



Young London Matters



GOVERNMENT OFFICE
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The emotional well-being and mental health of young Londoners A focused review of evidence



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Executive summary



Introduction

As one of its four priority areas, *Young London Matters* (YLM) has aims to improve the emotional well-being and mental health of children and young people. A pan-London group of local and regional experts has been established to advance progress within this priority field (known as Strand Group 1). This group aims to develop the capacity of local authorities and children's trusts to develop effective infrastructure, networks and pathways for children and young people to access good quality and timely support and services to improve their emotional well-being and mental health.

To support the work of the YLM Strand Group 1, an overview was commissioned of published and electronically accessible literature of relevant research on children and young people's emotional well-being and mental health in London, and studies which identify what is known about successful approaches to promoting and supporting emotional well-being and mental health in a range of settings. The Thomas Coram Research Unit at the Institute of Education, University of London, was asked to undertake the review.

Conducted over a period of eight weeks (in order to meet the timetable set by the Strand Group), this focused and time-limited review provides an overview of the current state of the literature.

Methods

Five principal search strategies were employed — a search of four major online academic bibliographic databases; manual searches of nineteen specialist journals relevant to the field of child emotional well-being and mental health; a review of eighty-four websites relevant to work with children and young people, emotional well-being and mental health and London; and direct contact with a range of professionals with a interest in this review, following up key references identified through each of the above four strategies.

Studies included in the review were:

- published in English between 2000 and 2007;
- either a systematic literature review, meta-analysis or other literature review, or an individual evaluation study;
- concerned with the emotional well-being and mental health of children, young people (aged between 3 and 18 years old) and/or their parents/carers, either nationally, or in London, or in other parts of the UK;
- focused particularly on mental health provision in schools and CAMHS.

Research undertaken in the USA, Canada and Australia was accessed, but only included in the review if it concerned an issue of interest for which there were no or very few UK-based studies. Studies which specifically focused on Attention Deficit and Hyperactivity Disorder, autism and neuro-developmental disorders, as well as substance use were excluded, following discussion with commissioners.

Over 1,369 articles and reports were initially identified as a result of the literature search. Two hundred and sixty of these were included in the initial analysis for the review, but several were subsequently rejected on the grounds of not being directly relevant to the objectives of the review (for instance, the article was mainly a description of a programme rather than a specific evaluation study). As a result, a final total of 214 studies and reports were drawn upon and findings from these have been included in this report.

Key findings

Definitions and understandings of emotional well-being and mental health

- Professionals from the 'education' and 'health' sectors often have different understanding of what is meant by 'emotional well-being and mental health', which in turn can lead to them suggesting alternative approaches to meeting the needs of children, young people, their parent(s) and carer(s).
- Children and young people usually associate the term 'mental health' with 'mental illness', and stigma plays a role in influencing their understandings of what these ideas mean.
- Children and young people frequently define 'mental ill-health' as being opposite to 'normal' and 'feeling in control'.
- When children and young people are asked about difficulties they experience, a wide range of concerns are mentioned, which go beyond a professional understanding of 'mental disorder'.
- Family and friends are central to children's and young people's understandings of feeling good, but also appear to be the source of many of their difficulties.

The national picture - the emotional well-being and mental health of children and young people

- One in ten children and young people aged 5-16 years old in the UK has a diagnosable mental disorder, of which five per cent have a diagnosable conduct disorder and four per cent have a diagnosable emotional disorder.
- A minority of children and young people report a persistent diagnosable mental disorder over three years (25 per cent for those with an emotional disorder and 20 per cent of those with a conduct disorder).
- As suggested by studies which examine children and young people's views on difficulties they experience, those presenting at CAMHS describe family and peer relationship problems, as well as emotional and behavioural difficulties. Stress at school is also a commonly reported concern.
- Six per cent of children and young people have reported self-harming behaviour or suicide attempts, and fifteen per cent have suicide ideation.

The regional picture - the emotional well-being and mental health of young Londoners

- Results from the ONS surveys are inconclusive in identifying any clear cut differences between children and young people in London and those elsewhere in the UK - rates of diagnosable mental disorders among children and young people in inner and outer London are not necessarily higher than in other parts of the UK.
- Bullying is a significant issue identified by young Londoners.
- Existing local CAMHS needs assessments are of variable quality, most partnerships use the ONS surveys to estimate the prevalence of diagnosable mental disorders in their localities. However, ONS figures together with the data from the CAMHS mapping project do enable London boroughs to calculate the estimated gap between need and service access by children and young people. As data and reports were only received from ten London boroughs it is not possible to draw robust comparisons across local authorities. Nevertheless some interesting differences do emerge. For example,
 - Greenwich estimated that more than half of children and young people requiring CAMHS support are not currently receiving it, and Kingston estimates close to three-quarters of those in need not accessing CAMHS.
 - Hounslow concluded Asian children and young people were under-represented in their CAMHS services, while Southwark found Black African children/young people to be under-represented and Black British, Black Caribbean and mixed white & Black Afro-Caribbean were over-represented.
 - Southwark found that waiting times for CAMHS were similar to the national average, while Hounslow had lower than national average waiting times. Kingston noted a reduction in their waiting times.
 - Half of Kingston's CAMHS referrals came from GPs, while one quarter came from this source in Southwark.

Emotional well-being and mental health - time trends, persistence and outcomes

- Over the last twenty five years the emotional well-being and mental health problems of children and young people appear to be increasing.
- Emotional well-being and mental health problems can persist in the short-term (18-36 months), but also into adulthood. This can have major short- and long-term cost implications for society.

Factors associated with emotional well-being and mental health problems

- There are differences in the types of emotional well-being and mental health problems among boys and girls (higher proportion of conduct disorders compared to emotional disorders respectively), and the age range when higher numbers present with difficulties (boys more likely to present with problems earlier on than girls).
- Evidence on the impact of ethnicity on emotional well-being and mental health problems is inconclusive (although children and young people from minority ethnic communities may be over-represented within CAMHS).
- There is evidence suggesting co-morbidity between physical ill-health and emotional well-being and mental health problems.
- Parental unemployment, living with step-siblings, being in a lone parent and/or low income household and having a parent with emotional well-being and mental health problems have all been found to be significantly associated with emotional well-being and mental health problems among children and young people.

- The following groups of children and young people have been documented as having particularly high rates of emotional well-being and mental health problems: those with learning difficulties, those with experience of local authority care, those with experience of offending, young asylum seekers and refugees, those with experience of bullying, gay or bisexual young men, and those who are homeless.

Access services to promotion emotional well-being and mental health

- Children and young people with emotional well-being and mental health problems are more likely to be in contact with statutory services, especially GPs (not surprisingly given the co-morbidity between physical and mental health noted above), the police/youth justice system, and education support services.
- Between one fifth and a quarter of children and young people with a diagnosable mental disorder had still not been seen by CAMHS 18 months and three years on. Furthermore, between 40 and 50 per cent of these children or young people had not been seen by any other services for these specific needs.
- Parental satisfaction with the support received was variable.
- Access to CAMHS in terms of numbers and the speed with which children and young people are seen seems to be improving over time.

Facilitating access to CAMHS - the role of non-CAMHS professionals

- Given that children and young people with emotional well-being and mental health problems are more likely to have had contact with statutory services; it would be beneficial for non-CAMHS services to be able to make more appropriate referrals.
- Links between CAMHS and GPs have resulted in training for primary care staff and the development of consultation services for professionals as well as direct support provision for children and young people; however measures are needed to improve GP's ability to identify problems of emotional well-being and mental health, and to increase referral rates.
- Increasingly, social (care) services are developing emotional well-being and mental health support provision, but clearer and quicker referral pathways to specialist CAMHS are still needed.
- Better links between schools and CAMHS are being established in the form of consultation among staff and direct support to children and young people. However, training for school staff is needed, specifically in making appropriate referrals.

Studies focusing on service access and use by particular groups of children and young people

- One study has suggested that the referral pathways for children and young people, and parental attitudes to 'help-seeking' may vary by ethnicity. Providing CAMHS support to children and young people with their specific cultural situations and circumstances in mind is necessary.
- A large gap exists between the needs of children and young people with learning difficulties and the provision of targeted and good quality emotional well-being and mental health support.
- A degree of improvement has been noted in emotional well-being and mental health service provision for children and young people in public care.

The importance of parents in understanding access to support for emotional well-being and mental health problems

- Barriers identified by parents to accessing support for their children include: the fear of being blamed, not know where to go, and concerns that the support would make no difference.
- Relatively high numbers of children and young people with significant emotional well-being and mental health problems are seen by GPs; detection by GPs has been suggested to be significantly increased if parents express concern about their child's emotional well-being and mental health during the consultation itself.

What makes services accessible and effective in children and young people's view?

- Friends and family were identified as a key source of support by children and young people, although respondents identified that sometimes they might require more specialist support, especially if they were experiencing family difficulties.
- Confidentiality, trustworthiness, being non-judgemental, listening and kindness were all qualities children, young people and their parents wish for from CAMHS staff. Children and young people also want more information about what they could expect from CAMHS.

- There is no consensus in studies of children, young people and parents/carers' views on whether they prefer school-based or community-based services. Concern that confidentiality is not fully respected by teachers is noted by a number of children and young people.
- Children and parents/carers differ in their experiences and views of CAMHS.
- Services should consider the specific concerns of boys and young men in accessing support services.

Demonstrably effective school-based approaches to promoting the emotional well-being and mental health of children and young people

- Universal school-based programmes aimed at promoting emotional well-being and mental health, sustained over a period of over one year, through the modification of the school environment as well as the development of adaptive cognitive and behaviour strategies among children and young people, offer evidence of an approach that is demonstrably effective.
- There is also strong evidence to suggest the value of universal approaches to promoting emotional well-being and mental health, combined with more targeted behavioural and cognitive-behavioural therapy work with those children and young people with identified emotional well-being and mental health problems.

Promising school-based approaches to promoting the emotional well-being and mental health of children and young people

- The health promoting school may have a positive impact on children and young people, especially when there is an active focus on promoting emotional well-being and mental health.
- Factors associated with promising approaches to promoting the emotional well-being and mental health of children and young people in schools include: a whole-school/universal approach, sustained implementation, involvement of all members of the school community, and a variety of programmes focusing on the school environment, behaviour and cognitive processes.
- Promising approaches for children and young people with emotional and behavioural difficulties (EBD) include: cognitive behavioural therapy, the provision of rewards, supporting children to monitor their behaviour, reduce aggressive behaviours and improve their social skills, as well as changing the seating arrangements in the classroom. Evidence supporting the use of 'circle time' as an intervention strategy is inconclusive.
- The FRIENDS programme (a cognitive-behaviour therapy (CBT) programme for children and young people with anxiety difficulties) appears to be a promising approach.
- The Triple P - Positive Parenting Programme which offers a tiered approach to supporting parents and carers has found evidence for the reduction in conduct problems.

Other school-based approaches to promoting the emotional well-being and mental health of children and young people with some evidence

- The provision of independent counselling services in schools can be effective in supporting children with emotional well-being and mental health problems.
- Targeted programmes for children and young people with depression can have positive outcomes, but there is no evidence to support the provision of universal programmes to reduce the risk of children and young people developing depression.
- Direct behavioural work with young children (aged 3-7 years old) with emotional well-being and mental health problems, alongside support to parents (the 'Scallywags Scheme') offers emerging promising evidence.

School-based approaches to promoting the emotional well-being and mental health of children and young people with variable or no evidence of success

- The evaluation of the 25 Primary Behaviour and Attendance Strategy pilot Local Authorities (funded by the DfES), which include the Social and Emotional Aspects of Learning (SEAL) programme, offers some positive results but the study does not offer a clear enough analysis of which of the numerous aspects of the initiative worked best (a situation which is further complicated by the variable implementation of the Strategy across local authorities).

- Not enough studies were identified to offer clear recommendations on ways to increase the early identification of children and young people with emotional well-being and mental health problems (such as the use of screening tools, the Australian RAMP model or training for teachers).
- Two very small studies of cognitive-behaviour therapy (CBT) work with children and young people with anger management difficulties or asylum seekers/refugees in schools were found to have an initial positive impact emotional well-being and mental health, but this was not maintained over time.
- Variable and limited evidence supporting the provision of universal suicide prevention programmes was found. In some cases, suicide prevention programmes have been found to be harmful to young men.

Demonstrably effective approaches to promoting the emotional well-being and mental health of children and young people in community and other settings

- Behavioural and cognitive-behavioural therapy for children and young people with emotional well-being and mental health problems and children with mild to moderate anxiety are demonstrably effective approaches.

Promising approaches to promoting the emotional well-being and mental health of children and young people in community and other settings

- Work with parents and carers offers relatively strong evidence, especially using CBT for parents/carers with children with conduct disorders. Five individual evaluation studies also suggest that supporting parents (in two studies using Brief Solution Focused Therapy) can have a positive impact on children as well as parents/carers.
- Promising programmes for supporting young people with emotional disorders include social skills training and involving all members of the family using multi-systemic therapy.
- Early and brief intervention programmes delivered through CAMHS have been found to reduce waiting times for children and their families, reduce numbers who do not attend their initial appointment (especially if parents/carers were asked to confirm they would attend before being placed on the waiting list), and increase the efficacy of CAMHS by reducing number of sessions a family required or ensuring referrals for more specialist support were more appropriate.

Approaches in community and other settings to promoting the emotional well-being and mental health of children and young people with variable or no evidence of success

- No positive outcomes were noted among studies evaluating CBT work with foster carer families.
- It is too early to conclude whether multi-systemic therapy may be effective for families with children with emotional well-being and mental health problems.
- Few methodologically rigorous evaluation studies were identified during the literature review which reported on community-based programmes and services aimed at promoting emotional well-being (with the exception of studies which reviewed early and brief interventions with children and their families, and programmes targeting parents).

Gaps in what we know

- The extent of emotional well-being and mental health needs of children and young people, rather than prevalence of diagnosable mental disorders, especially within London boroughs.
- How parents and carers understand the emotional well-being and mental health needs of their children, and what facilitates and hinders their access to support.
- Studies evaluating programmes aimed at promoting or supporting childhood emotional well-being and mental health tend to have been conducted in the USA. Only a small number of methodologically strong evaluation studies from the UK were identified during the literature search which informed this review.
- A larger number of studies evaluating school-based programmes were identified than studies of other settings. Programmes evaluated in non-school-based settings tended to focus on the effectiveness of cognitive-behaviour therapeutic approaches, early and brief CAMHS intervention initiatives, and approaches working with parents. Few studies were found which evaluated other types of community-based programmes in meeting the emotional well-being and mental health needs of children and young people (such as through the use of youth groups and clubs).

Key principles underpinning successful approaches to promoting emotional well-being and mental health

- In schools - whole-school or universal programmes should be complemented by targeted support for those with emotional well-being and mental health problems. Furthermore, programmes required sustained investment, should be integrated into the curriculum and involve the whole school-community.
- The involvement of parents and carers is central to effectively meeting the emotional well-being and mental health problems of children and young people: firstly because they are strongly associated with children and young people's emotional well-being and mental health; secondly, they may play a role in facilitating access to support services; and thirdly, because programmes supporting parents alongside initiatives aimed at children and young people have been shown to have a positive impact.
- Programmes should aim to identify children, young people and families requiring support as early as possible and reducing the waiting time between identification of a problem and first appointment as this not only meets with high levels of parental satisfaction but also with more efficient CAMHS services.
- A number of service and staff characteristics were identified by children, young people and their parents/carers as facilitating access to support services: confidentiality, trustworthiness, being non-judgemental, listening, kindness, and being given clear information about what to expect when they came to the service.

Recommendations to the Strand Group

Principles to inform the development of future programmes

Three further principles to inform the work of the Strand Group are proposed, which should sit alongside the four principles underpinning successful approaches to promoting emotional well-being and mental health detailed above:

- The need for a common language and shared conceptual framework to be developed among professionals working in different sectors, and between children, young people, parents/carers and professionals;
- The value of involving potential and actual programme beneficiaries in the development, review and evaluation of any new initiative; and,
- The importance of developing programmes that take into consideration gender, ethnicity and special needs differences in the emotional well-being and mental health of children and young people.

Key issues and groups to focus on in London

- Initiatives should aim to meet the immediate needs of children and young people with diagnosed and diagnosable mental disorders, but also broader emotional well-being and mental health needs such as family and peer relationship difficulties, bullying, and stress due to academic pressures.
- Children and young people with learning difficulties, those living in public care, young offenders, those with long-term physical health problems, and those living in households with parent(s) with mental health problems, headed by a single parent; parental unemployment, or reconstituted families should be targeted for specialist support.

Successful approaches to promoting children's and young people's emotional well-being and mental health

- Universal emotional well-being and mental health promotion work in school settings, alongside targeted programmes for those children, young people and their parents/carers identified as, or likely to be, experiencing emotional well-being and mental health problems.
- Programmes which aim to improve the early identification of children, young people and families likely to experience emotional well-being and mental health problems and facilitate rapid and effective access to initial support.

