This briefing provides an overview of mental health support for children and young people. It outlines the structure of NHS child and adolescent mental health services (CAMHS) and examines challenges for service delivery, such as waiting times to access services, workforce balance and the provision of age-appropriate care. It outlines some recent trends related to the mental health of children and young people and highlights some key issues affecting children and young people across different stages of their development – from infant mental health to the needs of young people transitioning from CAMHS to Adult Mental Health Services at the age of 18 and over.

This briefing may be read in conjunction with SPICe Briefing Child and Adolescent Mental Health – Legislation and Policy, which surveys recent mental health legislation and outlines the policy context currently shaping support for mental health services.

The economic cost of poor mental health in Scotland has been [estimated](#) at £10.7 billion per year (see page 3). [Estimates suggest](#) between 1 in 10 children and young people may have a diagnosable mental health disorder, and some [recent studies](#) indicate the number of young people with symptoms of mental ill health may be higher (Office of National Statistics 2004a; ONS 2015). The personal, social, and economic costs of poor mental health are high. The life expectancy of people with serious mental health problems is 15 to 20 years lower than the general population (see pages 5-7).

The overall prevalence of mental health problems amongst children and young people appear to have increased. The total number of CAMHS referrals received in 2015 was 30,208 this represents a 13.5% increase on the total number of referrals in 2013 (26,606) (see page 8). However, the number of referrals to specialist mental health services is still below estimates of prevalence.

Child and Adolescent Mental Health Services in Scotland are arranged in four 'tiers' of care. Support at tier one may be provided by people working in universal services. Tier two support is often provided by CAMH workers in primary care or community settings. Tier three is specialist support for people with severe, complex and persistent disorders. Tier four provides specialist services for young people at risk of rapidly declining mental health, serious self harm or who require a period of intensive input (see page 11).

Recent workforce information shows a 30% overall increase in the workforce since 2009. The current overall staffing level in Scotland represents 18.5 whole time equivalent CAMHS clinical workers per 100,000 of the population ([ISD 2016c](#)). The Scottish Government's current workforce target is 20 whole time equivalent CAMHS clinical workers per 100,000 of the population. While investment has boosted the overall CAMHS workforce significantly, there are reports of unfilled posts and difficulties recruiting highly experienced clinicians.

The Scottish Government has [waiting time targets](#) for access to CAMHS treatment, which state that 90% of patients should wait no longer than 18 weeks for treatment. However, many health boards fail to meet these targets (see pages 20-23 for waiting times data).

INTRODUCTION

This briefing outlines recent trends relating to the mental health of children and young people in Scotland, focusing on the prevalence of mental health problems and the impact of inequalities on mental health. It outlines the structure and delivery of Child and Adolescent Mental Health Services (CAMHS), which are organised in a 'tiered' model of care. The 'tiered' model includes support provided by practitioners working in universal services, and other professionals working with children and young people. A wide range of third sector organisations also support the mental health needs of children and young people: from leading preventative and promotional work, to providing support to children and young people with significant social and emotional difficulties. This briefing examines challenges for service delivery, particularly CAMHS waiting times targets, workforce balance and the provision of age-appropriate care.

As the mental health needs of children and young people vary according to their stage of development, this briefing highlights some key issues at different stages - from infant mental health to the needs of young people transitioning from CAMHS to adult mental health services at the age of 18 and over. A glossary of terms related to more common mental health problems occurring during childhood and adolescence is provided at [Annexe A](#).

The long term economic costs of poor mental health are significant. One [European study](#) placed the costs of mental health problems experienced by children and/or young people between £11,030 and £59,130 per person per year (WHO 2008). [Research](#) by the Scottish Association of Mental Health ([SAMH](#)) in 2011, estimated the overall cost to the Scottish economy to be £10.7 billion per year. More recently, a [study](#) led by the London School of Economics and the [Centre for Mental Health](#) estimated that the impact of perinatal mental illness and the intergenerational effect of poor child mental health costs the UK as much as £8 billion per year (Bauer *et al* 2014).

Mental health services in Scotland face a number of challenges. The overall number of referrals to specialist CAMH services is rising, waiting lists are long, there is high demand for intensive treatment, and there is an increased need for preventative work. A 2013 [report](#) on the UK wide CAMHS workforce by the Royal College of Psychiatrists (RCPsych) summarised pressures on service delivery as follows:

“specialist CAMHS continue to function in an environment where demand frequently exceeds capacity. There are often concerns about access thresholds being set too high, the inability of services to offer an appropriate range of evidence-based interventions, and a ‘clinic-bound’ approach [...] As a result of capacity shortage, many struggle to meet waiting-time targets and to implement recommendations set out in clinical guidelines and government directives” (RCPsych [2013](#), p.12)

The [Mental Welfare Commission](#) (MWC) stated:¹

“we need a wider focus on prevention and wellbeing, and faster access to community-based support for a much larger number of young people. Currently young people may wait up to 18 weeks to be assessed, only to be told their situation is not sufficiently serious to access CAMHS, with little else on offer and months passed with no intervention” (MWC [2016a](#), p.3)

¹ The Mental Welfare Commission (MWC) is the statutory body with responsibility for monitoring Scotland's Mental Health Services.

The Scottish Youth Parliament's recent research, [Our Generation's Epidemic](#) (2016a) indicates that young people aged 12 to 25 may have low awareness of what mental health self-help information, guidance and services are available in their local area. 70% of respondents who had experience of a mental health problem did not know what self-help support was locally available. 27% of respondents did not feel that their school, college, university or workplace

TERMS USED

The terms used to discuss the mental health needs of children and young people can be complex and similar terms may be used in different ways. Additionally, services used by children and young people may define 'children', 'adolescent' or 'young people' differently, and the age at which a young person is considered to have the capacity to make decisions and hold certain rights may vary depending on the service in question and the relevant legislation.

- Mental health – An umbrella term which may denote both mental health problems and mental wellbeing. The World Health Organisation (WHO) defines mental health as “a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO [2016](#)).
- Mental health problem – A broad term which can refer to any long-term or short-term difficulty a person experiences with their mental health.
- Mental disorder – May refer to mental health problems which are severe and/or chronic in nature, and limit ability to manage everyday situations and tasks. It is used in the [Mental Health \(Care and Treatment\) \(Scotland\) Act \(2003\)](#) to include mental illness, learning disability or related disorders.
- Mental illness – Typically refers to a diagnosable psychiatric condition.
- Rights-based approach – Generally, the term 'rights-based' is used to describe an approach to the treatment and care of people with mental health problems which focuses on safeguarding and upholding their human rights. The [Mental Welfare Commission for Scotland](#) (MWC) describes a rights-based mental health system as “giving people greater opportunities to participate in shaping the decisions that impact on their human rights. It also means increasing the ability of those with responsibility for fulfilling rights to recognise [...] those rights, and making sure they can be held to account” ([2015a, p.11](#)).¹

provided a supportive environment to talk about mental health.

PREVALENCE AND TRENDS

In 2003, the [Scottish Needs Assessment Programme Report](#) (the ‘SNAP Report’) found that 10% of children and young people “have mental health problems which are so substantial that they have difficulties with their thoughts, their feelings, their behaviour, their learning, their relationships, on a day-to-day basis” (p.6). In 2004, a UK-wide survey found that one in ten children and young people aged 5 to 16 had a clinically diagnosed mental disorder (ONS, [2004a](#)).

In 2011, [NHS Health Scotland](#)² published a set of [Children and Young People’s Mental Health Indicators](#) which were developed as a tool for monitoring the mental health of children and young people in Scotland. The indicators were first used in the Scottish Public Health Observatory’s (ScotPho) [2013](#) report on the mental health of children and young people. This report suggested that the mental wellbeing of children and young people had remained “relatively constant” over the past five years, while some measures of mental wellbeing showed improvement. For indicators of mental health problems over the same period, “approximately half improved and half remained stable or showed no obvious pattern over time” (p.92).³

Other recent studies suggest that the prevalence of mental health problems among children and young people has increased. In 2015, a UK-wide [report](#) indicated that in 2011 – 2012 one in eight children aged 10 to 15 reported symptoms of mental ill-health (ONS 2015). Also in 2015, [analysis](#) of data from the 2013 [Scottish Adolescent Lifestyle and Substance Use Survey](#) (SALSUS) indicated that around 23% of S2 pupils and 26% of S4 pupils had emotional and/or behavioural problems (Scottish Government 2015).

The Scottish Government has part funded new UK-wide research led by the ONS into the prevalence of mental health problems (2016b). Data collection will begin in 2017.

INEQUALITIES

Mental health problems are not equally prevalent among all groups of children and young people. The mental health needs of children and young people differ significantly depending on their stage of development. Studies also indicate some groups of children and young people are at particular risk of developing mental health problems. For example, it is estimated that 45% of Looked After Children (LAC) in Scotland may have a mental health problem (ONS 2004b).

The [2015 report](#) on data from the 2013 Scottish Adolescent Lifestyle and Substance Use Survey shows a variety of trends. The report suggests that children and young people’s mental health and wellbeing is influenced by many social and environmental factors, and there are clear inequalities in the mental health of children and young people:

- 15-year-old girls in Scotland appear to be suffering “much poorer” mental health and wellbeing than other children and young people – indications of emotional problems in this group rose from 28% in 2010 to 41% in 2013 (p.4).
- Fewer young people had conduct disorders in 2013 compared to 2006, and there has been an increase in pro-social behaviour since 2006.

² [NHS Health Scotland](#) is a national health board focused on improving public health and reducing health inequalities.

³ More information on the [Children and Young People’s Mental Health Indicators](#) or other measures of mental wellbeing often employed in these surveys (such as the Strengths and Difficulties Questionnaire and the Warwick-Edinburgh Mental Wellbeing Scale), can be found at [Health Scotland](#).

- Reported emotional problems and peer problems increased between 2010 and 2013.
- Those with a “limiting illness or disability tended to suffer from poorer mental health and wellbeing” (p.38).
- Pupils who “had a mixed or multiple ethnicity” tended to suffer from poorer mental health and wellbeing than others (p.38).
- Higher levels of deprivation correlated with poorer mental health and wellbeing. Data based on the Scottish Index of Multiple Deprivation (SIMD), receipt of Free School Meals, and perceived family affluence all showed a relationship with mental health and wellbeing. Of these measures, perceived family affluence showed the strongest relationship with mental health and wellbeing.
- The nature of young people’s friendships was associated with mental wellbeing: 75% of girls with no close friends showed a “borderline or abnormal” score on the ‘Strengths and Difficulties Questionnaire’ used to measure mental health.
- Young people who “disliked school, felt pressured by school work, truanted on multiple occasions or had been excluded had poorer mental health and wellbeing than those that did not”. Pupils who stated they did not like school were four times more likely to have borderline or abnormal scores than those who said they liked school a lot (p.8, p.27).

The most recent analysis of the [Health Behaviour in School Aged Children](#) (HBSC) survey found that a high proportion of 15 year old girls in Scotland reported symptoms of poor mental health. The mental health of young people in Scotland also appeared to be influenced by socioeconomic inequality to a greater degree than in other European countries (WHO [2016](#)).

Findings of a [2015](#) UK-wide review of children’s wellbeing indicated that children who are bullied frequently were four times more likely to have symptoms of poor mental health (ONS 2015).

[LGBT Youth Scotland](#) has recently conducted research on the mental health of LGBT young people. Initial findings suggest that 40.1% of all LGBT respondents and 66.7% of transgender respondents considered themselves to have a mental health problem (2016).

REFERRALS TO SPECIALIST CAMHS

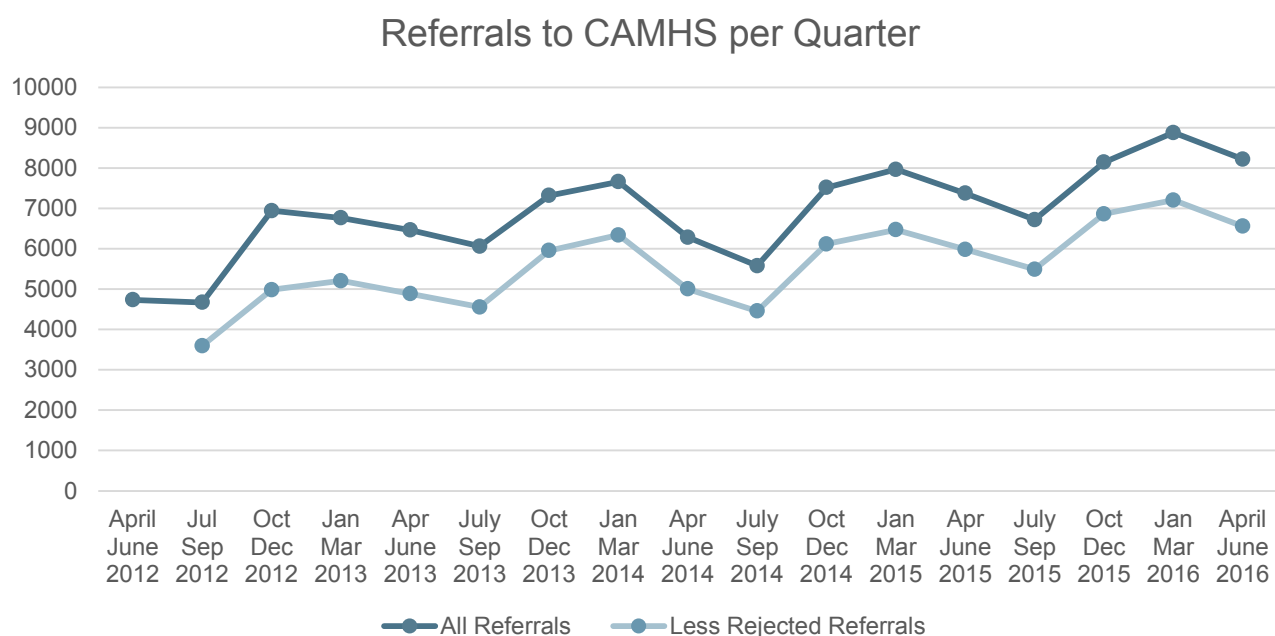
While the overall prevalence of mental health problems amongst children and young people may appear to have increased, recent NHS data also shows several clear trends. Referrals to specialist CAMH services and hospital admissions related to self-harm have increased.

