

FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND
SECTION 3: SERVICE PROFILES

SERVICES FOR CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH OR BEHAVIOURAL PROBLEMS¹

Prevalence: 20% of pre-school children have emotional problems, 70% being rated as severe.

7% of 10-11 year olds may have a psychiatric disorder, with the rate doubling in inner city areas.

Up to 20% 14-15 year olds are likely to have a significant emotional and behavioural disorder. Boys are twice as vulnerable as girls, except in early childhood and in later adolescence when it equalises and reverses for affective disorders.

Within the 15-25 year age range is the commonest time of onset of the first symptoms of manic depressive disorder, schizophrenia (in males), and eating disorders.

Children with physical illness are twice as vulnerable. About one in four children visiting a general practitioner has a emotional or behavioural disorder.

In the age group 14-19 about 400 per 100,000 attempt suicide. 7 to 8 complete suicide, boys outnumbering girls by 3 or 4 to 1.

Service Element	Description of Needs	Ways in Which Services May Respond
A Balanced Service	<p>Specifying the service.</p> <p>Each commissioner should ensure that it has contracts with appropriate specialist providers elsewhere if the incidence of a particular condition is too low to justify a local service.</p> <p>A tension exists between the concentration of specialist skills and the distance families have to travel to receive tertiary or supra-regional care .</p>	<ul style="list-style-type: none"> • There should be clarity about the age range covered by the local service and the boundary between childhood and adolescence services (if there are separate services) and good links between them. • The upper limit of age for education and social work authorities has increased and joint working suggests health should follow suit. • Commissioners must ensure that education is linked to treatment programmes. • A balance needs to be struck across the range of services: preventative and early intervention programmes for young people at risk, consultation and liaison with primary care and other agencies as to the need for facilities for the most severely disturbed young people; training and research.
Organisation	<p>A comprehensive child and adolescent mental health service will operate at several different levels:</p> <p>Tier 1: Problems which require non-psychiatric professional help at the primary care level, in schools or in the wider community.</p> <p>Tier 2: More serious problems which require the intervention of professionals with specialist knowledge of child mental health in support of Tier 1 care staff.</p> <p>Tier 3: Serious and complex disorders which require the specialist</p>	<p>The aims of work are:</p> <p>Tier 1:</p> <ul style="list-style-type: none"> • mental health promotion; • early screening for high risk children; • support and training for primary health care teams and community child health teams, teachers, social work staff and others who work with young people. <p>Tier 2:</p> <ul style="list-style-type: none"> • individual professional work in response to referrals; <p>Tier 3:</p> <ul style="list-style-type: none"> • multi-professional specialist child and adolescent psychiatry service;

¹“Child and Adolescent Mental Health Services - Together We Stand”: A NHS Health Advisory Service Thematic Review HMSO (1995)

SERVICES FOR CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH OR BEHAVIOURAL PROBLEMS (continued)