Key principles for evaluating programmes to promote the emotional and well-being of children and young people

Five key principles could form the basis of an evaluation framework adopted by Strand Group-funded programmes:

- Using a standardised tool for measuring emotional well-being and mental health;
- Using qualitative approaches to elicit the views of stakeholders in order to explore how and why changes may have occurred as a result of programme implementation and involvement;
- Collecting data from a number of different stakeholders;
- Collecting data at a minimum of two points in time; and
- Using a comparison, control or waiting list group-design.

Additionally, funded programmes should evaluate how they make a wider contribution to the services and support structures that are already in place in a geographical locality - examining for instance:

- Whether clear (and formal) referral protocols and pathways have been established between the funded initiative and other programmes or services (which could be assessed by checking professionals, children, young people and their parents/carers' knowledge and perceptions of the new initiative);
- The length of time children, young people and/or their parent(s)/carer(s) have to wait for an appointment with the funded programme from the point of self-referral or referral from another service;
- Whether the initiative offers consultation, advice and training to other local professionals.

Finally, a third tier of data collection should be undertaken to explore how funded initiatives contribute to the attainment of local authority-level indicators and targets. This could include:

- Examining how the programme has helped to increase access to emotional well-being and mental health support for children, young people and their parent(s)/carer(s) locally (measured by recording the number of people who are in receipt of the programme in a specified period of time);
- Where a programme or activity fits within a wider system of local support structures (examined by exploring perceptions of other professionals, children, young people and their parents/carers; whether the initiative is integrated into any information leaflets or referral flow-charts; and whether the service or its workers are involved in assessing the meeting the needs of children and families discussed in Child Protection Conferences and for whom a Common Assessment Framework is undertaken); and,
- Whether a programme or activity has increased accessibility of services to those groups considered to have the greatest needs (assessed by recording referral to, and up-take of, the programme by particular group of child/young person and compared with data from other services or expressed as a proportion of the total population of that group within the local authority).

Areas requiring further research

Four key areas requiring further research are identified:

- London borough-based research which identifies levels and types of problems among different groups of children and young people;
- In-depth qualitative research to examine children, young people's and parents/carers' understandings of emotional well-being and mental health; differences in perceptions of emotional well-being and mental health and service accessibility by gender and ethnicity; views on school-based as compared with community-based services;
- Research to examine how the skills and capacities of families and friends could be further developed to play a support role; and,
- How to develop professionals' capacity to identify emotional well-being and mental health problems early and to make appropriate referrals.

1 Introduction



1.1. The policy context

In 1999, the Department of Health (DH) published the National Service Framework (NSF) for Mental Health. This document focused primarily on 'the mental health needs of working age adults up to 65' (DH, 1999: 3). Subsequently, in 2004, a further document was published, the NSF for Children, Young People and Maternity Services. One of the Standards associated with this latter NSF concerns with 'the mental health and psychological well-being of children and young people' (DH, 2004), here defined as those from birth to age eighteen.

Alongside the launch of the NSF, the Government established a Public Service Agreement that 'comprehensive Child and Adolescent Mental Health Services (CAMHS) should be commissioned in all parts of England by the end of 2006' (Appleby et al., 2006: 30). The annual CAMHS Mapping exercise (<http://www.childhealthmapping.org.uk/>) has identified significant development in services for child and adolescent mental health such as: increased expenditure, staffing, capacity, and reduced waiting times (Appleby et al., 2006).

1.2. Young London Matters

Young London Matters (YLM) was launched on 31st October 2006 and is managed by the Government Office for London (GOL). Building on the success of the DfES' London Challenge for Schools (<http://www.dfes.gov.uk/londonchallenge/index.shtml>), YLM's primary aim is to deliver the national *Every Child Matters* strategy across the capital, specifically focusing on improved outcomes for vulnerable groups of children and young people.

Four priority areas have been identified: (i) improving the emotional well-being and mental health of children and young people; (ii) reducing teenage conceptions; (iii) improving the educational attainment of Black African and Caribbean boys, as well as that of children in care; and (iv) improving the capacity of local authorities, the voluntary children's sector, and children and young people to work together to improve outcomes for children and young people. Each priority area has brought together a pan-London group of local and regional experts to develop and oversee a work plan until March 2008.

The group responsible for the first priority area (known as Strand Group 1) is working to develop the capacity of local authorities and children's trusts to develop effective infrastructure, networks and pathways for children and young people to access quality and timely support and services to improve their emotional well-being and mental health.

1.3. About this review

To support the work of the YLM Strand Group 1, the GOL commissioned an overview of published and electronically accessible literature of relevant research on children and young people's emotional well-being and mental health in London, and studies which identify what is known about successful approaches in promoting and supporting emotional well-being and mental health in a range of settings. More specifically, the objectives of the review were to:

- 1 identify key issues of relevance to the emotional well-being and mental health of children and young people in London, as well as specific challenges experienced in accessing effective Tier 1, 2 and 3 CAMHS services;
- 2 bring together what is known about successful approaches employed by statutory and non-statutory bodies to support children and young people's emotional well-being and mental health in a range of settings;
- 3 identify how good practice and the effectiveness of programmes/activities has been measured in previous studies, and suggest a framework for evaluating the performance and outcomes of initiatives aimed at promoting and supporting children and young people's emotional well-being and mental health in different settings.

This review had to be undertaken over a period eight weeks to meet the timetable set by the Strand Group, so what follows is of necessity a focused stock-take of evidence, rather than a comprehensive review of all available literature and issues of effectiveness. The limited time available in which to produce the review has also influenced the degree to which unpublished and so-called grey literature reports (relevant to London) could be sourced and included.

2 Methodology



In this section, we outline the range of methods used to identify the evidence analysed in this review. We first outline the principal search strategies used to identify published papers and articles. We then highlight the inclusion and exclusion criteria used to select papers for inclusion, and describe how individual articles were categorised and analysed. We conclude by noting the outcomes of the search strategies used.

2.1. Principal search strategies

Five principal search strategies were employed to inform this literature review:

- A search of four major on-line academic bibliographic databases;
- Manual searches of nineteen specialist journals relevant to the field of child emotional well-being and mental health;
- A review of the contents of eighty-four websites relevant to work with children and young people, emotional well-being and mental health, London; this included an extensive search of three web-based databases of published research;
- Contacting a range of professionals with an interest in this review, requesting recommendations for additional references and non-web accessible reports or studies;
- Following up key references identified through the above four strategies.

2.1.1. Academic database search

The following four major on-line bibliographic searches were undertaken to identify relevant studies: Medline, PsycInfo, ERIC (Educational Resources Information Centre) and Social Science Abstracts. Together, these databases offer a reasonably comprehensive review of contemporary evidence from across the medical and social sciences. Each of these databases was interrogated using the following key words and combinations of them: emotional well-being, mental health, mental health problems, mental health illness, emotional and behavioural difficulties, emotional problems, psychology, psychiatry, psychiatric disorder, antisocial behaviour, disability, children, young people, London.

2.1.2. Manual searches of journals

The following specialist journals were manually searched for articles of relevance to the commissioned review:

Journals of special relevance to professionals in child psychiatry

Child and Adolescent Mental Health (volumes 5-12)

Child Psychology and Psychiatric Review (volumes 5 - 6)

Clinical Child Psychology and Psychiatry (volumes 5-11)

Journal of Child Psychology and Psychiatry (volumes 41-48)

Journals that focus more broadly on mental health, across all ages

Australian e-journal for the Advancement of Mental Health (volumes 1-5)

International Journal of Mental Health Promotion (volumes 2-8)

Journal of Mental Health Promotion (volumes 1-3)

Journal of Public Mental Health (volumes 2-5)

Mental Health Research Review (volumes 7-9)

Mental Health Services Research (volumes 2-7)

The Journal of Mental Health Workforce Development (volume 1)

The Mental Health Review (volumes 8-11)

Journals that focus on emotional well-being and mental health in school

Emotional and Behavioural Difficulties (volumes 5-10)

Journals with a focus on health promotion

Health Education (volumes 100-107)

Health Education Journal (volumes 59-65)

Health Education Research (volumes 15-21)

Other journals of interest

British Medical Journal (this journal was searched electronically using the following topics: adolescents & child and adolescent psychiatry)

Health and Place (volumes 6-13)

Journal of Black Psychology (volumes 26-33)

2.1.3. Website searches

The websites which were searched could be categorised into the following groups:

Other research databases

Current Educational Research in the UK (CERUK) - searched using the following keywords: mental health, emotional and behavioural difficulties, emotional problems, psychiatric disorders, CAMHS.

National electronic Library for Health (NeLH) - searched the Mental Health Specialist Library's child and adolescent conditions; and the Child Health Specialist Library - mental health, adolescence, community child health (education and schools sub-section).

National Institute for Health & Clinical Excellence (NICE)

National government departments

Department for Education and Skills - searched Research Publications for published studies using the following keywords: mental health, emotion, well-being.

Department of Health - searched Research Publications for published studies using the following keywords: mental + children; emotional + health.

National organisations concerned with children, young people and/or emotional well-being and mental health

British Association for Counselling and Psychotherapy

ChildLine

Medical Foundation for the Care of Victims of Torture

Mental Health Foundation

National CAMHS Support Service (NCSS)

National Children's Bureau

The Royal College of Psychiatrists (RCP) - searched College Research and Training Unit Publications, and FOCUS sections of the RCP website.

Young Minds

Regional government organisations

Government Office for London

Greater London Authority

London Health Commission

London Health Observatory

London Strategic Health Authority

All 33 London boroughs and 31 primary care trusts

London universities

CAMHS Evidence Based Practice Unit and Centre for Outcomes Research and Effectiveness at UCL

Department of Child and Adolescent Psychiatry and The Centre for Parent and Child Support (a partnership unit with South London and Maudsley NHS Trust) at Kings College London

Evidence for Policy and Practice Information and Co-ordinating (EPPI) Centre, Institute of Education

Other websites

Australian Network for Promotion Prevention and Early Intervention for Mental Health

The Campaign Against Living Miserably (C.A.L.M.)

2.1.4. Contact with relevant professionals and organisations

All members of the YLM Strand Group 1 were contacted by e-mail, requesting they send the research team any relevant reports, references, needs assessment they knew about and felt should be included in the review. This request was also made in person to the members who attended the 22 February 2007 meeting of the Strand Group. Five members of the Strand Group responded to these requests, sending a number of suggestions to the researchers.

Via one of the London Regional Development CAMHS Worker, the research team also made e-mail contact with all London CAMHS Partnership Chairs requesting they send any local needs assessments or service user studies. Three professionals sent reports.

2.1.5. Inclusion and exclusion criteria

Databases and journals were searched using the following criteria:

- published in English;
- published between 2000 and 2007;
- which took the form of systematic literature reviews, meta-analysis, other literature reviews, evaluation studies, randomised controlled trials, pilot studies, interventions;
- focused on children and young people aged between 3 and 18 years old;
- which were concerned with emotional well-being and mental health (or mental disorder and other related terms) and children, young people and/or parents nationally, in London, in other parts of the UK, specifically in schools and CAMHS. Research undertaken in the USA, Canada and Australia was initially sourced, but studies were only included in the review if they focused on an issue of interest for which there were no or very little published UK-based research.

Studies which specifically focused on Attention Deficit and Hyperactivity Disorder, autism and neuro-developmental disorders, as well as substance use were excluded, following discussion with commissioners.

2.2. Categorisation and analysis of the literature

As studies were identified during the literature search, they were categorised according to the objective and sub-section within each objective of the review they were most relevant to. Objective sub-sections were developed in consultation with the YLM Strand Group 1.

For the first objective of this review (see sections three and four of this report) studies were grouped according to the following: children, young people and parents' views about emotional well-being and mental health; national prevalence data; London prevalence data; factors associated with emotional well-being and mental health problems; access to CAMHS studies.

Objective two studies (see section five of this report) were grouped according to the type of methodology - systematic reviews, other literature reviews, individual evaluation studies with a control/waiting list group, individual evaluation studies, and articles or reports describing services or service provision.

Finally, the few papers that helped address objective three (see section six of the report) were grouped together.

Once this initial categorisation had been completed and relevant papers identified, different members of the research team took responsibility for undertaking an in-depth analysis of relevant literature identified for the various sections. It was during this process that some initially included studies were excluded because following closer inspection the research was assessed not to be directly relevant to the review.

Two members of the research team (CM and EK) undertook snap-shot checks of the studies they had each decided to include in the initial and final analysis for the review. The results of the initial list of included studies from two of the four on-line academic bibliographic databases (all searched by the same researcher) were checked by the second researcher, who concurred with 90 per cent her colleague's choices. The same process was followed for three of the specialist journals selected for manual searching. Again concurrence between researchers was high, at 80 per cent.

Studies to be included of relevance to service access were initially assembled by one researcher, after which the second researcher conducted the analysis and prepared the initial draft of this section of the report (section four). This was then checked by her colleague and about five further references added. Time and financial constraints meant that further checks of this nature to increase reliability and consistency of the studies reviewed were not possible.

2.3. Outcome of the search strategies employed

The combined on-line databases searches yielded a total of 567 journal articles, of which 80 were of special interest. On closer inspection, 62 of these journal articles were excluded because they did not directly respond to the three objectives which informed the review, or did not report on original research (but were book reviews or editorials for instance). The manual search of relevant journals initially identified 217 articles of potential interest, of which 100 were included in the initial literature categorisation process. The reasons for excluding 117 articles initially identified in the manual journal searches included: the article described a programme rather than reporting on an evaluation of service; offered more of a commentary on recent policy or practice developments than reporting on original research.

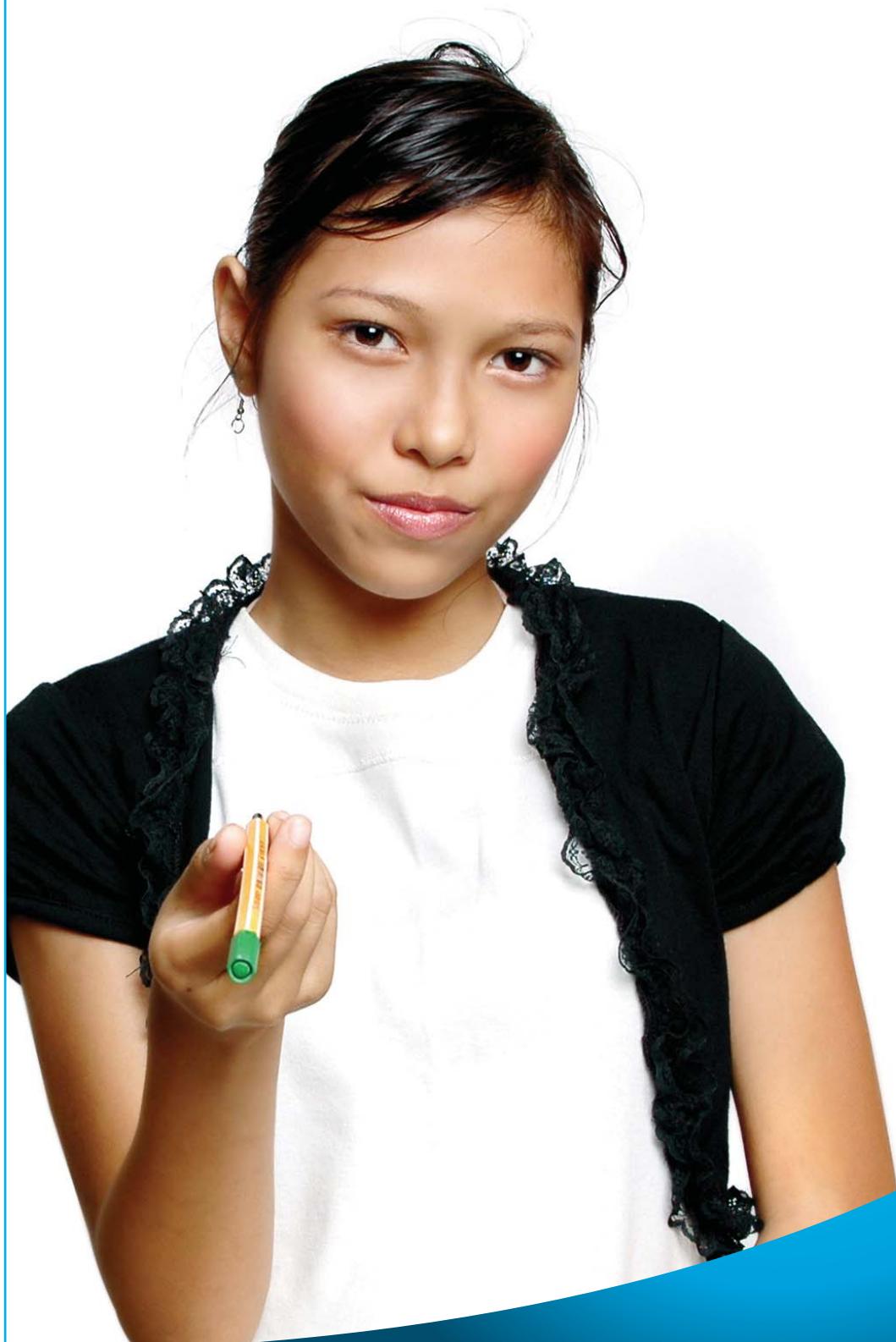
Website searches (detailed in 2.1.3) led to the identification of 585 articles and reports, of which 142 were included in the initial literature categorisation process. A number of the same journal articles were identified using the different search strategies. Individual search results for the following websites may be of interest to readers:

- CERUK - 53 studies identified, of which 36 were included in the initial categorisation process
- Department for Education and Skills - 10 studies, 7 of which were included
- Department of Health - 99 studies, of which 6 were of relevance or studies not previously identified in CERUK
- National electronic Library for Health - 306 studies, of which 27 studies were included in the initial categorisation process

Following further in-depth analysis of the 260 references initially categorised, 46 articles and reports were excluded. There were five main reasons for excluding the final 46 references at this stage of the review.