The NHS [Information Services Division](#) (ISD) began publishing numbers of referrals to specialist NHS Child and Adult Mental Health Services in 2012. Since 2012, the total number of referrals per quarter to CAMHS services has risen from a low of 4670 (3595 less rejected referrals) in October – December 2012 to a high of 8879 (7204 less rejected referrals) in January - March 2016. The number of accepted referrals in these two particular quarters has more than doubled (ISD 2016a). However, improvements to CAMHS data collection may account for some of the increase in numbers of referrals over time (Audit Scotland 2016). Figure 1 illustrates the overall rise in CAMHS referrals.

The total number of CAMHS referrals received in 2015 was 30,208 (24,807 less rejected referrals). This represents a 13.5% increase on the total number of referrals in 2013 (26,606) and a 20.4% increase on the number of accepted referrals (20,597). It appears that referrals to CAMHS typically dip in the third quarter of the year (July to September).

It should be noted that the number of referrals specialist mental health services receive is still below estimates of prevalence.

Figure 1: Trends in Referrals to CAMHS, 2012 – 2016



Source: ISD Data Tables, Referrals, 2012 – 2016. (ISD 2016a)

HOW MENTAL HEALTH SERVICES ARE PROVIDED FOR CHILDREN AND YOUNG PEOPLE

Mental health services for children and young people in Scotland are primarily delivered by the NHS and local authorities, and may also be delivered by third sector organisations.

CAMHS PRACTITIONERS

Much of the work led by NHS CAMHS involves multi-disciplinary teams, and draws on a broad range of expertise. Brief definitions of different CAMHS practitioners are provided here:

CAMHS Psychiatrist	A medically trained specialist qualified to assess, manage and treat mental health disorders in people aged under 18 and older people with eating disorders which began in childhood or adolescence, or who are transitioning from CAMHS to Adult Mental Health Services. Psychiatrists may prescribe medicine and authorise treatment such as surgery or enforced nutrition (RCPsych 2014a).
Consultant CAMHS Psychiatrist	A highly experienced Psychiatrist with more specialised expertise. They provide clinical leadership for wider teams and may 'meta-manage' the care of a number of cases led by CAMHS Psychiatrists.
Clinical Psychologist	Provides assessment and treatment informed by psychological approaches (including psychometric assessment and psychological therapy such as cognitive behaviour therapy) supporting people's psychological functioning, emotional wellbeing and development. Practitioners hold a Doctorate in Clinical Psychology (RCPsych 2012).
Child & Adolescent Psychotherapist	Experienced therapists providing age-appropriate, individualised, psychotherapy which is sensitive to the family situation and social context the child or young person experiences. Therapy may involve

	careful observation of a child playing or drawing. Often used when patients have not responded to other psychological treatments.
Mental Health Officer (MHO)	MHOs are social workers with specialist mental health training. MHOs have statutory duties under the 2003 Act, and are responsible for determining whether a person may be detained under the 2003 Act if considered a risk to themselves or others.
Primary Mental Health Officer (PMHO) or Mental Health Link Worker (MHLW)	PMHWs - otherwise referred to as 'Mental Health Link Workers' or 'Link Workers' - provide consultation, training, advice and support to Primary Care workers and other professionals working in children's services. They also provide direct interventions to people experiencing a wide range of mental health problems which do not meet the threshold for more intensive CAMHS support. They are involved in the early identification of mental health problems and may refer people to specialist CAMHS.
Educational Psychologist	Assesses people who are experiencing problems in educational settings and leads interventions focused on improving their learning.
Speech and Language Therapist	Provides treatment for children and young people experiencing specific difficulties communicating.
Occupational Therapist	Provides therapy focused on helping a child or young person overcome difficulties experienced in the course of daily life. May work with children and young people whose conditions include Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder, Anxiety and Behavioural disorder.

TIERS OF CARE

Child and Adolescent Mental Health Services in Scotland have been arranged in 'tiers' of care for the past two decades.⁴ This approach is intended to provide a 'stepped' and 'matched' model of intervention, whereby the mental health needs of many children or young people may be met by professionals working in universal services, and those with more particular needs may receive targeted specialist support. CAMHS draw upon a wide range of mental health professionals. The following section outlines the support provided at different tiers of care:

Tier One – Support at Tier One may be provided by practitioners working in universal services. These practitioners should be able to offer advice and support for less severe mental health difficulties; to contribute to positive mental health promotion; to identify mental health problems early and refer children and young people on to more specialist services as required. Practitioners may include: health visitors; GPs; school nurses; teachers; social workers; youth justice workers; workers in the third sector.

Tier Two – Support provided at Tier Two may be delivered by CAMH workers in primary care and/or community settings, who may be known as Primary Mental Health Workers (PMHWs) or Mental Health Link Workers (MHLWs or 'Link Workers'). PMHWs are supported by CAMH specialists. At this Tier, PMHWs or CAMH specialists may also provide consultation and training to Tier One practitioners, and be involved in identifying more complex mental health

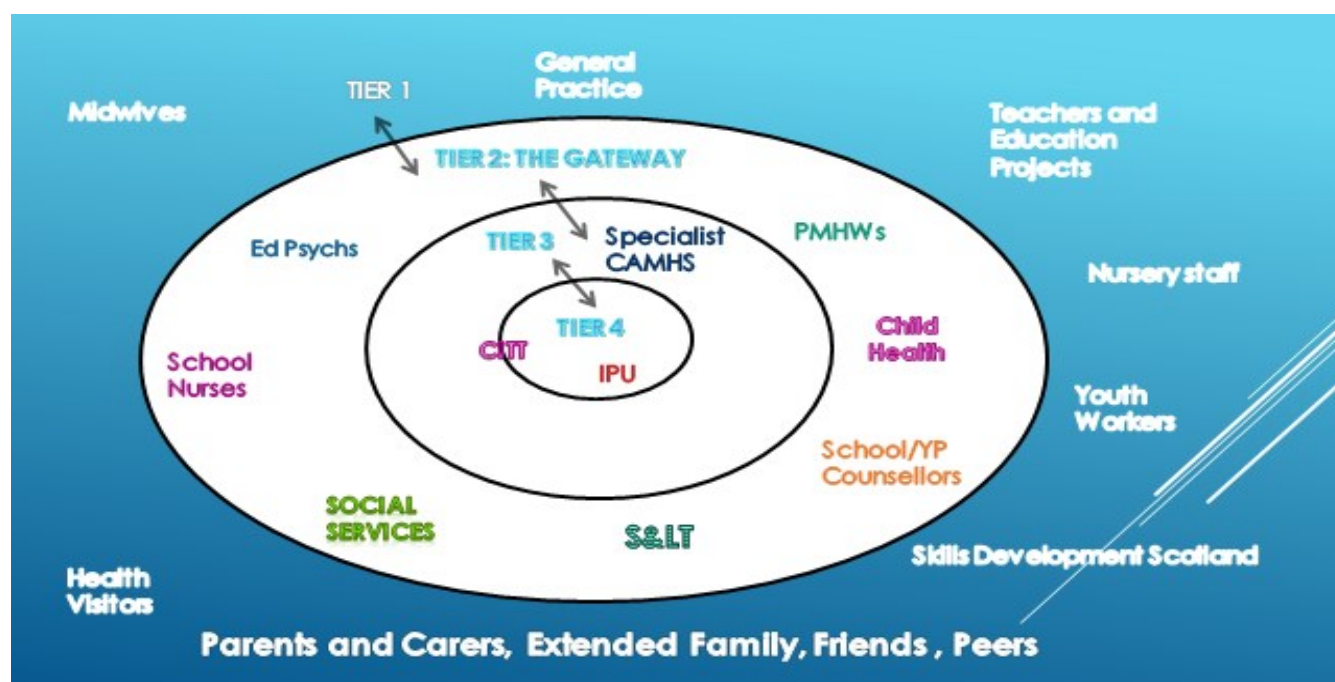
⁴ The Tiered Model of Care led from the recommendations of the NHS Health Advisory Service Report 'Together We Stand' (1995).

needs requiring specialist intervention. Tier Two practitioners may provide consultation, advice and support to other health practitioners and families.

Tier Three – Tier Three provides specialist services for children and young people with more severe, complex and persistent disorders. Support may be delivered by multidisciplinary teams working in a community health setting, or a child and adolescent psychiatry outpatient service. Team members are likely to include: child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and art, music and drama therapists.

Tier Four – Tier Four provides specialist services for children and young people deemed to be at greatest risk of rapidly declining mental health; serious self-harm; or who require a period of intensive input for assessment and/or treatment. Tier Four services may be delivered by community treatment teams, in day units or in inpatient units. A consultant child and adolescent psychiatrist or clinical psychologist is likely to have clinical responsibility for overseeing the assessment, treatment and care of each Tier Four patient.
(Adapted from ICP Toolkit [2011](#))

Figure 2: Tiered Model of Care



Source: McFadyen, A. Improving Child and Adolescent Mental Health Services (2016).

Figure 2 illustrates the wider system of Child and Adolescent Mental Health Support, involving input from universal services, and professionals in children's services and school settings. S< – Speech and Language Therapists; CITT – Community Intensive Treatment Teams; IPU – Inpatient Psychiatric Unit; PMHW – Primary Mental Health Workers.

Pathways to Treatment

Thresholds for intervention at Tier Three and Four are high. General guidance produced by the Scottish Government's CAMH Delivery Board in September 2009 specifies that referrals are appropriate when a child or young person is suspected to have a "mental disorder or other condition" which results in "persistent symptoms of psychological distress" and meets at least one of the following criteria:

- An associated serious and persistent impairment of their day to day social functioning.
 - An associated risk that the child/young person may cause serious harm to themselves or others.
- ([ISD 2012](#) p.2)

Individual health boards may offer more detailed contextual guidance to practitioners.

While the tiered model of care indicates how children and young people may be supported by different services and professionals, depending on their needs, pathways to care can be complex and professionals responsible for children may not always clearly understand which route to support is most appropriate. [CAHMS training resources](#) produced by NHS Education Scotland noted that, “the diversity of the range of potential help can also produce uncertainty or confusion about how or where a problem is best addressed.” They commented further: “Except for educational problems and child protection concerns, there are few integrated care pathways and still fewer assessment tools to determine down which path a particular problem should be directed” (HeadsUpScotland 2011, p.21). In 2011, Healthcare Improvement Scotland (HIS) published [Integrated Care Pathways for Child and Adolescent Mental Health Services](#). Integrated Care Pathways (ICPs) outline the steps expected in people’s care and treatment.

Service Provision by NHS Board

CAMHS services are not provided uniformly across all health boards. This section provides a brief introduction to CAMHS across health boards; spending across boards; some discussion of workforce issues; waiting times and discussion concerning inpatient admissions.