Service Element	Description of Needs	Ways in Which Services May Respond
<p>Organisation (continued)</p>	<p>help of a multi-professional care team, with the young person and family seen in out-patients.</p> <p>Tier 4: Extremely severe and complex problems which have failed to respond to help at the other levels need specialist facilities such as in-patient or day patient</p> <p>Children and young people should not be admitted to adult general psychiatry wards. Commissioners will have to implement arrangements to ensure more appropriate provision.</p> <p>Commissioning agencies must:</p> <ul style="list-style-type: none"> • have a sound knowledge base on the mental health requirements of children and adolescents and effective interventions; • be responsive to the needs of their local population to ensure services develop from a relevant strategy are prioritised appropriately and are organised to make it happen. 	<p>Tier 4</p> <ul style="list-style-type: none"> • To provide services for children and adolescents with extremely severe and complex problems including in-patient or secure provision, and very specialist inputs for special needs. • At each Tier health workers must relate closely to their counterparts in social work and education. This should help to avoid patients or families failing to access the service they need. • As a young person moves into adulthood there should be a continuity of treatment and approach.
<p>Identification of Potential or Serious Problems and Availability of Services for Assessment and Referral.</p>	<p>Emotional and behavioural disorders in children and young people have to be assessed accurately. These disorders can include formally diagnosed mental disorders. Disorders arise from a number of causes and require the complementary and specialist skills of different disciplines. The mental health gain from investment in therapeutic resources during childhood improves both the quality of life for the child and his/her social environment and his/her physical and mental health.</p> <p>Jointly provided services create the opportunity not only for mental health gain, but for gains in education, employment, law and order and welfare. There is a close interaction between the child, the child's carer (with the possibility of mental health problems in the latter), the wider family (and any history of mental health difficulties), the school and society in general. Parents, teachers and care workers must be able to raise concerns with available and receptive staff members in the primary health care and community child health teams who have been trained to be aware of the implications of a problem. This will ensure that only clinical problems requiring more specialist input will be referred to Tier 2 and above, thus avoiding overload of the specialist services.</p>	<ul style="list-style-type: none"> • A service should be collaborative, multi-agency based, and planned on the basis of the local population within a specified age range. • Child and adolescent services must be co-ordinated closely to be effective, through joint commissioning, and partnership between purchasers and providers . • There must be a protocol covering priority referral to health. The medicalisation of social problems must be avoided. • Particularly in children's services the system must be seamless, with smooth cross boundary working between and within agencies and between professionals and specialists of any kind. • Because of the complexity of the service all must work systematically to agreed quality standards which are audited regularly. • Members of the mental health team have an important role to play in the education and training of front line workers (with regard to the identification of problems such as Attention Deficit Syndrome, Asperger's Syndrome and Childhood Autism).

SERVICES FOR CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH OR BEHAVIOURAL PROBLEMS (continued)

Service Element	Description of Needs	Ways in Which Services May Respond
<p>Hidden Needs</p>	<p>There are risks of certain children missing out on child health surveillance where families are mobile, living in temporary accommodation or homeless, or when the young person is missing school, has left home or has no regular occupation.</p> <p>Victims of abuse may not feel able to confide immediately in workers who know their carer. Young people may not be able to approach the family or the general practitioner about certain issues, and school nurses or teachers may be the first to suspect or hear about a serious problem.</p> <p>A number of children and young people involved in road traffic accidents or other such episodes may develop post-traumatic stress disorder which may not be immediately apparent.</p>	<ul style="list-style-type: none"> • Health agencies should work to a common record. • Partner agencies should work to a common protocol for the handling of confidential or highly sensitive information. • Records should include details of emotional and behavioural difficulties and their management, and of potentially traumatic events, eg divorce. • Flexible and responsive outreach services to support front line workers in teaching, primary care and community child health staff. • Confidential self referral services including telephone advice or a helpline. • Services should be “user friendly” and sensitive to race, culture and gender issues.
<p>Children and Young People in Relation to Drugs of Abuse.</p>	<p>Illicit drug use among young people appears to be more prevalent in Scotland, with a broader range of drugs taken, more frequently. Solvent use remains a problem.</p> <p>The age at which drugs are first encountered and used appears to be decreasing in the UK. A survey of 12-15 year old school children in a Scottish city reported over 10% of 12 year olds as ever having taken a drug. This figure rises to over 50% by age 15 years. There will be another user of drugs in a significant proportion of the families of young people.</p> <p>There is research evidence to indicate the earlier the age of drug initiation the greater the likelihood of later problems with drugs. Early initiation of drug use is strongly associated with childhood behaviour problems, early drunkenness, early tobacco use and the subsequent development of more severe drug problems.</p>	<ul style="list-style-type: none"> • It is important to support the efforts of young people to remain drug free. • It is also important to encourage young people who started to experiment with drugs to end their use. • Those who have become firmly embedded in the drug scene are at high risk, both in the short and longer term. • A single firm message on prevention of drug use is unlikely to be acceptable to the second and third groups. A message based solely on harm minimisation will undermine the efforts of the first group. • Partner agencies need to develop a common approach based on sensitivity to these complexities, and the needs of individual young people. • There is a need to provide drug education within the primary school setting, perhaps with a focus on those beginning to develop behavioural problems