Firstly, the majority of identified literature reviews were used to check the review's findings, rather than using them as a primary source of evidence¹. A second reason for excluding a study at this stage of the analysis was that the research had been conducted in a country outside the UK and enough UK-based studies on that particular issue had been identified and included in the review already². Thirdly, on closer inspection, the reported study either had such a weak methodology it was not felt to offer strong enough evidence for consideration in the review (for instance, an article describing a small case study of work with a particular group of young people in a school which did not report any real data on outcomes³) or too little information about the evaluation undertaken and the results of the evaluation were reported⁴. Fourthly, an article did not actual report on any original research but was more of a commentary on recent policy or practice developments⁵. Finally, an article or report was either focused on in-patient CAMHS work⁶ or a review of effective treatments for a diagnosable mental disorder⁷ more relevant to psychiatrists or clinical psychologists than the broader audience for whom this review has been commissioned. In total 214 studies and reports were reviewed and can be found referenced in the next sections of this report.

3 Emotional well-being and mental health among children and young people - definitions, prevalence and associated factors



In this section, we provide a concise overview of the range of definitions used by professionals as well as children and young people regarding 'emotional well-being and mental health'. Following this, we focus on what is known in relation to the extent of emotional well-being and mental health problems in children and young people nationally, and more specifically in London. A summary of the research evidence on factors associated with increased emotional well-being and mental health problems will conclude this part of the report.

3.1. Definitions and understandings of emotional well-being and mental health

Summary:

- Professionals from the 'education' and 'health' sectors often have different understanding of what is meant by 'emotional well-being and mental health', which in turn can lead to them suggesting alternative approaches to meeting the needs of children, young people, their parent(s) and carer(s).
- Children and young people usually associate the term 'mental health' with 'mental illness', and stigma plays a role in influencing their understandings of what these ideas mean.
- Children and young people frequently define 'mental ill-health' as being opposite to 'normal' and 'feeling in control'.
- When children and young people are asked about difficulties they experience, a wide range of concerns are mentioned, which go beyond a professional understanding of 'mental disorder'.
- Family and friends are central to children's and young people's understandings of feeling good, but also appear to be the source of many of their difficulties.

3.1.1. Professional conceptualisations of emotional well-being and mental health

Within the field of children's services, there has been a rapid expansion in the range of terms used to describe children's social and emotional well-being and mental health. For some professionals, terms such as 'emotional well-being and mental health', 'emotional well-being and health', 'social and emotional health', 'mental health' are used interchangeably; others argue that there are significant differences in each term's meaning and stance. The proliferation in terminology that aims to capture the vast range of externalising and internalising behaviours into a unifying concept highlights some of the tensions experienced between professional groups and the often marked differences in their theoretical and philosophical orientations.

Within health services, such as psychiatry, clinical psychology and counselling psychology, the term most widely used to describe children and young people experiencing difficulties of a psychological or emotional nature is 'mental health'. Implicit in this term is the assumption of mental illness, disorder or problem and the need for a process of diagnosis, management and treatment, based usually in a hospital, clinic or community setting. However, more recently the definition of 'mental health' has been expanded to embrace a broader conceptualisation of well-being and to acknowledge the wider social factors that influence 'mental health'.

By contrast, education professionals, such as educational psychologists, learning mentors, special needs co-ordinators and specialist peripatetic teachers, are more likely to use terms such as emotional well-being, social, emotional and behavioural problems, emotional literacy and resilience when describing the difficulties young people encounter. These differences in orientation are significant in the context of an education system that aims to embrace inclusion, and where vocabulary associated with a deficit discourse often feels at odds with socially constructed understandings which recognise the influences of context on children's behaviour and functioning. Implicit in the different stances often held by education and certain 'health' professionals is a perspective, not only of where the difficulties reside, but also where and how interventions should be focused (Prior, 1997; Cox, 2004).

Such conceptual differences can lead to misunderstanding and miscommunication between the different professional groups (Atkinson et al., 2007), and the development of services that are potentially incompatible - for instance, offering children clinic- or hospital-based services where community- or school-based interventions might be more advantageous in terms of facilitating their inclusion in the school, where the problems are occurring.

Every Child Matters which adopts a broad and holistic stance towards supporting children's development and is described as: 'a new approach to the well-being of children and young people from birth to age 19' (<http://www.everychildmatters.gov.uk/aims/> - accessed 2nd April 2007), has as its core aims the removal of barriers to effective professional communication, the creation of a common vocabulary, and the development of seamless services that wrap around the child.

3.1.2. Children's and young people's understandings of emotional well-being and mental health

Harden et al. (2001) reviewed twelve UK studies of young people's views on emotional well-being and mental health published between 1990 and 1999. The authors concluded that young people tended to equate the term 'mental health' with 'mental illness' and do not see it as strongly relevant to their own lives (Armstrong et al., 2000; Sellen, 2002; Swales, 2005).

Many of the 145 young people drawn from different socio-economic and ethnicity backgrounds across four Scottish schools who participated in a study by Armstrong et al. (2000) had difficulties defining 'mentally healthy' (also supported by Gale, 2006, who worked with younger children aged between 5 and 11 years of age already in contact with CAMHS). Some young people equated the term with normality, but struggled to define this as well. While children and young people consulted in Leeds suggested 'mental is used as if you are actually mental but emotional is just normal' (Swales, 2005: 17).

Unlike Armstrong et al.'s (2000) study which explored the attitudes and perceptions of a broad range of Scottish young people's attitudes towards positive mental health and mental illness, focus group discussions with young people aged 10 and 11 years-old from two schools in West Sussex analysed by Roose and John (2003) concluded that their participants' understanding of mental health was quite 'sophisticated' (p. 547), as the children saw mental health as a complex issue which incorporated a range of behaviours and emotions. One participant explained that 'mental health is really peace of mind and your emotions [not] overbalancing' (Roose & John, 2003: 547).

Smith & Leon (2001) in their work with young people who had experienced a 'mental health crisis' also felt 'young people were very able to articulate what a mental health crisis means to them. The results demonstrate that for young people, a mental health crisis is a subjective experience resulting from a variety of personal and social circumstances and factors' (p. 17).

Feeling out of control was a sensation often described by these young people (as it was by the children and young people who had been admitted to CAMHS in-patient care interviewed by Hepper et al., 2005; and young offenders interviewed in Anderson et al., 2004).

The studies reviewed by Harden et al. (2001) suggest that young people experience a wide range of concerns which affected their emotional well-being. These include academic expectations (West & Sweeting, 2003; Williams & Pow, 2007 - reported by over four-fifths of 15 and 16 year-olds participating in this study of three Scottish schools), friendship and family difficulties (Armstrong et al., 2000; Roose & John, 2003), violence and bullying (Roose & John, 2003; Williams & Pow, 2007), boredom (Armstrong et al., 2000), environmental pollution and poverty.

In Roose & John (2003)'s work among young people in West Sussex found that four main factors were seen by those interviewed as contributing to mental health: family and friends; having people to talk to; personal achievements; and feeling good about oneself. Family and friends were seen as central to affecting how young people felt - if families could provide a sense of security, be a source of support and offer a positive sense of self-worth then young people, particularly the Pakistani/Bangladeshi young men and women interviewed, identified families as protective to their mental health. Young women were found to be more likely to approach family and friends for support, while young men described bottling their emotions up and internalising them (ChildLine, 2003). Some young people in this same study described taking out their anger and frustration through aggression towards inanimate objects, and sometimes siblings or peers (Roose & John, 2003).

Gender differences in emotional well-being and mental health experiences were also noted by Sellen (2002) who undertook a piece of action research with young people from black and minority ethnic communities in Lambeth. Young people aged between 11 and 19 years old were invited to a music event at Brixton Academy and 141 completed a short questionnaire on emotional well-being and mental health. Gender differences in what makes young people 'feel good' were identified (Williams & Pow, 2007), with the largest divergence

occurring around the issue of sexual activity (a quarter of young men reported that sexual activity made them feel good, yet only four per cent of young women did). Young women reported that spending money was the activity most likely to make them feel good.

Gale's (2006) study of twenty children and their parents'/carers' attitudes and experiences of mental health, who had been referred to CAMHS for the first time, highlighted how strongly stigma influenced people's experiences and definitions of mental health (Pinfold, et al., 2003; Hepper et al., 2005; Anderson et al., 2004; Swales, 2005).

Williams & Pow (2007) in their study of 496 15 and 16 year-olds across three schools in Scotland also found that gender (in this case being a young man) influenced negative and stigmatizing attitudes towards those with 'mental health problems' (p. 10).

Given the range of definitions and understandings identified in the literature, we use the broad term 'emotional well-being and mental health' throughout this review. This term recognises that there are many influences on children and young people's well-being, including those that relate to social, economic and contextual factors, as well as those that are specific to particular groups and individuals. The term also suggests a positive focus on emotional well-being and mental health, rather than a negative understanding of mental health as implying problems or illness. Furthermore, our aim has been to use a term that is inclusive of the range of interests and professional backgrounds and concerns of those involved in the YLM Strand Group.

3.2. The national picture - the emotional well-being and mental health of children and young people

Summary:

- One in ten children and young people aged 5-16 years old in the UK has a diagnosable mental disorder, of which five per cent have a diagnosable conduct disorder and four per cent have a diagnosable emotional disorder (Meltzer et al., 2000; Green et al., 2005a).
- A minority of children and young people report a persistent diagnosable mental disorder over three years (25 per cent for those with an emotional disorder and 20 per cent of those with a conduct disorder – Meltzer et al., 2003a).
- As suggested by studies which examine children and young people's views on difficulties they experience, the Audit Commission (1999) found that those presenting at CAMHS describe family and peer relationship problems, as well as emotional and behavioural difficulties. Stress at school was reported by over half of the young people sampled in The Priory Group (2005) nationally representative study.
- Six per cent of children and young people have reported self-harming behaviour or suicide attempts (over their lifetime or the past year - Meltzer et al., 2000; Hawton et al., 2002 respectively), and fifteen per cent have suicide ideation (in the past year or over their lifetime - Hawton et al., 2002; The Priory Group, 2005 respectively).

The Office for National Statistics (ONS) has undertaken two stratified random sample surveys (one in 1999, another in 2004) to estimate the prevalence of diagnosable mental disorders⁸ (as defined by the International Classification of Diseases, tenth revision (ICD-10)) among 5 to 159 year-olds in Great Britain. In 1999, the prevalence of diagnosable mental disorders among child and young people aged 5 to 15 years old in England, Scotland and Wales was shown to be at ten per cent, of which five per cent had a clinically significant conduct disorder, four per cent suffered from an emotional disorder (such as anxiety or depression) and a further one per cent were rated as hyperactive. Autistic disorders, tics and eating disorders were found in half a percent of the sampled population (Meltzer et al., 2000).

⁸'Diagnosed' mental disorders refer to cases where an appropriately qualified mental health professional, such as a psychiatrist or clinical psychologist, has assessed an individual as having a mental disorder as defined by the International Classification of Diseases (ICD-10). These assessments would usually take place in a clinical environment. In research which draws on epidemiological and community samples, researchers will often report on the prevalence of 'diagnosable' mental disorders, where the emotional well-being and mental health problems reported by an individual are likely to meet the criterion for a diagnosed mental disorder, but usually this individual has not received a formal clinical diagnosis to that effect. In the two ONS studies reported on widely in this review, participants drawn from a community sample were seen by a psychiatrist. Thus, theoretically, it could be argued the studies report on the prevalence of diagnosed 'mental disorders'; however, as the assessments were not made in a clinical setting it would be more accurate to describe the results reported in most studies as prevalence levels of diagnosable mental disorders.

The second survey in 2004 increased the age range covered to 16 years.

When the survey was repeated five years later, the authors found no significant differences in prevalence between 1999 and 2004 in the overall proportions of children with a diagnosable mental disorder (Green et al., 2005a). The authors also investigated the persistence of diagnosable mental disorders among children and young people at 18-months and three years after the original 1999 survey (Goodman, et al., 2002; Meltzer et al., 2003a respectively). Meltzer et al. (2003a) found that, three years later, a quarter of study participants continued to have an diagnosable emotional disorder, while as many as two-fifths of participants were reported to still have a diagnosable conduct disorder.

In 1999, the Audit Commission collected information about the children and young people who presented to specialist CAMHS throughout England and Wales during a four-week period, using the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), which captures a broader range of emotional well-being and mental health problems than the ONS studies (which only measured clinically diagnosable mental disorders). The Audit Commission (1999) found that the four categories which presented most frequently (in 60 to 80 per cent of cases) were: problems with family life and relationships; problems involving emotional and related symptoms (including eating disorders); problems with peer relationships; and disruptive, antisocial or aggressive behaviour (p. 17).

Similarly, a study commissioned by The Priory Group (2005), which surveyed 1,000 demographically representative young people aged 12 to 19 years old, found that 54 per cent reported feeling stressed about their school work, and the authors estimated that 15 per cent of all young people in Britain are likely to have considered suicide, and 13 per cent will have actually self-harmed. The Priory Group figure appears to be higher than that found by other studies which have specifically examined self-harming and suicide ideation or behaviours.

Meltzer et al. (2001), using the 1999 ONS survey, found that six per cent (or 1 in 17) young people aged 11 to 15 years old reported trying to harm, hurt or kill themselves. In a smaller, regional study by Hawton et al. (2002) involving 41 secondary schools and using a self-report survey, the researchers found that of the 6,020 mainly 15 and 16 year-old students who took part, seven per cent had carried out an act of deliberate self-harm in the previous year (the main methods for self-harming were cutting and poisoning). Suicide ideation (without self-harming) was reported by 15 per cent of the pupils.

Specific prevalence data on another emotional well-being and mental health problem, diagnosable obsessive-compulsive disorder, was also identified. Using the 1999 ONS survey, Heyman et al. (2003) found an overall prevalence rate of a quarter of a cent but noted that this rate increased with age and that few (12 per cent) of these children or young people had been seen by CAMHS.

3.3. The regional picture - the emotional well-being and mental health of young Londoners

Summary:

- Results from the ONS surveys are inconclusive in identifying any clear cut differences between children and young people in London and those elsewhere in the UK – rates of diagnosable mental disorders among children and young people in inner and outer London are not necessarily higher than in other parts of the United Kingdom (Meltzer et al., 2000; Green et al., 2005).
- Bullying is a significant issue identified by young Londoners (Healey, 2002; The Institute of Community Health Sciences, 2003; Greater London Authority, 2004).
- Existing local CAMHS need assessments are of variable quality, most partnerships use the ONS surveys to estimate the prevalence of diagnosable mental disorders in their localities. However, ONS figures together with the data from the CAMHS mapping project (<http://www.camhsmapping.org.uk/>) do enable London boroughs to calculate the estimated gap between need and service access by children and young people. As data and reports were only received from ten London boroughs, it is not possible to draw robust comparisons across local authorities. Nevertheless, some interesting differences do emerge. For example,
 - Greenwich estimated that more than half of children and young people requiring CAMHS support are not currently receiving it, and Kingston estimates close to three-quarters of those in need not accessing CAMHS.
 - Hounslow concluded Asian children and young people were under-represented in their CAMHS services, while Southwark found Black African children/young people to be under-represented and Black British, Black Caribbean and mixed white & Black Afro-Caribbean were over-represented.
 - Southwark found that waiting times for CAMHS were similar to the national average, while Hounslow had lower than national average waiting times. Kingston noted a reduction in their waiting times.
 - Half of Kingston's CAMHS referrals came from GPs, while one quarter came from this source in Southwark.