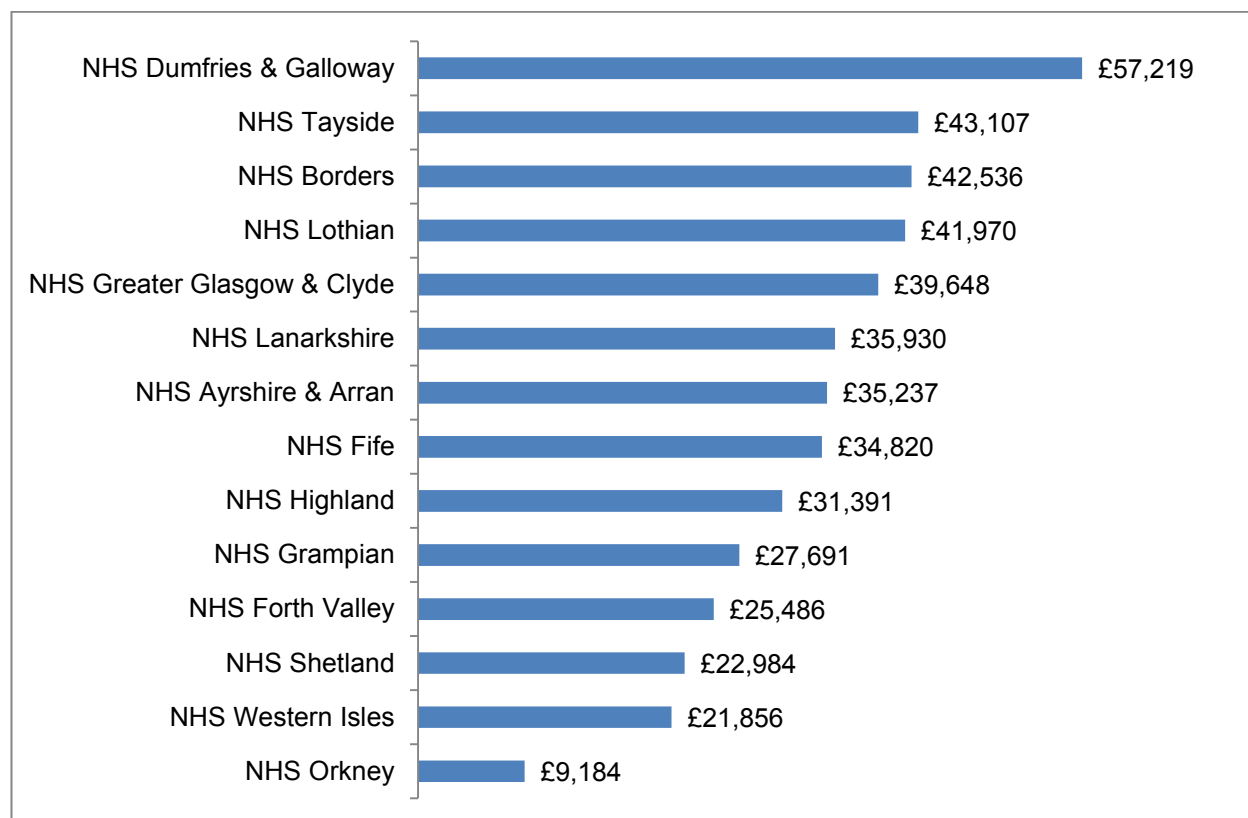
Spending by NHS Board

ISD’s [CAMHS Benchmarking Toolkit](#) provides a range of data measuring performance. It does not provide details of overall spending by NHS board of residence. It does however provide data on spending on wages for each board’s community CAMHS services per 1,000 young people aged under 18 based on Community CAMHS Psychiatry wages budget plus total spend on Community CAMHS Agenda for Change Clinicians wages.

Nationally, there has been an uplift in spending directly on wages for Community CAMHS services: from £32,785 per 1,000 young people in the first quarter of the 2012-13 financial year, to £36,788 in the third quarter of 2015-14 - an overall increase of around 12.2%. (ISD [online](#), Community CAMHS Wages Budget).

There are disparities in funds spent on community CAMHS services between boards. In the last quarter of data recorded, the community CAMHS wages budget in NHS Dumfries and Galloway was £57,219 per 1,000 people under 18. NHS Orkney spent £9,184 per 1,000 under 18s in the same quarter. It should be noted, however, that be noted that figures published by the ISD do not necessarily reflect the wider public sector workforce supporting CAMHS in its entirety. Other professionals directly involved with CAMHS may be employed in other areas of the NHS, or by local authorities working in partnership with the NHS. Also the variation in the average wages at board level may be due to the varying levels of qualifications held by clinicians.

Figure 3: Community CAMHS Wages by Board, per 1,000 people aged under 18 (as at Quarter 3 2015/16).



Source: Annual averages based on CAMHS [Benchmarking Toolkit](#) quarterly figures.

CAMHS WORKFORCE

In 2009, the Scottish Government committed central funding to increasing the NHS CAMHS workforce ([ISD 2016c](#)). This led to investment of £6.5 million in the CAMHS workforce between 2009 and 2013 ([Scottish Government 2011](#)). ISD provides quarterly reports on the NHS CAMHS workforce in Scotland. Again, it should be noted that these figures may not reflect the wider public sector workforce supporting CAMHS in its entirety, as other professionals may be employed in other areas of the NHS or by local authorities.

Recent workforce information released shows a 30% overall increase in the workforce since 2009. This increase is from 764.6 whole time equivalent (WTE) (883 headcount) to 993.5 WTE (1,154 headcount) by 31 March 2016. The pattern has been one of steady increase since 2009. The current overall staffing level in Scotland represents 18.5 WTE CAMHS clinical workers per 100,000 of the population ([ISD 2016c](#)).

The Scottish Government's current CAMHS workforce target is 20 WTE pwe 1,000 population. The 2005 strategic review of Scotland's CAMHS workforce, [Getting the Right Workforce](#), indicated that an effective workforce should provide at least 15 – 20 WTE staff per 100,000 of the total population. The review noted that this ratio does not take account of variation in the proportion of young people in populations across Scotland, or the need for higher levels of staffing in areas with a widely scattered population or areas of high deprivation (Scottish Government 2005a).

Another workforce model suggested a ratio of 19.3 WTE CAMHS staff would meet demand on services where staff are not involved in teaching, and 24.2 WTE reflected the level of staffing required when time is committed to teaching (Kelvin 2005).

The Mental Health Foundation's 2016 [review](#) of mental health services noted that reports on the mental health workforce "identify a gap in data, with current vacancies in teams due to absence, illness or internal movement not being known, meaning that in practice staff could feel limited or no immediate net gains to the workforce in terms of numbers" (p.76). The review also observed that some CAMHS teams felt problems filling posts (including specialist consultants' posts) compounded with a rise in referral rates, led to difficulties meeting the 18 week CAMHS treatment time target.

Balance of CAMHS Workforce

The optimal balance of the CAMHS workforce is complex since the mental health needs of children and young people vary significantly according to their stage of development. Different mental health conditions require support from a different mix of staff, and measuring the CAMHS workforce against the population of a given health board (or the number of people aged under 18) does not necessarily reflect the needs of a particular demographic. Workforce data published by ISD in February 2016 indicates that around 1% WTE staff see patients aged over 18. 24% see patients aged 16 or 17; 40% patients aged 12 to 15; 30% patients aged 5 – 11 and 5% patients aged four or under ([ISD 2016d](#)).

Guidance issued by the Royal College of Psychiatrists (RCPsych) in 2005 recommended that 5 WTE staff should be committed to primary mental health work (York and Lamb 2005).

Despite the overall increase in the CAMHS workforce, some have voiced concerns that there are gaps in provision in some key areas and that the current balance of the workforce does not reflect demand for highly experienced clinicians. The CAMH professional groups to have expanded most since 2009 are Psychology (87.8% increase); Occupational Therapy (30.5% increase) and Nursing (30.2% increase) ([ISD 2009](#), table 1 and [2016c](#)).

Not all groups of professionals have expanded. The number of WTE medical professionals (including psychiatrists of all grades) has fallen by around 5.8% between 2009 and 2016 (ISD 2009 and [2016c](#)). As of 31 March 2016, Scotland's CAMHS workforce includes 1.5 WTE medical professionals (of all grades) per 100,000 total population (ISD 2016c).

Psychiatrists

The RCPsych notes particular difficulties recruiting, training and retaining consultant psychiatrists (RCPsych 2016). In 2014, 13 advanced training posts (required in order to qualify as a consultant psychiatrist) were advertised and only 5 were filled. As consultant psychiatrists oversee the care of cases managed by other clinicians, the impact of shortages in this area may cascade down.

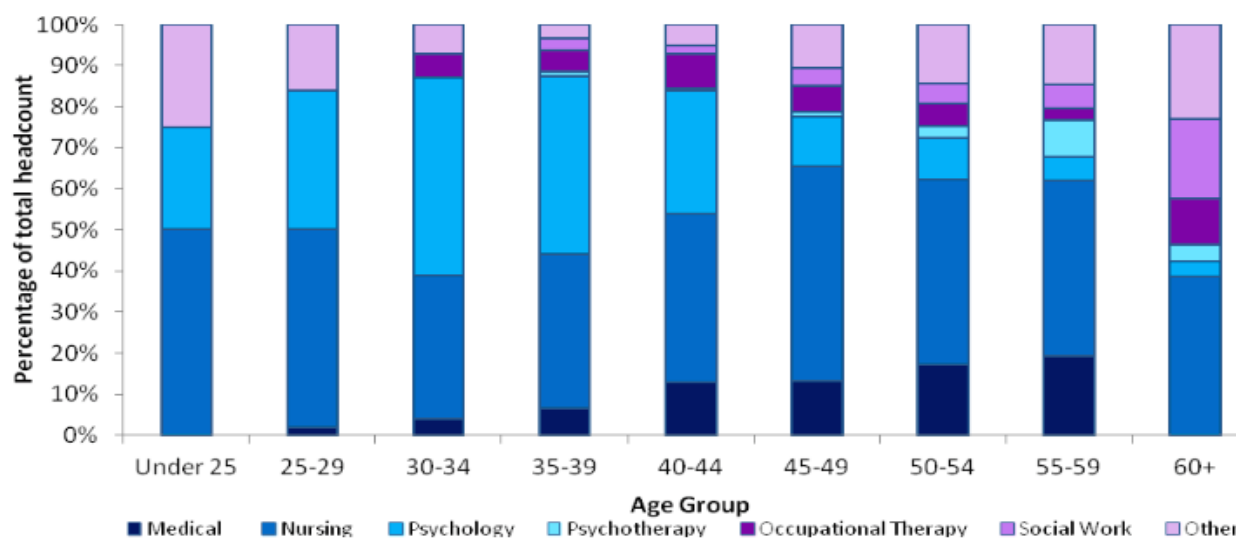
Guidance on optimal numbers of CAMHS psychiatrists varies. The number of psychiatrists required also depends on whether CAMHS services are provided to children and young people up to the age of 16, or to all those up to the age of 18. Like other senior professionals in the CAMHS workforce, consultant psychiatrists may also have teaching and research responsibilities which impact upon required staffing levels.

In 2005, guidance issued by the RCPsych recommended 1.5 WTE CAMH Psychiatrists (York and Lamb 2005). In 2014, updated workforce guidelines from the RCPsych recommended that Tier 2 and 3 CAMHS services required 2.4 WTE Consultant Psychiatrists to meet the needs of children and young people up to 16 years of age. Services for 16 and 17 year olds would require an additional 1.45 WTE Consultant medical professionals without teaching responsibilities, and 1.8 WTE if teaching responsibilities are factored in (RCPsych 2014b).

Very few of the cohort of CAMHS staff aged under 25 belong to medical professions, and there are few medics in the sector under the age of 35. Other key groups of practitioners such as

psychotherapists are chiefly aged over 50. The following figure illustrates the relative percentage of CAMHS professionals by age group, as of December 2015 (ISD 2016d).

Figure 4: ISD Workforce Data



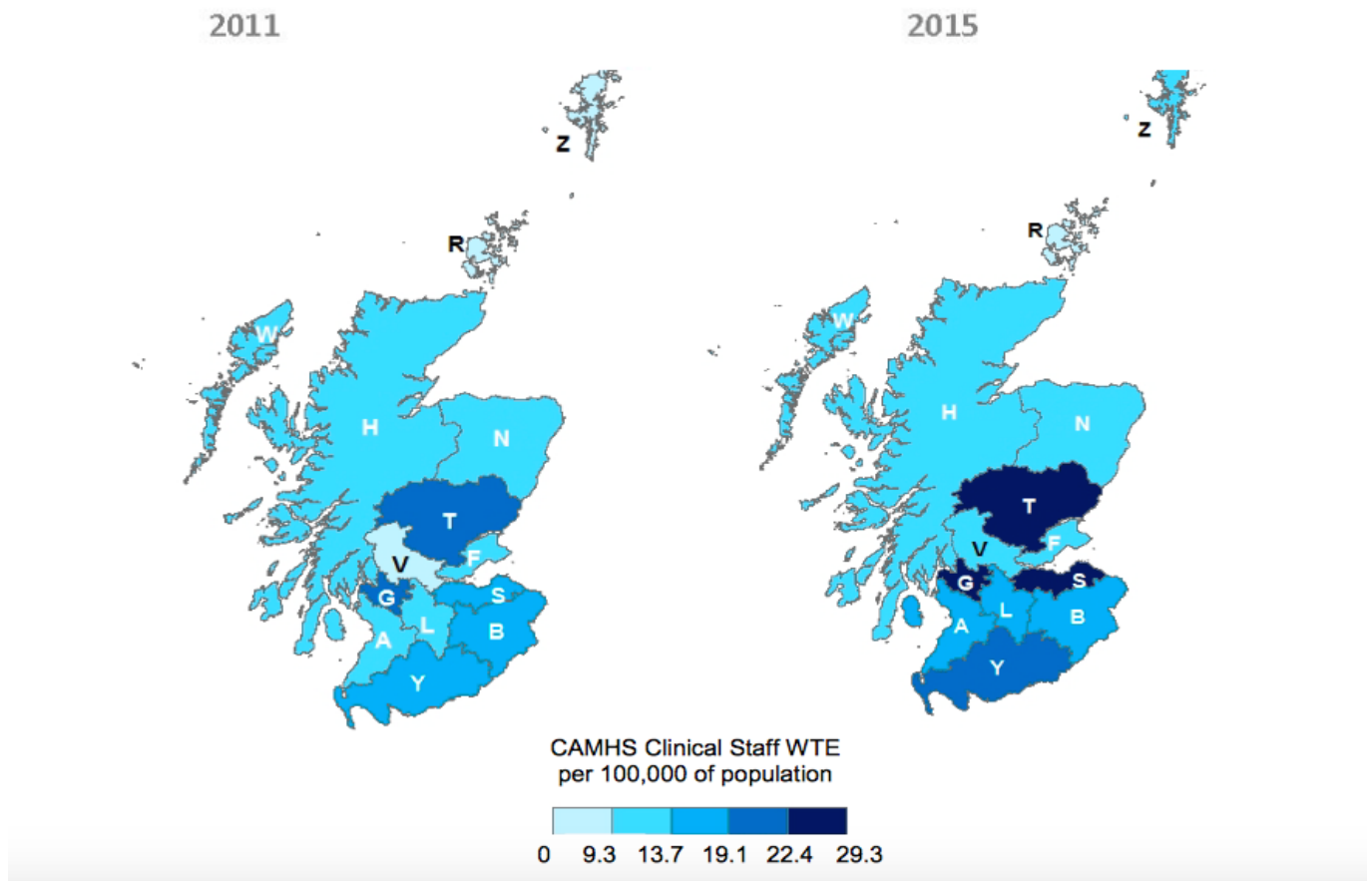
Source: ISD 2016d

CAMHS WORKFORCE BY HEALTH BOARD

There are disparities in the level of CAMHS staffing between health boards. As of 31 March 2016, four health boards meet or exceed the target 20 WTE staff per 100,000 of population. Seven report fewer than 13.7 WTE (ISD 2016c). These calculations are based on the general population and do not account for any variations in the proportion of young people aged under 18 served by any health board.

The following figure illustrates the proportion of CAMHS clinical staff per 100,000 of the population throughout Scotland's regional boards.

Figure 5: ISD Regional Workforce Data



Source: ISD, 2016d.

Educational Psychologists

Educational Psychologists are generally employed centrally by education authorities and their numbers are therefore not reflected in NHS CAMHS workforce data. There have been around 400 Educational Psychologists employed in Scotland in recent years though this fell to 370 in 2015 (Scottish Government [2016c](#), table 3.5).

The National Association of Scottish Principle Educational Psychologists (NASPEP) and the Scottish Division of Educational Psychologists (SDEP) have expressed concern about the number of trained educational psychologists in Scotland, and the impact of funding for MSc Educational Psychology students being cut in 2012 (Educational Institute of Scotland [2012](#)).

ELIGIBILITY AND PROVISION BY AGE

The Mental Health (Care and Treatment) (Scotland) Act (2003) requires all health boards to provide age-appropriate services to children and adolescents up to the age of 18, and this duty was due to be fully implemented by 2015.

The majority of NHS Boards offer most CAMHS services to people up to the age of 18. The following exceptions, as of 31 March 2016, are detailed over:

Ayrshire and Arran	Up to 18 if in full-time education.
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Dumfries and Galloway	Child Clinical Psychology Service is not available to those aged 16 or over who are not attending school. CAMHS “occasionally” available beyond 18 th birthday.
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Forth Valley	Learning Disabilities CAMHS available up to the age of 16.
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Highland	CAMHS not available to those aged 16 or over who are not in full time secondary education. Learning Disabilities CAMHS available up to 19 th birthday if in full time education.
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Lanarkshire	Tier Three Child and Family Clinic Teams only work with those aged 16 or over if they were referred before their 16 th birthday.
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Shetland	Up to 18 if in full-time education.
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Tayside	Most CAMHS are not available to those aged 16 or over who are not in full time secondary education. Learning Disability CAMHS and Tier 4 services are available up to the age of 18.
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Source: ISD, 2016c.

Although all health boards have been required to extend the upper age range of CAMHS services, some services have noted that no additional resourcing was designated to manage the new range of provision.

The last national strategy to focus exclusively on the mental health of children and young people was [The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care](#) (2005) ('the Framework'). The Framework recommended that while “pragmatic but flexible use of [an individual's] 18th birthday may be regarded as a reasonable referral guideline for new referrals to mainstream child and adolescent mental health services”, young people with significant mental health needs may benefit from services extending beyond this point. The Framework observes that there are risks of “discontinuities” in service provision when young people are required to transition to Adult Mental Health Services. It notes that young people looked after by a local authority “may remain in the child care system until there are 19 years old, and in some circumstances, until they are 21 years old.” Similarly, “offenders are considered “young” until the age of 21. Accordingly, the Framework recommends that “Where liaison arrangements with child and adolescent mental health services are established for younger clients, it would seem arbitrary and unhelpful to exclude older young people while they remain in these settings” (p.18-19).

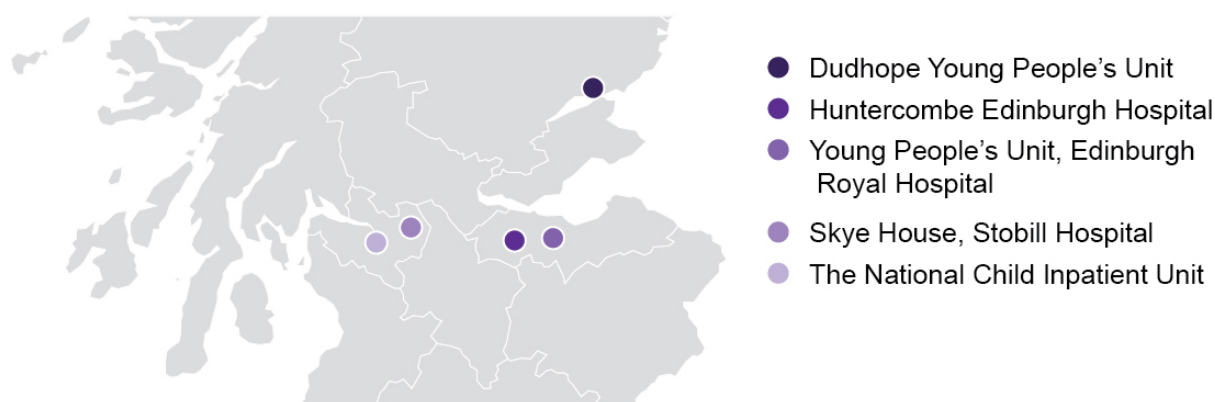
Since the commencement of the 2003 Act and the publication of the 2005 Framework, obligations placed on local authorities with respect to looked after young people have been altered by provisions of the [Children and Young People \(Scotland\) Act 2014](#). Looked after young people now have the right to remain in their placement until 21 and local authorities have a duty to support care leavers up to the age of 26. This could alter best practice in delivering mental health services to looked after young people and care leavers in this age range.

CAMH INPATIENT UNITS

Specialist CAMH inpatient facilities were rationalised in the late 1990s and early 2000s. Inpatient units in Fife, Dumfries, Aberdeen, Dundee and Lothian were closed. These closures were in line with an overall shift away from delivering care in hospital settings towards more community-based services.

There are currently 4 NHS inpatient CAMHS units in Scotland. Together they provide 54 inpatient beds. Two of these units are based in Glasgow, one in Edinburgh and one in Dundee. Some NHS Boards may also refer patients to Huntercombe Hospital in Edinburgh, a private inpatient facility for young people with eating disorders and/or other mental health problems. Tier Four inpatient care tends to be planned on a regional basis between boards.

Figure 6: NHS Inpatient CAMHS units



Source: SPICe

The National Child Inpatient Unit, Glasgow

Provides 6 inpatient beds to children aged 5 to 12 with some flexibility at either end of the age range depending on clinical need. Day patient facilities are available to children in the process of being admitted or discharged as inpatients. This unit was previously based at Yorkhill Hospital in Glasgow, and when relocated in 2014 the number of inpatient beds was reduced from 9 to 6. Day patient treatment available to the wider under-12 population was also reduced. This facility considers admissions from boards across Scotland.

[Skye House](#) (Stobill Hospital), Glasgow

A General Adolescent Inpatient Unit for young people aged 12 to 18. Provides a total of 24 beds, including 2 short-stay beds.

[Young People's Unit](#) (Royal Edinburgh Hospital) Edinburgh

A General Adolescent Unit for inpatients aged 10 to 18. Provides 12 beds. Admits patients from NHS Fife, NHS Borders and sometimes other areas of Scotland.

[Dudhope Young People's Unit](#), Dundee

A General Adolescent Inpatient Unit for young people aged 12 to 18. Provides 12 beds. Supported by the North of Scotland CAMHS project.

[Huntercombe Hospital, Edinburgh](#)

A private hospital to which the NHS refers young people. It offers inpatient facilities to young people aged 11 to 18. Services include an Independent Eating Disorder Unit. Provides 22 beds.

Forecasting demand for Tier Four services precisely is difficult as there is no agreed methodology for assessing need and projecting local service models ([North of Scotland Public Health Network](#) 2010). General guidance from the RCPsych estimates that “24 – 40 in-patient CAMHS beds per 1 million total population are required to provide mental health services for children and adolescents up to age 18 with severe mental health problems that require emergency or very intensive treatments” (RCPsych 2013 p.37).

The total number of beds does not reflect circumstances which may make inpatient beds unavailable. For example it was reported in 2016 that the Dudhope Young People’s Unit had to stop admitting young people to four beds due to lack of staffing when a consultant psychiatrist post was unfilled (MWC [2016b](#)). A report by the MWC also noted that the National Child Inpatient Unit was required to temporarily stop admitting any high risk children and/or children with significant behavioural difficulties due to practical issues arising when the unit was transferred to a new site in 2015. The report took the view that, “given the national status of the unit and the frequency of behavioural disturbance in the catchment population of children that the unit serves this state of affairs cannot be seen as acceptable” ([Puttick](#) 2016).

As inpatient CAMH services are largely concentrated in the central belt, with no specialist inpatient provision north of Dundee, children and young people requiring inpatient care may be required to travel away from home to receive appropriate care. The [Scottish Children’s Services Coalition](#) (SCS) (an umbrella group which represents, among others, some independent and third sector care providers) has campaigned for children and young people to receive age-appropriate care close to home, stating:

“Many children and young people who do receive treatment are therefore being treated far from home, often leaving them feeling isolated and delaying recovery. For many children and young people who require inpatient mental health care, a lack of services means that they are left longer with their families, often until the family reaches crisis point. Or they are admitted to non-specialist adult and paediatric hospital wards” (SCS [online](#))

The Mental Health Foundation’s 2016 [review](#) of mental health services also commented on difficulties arising from a lack of local inpatient provision. The report observes “it was felt that” accommodating young people in inpatient units far from home could “lead to considerable distress for the young people and also caused time and financial issues for families, friends and carers” (p.49). The review found that in 2013 the number of CAMHS inpatient beds available met around 50% of demand, and some practitioners thought CAMHS inpatient facilities were “difficult to access” (p.74).

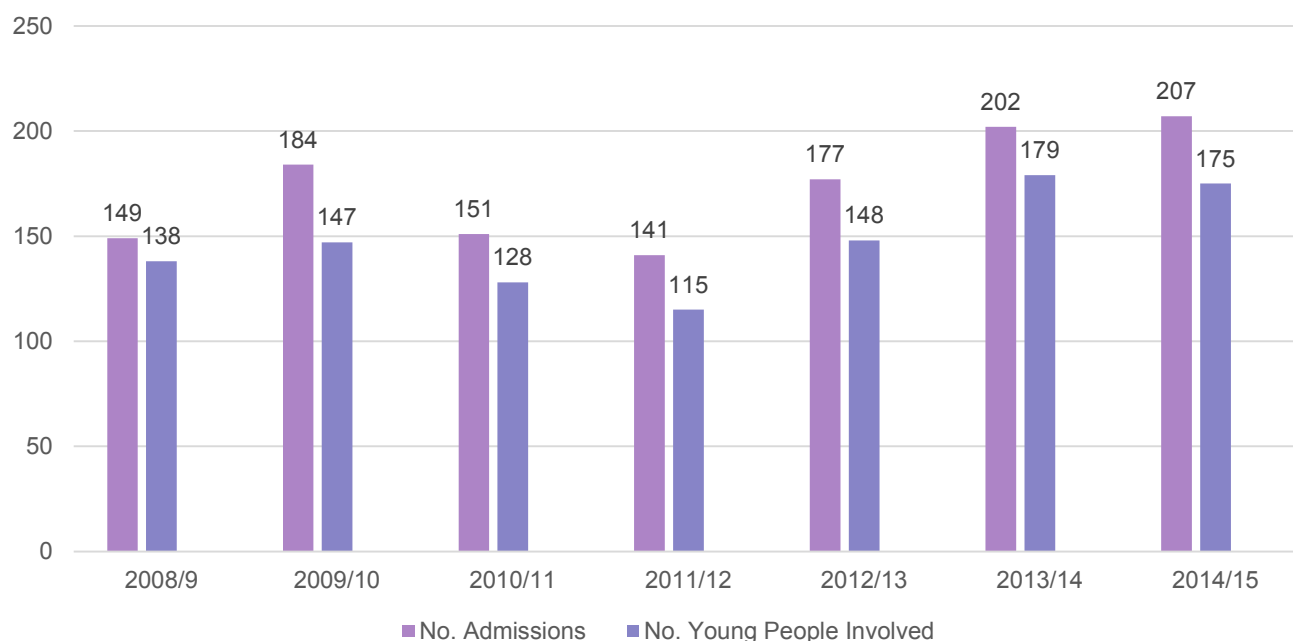
CAMH Admissions to Non-Specialist Units

The Mental Welfare Commission (MWC) monitors the number of admissions of under-18s to non-specialist inpatient units, and reports on these figures biannually. The MWC stresses that all health boards have a duty to provide age appropriate care to young people aged under 18 under the 2003 Act. The MWC's [2012/13 report](#) indicated improvements, as "CAMH services are making strenuous efforts to admit under-16s to specialist services, and that work has been in progress nationally to develop agreed criteria for the admission to and discharge from specialist in-patient units" (2014, p.7).