3.3.1. Pan-London studies

The two ONS surveys (Meltzer et al., 2000 and Green et al., 2005a) have examined the prevalence of diagnosable mental disorders among children and young people by region. Meltzer et al. (2000) found that children and young people in inner London had the highest rate of diagnosable mental disorders when compared to outer London and other regions and countries of the UK. Rates among boys and young men in particular were found to be higher than their peers in other regions, especially among the 11 to 15 year olds (nine per cent had an emotional disorder and 11 per cent had a conduct disorder compared to the five per cent and nine per cent across England respectively). While prevalence of any diagnosable mental disorder was close to eleven per cent for children and young people in inner London, prevalence was below ten per cent for the other regions. However, in the subsequent 2004 ONS survey, the prevalence of diagnosable mental disorders in both inner and outer London was lower than the prevalence for England overall (nine per cent compared to just over ten per cent respectively).

Roberts & McNeish (2005) reported that there had been 13 suicides between 2001 and 2003 in young people under 15 years of age in London. Among 15 to 19 year olds, deaths from suicide and undetermined injury rose to 59 (41 of whom were young men) in the same time period - three per cent of the total number of suicides in London. Using hospital episode statistics for 2003/04 on admissions for self-harm, noted by the authors to be variously recorded and therefore not wholly reliable, Waltham Forest, Lewisham, Islington and Hillingdon showed particularly high rates of self-harm by 10 to 19 year-olds, while Bexley and Sutton had the lowest rates.

Healey's (2002) survey of nearly 400 pupils from 41 London schools found that more than half of the respondents said that they had been bullied and nearly a quarter had experienced racism. The 2004 Greater London Authority Young Londoner's Survey, which involved 1,072 young people aged 11 to 16 years old across 150 randomly selected locations across Greater London, also found bullying to be a real and common issue for children and young people: 22 per cent of respondents said that they had been bullied, 46 per cent of young people said that bullying was a problem on public transport; 54 per cent of participants said it was a problem in neighbourhoods; and 61 per cent of respondents said it was a problem in school.

3.3.2. London borough data and studies

For this review, all thirty-three London borough websites were searched for relevant information or reports. Some London boroughs had made their CAMHS needs assessments public; and the research team received copies of two boroughs' needs assessments directly from their CAMHS Partnership Chairs. The vast majority of the needs assessments seen by the research team had not actually undertaken a piece of independent research to identify level of need, but had estimated their rates of diagnosable mental disorder by using the 1999 or 2004 ONS data. The following section will focus on reporting data collected from London boroughs (listed alphabetically) which is new, rather than estimates based on national data.

- **Barnet** recorded eight suicides among young people aged 16 to 19 years old in the period from 1993 to 2003. Hospital records in 2002/03 showed that 70 per cent of in-patients due to deliberate self harm were 14 and 15 years-old.
- The 2004 **Greenwich** mental health needs assessment concluded that around 1,900 children and young people were being seen by CAMHS, yet this likely represented less than half of those with a need for treatment and support.
- A 2004/05 review of CAMHS in **Harrow** listed local service developments, but also showed that all young people aged under 18 years in contact with the Youth Offending Team, who 'manifested' mental health difficulties had been referred to CAMHS. Waiting times for CAMHS were reported to be lower than the national average (with all children and young people being seen within 13 weeks compared with the national figure of 93 per cent seen within 26 weeks).
- The **Hounslow** CAMHS needs assessment 2006 estimated prevalence and need for CAMHS services based on the 2004 ONS statistics. It also provided a comprehensive analysis by diagnosable mental disorder, gender, 'vulnerable' group, and incorporated findings from other research to check their estimated figures and offer an insight into issues which might affect particular groups of children and young people. The Hounslow needs assessment also integrated the results of the 2004 and 2005 CAMHS mapping exercise to examine service provision as well as estimate the gap between need and provision (the gap was concluded to be 2,500 children - eight per cent of under-18 years of age population). The needs assessment discussed 'what do we know locally?' and found that Hounslow had particularly high levels of children with behaviour problems, kinetic disorders/attention deficit and hyperactivity disorder and autism. For instance, the report noted that one third of referrals made to CAMHS were for children with behaviour problems which were not reaching the criteria of having a 'clinically diagnosable mental disorder'. The report also concluded that there was a large under-representation in CAMHS of Asian young people (only six per cent of CAMHS patients were Asian, among a local child and young person population of approximately 44 per cent). Finally, the needs assessment reported 2005/06 Hounslow Youth Counselling Service which offers some insight into the issues young people present with: 'emotions' - 30 per cent and relationships - 24 per cent. An almost equal proportion of young men and women, as well white and minority ethnic young people were found to use the service.
- **Kingston** published a detailed needs assessment which included data on schools with the highest proportion of children and young people eligible for free school meals, with the highest proportion of authorised and unauthorised absences, as well as data on particular groups such as children in need, children looked after, children with disabilities and those with special educational needs. Using the 1999 ONS and 1991 Census data, estimates for prevalence of diagnosable mental disorders by ward were calculated. Local data from 2003/04 found that on average 53 referrals are made to CAMHS a month and that waiting times for non-urgent appointments had fallen in this time period from 12-15 weeks to 10-12 weeks. Just over half of the referrals had come from general practitioners (GPs). An audit over eight months of attendance at the Accident and Emergency Departments found that 62 per cent were for overdoses and 50 per cent were offered follow-up support from CAMHS. The report estimates that only

28 per cent of children and young people with an expected diagnosable mental disorder in Kingston are referred to CAMHS annually. Finally, the report offers a summary of the evidence of effectiveness for 'interventions' for diagnosed mental health disorders.

- A comprehensive needs assessment in **Southwark** was published in 2006. This report integrated data drawn from a range of sources: ONS, South London and Maudsley (SLAM), 2004 National CAMHS Mapping Exercise, a stakeholder survey, consultation with parents and stakeholders, local research and wider literature. Using ONS data, the overall prevalence rate of diagnosable mental disorder in children in Southwark was estimated to be 12.5 per cent (compared to the nine and a half per cent nationally), with wards in Peckham and Camberwell estimated to have particularly high rates. Two-fifths of those attending Tier 2 and 3 CAMHS in Southwark had emotional disorders, while an eighth had conduct disorders and 13 per cent had hyperkinetic disorders (these rates are higher than the London average of presentations to CAMHS). This assessment also reported that children in public care and those under the supervision of Youth Offending Teams are under-presented in Tier 2 and 3 CAMHS. A wide variation in service up-take between different black and minority ethnic groups was also noted (Black Africans are under-represented, while Black British, Black Caribbean and mixed white & Black Afro-Caribbean children and young people are over-presented). Compared to Lambeth in-patient bed occupancy over the past three years in Southwark was lower, but higher when set alongside the other boroughs using SLAM. Twenty-three per cent of referrals to SLAM came from GPs, while eighteen per cent came from social services. While a higher proportion of children aged under 10 years accessed CAMHS than the national average, 11 to 14 year-olds were less likely to be accessing these services. The assessment concluded that the borough compared favourably with national figures in relation to the proportion of children and young people waiting for more than twelve weeks for their first appointment (Petrie, 2006).
- Other reports were identified from Croydon, Haringey, Hillingdon, Newham and Southwark. Two of these only offered estimates of diagnosable mental disorders within the local authority based on ONS data (Croydon and Haringey), two others reported some hard or approximate figures on level of need for each CAMHS Tier but with little contextual and comparative data (Hillingdon and Southwark), and one other listed services offering support regarding mental health and emotional well-being (Newham).

None of the other twenty-two boroughs appeared to have easily accessible data on their website or responded to the review team's request for reports sent out via one of the London CAMHS Regional Development Workers.

A number of published studies were identified for inclusion in this review. Davis et al. (2000b) undertook a needs assessment in **south-east London** (Lewisham and Lambeth). Two hundred and fifty three randomly selected children and young people aged 0 to 16 years old were interviewed using the Association for Child Psychology and Psychiatry core data set. Seventy two per cent of children were assessed as having at least one significant psychosocial problem, while just over a third experienced three or more. Boys aged 5 to 10 years old were shown to have more problems than girls. Drawing on this study, Attride-Stirling et al. (2001) found that only one third of parents had accessed specialist child mental health services, while almost half had used primary care or community services. Half of the parents surveyed reported their experience of mental health services had been satisfactory, while a quarter felt they were less than satisfactory.

Healy et al. (2002) examined emergency presentations to the Maudsley Hospital or to the Accident & Emergency Department of King's College Hospital (south-east London) during 1997. Mean age at the time of emergency presentation was 14.5 years of age, a similar proportion of young men and women presented, and the ethnic profile of these emergency presenters was similar to that of the local age-equivalent population. Almost two-thirds of presentations were for deliberate self-harm (a large proportion of whom were young women - 83 per cent). Between two-fifths and one half of all young people had previous contact with CAMHS or social services.

In **east London**, the RELACHS study offered information regarding levels of 'psychological distress' (The Institute of Community Health Sciences, 2003: 10) as measured by the Strengths and Difficulties Questionnaire among 2790 young men and women, aged 11 to 14 years old, from a representative sample of 28 east London secondary schools (in the boroughs of Hackney, Tower Hamlets and Newham). Young men reported higher rates of psychological distress at ages 11 to 12 years old than between 13 and 14 years old and were more likely than young women to be experiencing conduct disorders. Young women were more likely to have emotional disorders, showed higher rates of psychological distress in the older age group (18

per cent compared to 16 per cent of boys and girls aged 11 to 12 years old). The authors concluded that 'rates of psychological distress in East London are considerably higher than national rates' (The Institute of Community Health Sciences, 2003: 10). Turning attention to the issue of bullying, highlighted by other young Londoners as a key issue for them, at least a fifth of young people in this east London study reported being bullied in the past school term. Young people also discussed experiences of racism and not feeling safe to be out alone in some localities.

Finally, two more studies highlighted young people's views of their local communities of **Waltham Forest** and **Redbridge** (Stockdale & Katz, 2002) or health needs in **Hounslow** (Percy-Smith et al., 2003). One tenth of the 104 young people who took part in Stockdale & Katz's (2000) research reported feeling unsafe walking alone in their neighbourhoods during the day. One third of the young people said they worried about their mother's health and between a quarter and fifth reported being concerned for friends' health in relation to smoking and drug use (respectively). Three-quarters of young people said they were 'stressed' (Stockdale & Katz, 2002: 120) by school work/exams. Using peer researchers, Percy-Smith et al. (2003) found that 'mental well being' (p. 24) was frequently mentioned as an important concern for young people in Hounslow. Young people clearly linked pressure to do well at school with substance use and emotional well-being and mental health problems such as depression and anxiety. The study participants displayed high levels of distrust towards health services, particularly GPs. Conflict within peer or familial relationships were also often highlighted as an issue for which young people wanted further support.

3.4 Emotional well-being and mental health - time trends, persistence and outcomes

Summary:

- In the past twenty-five years, the emotional well-being and mental health problems of children and young people appear to be increasing (Collishaw et al., 2004).
- Emotional well-being and mental health needs can persist in the short-term (18-36 months), but also into adulthood (Goodman et al., 2002; Meltzer et al., 2003a; Maughan & Kim-Cohen, 2005; Healey et al., 2003; Collishaw et al., 2004; Simonoff et al., 2004). This can have major short- and long-term cost implications for society (Knapp et al., 1999; Scott et al., 2001).

Collishaw et al. (2004) found that emotional well-being and mental health 'problems' had increased over the last quarter of a century, with increasing trends in behavioural difficulties noted between 1974 and 1999, and increased emotional problems found between 1986 and 1999. West & Sweeting's (2003) longitudinal study in West Scotland found a similar trend of increasing emotional difficulties among some groups of young women (those who might be considered 'middle class'), but not for young men. Reasons for increasing emotional well-being and mental health difficulties are likely to be related to family and socio-economic changes, but also broader societal changes and generational effects (Collishaw et al., 2004).

As discussed above, a minority of children and young people continue to experience diagnosable mental disorders over a period of 18 months (Goodman et al., 2002) and a three-year period (Meltzer et al., 2003a). Similarly, studies have found an association between childhood diagnosed mental disorders and difficulties in psycho-social functioning in adulthood (diagnosed mental disorders, substance misuse, inter-personal relationships - Maughan & Kim-Cohen, 2005; employment - Healey et al., 2003; offending - Collishaw et al., 2004; Simonoff et al., 2004). Other studies have estimated the short- and long-term costs of childhood emotional well-being and mental health problems (Knapp et al., 1999; Scott et al., 2001). [For further details on the studies mentioned in this section, see Appendix One.]

3.5. Factors associated with emotional well-being and mental health problems

Summary:

- There are differences in the types of emotional well-being and mental health problems among boys and girls (higher proportion of conduct disorders compared to emotional disorders respectively), and the age range when higher numbers present with difficulties (boys more likely to present with problems earlier on than girls) (Audit Commission, 1999; Meltzer et al., 2000; O'Herlihy et al., 2004; Green et al., 2005a).
- Evidence on the impact of ethnicity on emotional well-being and mental health problems is inconclusive (although children and young people from minority ethnic communities may be over-represented within CAMHS - Audit Commission, 1999; O'Herlihy et al., 2004; Tolmac & Hodes, 2004).
- There is evidence suggesting co-morbidity between physical ill-health and emotional well-being and mental health problems (Meltzer et al., 2000; Meltzer et al., 2003a; Fagg et al., 2006).
- Parental unemployment, living with step-siblings, being in a lone parent and/or low income household and having a parent with emotional well-being and mental health problems have all been found to be significantly associated with emotional well-being and mental health problems among children and young people (Audit Commission, 1999; Meltzer et al., 2000; Green et al., 2005).
- The following groups of children and young people have been documented as having particularly high rates of emotional well-being and mental health problems: those with learning difficulties (Audit Commission, 1999; Meltzer et al., 2000; Emerson, 2003.; O'Herlihy et al., 2004), those with experience of local authority care (McCann et al, 1996; Audit Commission, 1999; Meltzer et al., 2003b; Blower et al., 2004; Teggart & Menary, 2005), those with experience of offending (Anderson et al., 2004; Harrington et al., 2005), young asylum seekers and refugees (Hodes, 2000; Fazel & Stein, 2002; Hodes & Tolmac, 2005), those who have experienced bullying; gay or bisexual young men (Remafedi et al, 1998), and those who are homeless (Craig et al., 1996; Craig & Hodson, 2000).

A number of UK-based studies have examined possible factors associated with a child or young person experiencing emotional well-being and mental health problems. Knowledge of possible 'risk' factors may help to improve early identification and intervention work, while understanding which factors are 'protective' or support resilience could inform the development of programmes to improve children and young people's emotional well-being and mental health.

Titterton et al. (2002) offer a useful understanding of how risk, protective and resilience factors may interact to influence a child or young person's emotional well-being and mental health problems. Titterton et al. (2002) define 'risk factors' as 'characteristics that are statistically associated with poor outcomes' (p. 23); 'protective factors' as those which promote positive emotional well-being and mental health; while 'resilience factors' should be seen as those factors which support children and young people who have experienced adversity to 'do well' (p. 23).

Below is very brief summary of the evidence of factors which are associated with emotional well-being and mental health problems. No comment is made here on the direction of the relationship between emotional well-being and mental health problems and the identified associated factors, as few studies are able to comment on this. Most authors argue there is likely to be a bi- or multi-directional causal relationship. [For a more detailed summary and review of the referenced studies, see Appendix Two].

- Gender - while overall boys and young men may record higher rates of diagnosable mental disorder (Meltzer et al., 2000), young women, especially those in the older age groups are likely to present in CAMHS (Audit Commission, 1999; O'Herlihy et al., 2004). Young women are more likely to have self-harmed (Hawton et al., 2002; The Priory Group, 2005) and have experienced emotional difficulties (such as anxiety and depression - Doyle, 2003; West & Sweeting, 2003), while boys and young men are more likely to have behavioural/conduct problems (Meltzer et al., 2000; Green et al., 2005a; Doyle, 2003).
- Age - rates of diagnosable mental disorders increase among older age groups (11-16 year-olds) (Meltzer et al., 2000; Green et al., 2005a), especially among young women (Audit Commission, 1999; Doyle, 2003; The Institute of Community Health Sciences, 2003; O'Herlihy et al., 2004).