The Mental Health Foundation's 2016 [review](#) of mental health services analysed admissions data from 2008 – 2013. It notes that the number of young people admitted to adult wards has increased, though this "should be understood in the context of increasing young people's admissions to inpatient provision overall" (p.71). The review states that the "proportion of young people admitted to adult wards as a percentage of all admissions has decreased from 75% to 50%" (p.71-72). This is based on data from 2008 – 2013. The report provides [further analysis](#) of the proportion of young people each regional health board admits to inpatient care.

However, the MWC's latest [2014 – 2015](#) report found that admissions to non-specialist inpatient settings had remained at a similar level as in the previous year (207 admissions involving 175 young people). The report indicated the MWC was "disappointed" to see that the number of admissions "has remained high" (p.2).

Figure 7: Number of CAMH Admissions to Non-Specialist Settings



Source of Data: Mental Welfare Commission, 2015.

However, the report also notes that "it is not clear from the figures whether the continuing high level of admissions reflects the number of cases where admission to a non-specialist ward is a positive choice" (p.2). Presently, boards are required to report admissions of under-18s to non-specialist units such as general paediatric wards or adult psychiatric units to the MWC. This data does not currently indicate whether admission to a non-specialist unit was taken in the child or young person's best interest because it allowed them to receive care close to home, or was thought more appropriate to their developmental stage than alternatives. The MWC is now seeking additional information from Responsible Medical Officers (RMO) when children and young people are admitted to non-specialist units. Information from individual case notes has

been reported to the MWC from October 2015 to March 2016, and will be presented in the MWC's next report on Children and Young People (MWC 2016c).

Many short term admissions of under-18s to adult wards may occur when a young person experiences a mental health crisis and is detained in an adult ward as a place of safety, or are related to drug or alcohol use. However, figures reported by the MWC do not include admissions for less than 24 hours or related solely to drug or alcohol use, so probably exclude the majority of such cases. Audit Scotland noted that crisis services tend to be developed within adult services with limited provisions for young people (Audit Scotland [2009](#)).

The MWC finds that the "level of specialist support to children and young people in non-specialist wards appears to be very variable" (2015, p.2). As a result, it is difficult to determine whether the care and support received generally fits their needs and developmental stage. The day-to-day conditions in adult mental health wards may also be highly variable, as they depend on the nature and severity of other mental health problems amongst other inpatients. It is therefore difficult to state whether a particular adult inpatient facility can generally be considered suitable for young people or children.

Specialist Forensic and Learning Disability Inpatient Provision

Scotland does not currently have any inpatient facilities providing appropriate specialist care for children or young people with mental health problems who also have learning disabilities or secure CAMH inpatient facilities for those who present high forensic risk. Consequently, children and young people with these complex mental health needs are transferred to inpatient facilities in England when possible.

Plans to develop a Forensic CAMHS unit attached to a secure school were previously developed around 2006, but did not progress. A report produced for the Forensic Mental Health Services Managed Care Network Advisory Board in 2010 indicated that developing an 8 to 10 bed secure Forensic CAMH unit would benefit the needs of young people currently in intensive psychiatric care units or in custody, as well as individuals who are not detained due to a lack of suitable facilities, or who would respond better to care in a secure hospital setting. The report also suggested that one CAMH Forensic unit would be unlikely to meet the specific needs of all young people, and some arrangements to transfer individuals to inpatient units in England would continue (Forensic Mental Health Services Managed Care Network Advisory Board 2010). Proposals for a low or medium secure unit are currently being developed by the National Services Division and a national working group is developing proposals for Learning Disability inpatient facilities (Scottish Parliament Health and Sport Committee [2016](#), NHSGGC).

WAITING TIMES

The Scottish Parliament's Health and Sport Committee's 2008 – 2009 Inquiry into child and adolescent mental health and wellbeing found that long waiting times for access to services was a widely reported problem, and considerable variation in waiting times existed across Scotland. The Inquiry's [Report](#) also noted concerns regarding the period some children and young people were waiting between initial appointments and later access to a programme of care and treatment (Scottish Parliament 2009a).

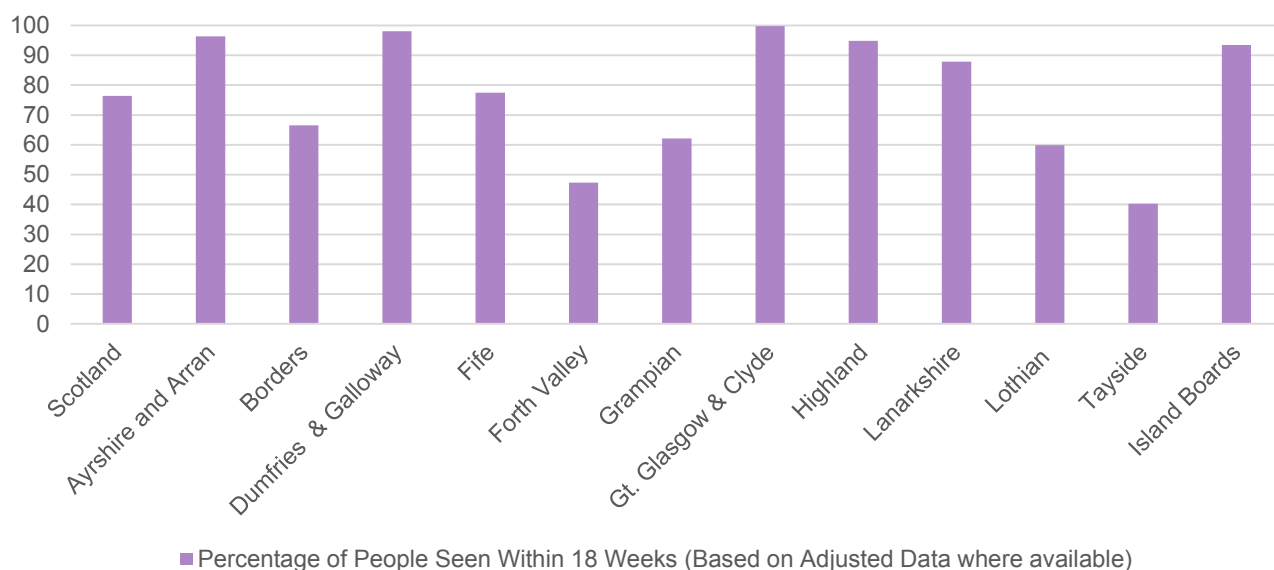
In 2009, the Scottish Government applied a HEAT Target to waiting times for access to specialist CAMH services. The target initially specified that, "By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMH services". In November 2010, the Scottish Government reduced the targeted waiting time to 18 weeks in order to work towards parity with standards for access to physical health services. The revised target was to be implemented by December 2014. The Scottish Government has determined that CAMH

services should achieve this standard for at least 90% of their patients. In November 2012 the Scottish Government issued further guidelines as to how certain data should be measured (Huggins [2012](#)). The target measures the time elapsed between a referral to treatment (RTT). This period is measured from the point when a specialist CAMH service receives a referral.

Qualifying referrals should meet the general criteria outlined in “CAMH Referral Criteria Guidance” (2009). This defines treatment as: “the start of a planned programme of intervention delivered by an appropriately qualified clinician designed to address agreed treatment goals”; or “the start of a coordinated treatment plan”; or “The start of a condition specific specialist multi-disciplinary assessment of screening (e.g. for a specific developmental disorder) (p.4). For more detailed information regarding the precise parameters of the target see ISD [CAMHS HEAT Target Updated Definitions February 2012](#).

Although a CAMHS Waiting Time HEAT Target has been in place since 2010, the performance of different health boards with regards to this target varies very widely. ISD publishes quarterly performance data on this target. Over the last calendar year, in some health boards fewer than 50% of patients referred to CAMHS services have waited under 18 weeks to access them, with this measure falling even lower in some quarters (ISD 2016d).

Figure 8: Average CAMHS Waiting Times; Percentage seen within 18 weeks (2015).

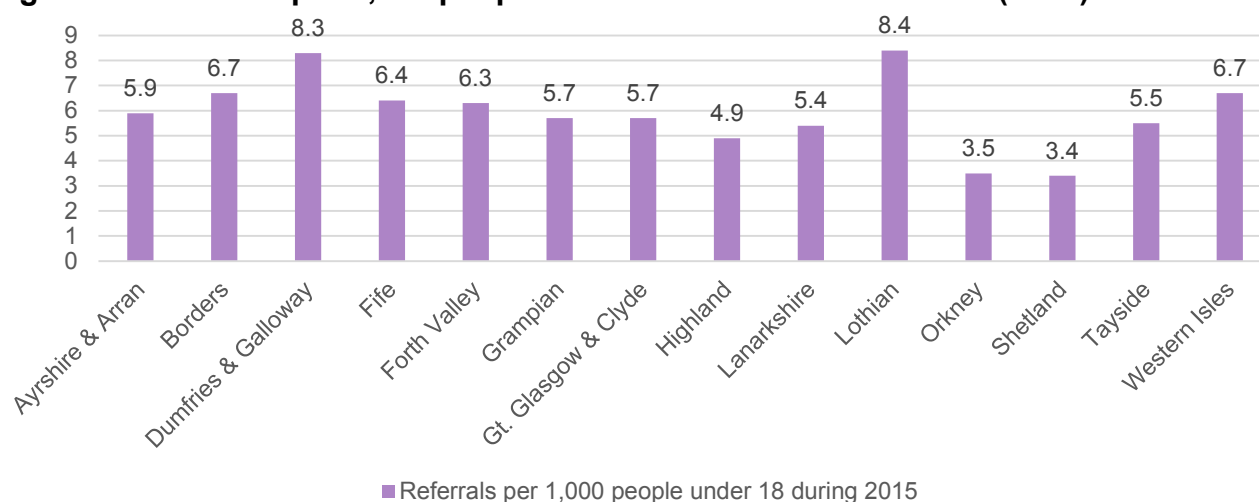


Source: ISD, 2016a Adjusted completed waits for people seen. Quarterly data tables 2015.

Number of referrals

The number of referrals services receive is an important indicator for the management of waiting times because waiting lists can build up when there is high demand for services. The number of referrals received by different health boards varies sharply. Again, the ISD cautions that it is not possible to directly compare referral rates across health boards, since not all provide the same services for all people aged under 18. However, considering the number of referrals per 1,000 people aged under 18 gives “an indication of relative differences in demand” ([2016d](#), p.12). The following figure shows the number of referrals per 1,000 people aged under 18 received by each health board in 2015, excluding rejected referrals.

Figure 9: Referrals per 1,000 people under 18 across NHS boards (2015)



Source: Annual averages based on CAMHS Benchmarking Toolkit quarterly figures.⁵

Rejected Referrals

In 2015, CAMHS received a total of 30,478 referrals of which 6,931 were rejected (ISD [2016e](#)). At different points, some health boards reject a far higher proportion of referrals than others. NHS Greater Glasgow and Clyde, for example, rejected 671 referrals in the last quarter of 2015, representing 33.8% of the referrals it received. In the same quarter, NHS Lothian rejected 122 referrals, 7.4% of the referrals it received.

Some NHS Boards and service delivery groups have discussed the matter of inappropriate referrals to specialist CAMH services, indicating that better information could be made available to GPs and other professionals working in primary care and children's services, developing understanding of the requisite criteria for referral.⁶ However, it is uncertain to what extent marked differences between the percentage of CAMH referrals refused by NHS boards are due to lack of clarity about appropriate pathways to care.

Performance Management

Different NHS Boards may be developing or trialling different approaches to reducing waiting lists for specialist CAMH services and increasing access, such as sending text message reminders ahead of booked appointments as is practice in some other services. The percentage of children and young people who "Did not attend" an initial appointment are generally high (ISD 2016b).

It is also possible that there are discrepancies in the way in which NHS boards measure RTT which would affect impressions of relative performance. The way in which RTT is measured may include cases where an individual is removed from a waiting list, declines treatment, or is considered to require no further treatment from specialist CAMH following an assessment appointment. At present, the target does not only measure time elapsed between a referral being received and the first appointment in a programme of care, but may also include individuals who have been removed from the waiting list for other reasons.

⁵ Quarterly figures are also available at <http://www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/child-and-adolescent-mental-health/>. NHS Shetland were unable to provide data from March to June 2015. No data is available for NHS Highland from March 2014 to October 2015, due to moving to a new patient management system. The equivalent referral rate in NHS Highland in 2013 was 4.5. NHS Orkney were unable to provide data from June – December 2015. The equivalent referral rate in 2014 4.9.

⁶ For example, this issue is discussed in the Minutes of East Renfrewshire Community Health and Care Partnership, 19 March 2014 Available at: <http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=11853&p>

CAPA

The Choice and Partnership Approach ([‘CAPA’](#)) is a clinical system which originated in CAMH services. Services implementing CAPA will provide a ‘Choice Appointment’ to potential patients whose referrals have been accepted. Choice Appointments may combine assessment and single session therapy. They are intended to determine whether patients need specialist support from that service, or could be directed to other forms of support, or whether - following input provided during the Choice Appointment - they could self-manage their difficulties without further directed support. CAPA guidance indicates, “We start with the idea that they don’t need specialist services and that they have the resources to manage. If they then choose not to return to the Partnership it’s because they feel positive about the plans they have made, without the need for services” (CAPA [online](#)).

Some organisations have indicated concerns that referrals redirected as a result of CAPA impacts demand for other services ([Association of Scottish Principle Educational Psychologists 2013](#)).

Impact of CAMHS Targets

Some have raised concerns that work within health boards to maintain or improve performance on the CAMHS waiting time target has diverted resources and strategic planning from services offered at lower tiers of care. Less capacity is then available to deliver services which focus on early interventions or preventative work, which may have a long-term effect on demand for services. The Scottish Primary Mental Health Workers (PMHW) Network, for example, submitted a [response](#) to a Scottish Government consultation on the 2012 Mental Health Strategy stating that, “many PMHW colleagues are being drawn away from that task and role into providing support to floundering tier 3 services, and providing waiting list initiatives and triage for tier 3” (Scottish Government 2012a, p.2).

KEY ISSUES

The following section briefly highlights some key issues in the provision of child and adolescent mental health services and support across various stages of development.

PARENTAL MENTAL HEALTH AND INFANT MENTAL HEALTH

There is strong evidence that children's mental health, wellbeing and development is affected by their parents' mental health. The Scottish Government's longitudinal study, [Growing up in Scotland: Maternal Mental Health and its Impact on Child Development and Behaviour](#), found that maternal mental health had a significant impact on the development of children by the age of four. It suggested that "supporting mothers with mental health problems may have a direct impact on young children's development and well-being and could enhance children's early school experiences" (Scottish Government 2010a, vii).

Perinatal Mental Health

A [2015 report](#) by the Royal College of Psychiatrists highlighted the prevalence and severity of perinatal mental health problems in Scotland. Perinatal mental health problems are common, and mental illness during pregnancy or in the first year after birth is thought to affect at least 1 in 10 women, and up to 1 in 5. The period following childbirth is also the period of greatest risk for developing severe mental illness in a woman's life. Mental illness is one of the leading causes of maternal death in the UK (Oates and Cantwell 2011), and a 2007 review of maternal deaths identified suicide as the overall leading cause of maternal death (Confidential Enquiry into Maternal and Child Health 2007).

'Perinatal mental health problems' refer to mental health problems which may occur in mothers during pregnancy and up to one year after a child's birth. This includes both the onset of mental problems and the reoccurrence of pre-existing problems (the perinatal period is one of particularly increased risk for those who previously experienced mental problems). Problems range in nature and severity, from adjustment disorders and distress, to severe depressive illness and postpartum psychosis (NSPCC [2015](#)).

The long term costs of perinatal mental illness are significant. A recent [study](#) by the London School of Economics and the [Centre for Mental Health](#) estimates that the most common forms of perinatal mental illness (perinatal depression, anxiety and psychosis) cost the NHS in the UK £1.2 billion per year, and put the total economic cost to the UK as over £8 billion per year. Almost three-quarters of this cost relates to adverse effects on the children of mothers with perinatal mental health illnesses (Bauer *et al* 2014).

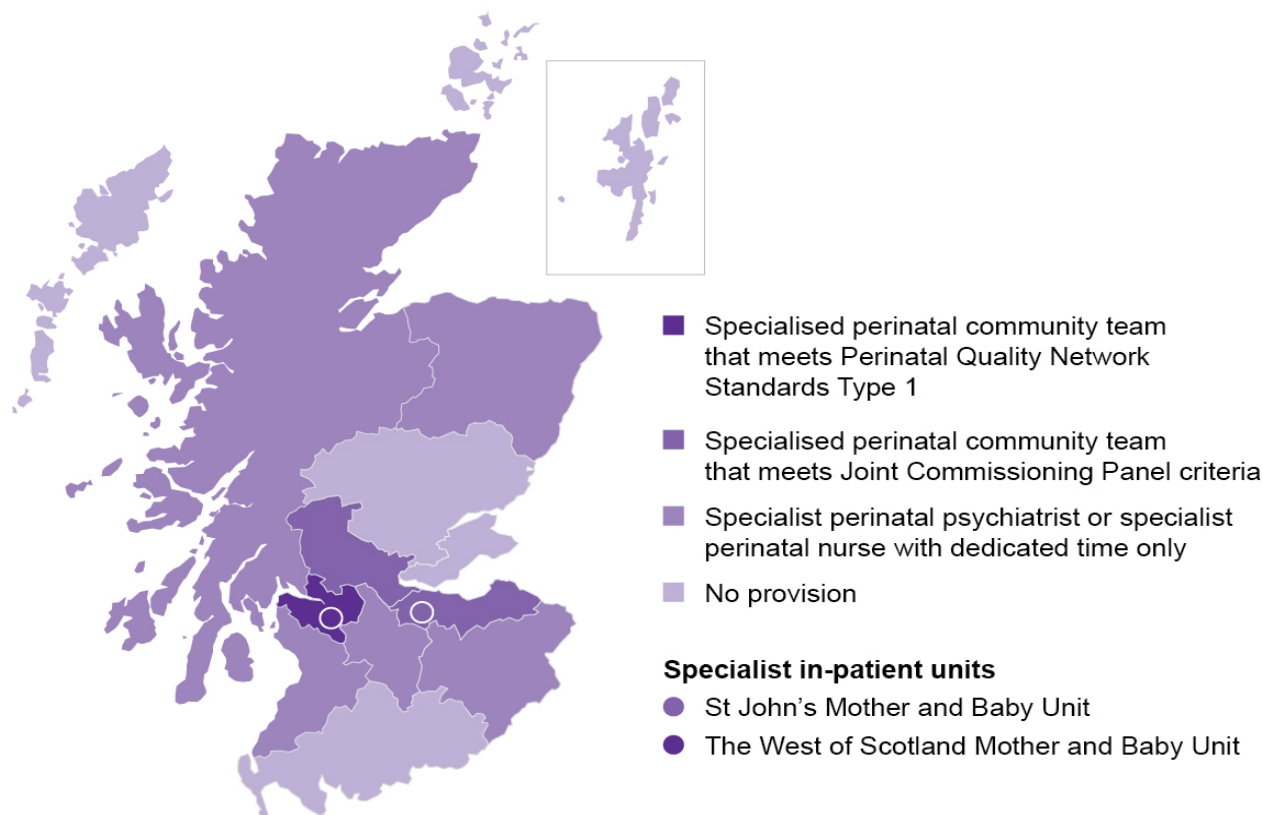
Some professional bodies have expressed concern that although the prevalence of perinatal mental health problems is high, rates of detection and appropriate intervention are low. Post-natal depression and depression during pregnancy is thought to go undetected in as many as one in two women (RCPsych 2015). While training and provision related to perinatal mental health has improved over the last decade, some organisations take the view that there is still not adequate support available in many parts of Scotland.

Two mother and baby inpatient units in Scotland provide hospital care for mothers with perinatal mental illness which allows them to continue caring for their child, up to the age of one. St Johns Hospital (Livingstone) provides 6 beds and Leverndale (Glasgow) provides 6. Levels of specialist community provision range widely across Scotland. In 2015, an [NSPCC report](#) found many health boards were not meeting best practice recommendations as outlined in [SIGN 127](#).

71% of health boards do not have any midwives or health visitors with accredited perinatal mental health training.

Only one health board, Greater Glasgow and Clyde, provides a specialised perinatal community team which meets the most comprehensive [standards](#) set out by the Royal College of Psychiatrists' Quality Network for Perinatal Mental Health Services in 2014. Six (including the three Island Health Boards, Dumfries and Galloway, Fife, and Tayside) have no specialist community perinatal mental health provision (Maternal Mental Health Alliance 2015).

Figure 10: Specialist Perinatal Mental Health Provision in Scotland.



Source: Spice. Data from the [Maternal Mental Health Alliance](#).

In June 2016, the Mental Welfare Commission published a [Perinatal themed visit report: Keeping mothers and babies in mind](#), focused on the care of women who require admission to hospital (MWC 2016d). The report makes a number of recommendations relating to staff training, measures to minimise the impact of treatment on patients' family life and compliance with legislation.

INFANT MENTAL HEALTH

Although the term infant mental health has entered public discourse relatively recently, consensus regarding the long term importance of the earliest years of a child's life upon their future mental wellbeing has increasingly informed policy over the last two decades.⁷ Recent policy and strategy in this area is wide ranging. The [Early Years Framework](#) emphasised the social benefits and economic advantages of early intervention (Scottish Government 2009). In

⁷ For a detailed overview of the long term impact of children's early years on their health, wellbeing and development see SPICE Briefing [SB 14/41 Health Inequalities – Early Years](#) (Burgess 2014). The NSPCC have also produced a comprehensive [review](#) of Infant Mental Health policy and practice from devolution to 2012.

2011, the [Early Years Taskforce](#) was established to steer development of further policies. The [National Parenting Strategy](#) (2012b) committed to making infant mental health training more widely available to professionals and investing in a new cohort of trainee child psychotherapists in 2013. In 2013, the [Early Years Collaborative](#) was launched: it aims to improve local community services for families.

A variety of local projects offer support to families with young children, and many provide targeted support focused on the needs of vulnerable families. Different models of parenting programmes are in operation across Scotland, including: the Solihull Approach; Triple P; Incredible Years; Mellow Parenting and the New Orleans Intervention Model.

Case Study: **New Orleans Intervention Model Pilot**

NSPCC Scotland, NHS Greater Glasgow and Clyde, and Glasgow City Council are piloting the [New Orleans Interventions Model](#). This model incorporates interventions rooted in attachment theory; parent-infant psychotherapy; and [video interaction guidance](#). Interventions are focused on strengthening parents' caring relationship with their child, with the aim of reuniting children with their parents (if found to be in the child's best interests) in cases where the child has been, or is likely to be, looked after due to abuse or neglect. The pilot's outcomes are being compared to those of typical social work assessment services in a randomised controlled trial.

Research and practice in infant mental health is typically rooted in [attachment theory](#). The NSPCC's 2015 report on perinatal mental health services found a high level of general awareness of the importance of attachment among professionals. However, the report also found that the majority of health boards "do not use a specific programme tool to assess infant attachment" and there "appears to be a lack of clarity" about what attachment is.

The Royal College of Psychiatrists in Scotland's [2015 report](#) notes that few mental health services in Scotland focus on the infant-mother relationship, and CAMHS receive few referrals for pre-school children. Expert evidence submitted to the Scottish Parliament's Health and Sport Committee on [13 May 2014](#) offers varied perspectives on early years intervention.

For further review of the research and evidence base surrounding policies and strategies focused on early years intervention, see [Talbut and Walsh](#) (2013). The authors note that while many strategies highlight the importance of providing targeted support to parents, the factors affecting childhood development are complex and interrelated: and "even after controlling for parenting skills, material disadvantage still plays a role in determining early years outcomes. On the other hand, poverty, by itself, does not necessarily lead to poor parenting" (p.11).

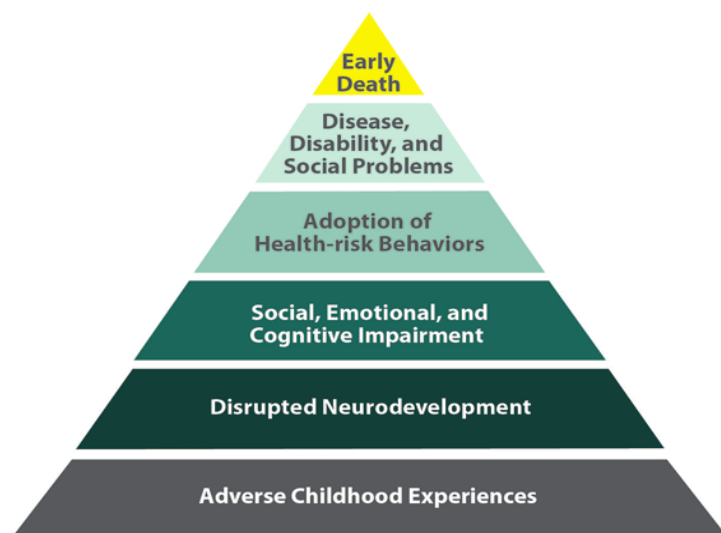
ADVERSE CHILDHOOD EXPERIENCES

Much current research into the impact of a child's family environment and social circumstances on their future health and wellbeing is informed by the premise that traumatic childhood experiences are linked to emotional problems and chronic disease later in life.⁸

This strand of research builds on the findings of the CDC-Kaiser Permanente Adverse Childhood Experiences Study (ACE Study), which analysed the childhoods and health outcomes of over 17,000 participants in the mid-1990s. The ACE study demonstrated an association between childhood trauma and a range of health, social and emotional problems. It measures 10 types of adverse childhood experiences (ACEs) including emotional, physical and sexual abuse; neglect; the mental illness of a household member; parental separation or divorce; the incarceration of a parent.⁹ The study found ACEs have a cumulative impact: the greater the number of ACEs a participant reported the greater their likelihood of health risking behaviour, disease and social problems (CDC [online](#)).