- Ethnicity - there is conflicting evidence in studies examining the impact of ethnicity on emotional well-being and mental health problems. While Meltzer et al. (2000) found no association between ethnicity and childhood diagnosable mental disorders, Green et al. (2005a) found that children and young people from Black Africa, Indian and Pakistani backgrounds are less likely to experience difficulties (Kramer et al., 2000). The RELACHS study actually found that white young people had greater emotional well-being and mental health problems than their minority ethnic peers (Fagg et al., 2006). Yet CAMHS appear to be seeing an over-proportional number of children and young people from minority ethnic background (Audit Commission, 1999; O'Herlihy et al., 2004; Tolmac & Hodes, 2004).
- Physical ill-health - is associated with increased probability of having emotional and well-being problems (Meltzer et al., 2000; Meltzer et al., 2003a; Fagg et al., 2006).
- Family and household factors - having a parent unemployed (Audit Commission, 1999; Meltzer et al., 2000; Green et al., 2005a), living with step-siblings (McMunn et al., 2001; Green et al., 2005a), living in a lone parent family (Audit Commission, 1999; Meltzer et al., 2000; Green et al., 2005a) likely to be due to being more likely to be living in poorer socio-economic circumstance (McMunn et al., 2001; Green et al., 2005a) are all factors found to be significantly associated with having emotional well-being and mental health problems.
- Parental emotional well-being and mental health problems are associated with increased probability of children and young people having similar difficulties (Audit Commission, 1999; Meltzer et al., 2000; McMunn et al., 2001; Meltzer et al., 2003a; Derisley et al., 2005).
- Learning difficulties - children and young people, especially boys, with recognised special education needs are more likely to have emotional well-being and mental health problems (Meltzer et al., 2000; Meltzer et al., 2003a; Fagg et al., 2006). A link between learning difficulties and disabilities and emotional well-being and mental health has also been found (Audit Commission, 1999; Meltzer et al., 2000; Emerson, 2003; O'Herlihy et al., 2004).
- Being in the care of the local authority - is significantly associated with having emotional well-being and mental health problems (McCann et al, 1996; Audit Commission, 1999; Meltzer et al., 2003b; Blower et al., 2004; Teggart & Menary, 2005). Children and young people in public care are four to five times more likely to have a diagnosable or diagnosed mental disorder than their peers who are not looked after. Diagnosed conduct disorders appear particular prevalent among this group of children and young people (McCann et al., 1996; Meltzer et al., 2003b).
- Offending - prevalence of the emotional well-being and mental health problems of young people known to the youth justice system have been estimated at between a third and just under half of this population (Harrington et al., 2005 and Anderson et al., 2004 respectively; strong associations between offending and emotional well-being and mental health problems also found by Lader et al, 2002 and Hammersley et al., 2003). Carswell et al. (2004) concluded that young offenders experienced 'clinically significant, impairing levels of depression/misery, worry, and problematic substance use' (p. 424) when compared to a demographically representative community sample.
- Young asylum seekers and refugees - reviews by Hodes (2000), Fazel & Stein (2002), Hodes & Tolmac (2005) have argued that recent studies of children and young people who are asylum seekers or refugees demonstrate they may require tailored emotional well-being and mental health support, due to the particular experiences and current living situations of this group.
- Bullying - experiences of bullying and being involved in bullying others has been associated with emotional well-being and mental health problems among both older and younger children (Salmon et al., 2000; Wolke et al., 2000).
- Young people who are lesbian, gay or bisexual - there appears to be an elevated risk of attempted suicide among young gay and bisexual men compared with young people in general (Remafedi et al., 1998).
- Homelessness - is associated with increased emotional well-being and mental health problems (Craig et al., 1996), and is likely to increase the risk of experiencing a persistent diagnosed mental disorder (Craig & Hodson, 2000). Difficulties often emerged prior to becoming homeless (Craig et al., 1996; Vasiliou, 2006).

Drawing on the ONS surveys it has been argued that there is an increased likelihood of children and young people having a diagnosable mental disorder when they experience a clustering of 'risk' factors (Meltzer et al., 2000; Green et al., 2005a)10. Titterton et al. (2002) also highlights that the presence of emotional well-being and mental health problems interacted with the environmental context, and suggest a bi-directional causal relationship. These authors recommend the use of a pathway perspective in order to create a more dynamic understanding of how changes in circumstances or support received could lead to an improvement in emotional well-being and mental health.

Meltzer et al. (2000) concluded that children and young people least likely to have a diagnosable mental disorder were those living: with married parents; parent(s) with qualifications above A-level or equivalent; in social class II households (managerial and technical); in owner occupied households; and in a detached house. Research specifically identifying protective or resilience factors appears scarcer, but support for using rewarding and non-punitive parenting strategies was found by Vostanis et al. (2006a), some cultural backgrounds (Bangladeshi - Stansfeld et al., 2004; 'South Asian' ethnic groups - Fagg et al., 2006), and although the vast majority of studies have been conducted in the USA, Koenig & Larson (2001) in a review of 'religious involvement' and mental health found mixed evidence (Ellison & Levin, 1998 and Samaan, 2000).

3.6. Areas requiring further research

Currently, most of the nationally representative or London-based studies focus on identifying the prevalence of diagnosable mental disorders, rather than using a broader definition of emotional well-being and mental health problems. This could mean that the extent of need among children and young people may well have been under-estimated. A linked issue is the need for more London borough-based research which identifies levels and types of need among different groups of children and young people (rather than estimates of need based on the ONS studies).

Given the important role played by parents and carers identified through this review (with regard to increased risks of poorer emotional well-being and mental health in children and young people, whether and in what ways support is accessed, and the need to involve parents directly in programmes), further research is needed to explore parents' and carers' understandings of emotional well-being and mental health, and the barriers they themselves experience in accessing support services in London.

There are a number of other factors that may affect children and young people's emotional health and well-being, such as experiencing domestic violence or other forms of abuse. These possible associated factors have not been reported on in this review, as the literature search did not identify any studies reporting specifically on these. However, it is likely that any clustering of such factors with others already identified would have a negative impact on the emotional well-being and mental health of children and young people.

4 Accessing services to promote emotional well-being and mental health



In this section, we offer an overview of research detailing findings relevant to access to support services addressing emotional well-being and mental health (data on access to London services was reported in the previous section). There is a focus on:

- data on proportion of children, young people and parents accessing support for emotional well-being and mental health problems;
- the ways that parents can facilitate (or hinder) access;
- what is known regarding the referral pathways and links between CAMHS and other statutory services;
- the sorts of barriers to access experienced by particular groups of children and young people; and,
- how children's and young people's views on 'help-seeking' may influence their motivation to access support.

4.1. Access to CAMHS - what do we know nationally?

Summary:

- Children and young people with emotional well-being and mental health problems are more likely to be in contact with statutory services (Meltzer et al., 2000; Ford et al., 2005), especially GPs (Attride-Stirling et al., 2001), the police/youth justice system, and education support services (Meltzer et al., 2000).
- Between one fifth and a quarter of children and young people with a diagnosable mental disorder had still not been seen by CAMHS 18 months and three years on (Ford et al., 2003 and Meltzer et al., 2003a respectively). Furthermore, between 40 and 50 per cent of these children or young people had not been seen by any other services for these specific needs (Haines et al., 2002 and Meltzer et al., 2003a respectively).
- Parental satisfaction with the support received was variable (Attride-Stirling et al., 2001; Ford et al., 2003; Meltzer et al., 2003a).
- Appleby et al. (2006) noted improving access to CAMHS in terms of numbers and the speed with which children and young people are seen over time.

A number of national studies have examined the extent of the gap between prevalence of emotional well-being and mental health problems (in most cases focusing on diagnosable mental disorders rather than broader emotional health and well-being) and access to specialist support within CAMHS. As the development of emotional well-being and mental health support has been receiving increasing attention and funding from national government (Atkinson et al., 2007), so the data reported below must be set in the context that even studies may no longer offer an accurate picture of the gap between need and access to support today. Yet an historical overview around access to CAMHS is central to understanding the current context, and significant gaps in provision and accessibility remain. Later (in Section 5) we will examine the effectiveness of receiving support outside the traditional CAMHS structure.

The 1999 Audit Commission national survey found that access to CAMHS for children and young people was extremely variable nationally - 'resources vary by a factor of seven, and staff numbers and types vary widely' (p. 50). Similarly, non-attendance at CAMHS appointments was quite high, with only one in five health trusts reported that they had a non-attendance rate of less than 15 per cent. At that point in time, only ten per cent of health trusts could offer a non-urgent CAMHS appointment within six months of referral.

Drawing on the ONS surveys, it has been found that many children and young people with a diagnosable mental disorder are in contact with another service. For instance, Meltzer et al. (2000) identified that almost half of the children and young people with a diagnosable mental disorder had been in contact with a GP in the past twelve months for any reason (and more likely to have seen the GP on repeated occasions), while only a third of those without a disorder had seen their GP in the same time period. Similarly, children with mental disorders were more likely to have been seen at an Accident and Emergency Department (26 per cent compared with 17 per cent of those without such difficulties), as well as educational services (50 per cent), specialist health care services (25 per cent), social services (20 per cent), and the police (43 per cent, twice the proportion of children who have no disorder). Contact with services varied by type of disorder, where children and young people with hyperkinetic disorders were more likely to have been seen by a professional, than those with behavioural and emotional disorders (81 per cent, 76 per cent and 63 per cent respectively).

A follow-up survey, 18 months after the 1999 ONS study explored service use by those children and young people with a diagnosable mental disorder in 1999. Ford et al. (2003) found that about half of them had not been in contact with any services, and only one fifth had been seen by CAMHS. Through interviews with parents, the researchers noted that the same proportion of parents felt that the support they had received had helped them and their children, as did those parents who reported it has made little or no difference. Contact with CAMHS was reported to have been brief and usually involved more than one service or professional.

Meltzer et al. (2003a) undertook a further follow-up study, this time focusing on children and young people with a 'persistent' diagnosable disorder (i.e. over three years). Similarly, only a quarter of these children and young people had been in contact with specialist mental health services during the previous year. Similar to the results in the first ONS survey, children and young people with hyperkinetic disorder (9 in 10) were more likely to be receiving professional support, than those with a conduct disorder (7 in 10), or those with an emotional disorder (6 in 10) (Meltzer et al., 2003a). Compared to Ford et al. (2003), Meltzer et al. (2003a) found parental assessment of services a little more positive - yet the authors noted that nonetheless between ten and forty per cent of those parents interviewed felt the support received from any statutory agency had made no difference to their child's difficulties. On average, parents reported having to wait five months for their children to be seen by CAMHS.

Ford et al. (2005) using the same data as Meltzer et al. (2003a) found that children and young people with a diagnosable mental disorder were significantly more likely to have been in contact with a statutory agency. Fifty-eight per cent of children and young people were found to have been in contact with at least one of the following services for support with emotional, behavioural or concentration difficulties: social services, special educational needs resources, the youth justice system and CAMHS. Parents most commonly approached teachers (two-fifths), primary health care professionals (one third), specialist educational professionals, such as educational psychologists (a quarter), and specialist CAMHS professionals (a quarter).

Examining use of services (not specifically CAMHS) by children and young people (aged 4 to 15 years olds) with emotional well-being and mental health problems (as measured by the Strengths and Difficulties Questionnaire) Haines et al. (2002) used data from another survey, the Health Survey for England (which had a sample of 5,913 children) and found that a substantial proportion (42 per cent) have not been seen by a professional about these difficulties. Yet, as indicated earlier, evidence to support a more optimistic outlook is offered by Appleby et al. (2006), who concluded there had been dramatic improvements in specialist CAMHS services being offered between 2002 and 2005. Forty per cent more cases were seen in this three year period (80,602 cases and 112,984 cases respectively). Children and families were also found to be getting access to services a little faster (52 per cent of new referrals were seen within four weeks or less by CAMHS in 2005 compared to 44 per cent in 2002).

Given the relatively high level of contact between a child or young person with a diagnosable mental disorder with any service reported above, improving early identification, offering initial support, making appropriate referrals, and reducing the waiting times for specialist CAMHS support would seem central to improving the emotional well-being and mental health of those most in need (Ford et al., 2007).

At the same time, several (perhaps more dated) studies have continued to highlight the gaps in service provision for young people aged over 16 years old (Street, 2000; Smith & Leon, 2001; Young Minds, 2002; Royal College of Psychiatrists, 2006). Phimister (2004) found that some services exclude those young people aged 16-18 years old if they are not in full-time education, and that many adult mental health services set an implicit minimum age of 18 for access to their services. A linked issue was the difficulties of managing a successful transition of young people from CAMHS to adult mental health services (Street, 2000; Young Minds 2002) - in 1999, less than one quarter of health authorities had specified transfer arrangements from CAMHS to adult services (Audit Commission, 1999).

Sayal (2006) undertook a systematic review of access to mental health services. The review was based mainly of US studies. Access to specialist services was found to be negatively affected by severity of the psychological difficulties (Haines et al., 2002), being a girl (Kramer & Garralda, 2000; Haines et al., 2002), and coming from a more disadvantaged socio-economic background (Haines et al., 2002). Significantly, Sayal (2006) concluded that parental awareness of symptoms and parental perception of problems were the first steps in the 'help-seeking process' (p. 649) (Kramer & Garralda, 2000).

4.2. Facilitating access to CAMHS - the role of non-CAMHS professionals

Summary:

- Given that children and young people with emotional well-being and mental health problems are more likely to have had contact with statutory services (Meltzer et al., 2000; Ford et al., 2005); it would be beneficial for non-CAMHS services to be able to make more appropriate referrals (Pettitt, 2003; Potter et al., 2005; Rothi et al., 2005).
- Links between CAMHS and GPs have resulted in training for primary care staff (Audit Commission, 1999; Bradley et al., 2003) and the development of consultation services for professionals as well as direct support provision for children and young people (Bradley et al., 2003); however measures are needed to improve GPs' ability to identify problems of emotional well-being and mental health (Sayal & Taylor, 2004), and to increase referral rates (Bower et al., 2003).
- Increasingly, social (care) services are developing emotional well-being and mental health support provision, but clearer and quicker referral pathways to specialist CAMHS are still needed (Kerfoot et al., 2004).
- Increasing links between schools and CAMHS have been noted (Pettitt, 2003) in the form of consultation to staff and direct support to children and young people, but more training for school staff is needed (Gowers et al., 2004; Rothi et al., 2005), specifically in making appropriate referrals (Ford & Nikapota, 2000).

In the UK, developing a multi-agency model of working is a central aim of Every Child Matters (Department for Education and Skills, 2003). A number of studies have explored the links between CAMHS and services such as GPs, paediatricians, social service departments and schools.

Potter et al. (2005) in a study of what non-CAMHS professionals wanted from CAMHS services in a part of Wales concluded that there was some agreement between referrers of which cases should be prioritised for support (children who self-harm, have a diagnosable mental disorder, who have been abused), but that such priority-setting was moderated by factors including the case's complexity and severity, and the availability and effectiveness of treatment. Acceptable waiting times between referral and first CAMHS appointment for non-urgent cases was an average of three and a half months according to the surveyed professionals. Potter et al. (2005) argued that given these findings it was crucial that professionals received training to improve identification of the severity level of a child or young person's emotional well-being and mental health problem and professionals' knowledge of whether, and how referral to CAMHS may be able to help meet a child's needs.

The Audit Commission (1999) identified that 56 per cent of CAMHS operated formal contracts with GPs, and that many services delivered training to this group of professionals. However, about one-quarter of health trusts had no real partnership arrangements between CAMHS and GPs. In a slightly later national study, Bradley et al. (2003) surveyed all CAMHS in England (83 per cent response rate) and found that two-thirds had run training and education initiatives for primary care services, one third offered a more structured consultation service within primary care, and one fifth ran outpatient clinics in primary care settings. One third had also developed primary mental health worker posts (the impact of these new roles is discussed in section five. From the same study, Bower et al. (2003) reported that referral from GPs to CAMHS were found to be relatively low at five to ten per cent. However, there were some exceptions, and size of general practice was found to be positively associated with referrals. Sayal & Taylor (2004) assessed the accuracy and rate of detection of diagnosable mental disorders among children aged 5 to 11 years old by GPs and found that only a quarter of children who scored highly on the Strengths and Difficulties Questionnaire and met the criteria for 'caseness' (p. 349) were identified by the GPs.

Social Service Departments were the focus of Kerfoot et al.'s national study (2004), which identified that such services were increasingly contributing to outreach consultation and support initiatives, through the use, for instance, of primary mental health workers or dedicated clinical psychology sessions, as well as developing innovative in-house provision for more serious (Tier 2 type) emotional well-being and mental health referrals. However, professionals working in Social Services Departments commented that some of the main areas of development for CAMHS were to reduce the length of time between referral and first appointment, making services more accessible for those children and young people in contact with social services, and the need for clearer protocols to make 'urgent referrals'.

Two studies have reported on the link between child psychiatry consultation services and paediatricians (Slowik & Noronha, 2004 - survey conducted in the West Midlands; Woodgate & Garralda, 2006 - survey in Greater London). Both studies concluded that emotional well-being and mental health problems of children accessing paediatric services were not being adequately met. Woodgate & Garralda (2006) found that only a minority of dedicated paediatric liaison services were being provided by specialist multidisciplinary CAMHS in Greater London.

The role of teachers was the focus of three other studies identified in the review. In Gowers et al. (2004) study, teachers in 291 primary schools reported they had received little in the way of training around emotional well-being and mental health (and in Rothi et al., 2005 teachers noted they were often unsure how to distinguish between 'mental health problems and emotional/behavioural difficulties' - p. 9), and expressed an almost unanimously interest in learning more. Teachers reported that their experiences of CAMHS was mixed, many reporting uncertainty about referral pathways, and that for pupils receiving CAMHS support they would value receiving feedback (Ford & Nikapota, 2000; Gowers et al., 2004; Rothi et al., 2005).