It is thought that the effects of chronic stress resulting from intensely distressing experiences negatively impact children's brain development, (Shonkoff *et al* [2011](#); Harvard Centre on the Developing Child [2013](#)). This may damage a child's ability to learn, regulate their emotions, and develop secure relationships. The following figure illustrates the way in which ACEs may lead to social and emotional difficulties, chronic disease and ultimately lower life expectancy.

Figure 11: Adverse Childhood Experiences



The 'ACE Pyramid': Source: [CDC](#) Online.

A more recent longitudinal study based on a cohort of participants in the UK found that chronic stress associated with ACEs had a measurable impact on individual's health by the age of 44 (Solis, C. *et al.* [2015](#)).

In Scotland, recognition of the impact of contextual factors on children and young people's health is embedded within the Scottish Government's policy GIRFEC and the national [Children and Young People's Mental Health Indicator set](#) (NHS Health Scotland 2011). The final report

⁸ See, for example [Glasgow's Healthier Future Forum: Thinking Ahead in the Early Years](#) (Glasgow Centre for Population Health 2015).

⁹ It should be noted that potential adverse experiences are not limited to the 10 ACEs measured by this study, which were chosen as they were those reported most frequently by participants.

on the development of the indicator set recommended that further data should be collected on the prevalence of ACEs among children and young people in Scotland, and data on the extent of other stressful life events (Parkinson [2012](#)).

EFFECT OF COMPULSORY MEASURES ON PARENT-CHILD RELATIONSHIPS

Although all those involved with the care and treatment of individuals with a mental health disorder are required by the 2003 Act to mitigate the impact of treatment on parent-child relationships, the Mental Welfare Commission's report [When Parents Are Detained](#) found that these duties "are generally unknown or neglected" (2013, p.5). The report reflected that some professionals are unaware of their duties in relation to parent-child relationships, while "others struggle to meet them because of inconsistent systems and a lack of resources" (p.5.). The MWC makes the following recommendations:

- As none of the formal documentation authorising compulsory measures records whether people have children, a social circumstances report (SCR) should be produced as a matter of priority whenever a parent of a child under 18 is detained. An SCR documents key information about an individual's personal circumstances, making it accessible to others involved in their care.
- Formal Care Plans required by applications for Compulsory Treatment Orders should reflect the needs of parent-child relationships.
- NHS Boards should audit the availability of child-friendly spaces for children visiting parents in hospital and work towards their provision in every psychiatric hospital.
- Support for the children and families of those with a mental health problem should be increased and better signposted.
- Local authorities and NHS colleagues should audit and promote the availability of age-appropriate information and educational material to help children understand the nature of their parents' mental health problem and treatment.

MENTAL HEALTH AND SCHOOLS

Since the 2003 SNAP Report, various policies and strategies have highlighted the importance of schools as context for meeting the mental health needs of children and young people. The 2005 Framework outlined "integrated, whole school approaches" which combine a wide range of initiatives to promote mental health and foster an inclusive environment (p.31). It made a range of specific recommendations, including the following:

- There should be a "named link person" within each NHS CAMHS team for every school (or cluster of schools) who could lead liaison with school staff.
- A CAMHS referral protocol should be agreed between schools and CAMHS teams.
- NHS CAMHS staff and schools should work together on a regular basis, providing training, consultation and advice for school staff and parents.
- CAMHS staff, local authorities and schools should coordinate further subject-specific training, and provide support for the mental health of education professionals.
- Schools should have accessible counselling services for students and staff.
- The school curriculum should address mental wellbeing.

More recently, a [2015](#) study of the Scottish Schools Adolescent Lifestyle and Substance Use Survey highlighted the impact pupils' experience of school may have on their mental wellbeing.

The study found that participants who disliked school were far more likely to report indicators of emotional or behavioural problems, and mental wellbeing was also linked to liking school.¹⁰

Case Studies: **Penumbra Youth Project** and **Lifelink Youth**

Penumbra's [Youth Project](#) supported schools in Fife between 2008 and 2016. It offered group work in schools, one-to-one coaching, and mental health promotion in schools. It provided an enhanced service to six secondary schools which included weekly provision of one-to-one support to pupils without the need for a referral from staff, drop-in services, group work and also trained pupils as peer mentors.

[Lifelink Youth](#) works with young people aged 11 to 18 in secondary schools and other agencies across Glasgow. Lifelink offers one to one counselling; group work and training programmes focused on self-awareness, self-esteem and positive relationships. Pupils are typically referred to the service by school pastoral or teaching staff. It also offers therapeutic mentoring for those at risk of offending or developing antisocial behaviour.

Recent research led by the Scottish Youth Parliament surveyed young people aged 12 to 25 throughout Scotland, and found that 45% of respondents would feel uncomfortable discussing their mental health with a teacher; 23% would feel comfortable doing the same (SYP 2016a).

Additional Support for Learning: Policy and Provision

The Scottish Government's 2016 Report, [Supporting Children's Learning](#), on the implementation of the [Education \(Additional Support for Learning\) \(Scotland\) Act 2004](#) and [2009](#) found that in many cases the additional support needs (ASN) of pupils with mental health problems were not being met effectively.

In 2012, the Scottish Government's strategy [Supporting Implementation of Additional Support for Learning in Scotland](#) had identified children and young people with mental health difficulties as one of a number of groups whose ASN were not being comprehensively met in mainstream schools (2012c). Local authorities and schools reported that a "lack of clear working definitions for mental health difficulties" was a "major factor" obstructing progress in this area, and schools were often "unclear about which services are available to them to access support for those with mental health difficulties" (p.7). The Strategy's suggested actions included the following:

- Highlight emotional health and wellbeing as part of implementation of health and wellbeing in Curriculum for Excellence. Continued promotion of approaches to promoting positive relationships in schools.
- Information on how to access CAMHS and refer children and young people.
- Harnessing resources to support understanding of mental health difficulties.

Rise in Numbers of Pupils with Additional Support Needs related to Mental Health Problems

Supporting Children's Learning reflects "anecdotal evidence that schools and their staff are experiencing more pupils affected by mental health problems". It also observes that the past five years of figures from the pupil census indicate a "steady rise" in the number of pupils whose "additional support needs arise as a result of a mental health problem", though the overall

¹⁰ Girls who stated they did not like school at all were almost five times more likely to have a borderline or abnormal SDQ score than those who said they liked school a lot.

number of pupils recorded as having a mental health problem remains “at a low level” (Scottish Government 2016, p.7).

The [Pupil Census](#) records pupils who have additional support needs. The number of pupils with ASN related to mental health problems has more than doubled since 2011: from 1,086 to 2,334. The census records pupils who have additional support needs due to social, emotional and behavioural difficulties (SEB) separately. The number of pupils in this category has risen from 20,430 in 2011 to 31,684 in 2015 (Scottish Government 2016d, table 1.8, 2011-2015).

Good Practice

Supporting Children’s Learning identified features of good practice in meeting the ASNs of children and young people with mental health difficulties. They encompass ‘strategic actions’; ‘planning and partnership’; ‘peer support and relationships’, and include the following:

- Authorities and schools have a clear strategy or policy for supporting children and young people who experience mental health difficulties.
- Local authorities and services provide high quality training which builds capacity of school communities to meet the increasingly diverse mental health needs of children and young people.
- Schools deliver effective planning for vulnerable children through enhanced support during key transition periods.
- Schools have high quality partnership working with health professionals to provide specialist support and advice for supporting children, young people.
- Schools provide children and young people with the language to recognise and express feelings and responses. Staff model appropriate responses and language for children.
- Young people take a leading role in supporting vulnerable peers and deliver programmes which improve the health and wellbeing of all.

The review offers a number of [case studies](#) covering a range of approaches, including staff training; targeted support; peer support and “whole school” perspectives.

Curriculum for Excellence

The Curriculum for Excellence (CfE) is the framework for the school curriculum for pupils aged 3 to 18. Its implementation formally began in August 2010. It specifies ten areas which pupil “experiences” and “outcomes” should cover, including health and wellbeing, and indicates that health and wellbeing should also be taught across the whole curriculum, in an interdisciplinary way where possible. For further information on the background and format of the Curriculum for Excellence see SPICe Briefing 13/13 [Curriculum for Excellence](#) (Kidner 2013).

Case Study: Mental Health and Wellbeing in Schools, Ayrshire and Arran

Ayrshire and Arran’s [Mental Health and Wellbeing Strategy 2014 - 2026](#) proposes outcomes for the promotion of positive mental health and wellbeing and a range of evidence-based activities. Ongoing activities relating to this strategy include:

East Ayrshire Council establishing a multi-agency steering group to develop a Mental Wellbeing Framework, helping schools to deliver CfE mental wellbeing experiences and outcomes for learners aged 3 - 18. The group audited existing resources; will identify examples of current good practice in schools; is preparing resources to help teachers respond to incidences of self-harm and guidance on referring pupils to local services.

Two secondary schools in South Ayrshire are piloting peer education initiatives. S6 peer educators have been trained to deliver sessions on managing stress to S3

SELF-HARM

Self-harm refers to a broad category of behaviours which may include: cutting oneself; ingesting poisonous substances; damaging drug and alcohol use.

There has been a significant rise in hospital admissions related to self-harm in Scotland. Data collated by the BBC in 2015 indicates that admissions in some parts of Scotland have doubled over a five year period (BBC [2015](#)). Third sector support services have seen referrals related to self-harm increase significantly. Penumbra's [Edinburgh Self-Harm](#) project, for example, saw referrals increase by 166% between 2009 and 2014. Referrals to specialist CAMH services related to self-harm have also increased, thought to be due both to an increase in rates of reporting and an increase in incidence.

However, specialist CAMH services are not always able to accept such referrals when the individual concerned does not meet the threshold for specialist CAMH treatment. It can be highly distressing for parents or others to learn that a young person is self-harming, and self-harm is often interpreted by parents and others as a suicide attempt, or an indication of suicidal ideation. In such cases, families of a young person who is self-harming can find refused referrals to CAMH services alarming (Royal College of Psychiatrists in Scotland 2016).

The recent [National Confidential Inquiry](#) into Suicide and Homicide by People with Mental Illness (2016) indicated that the majority of children and young people who died as a result of suicide had self-harmed in the past. The inquiry's head of suicide research stated, "Self-harm is strongly associated with increased future risk of suicide and is one of the main warning signs. It is crucial that there is improved help for self-harm and access to mental health care". Most young people, however, who self-harm are not necessarily considered at serious risk. The Scottish Association for Mental Health are calling for greater education and training about self-harm for medical professionals (particularly GPs and A&E staff) and teachers, and improved support for parents (SAMH [2016](#)).

Case Study: [SeeMe](#)

SeeMe is a national anti-stigma organisation. [On Edge](#) is a resource pack for teachers and other practitioners working with young people developed by NHS Greater Glasgow and Clyde, and is available through the SeeMe Scotland website. It comprises four lesson plans designed to give pupils a rounded view of self-harm and the support available. It is thought that self-harm among young people is a growing public health problem. On average two teenagers in every secondary school classroom may have self-harmed.

SeeMe is currently redeveloping [What's on your Mind](#), a resource pack for young people and practitioners working with them. Resources have been coproduced with young people from across Scotland, and developed in order to create open conversations about mental health, increase awareness and develop young people's ability to challenge stigma. Materials will be piloted in schools until December 2016.

The Mental Health's Foundation's 2016 [review](#) of mental health services found that self-harm was an increasing public health concern in Scotland:

- Participants perceived an increase in referrals to CAMHS relating to self-harm and/or suicidal ideation.
- Many participants discussed stigma experienced when seeking help for self-harm from medical professionals, and the report indicates evidence of "significant attitudinal and

behavioural issues” among A&E professionals (p.52). Examples of poor practice included: lack of empathy; failure to use a psychiatric liaison team and people being provided information leaflets instead; giving low priority to patients who had self-harmed; stitching without anaesthetic; refusal to stitch wounds.

- Improvement and good practice was reported among psychiatry liaison teams which “work to improve links between emergency departments and mental health services”, though “the presence of a psychiatric liaison team in itself seems to be no guarantee against stigma and discrimination” (p.52).
- NHS Greater Glasgow and Clyde Adolescent Self-Harm Service and NHS Lothian Self-Harm Service were highlighted for instituting innovative practice.