In a national study of joint working between CAMHS and schools conducted by Pettitt (2003), respondents reported that they worked directly with schools (secondary, primary and Emotional and Behavioural Difficulties schools - 81 per cent, 76 per cent, 72 per cent respectively). About one half of CAMHS had established links with Local Education Authorities, CAMHS teams in schools were usually composed of one or more of the following professionals: clinical psychologists, community psychiatric nurses and social workers. 'The most common form of work was consultation and support to school staff, often on a case by case basis with children referred to their service. [CAMHS professionals] also provided consultation on behaviour, training and supervision to school staff, and contributed to health promotion activities. Seventy per cent of CAMHS provided direct work with children, included individual and group work in schools, assessment and observation. Many services attempted to work with parents in school settings, especially with early years and primary age children' (Pettitt, 2003: 8). Joint working in schools was reported by respondents to have had positive effects on students, education staff, and CAMHS professionals - mainly because education staff became more knowledgeable about external support services, and CAMHS professionals felt they were receiving more appropriate referrals, reaching children and young people they might not have otherwise worked with, and that they were reaching those with problems earlier.

4.3. Studies focusing on service access and use by particular groups of children and young people

Summary:

- One study has suggested that the referral pathways for children and young people (Daryanai et al., 2001), and parental attitudes to 'help-seeking' (Stein et al., 2003) may vary by ethnicity. Providing CAMHS support to children and young people with their specific cultural situations and circumstances in mind is necessary (Hodes & Tolmac, 2005; Street et al., 2005).
- A large gap between the needs of children and young people with learning difficulties and provision of targeted and good quality emotional well-being and mental health support has been noted (London Strategic Framework Group, 2000; McCarthy & Boyd, 2002; Foundation for People with Learning Disabilities, 2005; National Health Service, 2006; Street et al., 2006).
- Improved provision for children and young people in public care has been recorded (Fletcher-Campbell et al., 2003; Appleby et al., 2006).

A report commissioned by the Mayor of London in 2003 indicated that people from black and minority ethnic communities are those most commonly cited as finding mental health services difficult to access because of either language barriers or cultural issues (Foster, 2003). A study by Daryanai and colleagues (2001) suggested that ethnic background influenced which service provider was likely to refer children and young people to CAMHS. While White British children were more likely to be referred by GPs, Black and South Asian children were more likely to be referred by specialist doctors, Black children by education services, and mixed race children by social services. Stein et al. (2003) explored differences in help seeking patterns between Pakistani and White British mothers. The research indicated that Pakistani and White British mothers were both good at identifying problems of emotional well-being and mental health in their children, yet, despite this, Pakistani mothers were less likely to seek treatment or consider a referral to CAMHS for mild or moderate problems.

Street et al. (2005) elicited the views of black and minority ethnic young people of 'mental health services' (p. 3). Young people said that do not understand how mental health services worked, where to get information about sources of help, and that there were worried about whether staff would understand their cultural and religious needs. National data reported by Appleby et al. (2006) suggested, however, that service use by black and minority ethnic young people in CAMHS was increasing. Comparing the findings of the 2005 and 2004 CAMHS mapping projects, there had been an increase of 34 per cent in the reported number of young black people seen by services.

Studies consulting children and young people who are asylum seekers and refugees have found that the school was identified by them as the key place for receiving support (Kidane, 2001; Marriot, 2001; Stanley, 2001; Hek & Sales, 2002). Schools were often the first point of contact these children and young people had with statutory services, leading some researchers to suggest that children and young people's initial experiences of school would affect their self-esteem, motivation, integration and aspirations for future (Candappa & Egharevba, 2000; Dennis, 2002; Rutter, 2003).

The Connecting for Health - Do Once & Share (DOAS) project (National Health Service, 2006) consulted numerous stakeholders, services users and providers nationally concerned with the needs of children and young people with learning difficulties, to develop a pathway for future service provision. The project reported that 'at the time of the project only 45 per cent of child mental health services were accessible to children and young people with learning disabilities, and three Strategic Health Authorities were without any specialist LD CAMHS provision (National Health Service, 2006: 12). In a smaller study, the Foundation for People with Learning Disabilities (2005) was interested to explore in more depth the types of services provided by the 48 CAMHS who according to the 2004 CAMHS mapping exercise were providing services for children with learning disabilities. Although there was a very low response rate of seventeen per cent, it was reported that four services made no provision, three reported patchy provision, seven had a CAMHS/Learning Disability Psychiatrist based in the Learning Disability Team, five had a distinct CAMHS/Learning Disability team based within mainstream CAMHS and only one service was integrated.

The London Strategic Framework Group (2000) surveyed regional services for children and young people with learning disabilities and mental health problems and found a significant lack of expertise in the field, highly fragmented services, which focused on crisis responses rather than proactive intervention services. Support to discrete groups (such as those aged 16 to 18 years old) was found to be particularly variable, with some areas having no services for this age group. Furthermore, twenty four-hour access to services for children and adolescents with learning disabilities was concluded to be a rarity. Street et al. (2006) also undertook a mapping of CAMHS/Learning Disability services in Greater London and found a wide variation across boroughs in relation to levels of provision and approaches of services.

McCarthy & Boyd (2002) concluded that availability of mental health services for children and young people with learning disabilities was poor, when compared to those provided for their non-learning disabled peers.

Meltzer et al. (2003b) found that children and young people in public care with any diagnosable mental disorder were more likely to have visited a health services recently than their counterparts with no disorder (one and a half times more likely to have visited their GP in the past two weeks, and almost twice as likely to have visited an emergency department within the last three months). Fletcher-Campbell et al. (2003) in their study on educational provision for children and young people in care found that professionals felt this group were prioritised for mental health support both through their care package and within the resources made available through schools. Using the 2004 and 2005 CAMHS mapping data, Appleby et al. (2006) concluded that since 2004 there has been an increase of 15 per cent in CAMHS service contacts by children in public care.

4.4. The importance of parents in understanding access to support for emotional well-being and mental health problems

Summary:

- Barriers identified by parents to accessing support for their children include: the fear of being blamed, not know where to go, and concerns that the support would make no difference (Meltzer et al., 2003a).
- Relatively high numbers of children and young people with significant emotional well-being and mental health problems are seen by GPs (Meltzer et al., 2000; Attridge-Stirling et al., 2001); detection by GPs has been suggested to be significantly increased if parents express concern about their child's emotional well-being and mental health during the consultation itself (Sayal & Taylor, 2004).

Sayal's (2006) systematic review on access emphasized the role played by parents in facilitating access to support for children and young people with emotional well-being and mental health problems. In the Section 5 of this report, parents again are shown to be central in understanding how emotional well-being and mental health problems can be met. Parents are often the first people who initially seek support for their children, especially if they are younger. Meltzer et al. (2003a) explored the barriers to accessing mental health services experienced by parents (with children who had diagnosable mental disorders). Twenty-nine per cent of parents reported that they had been concerned about being branded a failure or blamed, seventeen per cent said they did not know where to go for help for such problems, and twelve per cent said that they thought any support they might receive would either not be helpful or might actually make things worse.

A study by Sayal & Taylor (2004) on the rate of detection of diagnosable mental disorders among children aged 5 to 11 years old over the course of one year (2000-2001) by GPs in Croydon found that the expression of parental concern during the GP consultation about an emotional well-being and mental health problems significantly increased recognition of a diagnosable mental disorder by GPs (from 25 to 88 per cent). The authors concluded that GPs' assessment of a diagnosable mental disorder was predicted more by the expression of parental concern than an accurate assessment of a disorder and that as few parents expressed such concern, more parental education should take place to improve early identification in the primary care settings.

4.5. What makes services accessible and effective in children, young people, parents/carers' views?

Summary:

- Friends and family were identified as a key source of support by children and young people (Meltzer et al., 2000; Armstrong et al., 2000; Sellen, 2002; Baruch & James, 2003; Roose & John, 2003; Swales, 2005), although respondents identified that sometimes they might require more specialist support, especially if they were experiencing family difficulties (Roose & John, 2003).
- Confidentiality, trustworthiness, being non-judgemental, listening and kindness were all qualities children, young people and their parents wish for from CAMHS staff (Armstrong et al., 2000; Attride-Stirling et al., 2001; Smith & Leon, 2001; Buston, 2002; Baruch & James, 2003; Roose & John, 2003; Curtis et al., 2004; Dogra, 2005; Swales, 2005; Day et al., 2006; Teggert & Linden, 2006; Transitional Years Mental Health Team, 2006; Street et al., 2007). Children and young people also want more information about what they could expect from CAMHS (Baruch & James, 2003; Swales, 2005; Day et al., 2006; Transitional Years Mental Health Team, 2006; Teggert & Linden, 2006; Street et al., 2007).
- There is no consensus in studies of children, young people and parents/carers' views on whether they prefer school-based or community-based services. Concern that confidentiality is not fully respected by teachers is noted by a number of children and young people (Roose & John, 2003).
- Children and parents/carers differ in their experiences and views of CAMHS (Baruch & James, 2003; Dogra, 2005).
- Services should consider the specific concerns of boys and young men in accessing support services (Childline, 2003; Goldthorpe & Webber, 2006; Williams & Pow, 2007).

Children and young people identified their peers as a key source of support and advice (Meltzer et al., 2000; Armstrong et al., 2000; Sellen, 2002; Baruch & James, 2003; Swales, 2005 - particularly those of secondary school age), as well as family members (Meltzer et al., 2000; Armstrong et al., 2000; Roose & John, 2003, Swales, 2005). Young people in Roose & John's (2003) study suggested peers and family could be useful in supporting them with 'everyday problems such as school issues and bullying' (p. 547), but that difficulties within the family might require more specialist support. Such a distinction between the support family and peers could offer and where emotional support needs required children and young people to 'talk to people you don't know' (Swales, 2005: 26) was also made by some of those young people who took part in the Leeds CAMHS participation exercise.

Staff who maintained confidentiality, were trustworthy and non-judgemental, listened and demonstrated kindness or warmth was seen as a significant determinant for improving accessibility of a service according to children and young people (Armstrong et al., 2000; Smith & Leon, 2001; Buston, 2002; Baruch & James, 2003; Roose & John, 2003; Curtis et al., 2004; Dogra, 2005; Swales, 2005; Day et al., 2006; Teggert & Linden, 2006; Transitional Years Mental Health Team, 2006) as well as their parents (Attride-Stirling et al., 2001). Concerns in relation to confidentiality meant that some young people suggested teachers (and school counsellors - Swales, 2005) were not always perceived as 'safe' to talk to (Roose & John, 2003; Swales, 2005 - although primary school pupils in Leeds felt more confident about approaching teachers for support than their secondary school peers). GPs were recognised as a source of information about possible support services, but young people responded variably to the suggestion that GPs might offer such emotional support themselves (Roose & John, 2003; Swales, 2005).

In a number of studies, children and young people explained they required information about what services were available and that it was also important for them to know what you could expect from such provision (such as the questions they would be asked, who would be there and how the services maintained confidentiality) (Baruch & James, 2003; Swales, 2005; Transitional Years Mental Health Team, 2006; Teggert & Linden, 2006).

There seemed to be no consensus in the studies reviewed as to whether services should be schools-based or in other settings in the community. Roose & John (2003) found that young people preferred an out-of-school setting as they believed it offered an increased likelihood of confidentiality (also found by Swales, 2005) and that such services would offer support for a range of problems, not just difficulties being experienced at school. However, two other studies of children, young people and parents who had used

CAMHS felt schools were a good venue for services; further suggesting that provision should be offered on the school site as well as in people's own homes (Baruch & James, 2003; Transitional Years Mental Health Team, 2006). Key for children and young people in Leeds was that CAMHS should drop the use of the term 'mental health' in labelling their services and replace it with 'emotional health' or 'emotional well-being' (Swales, 2005). Children and young people consulted by Swales (2005) and the Transitional Years Mental Health Team (2006) also commented that CAMHS should offer a 'homely' environment (Transitional Years Mental Health Team, 2006: 6).

Children, young people and parents with experience of CAMHS argued that services should not make people wait more than four weeks or so for an emergency appointment (Baruch & James, 2003). Parents consulted in Baruch & James (2003) wanted services which were as holistic as possible; which offered advice, not just assessment and diagnosis; and which supported both them and their children.

Baruch & James (2003) reported that consultation with both parents and children who had used CAMHS showed that their expectations and views of such services differed, particularly with regard to gender (a finding echoed in Dogra's literature review on what children and parents want from mental health services, 2005). Williams & Pow (2007) have called for gender specific educational programmes in relation to emotional well-being and mental health. Goldthorpe & Webber (2006) and Childline (2003) have published reports focusing specifically on boys' and young men's views on the support they needed. Boys and young men in East Leeds explained that services should combine the offer of emotional support with a range of sports and social activities (Goldthorpe & Webber, 2006). ChildLine (2003) found that boys and young men often felt unable to talk to another person about their worries and so delayed accessing a service. To promote access to services among boys and young men, providers should seek to respond to the specific concerns identified in this report, such as their worries about not being 'masculine' enough.

Finally, for children and young people who had used CAMHS services, three key issues are of relevance to improving service accessibility. Smith & Leon (2001) found that few of the young people who had experienced a 'mental health crisis' and initially gone to their GPs for support had found this experience helpful. Day et al. (2006) and Street et al. (2007) found that few of the CAMHS users they consulted felt they had received enough information about what to expect prior to attending (a key determinant for accessibility identified by studies discussed above), which Ross & Egan (2004) found led to high levels of anxiety among children and young people while waiting for their first appointment. A linked issue was that few children and young people had felt sufficiently involved in their treatment, care and discharge plans (Hepper et al., 2005; Transitional Years Mental Health Team, 2006; Street et al., 2007).

5 Approaches to promoting the emotional well-being and mental health of children and young people



In this section we report on successful and less successful approaches to promoting the emotional well-being and mental health of children and young people.

The literature search identified a number of reviews bringing together what is known about effective interventions for specific diagnosed mental disorders (Davis et al., 2000a; Fonagy et al., 2002; Wolpert et al., 2006). However, these have not been included in the analysis for this review as the focus here is on the broader emotional well-being and mental health problems experienced by children and young people.

All the studies identified during this review which reported on evaluations of programmes aimed at promoting the emotional well-being and mental health of children and young people, or those children and young people with emotional well-being and mental health problems, were analysed and categorised into four groups:

- Demonstrably effective approaches;
- Promising approaching;
- Approaches for which there was some evidence of success; and
- Approaches which offered variable or no evidence of success in leading to improved outcomes for children, young people and/or their families.

Although the previous sections of this review have prioritised UK-based studies, given the relative dearth of programme evaluation studies identified, studies undertaken in other English-speaking countries, chiefly in the USA and Australia, have been included.

'Demonstrably effective approaches' were identified from the findings of systematic reviews. The research team examined the systematic review authors' own conclusions about the degree of confidence with which they were able to make recommendations about effective approaches to inform our decision about which category of evidence the systematic review study should be accorded.

Programmes categorised as 'promising approaches' were drawn both from systematic review studies and from some individual evaluation studies. If systematic reviews concluded that while the evaluated programmes they assessed could lead to positive outcomes, but that conclusions to date could only be tentative (usually because only a relatively small number of studies had been included in the review or the outcomes were not as significant as those determined to be 'demonstrably effective'), these programmes were categorised as 'promising approaches'. Authors of these systematic reviews usually called for the need for further research and stronger evaluation designs.

Individual evaluation studies were included in this category of evidence if more than one study of the same or a similar programme had been undertaken and found a positive impact on emotional well-being and mental health (which had been sustained over time), and the evaluation research design was methodologically rigorous (for instance, a comparison/control/waiting list group was used, children and young people were followed over a period of time after completion of the programmes, and recognised measures of emotional well-being and mental health were used).

Some evaluation studies of programmes implemented in school settings were methodologically sound and suggested positive outcomes for children and young people's emotional well-being and mental health, yet only one study of such a programme was identified during the literature search. These studies were therefore said to offer 'some evidence' for a successful approach.

Finally, those studies evaluating programmes aimed at meeting the emotional well-being and mental health problems of children and young people which were methodologically weak, showed different or mixed outcomes between studies, and/or negative outcomes were categorised as studies with 'variable or no evidence' of success.

5.1. School-based approaches

5.1.1. Demonstrably effective school-based approaches to promoting the emotional well-being and mental health of children and young people

Summary:

- Universal school-based programmes aimed at promoting emotional well-being and mental health, sustained over a period of over one year, through the modification of the school environment as well as the development of adaptive cognitive and behaviour strategies among children and young people, offer evidence of an approach that is demonstrably effective (Durlak & Wells, 1997; Wells et al. 2003; Green et al., 2005b).
- There is also strong evidence to suggest the value of universal approaches to promoting emotional well-being and mental health, combined with more targeted behavioural and cognitive-behavioural therapy work with those children and young people with identified emotional well-being and mental health needs (Durlak & Wells, 1998; Green et al., 2005b).

Four systematic reviews in the area of emotional well-being and mental health promotion for children and young people in school settings (with one review specifically focused on primary school settings - Green et al., 2005b) were identified in the literature search and offered evidence of demonstrably effective approaches (Durlak & Wells, 1997; Durlak & Wells, 1998; Wells et al., 2003; Green et al., 2005b).

Durlak & Wells (1997) reviewed 177 programmes designed to prevent behavioural and social problems in children and young people living in the USA. The majority of studies ($N=129$) were conducted in schools and targeted the general population of pupils, as well as high-risk groups defined in the study to include children whose parents had divorced among others. Three types of prevention programmes produced significantly high effects: those that modified the school environment, those that focused specifically on meeting the needs of individual children and young people (especially those using behavioural and cognitive behavioural strategies), and those that attempted to help children and young people negotiate stressful transitions.

A year later the same authors published a systematic review of 130 programmes aimed at early identification of children and young people with emotional well-being and mental health problems. Results showed that programmes based on behavioural and cognitive-behavioural therapy (CBT) for children with emotional well-being and mental health problems appeared as effective as psychotherapy for children with diagnosed mental disorders. Children and young people participating in behavioural or CBT programmes recorded better outcomes than their peers in the control group by approximately 70 per cent. Moreover, behavioural and CBT programmes for dealing with emotional well-being and mental health problems appeared to be more effective than previously evaluated CBT programmes to prevent smoking, alcohol use, and offending in young people.

In 2003, Wells and colleagues reviewed studies which evaluated a universal approach to promoting emotional well-being and mental health, and compared these with programmes that took more of a 'problem prevention' focus in schools (primary and secondary schools). All except two of the reviewed studies had been conducted in the USA. Using a relatively strict set of inclusion criteria, only 17 studies (evaluating 16 programmes) were included in the review. Positive evidence of effectiveness was obtained for programmes that adopted a whole-school approach, were implemented continuously for more than a year, and were aimed at the promotion of emotional well-being and mental health and focused on changing the school environment. Little evidence was found to support brief classroom-based programmes aimed at preventing 'mental illness' (Wells et al., 2003: 197).

The study by Green and colleagues (2005b) was a review of systematic reviews specifically focused on the effectiveness of school-based interventions in promoting the social and emotional health and well-being of primary school-aged children. Eight systematic reviews met the inclusion criteria for Green et al.'s (2005b) review and included two reviews described previously (Durlak & Wells, 1997; Wells et al., 2003). The authors reported on a total of 322 individual evaluation studies, most of which evaluated classroom curricula. The curricula included a range of cognitive, affective, behavioural and skill-training approaches - problem-solving skills, the promotion of self-esteem, reducing aggressive behaviour, tackling bullying and violence, strategies for coping with stress. Given the considerable overlap between the studies reviewed by Wells et al. (2003)

and Green et al. (2005b), it is perhaps not surprising that these latter authors also concluded that a promotional rather than prevention approach was more effective, as were initiatives aimed at changing the school environment rather than brief classroom-based, individually focused programmes.

The strict inclusion criteria applied by the reported systematic reviews mean that while conclusions can be drawn with confidence, the reviews only considered a limited variety of programmes. Durlak & Wells (1997 and 1998), who applied slightly less strict inclusion criteria when selecting studies to be reviewed called for future research to improve the quality of evaluation designs used, offer clearer specification of the goals and ways in which the evaluated programmes were implemented, explore the outcomes of such programmes over a longer period of time, and finally examine how the various characteristics of a programme might have influenced the outcomes noted.

5.1.2. Promising school-based approaches to promoting the emotional well-being and mental health of children and young people

Summary:

- The health promoting school may have a positive impact on children and young people, especially when there is an active focus on promoting emotional well-being and mental health (Lister-Sharp et al., 1999).
- Factors associated with promising approaches to promoting the emotional well-being and mental health needs of children and young people in schools include: a whole-school/universal approach, sustained implementation, involvement of all members of the school community, and a variety of programmes focusing on the school environment, behaviour and cognitive processes (Rones & Hoagwood, 2000; Green et al., 2005b).
- Promising approaches for children and young people with emotional and behavioural difficulties (EBD) include: cognitive behavioural therapy, the provision of rewards, supporting children to monitor their behaviour, reduce aggressive behaviours and improve their social skills, as well as changing the seating arrangements in the classroom. Evidence supporting the use of 'circle time' as an intervention strategy is inconclusive (Evans et al., 2003).
- The FRIENDS programme (a CBT programme for children and young people with anxiety difficulties) appears to be a promising approach (Barrett et al., 2006; Stallard et al., 2007).
- The Triple P – Positive Parenting Programme which offers a tiered approach to supporting parents and carers has found evidence for the reduction in conduct problems (McTaggart & Sanders, 2003).

A number of promising approaches to promoting emotional well-being and mental health among children and young people in school settings have been identified. The importance of a whole-school approach was earlier highlighted (Lister-Sharp et al., 1999; Rones & Hoagward, 2000; Mukoma & Flisher, 2004). Programmes for pupils with 'emotional and behavioural difficulties' (EBD) in primary schools (Evans et al., 2003) also showed encouraging results.

Rones & Hoagward (2000) evaluated 47 school-based interventions specifically designed to influence students' emotional, behavioural, and/or social functioning. Most of the studies reported on work in the USA. The authors concluded that there were no particular right or wrong activities that made up successful school-based interventions, but that a number of common factors should inform the development of programmes: consistent programme implementation; the inclusion of parents, teachers or peers; the use of different types of programmes (such as those focused on behaviour, emotions and cognitive process, and the environment); the integration of programme content into general classroom curricula; and the adoption of age- and developmentally-appropriate programme components.

Lister-Sharp and colleagues (1999) evaluated the effectiveness of health promoting schools. They concluded that this approach offered promising evidence of effectiveness. The authors suggested that the development of programmes aimed at promoting emotional well-being and mental health would most likely improve the overall effectiveness of health promoting schools. Furthermore, they recommended the development of clear-cut measures of young people's emotional well-being and mental health for use in future evaluations.

Lister-Sharp et al. (1999) also noted that existing programmes focussed too little on the health and well-being of school staff. The review concluded by arguing that continued investment and ongoing evaluation were necessary in order to be able to provide demonstrably effective evidence for this approach.

The review conducted by Evans et al. (2003) grew out of a series of workshops and seminars held by the National Foundation for Education Research (NFER) in England in 1999. The authors reviewed 28 outcome evaluation studies described in 27 articles, four of which had been conducted in the UK. Several of the programmes developed for pupils with EBD had positive outcomes from at least one reliable individual evaluation study. The majority ($N=25$) of outcome evaluations identified applied behavioural or cognitive behavioural strategies rather than trying to modify the school context. None of the studies evaluated psychotherapeutic strategies. Effective strategies based on programmes focused on behavioural modification strategies involved the whole classroom. Common to all programmes was the provision of rewards such as minutes of free-time for play, listening to music for on-task and non-disruptive behaviour, and loss of rewards for off-task and disruptive behaviour. The effective cognitive-behavioural strategies identified included: teaching children aged 7 to 9 years old to monitor their own behaviour; strategies to reduce aggressive behaviour or improve social skills. One methodologically rigorous evaluation from the UK found that changing classroom seating arrangements from tables grouped together, to a row-formation had a positive effect. Evans et al. (2003) noted that more rigorous evaluations of the use of circle time were needed.

Drawing on findings from individual evaluation studies, two programmes appear to be worth further consideration: the FRIENDS Programmes and Triple P - Positive Parenting Programme.

The FRIENDS programme is a ten-session cognitive-behaviour therapy (CBT) programme for children and young people with anxiety delivered in schools either by teachers or psychologists. Stallard et al. (2007) have also described the FRIENDS programme as 'a universal preventative emotional health programme' (p. 33). Barrett et al. (2006) (following on from previous studies that demonstrated the positive impact of FRIENDS on children aged 10 to 13 years old over a 12-month period) used a control-group design and a three year post-programme follow-up of 692 children and young people. The main findings from this Australian study was that participation in the FRIENDS programme significantly reduced anxiety and depression symptoms, particularly among the younger age group (those aged 9 to 10 years old with more modest impacts registered by young people aged 14-16 years old). Even three years following the ten-week programme, participants were judged to be at lower risk of an emotional disorder than those in the control group.

Stallard and colleagues (2007) have recently reported the preliminary findings of their attempt to examine the effectiveness of delivering the FRIENDS programme in a UK-school-setting. Using a previously-developed workbook, FRIENDS employs groupwork, quizzes, role plays and other games to help children identify anxious feelings and thoughts, and ways in which they might deal with these. The programme was delivered to a whole class of Year 5s in one City of Bath school and two more rural schools in North East Somerset by two trained school nurses, who were supported by the class teacher and any classroom assistants.

In all, 106 children aged 9 to 10 years old took part in FRIENDS. Children's self-esteem and anxiety levels were measured at three points in time - six months prior to the commencement of the programme, at the beginning of the FRIENDS programme and again three months after completion. Significant improvements in anxiety and self-esteem were noted at three months after completing the programmes, whereas anxiety and self-esteem levels had remained stable in the six months prior to taking part in FRIENDS. These significant improvements were also noted for those children for whom anxiety and self-esteem levels pre-FRIENDS were of concern. Stallard et al. (2007) concluded that 'further studies with larger cohorts using diagnostic interviews are required to substantiate these findings' (p. 36), but the strong evidence from Australia combined with this UK-based small-scale, single cohort, limited follow-up post-programme study does suggest the FRIENDS programme may be a promising universal approach to supporting children's emotional well-being and mental health, specifically in relation to anxiety, depression and self-esteem.

Barrett et al. (2003) evaluated FRIENDS when delivered in urban Australian schools with large populations of refugee and immigrant children and young people from non-English speaking backgrounds. Findings suggest that the programme was effective in increasing self-esteem and reducing anxiety and depression both immediately after, and six months on, when compared to a waiting-list control group.

The Triple P: Positive Parenting Programme was conducted in Australian school settings and focused on parents. This programme usually offers five levels of activities from a universal media and information

campaign, to brief consultation sessions, to more intensive individual and group parent training or family-based interventions, dependent on level of need. In McTaggart & Sanders' (2003) study of this programme, parents of children in the first year across 25 primary schools in Melbourne were offered two sets of activities - a media and information campaign, and group parent training. Of the three Triple P programme evaluations identified for this review, McTaggart & Sanders (2003) offered the strongest research design - data gathered from a little under 500 children whose parents participated in the programme (only a fifth of parents opted to take part in both elements, including the nine-hour group training), with a similarly sized waiting list group. Based on teacher reports of children's classroom behaviour (using the Sutter-Eyberg Student Behaviour Inventory) pre-, immediately post- and six-months after the intervention, the authors concluded that the programme was able to prevent the development of 'conduct problems' (McTaggart & Sanders, 2003: 8) in children.

Ralph & Sanders (2003) undertook a smaller programme for parents of 12 to 13 year olds in a less urbanised area of Australia. Twenty-seven parents attended all eight group sessions run in the school library. Despite encouraging results in relation to a reduction in parent-reported parent-teenager conflict, decreased scores on laxness and overly-reactive parenting styles, and improvements in parental self-efficacy, self-sufficiency, self-management, levels of depression, anxiety and stress, the authors noted that encouraging parental participation and sustaining their involvement over the whole course was a challenge.

Cann et al. (2003) reported on pre- and post- Triple-P programme data collected from 598 mothers of children aged less than one and up to fifteen years old who either participated in the group parenting element of the programme, intensive individual support or the enhanced family-based intervention. Nearly half of the participating parents' children were assessed to have behavioural problems in the clinical range according to the Eyberg Child Behavior Inventory. Post-intervention, improvements were noted in the disruptive behaviour of children, parental confidence, self-efficacy, stress, anxiety and depression levels, and reductions in 'dysfunctional parenting practices' (p. 7). Although the latter two studies are weaker methodologically, the accumulation of evidence suggests that the Triple P programme may well be a promising school-based approach to improving child and parent emotional well-being and mental health.

5.1.3. Other school-based approaches to promoting the emotional well-being and mental health of children and young people with some evidence

Summary:

- The provision of independent counselling services in schools can be effective in supporting children with emotional well-being and mental health problems (Adamson et al., 2006).
- Targeted programmes for children and young people with depression can have positive outcomes, but there is no evidence to support the provision of universal programmes to reduce the risk of children and young people developing depression (Merry et al., 2007).
- Direct behavioural work with young children (aged 3-7 years old) with emotional well-being and mental health problems, alongside support to parents (the 'Scallywags Scheme') offers emerging promising evidence (Lovering et al., 2006).

The provision of counselling services in schools is increasing (Baginsky, 2004), and despite a dearth of evaluation of such provision, a longitudinal study using a control group design by Adamson et al. (2006) in Northern Ireland offers some evidence of positive impact. Children and young people in the control group ($N=110$) completed the Strengths and Difficulties Questionnaire on a weekly basis over four weeks (not as long a period as those children receiving counselling), their intervention counterparts ($N=202$) completed the same questionnaire at every counselling session as did the counsellor, while parents and teachers completed the informant version of the questionnaire every other week. A reduction in the Strengths and Difficulties Questionnaire scores reported by those receiving counselling was noted week-on-week throughout the intervention, and substantiated by the counsellors, teachers and parents, when compared to those children and young people in the control group (whose scores on the questionnaire actually increased slightly over the four-week period over which they were followed). Counselling provision appeared to be particularly effective for those who identified bullying or family separation as their main reason for accessing the service. Despite such promising evidence, without any further studies identified as part of this time-limited review for such services, it is not possible to state that this is a demonstrably successful or necessarily promising approach.

Merry et al. (2007) evaluated the effectiveness of universal and targeted interventions to reduce the risk of undiagnosed depressive disorder in children and young people. Only two controlled trials met the inclusion criteria and neither showed any effect. Targeted psychological interventions (usually based on CBT strategies) were shown to be effective when impact was measured immediately after the programmes had been completed. Despite small effect sizes, significant reductions in depressive episodes were found. Universal educational interventions were concluded to have no effect. Despite some positive results, the small number of included studies means that it is not possible to state that this is a demonstrably successful or necessarily promising approach.

Lovering et al. (2006) described an evaluation of the 'Scallywags Scheme' delivered in Cornwall, targeting the most deprived areas of the county. Although the study is relatively weak methodologically, it is mentioned here since the programme integrates direct behavioural work with young children (aged 3 to 7 years old) with emotional well-being and mental health problems (found to be effective by Durlak & Wells, 1998 and Evans et al., 2003), and their parents in both the school and home over a six month period (working with parents also appears to have a strong enough evidence base to suggest it is a promising approach, detailed further below - Attride-Stirling et al., 2004; Jarvis et al., 2004; Vostanis et al., 2006b). Lovering et al. (2006) used three measures before, during and after completion of the programme - Eyberg Child Behavior Inventory, Boxhall Profile and Parenting Stress Index - Short Form, Third Edition. Three hundred and sixteen children completed the programme and follow-up data was collected. Significant reductions in clinically significant levels of 'problem behaviours' (Lovering et al., 2006: 96) by at least 50 per cent of participating children were reported by parents, which were maintained over six months by the sub-sample of 160 children longitudinally followed. Levels of parental stress were found to have decreased from 74 per cent pre-intervention and 44 per cent post-intervention. While 50 per cent of the parents attended less than half of the parent group sessions, low levels of attendance was not associated with poor outcomes.

5.1.4. School-based approaches to promoting the emotional well-being and mental health of children and young people with variable or no evidence of success

Summary:

- The evaluation of the 25 Primary Behaviour and Attendance Strategy Local Authority pilots (funded by the DfES), which include the Social and Emotional Aspects of Learning (SEAL) programme, offers some positive results but the study by Hallam et al. (2006) does not offer a clear enough analysis of which of the numerous aspects of the initiative worked (a situation which is further complicated by the variable implementation of the Strategy across local authorities).
- Not enough studies were identified to offer clear recommendations on ways to increase the early identification of children and young people with emotional well-being and mental health problems (such as the use of screening tools, the Australian RAMP model or training for teachers – Levitt et al., 2007; Shortt et al., 2006; Cowling et al., 2005 respectively).
- Two very small studies of CBT work with children and young people with anger management difficulties or asylum seekers/refugees in schools were found to have an initial positive impact on emotional well-being and mental health, but this was not maintained over time (Humphrey & Brook, 2006 and Ehnholt et al., 2005 respectively).
- Variable and limited evidence supporting the provision of universal suicide prevention programmes was found (Ploeg et al. 1996; 1999, Guo & Harstall, 2002). In some cases, suicide prevention programmes have been found to be harmful to young men.