MENTAL HEALTH AND GENDER IDENTITY

The number of children young and people referred to specialist gender identity services is rising. In 2014 the number of referrals to Scotland’s specialist gender identity service for children and young people (the Sandyford Child and Adolescent Gender Identity Service or ‘Young People’s Gender Clinic’ in Glasgow) stood at 90. In 2015 the service received 178 referrals.¹¹

‘Transgender people’ or ‘trans people’ is an umbrella term that covers the range of ways people may find their experience of their gender differing from assumptions in the society they live in. (Georghiou [2016](#))

The Sandyford is the only NHS service in Scotland offering specialist support to children and young people experiencing distress relating to their gender, including gender dysphoria and/or individuals who identify as, or think they may be, transgender.¹² The Young People’s Gender Clinic will offer assessment and care to young people aged from 12 to 18 and children aged 7 years and above. Children aged under 7 are referred to their local CAMHS for support.¹³ In some cases children and young people aged over 7 may also be referred to local CAMHS for further assessment and support (Sandyford [2012](#)). If appropriate, children aged under 13 may be referred to paediatric endocrinology services at the Royal Hospital for Children, Glasgow.

Currently, there is no specialist support in Scotland for children aged under 7 who are experiencing difficulties relating to their developing gender identity. If there is a clinical reason, children and young people requiring assessment may be referred to the Gender Identity Development Service at the Tavistock and Portman Clinic in London, which supports children and young people up to the age of 18. The Tavistock and Portman Clinic has received eight referrals from Scotland since 2010, three of which were in 2015/2016.¹⁴

The Sandyford’s caseload is currently managed by one consultant child and adolescent psychiatrist providing services one day a week, and there is a considerable waiting list for assessments. Evidence recently presented to the Scottish Parliament Equal Opportunities Committee on [4 February 2016](#) suggests waiting times are now over a year long, though people will be assessed sooner if in acute distress, are self-harming or have attempted suicide. Information provided by NHS Greater Glasgow and Clyde shows that in 2014 the average waiting time for access to the service was eight months, and 90 children and young people were

¹¹ Information provided by NHS Greater Glasgow and Clyde.

¹² Other support may be offered by Sandyford Counselling and Support Services; LGBT Youth Scotland and CAMHS services may also be available to young people who require support from the Sandyford Child and Adolescent Gender Identity Service and who also have mental health problems.

¹³ Information provided by the NHS Greater Glasgow and Clyde.

¹⁴ Data provided by the Tavistock and Portman Clinic on 7 June 2016. Data provided by NHS Greater Glasgow and Clyde states that no referrals were made to this service in 2014 or 2015. No reliable earlier data is available.

on the waiting list. In 2015 the average waiting time was 12 months and 218 children and young people were on the waiting list.¹⁵ This services operates outwith the CAMHS framework, and waiting times are not reported to CAMHS or other agencies.¹⁶

Current Developments

Currently, a young person may consent to medical treatment relating to their gender identity from the age of 16, but cannot change the gender stated on their birth certificate and gain legal recognition of their acquired gender until the age of 18. The Scottish Transgender Alliance's (STA) Equal Recognition campaign is calling for legislation in Scotland to reform the [Gender Recognition Act \(2004\)](#). The STA's proposed reforms include reducing the age from which people can get legal recognition of the gender they live as to 16, and for under-16s to be able to apply for gender recognition with the consent of their parent or guardian. The STA also proposes removing the requirement for psychiatric diagnosis from legal gender recognition, in favour of self-declaration (Georghiou [2016](#)).

TRANSITIONS FROM CAMHS

Most health boards now provide specialist CAMHS to eligible children and young people up to the age of 18, and best practice guidelines indicate that CAMHS support should be ongoing for particularly vulnerable young people or those with very complex needs. The 2005 Framework observes that there are risks of "discontinuities" in service provision when young people are required to transition to Adult Mental Health Services. It notes that young people looked after by a local authority "may remain in the child care system until there are 19 years old, and in some circumstances, until they are 21 years old" (p.19). Similarly, "offenders are considered "young" until the age of 21. The Framework comments that "Where liaison arrangements with child and adolescent mental health services are established for younger clients, it would seem arbitrary and unhelpful to exclude older young people while they remain in these settings" (p.19).

The Mental Welfare Foundation's 2016 review of mental health services found participants reported improvements in transitions between CAMHS and adult mental health services. However, it also noted that access to specialist services for young people, such as Early Intervention in Psychosis teams and support focused on looked after young people was limited, particularly outside major cities. Some review participants felt that links between CAMHS and paediatric services could improve.

In [March 2016](#), the Scottish Youth Parliament (SYP) held a Mental Health Discussion Event. Participants offered a range of perspectives on transitions from CAMHS to Adult Mental Health Services. Many indicated support for a "bridging service" or other transitional arrangements which would minimise disruption to care and smooth pathways to Adult Mental Health Services. One participant highlighted the ways in which abrupt transitions can affect the recovery process: "Suddenly there is a reduced frequency for meetings which means less support. New staff mean new relationships need to be built. All the change could distress young people, stop progress [or] potentially set them back. Creating a service to support young people through this transition [to adult services] would be invaluable" (SYP 2016b 4.3).

The SYP's recent research, *Our generation's epidemic*, found several respondents "asserted the need for a mental health service tailored to 16 to 26 year-olds" (SYP 2016a). The report notes [guidance](#) produced by the Mental Health Foundation and Paul Hamlyn Foundation suggesting that adult mental health services are often not "young person friendly" and young people aged 16 – 25 have "their own distinct mental health needs" (Right Here 2014, p.4).

¹⁵ Information provided by NHS Greater Glasgow and Clyde.

¹⁶ The Young People's Gender Clinic works with CAMHS to fully support children and young people.

College and University Counselling Services

Demand for mental health support at Colleges and Universities is high. In November 2015 a National Union of Students (NUS) poll found that 78% of respondents had experienced problems with their mental health in the past year, and 58% of respondents had sought support for a problem with their mental health within the last year ([Gil 2015](#)). Data recently obtained under FOI by the NUS in Scotland shows that the number of students at higher education seeking mental health support has increased by an average of 47% between 2011/12 and 2014/15. There is wide variation in the proportion of students seeking mental health support between institutions, and the level of investment in mental health services also varies considerably (NUS 2016a).

Current activities and investment in this area include £100,000 of Scottish Government funding supporting the NUS Scotland campaign [Think Positive](#) up to 2018.

NUS in Scotland has recommended that student advisors and academic mentors be provided mental health training, as these staff are often the first point of contact for students dealing with mental health concerns ([NUS](#) 2016b, p.4). The Scottish Youth Parliament's recent research found that 16% of respondents aged 18 – 26 would feel comfortable talking about their mental health to a lecturer (SYP 2016a).

ANNEXE A: TERMS USED – MENTAL HEALTH PROBLEMS, CARE AND TREATMENT

More common mental health problems at different stages of development

Perinatal Mental Health	Refers to a woman's mental health during pregnancy and the year following birth. Includes conditions such as antenatal depression, postnatal depression, maternal obsessive compulsive disorder, postpartum psychosis and post-traumatic stress disorder. More information is available from Maternal Mental Health – Everyone's Business .
Postpartum Psychosis/ Puerperal Psychosis	<p>The onset of psychotic symptoms in women days or weeks after birth. Psychosis causes people to perceive or interpret things differently from those around them. The two main symptoms of psychosis are hallucinations or delusions. Other symptoms may include anxiety, restlessness and behaviour that is out of character.</p> <p>Estimated Prevalence: Around 1 in 1000 women who give birth.</p> <p>Care and Treatment: Postpartum psychosis is a psychiatric emergency which may require inpatient treatment and medication.</p> <p>More information about psychosis is available from the NHS online</p>
Postnatal Depression	<p>Symptoms of postnatal depression may include: persistent feelings sadness and low moods; feelings of anxiety, irritability or apathy; feelings of guilt, hopelessness or self-blame; difficulty bonding with the baby; difficulty concentrating or making decisions; thoughts about suicide or self-harm. Postnatal depression can start at any time in the first year after giving birth, and symptoms can become in the first 2-6 weeks after birth.</p> <p>Estimated Prevalence: Severe depressive illness is thought to affect 30 women in every 1000 who give birth. Mild to moderate depressive illness and anxiety is thought to affect around 100-150 women in every 1000 who give birth.</p> <p>More information is available from the Royal College of Psychiatrists.</p>
Attention Deficit Hyperactivity Disorder (ADHD)	<p>Behavioural symptoms include inattentiveness, impulsivity and hyperactivity. Most cases are diagnosed between the age of 6 and 12. Symptoms may improve with age, but many people diagnosed with ADHD experience other problems.</p> <p>Estimated Prevalence: 2-5% of school aged children</p> <p>Care and Treatment: Symptoms may be managed using a combination of medication and therapy to help children and their families understand and change behaviours.</p> <p>More information about ADHD is available from the NHS online.</p>
Conduct Disorder	A disorder diagnosed in childhood and adolescence characterized by

persistent aggressive behaviour, destruction of property, deceitfulness and serious violation of age-appropriate rules over a period of 6 months or longer ([ICD-10, F91](#)).

Estimated Prevalence: 5% of children aged 5 to 16. Prevalence increases with age and more boys than girls are diagnosed with conduct disorders.

Care and Treatment: Assessment will consider coexisting mental health problems or developmental disorders. Treatment may include psychological therapies to help children understand their feelings and behaviour or programmes to help families manage and improve their child's behaviour. Medication may be considered if young people with severe, persistent aggressive behaviour have not responded to other treatments.

[More information](#) is available from the Royal College of Psychiatrists.

Autistic Spectrum Disorder (ASD)

ASD is a lifelong developmental disability affecting communication, social interaction and social imagination. People with ASD may have difficulty interacting and communicating with others and may exhibit repetitive or rigid patterns of behaviour. The degree of impairment people with ASD experience varies. Many people with ASD are diagnosed with coexisting mental health problems

Estimated Prevalence: 1 in 100 people. More boys are diagnosed with ASD than girls.

Care and treatment: As ASD is a developmental disability it cannot be 'cured', however specialist behavioural interventions can support children and young people with ASD. CAMHS professionals are involved in the assessment and diagnosis of ASD.

More information is available from [Scottish Autism](#).

Eating Disorders

Eating disorders include conditions such as anorexia nervosa and bulimia nervosa. Some young people may be diagnosed with an eating disorder not otherwise specified (EDNOS) when they show some, but not all, of the symptoms of any one disorder. Eating disorders can affect people physically, psychologically and socially. Symptoms can include severely restricting food and meals; taking laxatives or medication to suppress appetite; compulsive overeating.

Estimated Prevalence: Anorexia and bulimia nervosa are more often diagnosed in women and girls than men and boys. Anorexia nervosa typically develops around the age of 16 or 17, and affects around 1 in 100 16 to 18 year olds. Bulimia nervosa typically develops around the age of 18 or 19. Up to 4 in 100 women experience Bulimia at one point in their lives.

Care and Treatment: Treatment for Anorexia may include a range of psychological therapies, risk management and interventions which involve the patient's family. Some people may require inpatient treatment. Treatment for Bulimia may include evidence based self-help programmes, psychological therapies, antidepressant

medication and specialised Cognitive Behavioural Therapy.

More information is available from the NHS [online](#) and [NICE](#).

First Episode Psychosis (or First Presentation Psychosis)

Refers to the first occasion when a person presents signs of psychosis. Psychosis causes people to perceive or interpret things differently from those around them. The two main symptoms of psychosis are hallucinations or delusions.

Estimated prevalence: The incidence of psychotic disorders varies widely across populations. Psychotic disorders are rare in people under the age of 14. Most people with a psychotic disorder first experienced symptoms between the age of 15 and 35. Some studies suggest that up to 3 in 100 people may have an episode of psychosis at some point in their life.

Care and treatment: [NICE guidelines](#) state all children and young people with a “first presentation of sustained psychotic symptoms (lasting 4 weeks or more)” should be referred urgently to an early intervention in psychosis service or a specialist CAMHS service. Early intervention teams specialise in working with people who have experienced their first episode of psychosis. Treatment may include medication, psychological therapy and other social support.

[More information](#) about psychosis is available from the NHS online.

Care and Treatment

Psychological Therapies

Psychological Therapies include a range of interventions intended to help people understand their feelings and thoughts and to change their behaviour. Therapies may involve one-to-one counselling, treatment in a group setting, or can involve the patient’s family or other people responsible for their care and support. Types of psychological therapy include:

Cognitive Behavioural Therapy (CBT): Focused on helping people to manage their psychological problems by understanding and changing their current feelings and behaviour.

Psychotherapy: In-depth therapy focused on helping people to understand how their past experiences and feelings can influence their relationships and behaviour.

Intensive Home Treatment Services

Intensive Home Treatment Teams provide a “rapid response, intensive specialist assessment, treatment and risk management in a community centre” for people who may otherwise need to be admitted to inpatient care ([NHS Lothian](#) 2011, p.6)

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