The systematic reviews examined here which focused on UK studies have provided insufficient evidence to make recommendations on possible programmes to support children and young people with emotional well-being and mental health problems in schools (Fletcher-Campbell, 2001; Harden et al., 2003). The results from these two reviews were inconclusive due to the limited number of studies which could be included. The 2003 review by Harden and colleagues specifically focused on strategies to support pupils with EBD needs in mainstream schools, while Fletcher-Campbell's (2001) review focused on three studies undertaken by the National Foundation for Educational Research (NFER) on children and young people with special educational needs, those in public care, and those more generally 'disaffected' (p. 69) from schools (included children and young people with disruptive behaviour, who were truanting, had a poor attendance record or were excluded).

Due to the prioritisation within current policy of improving attendance and implementing the Social and Emotional Aspects of Learning (SEAL) programme (HM Treasury & Department for Education and Skills, 2007), Hallam et al.'s (2006) study which evaluated the 25 Primary Behaviour and Attendance Strategy pilots funded by the Department for Education and Skills between 2003 and 2005, is described here. The pilots included a range of components such as professional development opportunities, SEAL curriculum materials (aimed to improve social, emotional and behaviour skills), small group work programmes with children requiring additional support. Using a mixed-method approach, Hallam et al. (2006) reported that teachers felt more knowledgeable and had more confidence to tackle behavioural problems, and school professionals also noted an improvement in children's behaviour and 'well-being' (p. 6). Exploring the impact of the programme on school pupils the research found changes in social skills and relationships and increased awareness of emotion in others, with younger children and girls benefiting most. Some evidence for a decrease in authorised absences and increase in attainment at Key Stage 2 was also found. Hallam et al. (2006) noted that parents should be more actively involved in the programme activities. As these pilots were variously implemented across local authorities, it is impossible to say how effective such a multi-pronged programme within schools might be.

The review also identified a few articles and reports which discussed ways to improve early identification of children and young people with emotional well-being and mental health problems. Unfortunately, none of the papers described strong evaluation methodologies, but given this is likely to be an area of some interest to schools and others, a short description of the studies found follows. Levitt et al. (2007) reviewed the evidence for different instruments which help to identify 'mental health' problems early on. Based on US studies, the authors distinguished between instruments that could be used as part of a universal screening programme (suggesting the use of the Systematic Screening for Behavioral Disorders tool) and a perhaps more feasible and sustainable approach which draws on professionals' current capacity to assess which children and young people might be 'at risk' (Levitt et al., 2007: 182), while using a more targeted screening tool (such as the Voice Diagnostic Interview Schedule for Children).

Two articles from Australia discuss the Risk Assessment and Management Process (RAMP) which offers schools a framework by which to identify and support children and young people with emotional well-being and mental health problems. Key components of this model include: reduce known risk factors, enhance protective factors, a team-based approach to support within the school and between the school and external agencies through the use of clear protocols. Fealy & Story (2006) described the model, while Shortt et al. (2006) reported on a process evaluation of RAMP in six primary and three secondary schools in Melbourne. Shortt et al. (2006) found that using this model children and young people not previously recognised to be at risk or receiving support were identified and that the professionals involved expressed satisfaction with the way RAMP had both increased their capacity and skills, as well as the support package offered to those students with problems. The implementation of RAMP in these schools had also led to a decrease in referrals made by primary schools especially to CAMHS and increased the knowledge of school staff of appropriate referral pathways.

Cowling et al. (2005) offered teachers a seminar on identifying and managing 'disruptive behaviour' (p. 4), facilitated an exchange between different schools about the approaches they used, and produced a resource book for teachers. At the same time, information about possible strategies for managing behaviour and where to seek further support was written up into short articles published in the school newsletters which were sent out to families. Using pre- and post-seminar questionnaires, Cowling et al. (2005) reported an increase in knowledge and understanding of 'disruptive behaviours' among teachers and other school staff, which were said to have been sustained one year on when some of the participants were interviewed again. Because the article reporting on the evaluation of this initiative does not provide details of how many participants actually completed the pre- and post-seminar questionnaires, and it appears that only five participating schools were re-interviewed one year later, it is hard to conclude with much confidence that such a programme could be effective. However, given the likely interest in such school-focused, capacity-development initiatives it was felt to be useful to share a range of programmes identified during the literature review on ways in which professionals' knowledge and capacity to identify and support child emotional well-being and mental health problems might be increased.

Three systematic reviews have evaluated school-based suicide prevention studies (Ploeg et al. 1996; 1999, Guo & Harstall, 2002). The authors reported some positive effects on reductions in suicide attempts,

depression, stress and anger levels, but, overall, the effects on increased knowledge and changed attitudes towards suicide were limited. More concerning, harmful effects were found for young men. Harden et al. (2001) concluded that current evidence did not support universal school-based suicide prevention programmes, with the possible exception of high risk groups when health professionals were involved.

In the next sub-section, two systematic reviews will be reported on which found some support for the use of cognitive behavioural therapy with children. It is therefore worth mentioning two very small but methodologically weak studies (because such small numbers were involved in these evaluated initiatives - less than 25 children and young people), as they reported on group cognitive behaviour therapy for children with anger management difficulties (Humphrey & Brook, 2006) and young asylum seekers/refugees (Ehntholt et al., 2005) delivered in schools.

Fifteen London-based 11-15 year old refugees and asylum seekers participated in a six-week programme, while a control group of eleven was placed on the waiting list. Clinically significant yet moderate improvements in post-traumatic stress symptoms, depression and anxiety levels were noted post-intervention but these were not found to have been maintained two months afterwards (Ehntholt et al., 2005). Lack of maintenance of the initial improvements in behaviour noted by Humphrey & Brook (2006), using the Revised Rutter Teacher Scale for School Age Children, among the twelve young people receiving cognitive behavioural therapy to manage their anger in an inner-city school in the north-west of England, suggests that such programmes may not be very effective.

5.2. Successful approaches in community and other settings

5.2.1. Demonstrably effective approaches to promoting the emotional well-being and mental health of children and young people in other settings

Summary:

- Behavioural and cognitive-behavioural therapy for children and young people with emotional well-being and mental health problems (Durlak & Wells, 1998; Evans et al., 2003) and children with mild to moderate anxiety (James et al., 2005; Barrett et al., 2006) are demonstrably effective approaches.

Two systematic reviews provided strong evidence for the use of behavioural and cognitive-behavioural therapy (CBT) for children and young people with undiagnosed disorders (Durlak & Wells, 1998) or children aged six years old and over with mild to moderate anxiety (James et al., 2005). The study by James et al. (2005) included 13 studies of children and young people visiting community-based or outpatient services. All types of CBT - individual, group or parental/family - demonstrated the same effectiveness.

5.2.2. Promising approaches to promoting the emotional well-being and mental health of children and young people in other settings

Summary:

- Work with parents and carers offers relatively strong evidence, especially using CBT for parents/carers with children with conduct disorders (Farmer et al., 2002; Dretzke et al., 2005). Five individual evaluation studies also suggest that supporting parents (in two studies using Brief Solution Focused Therapy) can have a positive impact on children as well as parents/carers (Heywood et al., 2003; Attridge-Stirling et al., 2004; Jarvis et al., 2004; Jackson, 2006; Vostanis et al., 2006b).
- Promising programmes for supporting young people with emotional disorders include social skills training and involving all members of the family using multi-systemic therapy (Topping & Flynn, 2007).
- Early and brief intervention programmes delivered through CAMHS have been found to reduce waiting times for children and their families (Heywood et al., 2003; York et al., 2004; Clemente et al., 2006; Jackson, 2006; Woodhouse, 2006), reduce numbers who do not attend their initial appointment (Jackson, 2006; especially if parents/carers were asked to confirm they would attend before being placed on the waiting list - Heywood et al., 2003 and Woodhouse, 2006), and increase the efficacy of CAMHS by reducing number of sessions a family required (York et al., 2004; Jackson, 2006) or ensuring referrals for more specialist support were more appropriate (Heywood et al., 2003; Whitworth & Ball, 2004; Clemente et al., 2006).

Four systematic reviews provided some encouraging results for the use of CBT with parents and carers (Woolfenden et al., 2001; Farmer et al., 2002; Dretzke et al., 2005; Topping & Flynn, 2007). Dretzke et al. (2005) looked at a number of studies to evaluate the effectiveness and cost-effectiveness of CBT for parents of children with conduct disorders. Overall, the results appeared to suggest that CBT could be an effective and potentially cost-effective therapy for parents and children. However, the relative effectiveness of different models of CBT (such as intensity, and setting) requires further investigation.

Farmer et al. (2002) evaluated 21 controlled trials of non-residential treatments for children with disruptive behavioural disorders or conduct disorders. The authors limited their search to interventions which included children aged 6 to 12 years old. Interventions could include children and young people, parent(s)/carer(s) or both. Results indicated that parent training and community-based interventions may be effective for children with conduct disorders.

However, Woolfenden and colleagues (2001) found less promising evidence when evaluating the effectiveness of family and parenting interventions aimed at tackling children and young people's behaviour, parenting approaches, parental emotional well-being and mental health, family functioning and relations. Eight randomised controlled trials were identified, all of which had been conducted in the USA. Results showed that family and parenting interventions significantly reduced the time spent by children in young offending institutions following completion of the programme. Measures used to support this claim were the reduced risk of being arrested and a decline in incidence of subsequent arrest at one to three years after programme completion. However, the various studies showed substantial heterogeneity in results, which suggested that there was insufficient evidence to link family and parenting interventions to a reduced risk of being incarcerated. The study found no effects on psycho-social outcomes such as children/young person's behaviour, family functioning, parenting approaches and parental mental health.

Harrington et al. (2000) at the University of Manchester conducted a controlled trial to compare the effectiveness and cost-effectiveness of parenting education for parents of children with behavioural disorders in community-based versus hospital-based services. Results indicated that there was no significant difference in the effectiveness and cost-effectiveness of parenting education by location. The authors concluded that location of CAMHS services may be less important than the range of services that were offered.

Overall, all authors conclude that further research is required to determine the effectiveness of parent training and education programmes, with a focus on evaluating short-term and long-term outcomes for children, young people, parent(s)/carer(s).

A number of individual evaluation studies of initiatives aimed at parent(s)/carer(s) were also identified through the literature search. These are described below, as they link to initiatives which aim to increase the responsive of services to possible emotional well-being and mental health problems and improving the effectiveness of CAMHS.

Topping & Flynn (2007) systematically reviewed 202 studies on the effectiveness of various 'psycho-educational' interventions for young people aged 11 to 18 years old diagnosed with serious emotional disorders. Results indicated that, in limited resource settings, programme planners should prioritise interventions focused on 'self-management training' (individual, family, group counselling, psychotherapies, CBT, behaviour modification, self-monitoring and self-management) and peer mediation of behaviour, as these appeared to be highly effective but with the caveat that they would have a smaller impact. In high resource settings, meanwhile, programme planners are encouraged to opt for 'social skills training' (i.e. life skills training), wraparound planning (a needs-driven, family-centred approach using a multi-member team of professionals, family members, and the child), and multi-systemic therapy (an intensive, home-based intervention for families) which, while being less cost-effective, had a larger impact.

Among the individual evaluation studies identified in this review, services or programmes reported on fell into three different categories: early and brief intervention services to reduce waiting times for assessment and referrals to specialist CAMHS (usually Tier 3); programmes targeting parents; and outreach or community-based CAMHS services (the latter are reviewed in section 5.2.3. of this report as fewer studies were found). The methodological rigour of the identified studies is highly variable, however, as is the number of articles found which have evaluated the various types of programmes. Emerging evidence for work with parents, and for early and brief intervention programmes suggests these may be 'promising approaches'.

5.2.2.1. Promising approaches to reducing waiting times for assessment and improving the appropriateness of referrals to specialist CAMHS

Clemente et al. (2006) evaluated an initiative developed within a current CAMHS service run by a range of mental health professionals in inner London. The Initial Assessment initiative worked as a form of triage, where two days a month were reserved to see newly referred families (a maximum of twelve families a month). Before being passed on to the clinical team, families were required to assure the service they would do their best to attend their appointment; and once families had been seen for the first time, a multi-disciplinary team meeting would discuss each case together to decide who the most appropriate clinician would be to take on the work. Length of time families had to wait between referral and first appointment, and rates of non-attendance at first sessions for this initiative were compared to data from a similar service in the same area of London which continued to operate a similar appointments system.

Over a six month period, 197 families were seen using the Initial Assessment model. Compared to the control service where average waiting time between referral and first appointment was twenty weeks, the service implementing the new initiative only had an average waiting time of nine weeks. Non-attendance at first appointment was also significantly lower when using the new triage system - ten per cent, compared to twenty-six per cent at the comparison centre. The authors noted that there was no difference in levels of eventual engagement between families accessing both services, but that the Initial Assessment service offered a more efficient service by helping to identify early on which families needed to be seen by the clinical team, and which did not.

York et al. (2004) evaluated the STARTER (See To Assess, Review, Treat, Evaluate, Review) clinics run in London from 2001 (after having been piloted for three months in 2000). Each clinic offered up to five appointments for new referrals a week, with a further two urgent slots a month. All new referrals were offered a maximum of three sessions. Over six months, 103 children and young people were seen by the STARTER clinics. Waiting times for a first appointment were reduced by three-quarters from eight months to eight weeks. One third of children and young people required three or fewer sessions.

Heywood et al. (2003) evaluated a consultation and advisory service established within a CAMHS team in a hospital in Stockport. The service saw only non 'complex and chronic' (p. 506) cases, and families were offered one to three sessions within four weeks of being referred. The evaluation found that waiting times and non-attendance were reduced, only 24 per cent of families were actually referred on to CAMHS and parental scores of the Strengths and Difficulties Questionnaire improved by 72 per cent following contact with the service. Six months on, these positive changes had been maintained and the research found that parental perceptions of their children's problems had changed - which was seen to be key in sustaining the change for families.

Four further studies of various initiatives aimed at reducing waiting time and developing processes for ensuring appropriate referrals to CAMHS were identified for the review. However, the evaluation methodologies used were far less rigorous than the three studies reported above (either because they did not use a comparison service/control group, or did not measure changes in the children's and families' emotional well-being and mental health). Woodhouse (2006) discussed a clinical psychology services in the Highlands of Scotland which developed an opt-in appointments system (where families confirm they would try and attend their appointment at the point of referral to be put on the service's waiting list - as in Clemente et al.'s study, 2006) and prioritising those cases in which it was assessed a psychological intervention would be able to benefit the child and their family. Waiting times were found to be reduced using this system from 58 weeks (average waiting time in the year prior to the implementation of the initiative) to 45 weeks after one year, then with the introduction of the prioritisation of cases in the second year, waiting times were further reduced to 19 weeks and seemed to be stabilizing at 13 weeks three years on. Non-attendance at the first appointment was also reduced from 39 per cent prior to the initiative, to 13 per cent.

Jackson (2006) described an initiative developed by the Norfolk Family Support Team where referred children and families were seen initially by two Primary Mental Health Workers in their home, where one professional assessed the child or young person, and the second professional met with the parents/carers. Using Brief Solutions Focused techniques, the evaluation of this initiative found that waiting times for a first appointment was reduced by eight weeks within five months and that the average number of sessions needed by a family was reduced from seven to one or two. Similarly, Whitworth & Ball (2004) evaluated an initiative in Wales using Primary Mental Health Workers, whereby these professionals worked with other services offering training, advice, consultation. One hundred referrals received by CAMHS prior to the setting up of the Primary Mental Health Worker team were compared to the last 100 referrals received by CAMHS before the date the analysis for the article was conducted. The authors concluded that Primary Mental Health Workers led to a more efficient CAMHS, by reducing the number of inappropriate referrals made by other agencies to CAMHS from 38 per cent to just one per cent. These positive outcomes are confirmed by another small study by Worrall-Davies et al. (2005) examining the impact of primary mental health workers in one part of Bradford. Trained health visitors and school health nurses examined each referral, either offering support over the telephone to the families, undertaking a few sessions with the family, or discussing the case with a group of professionals. Referrals from primary care to CAMHS were found to have reduced from 157 during the previous year to just six the next.

5.2.2.2. Promising approaches targeting and involving parents and carers

Involving parents in work to tackle the emotional well-being and mental health problems of their children formed a central component of several of the advisory and brief intervention initiatives discussed above (see for instance Heywood et al., 2003 and Jackson, 2006). The number of individual evaluation studies identified for this review (not including those considered by the systematic reviews discussed above) on specific parenting interventions was small, evaluated quite different types of work with parents, and they used relatively weak research designs. However, based on the evidence offered by systematic reviews on this issue together with the three studies detailed below, it could be strongly argued that programmes targeting parents should form an essential component to any strategy which aims to improve children and young people's emotional well-being and mental health. In support of the importance of parental perceptions and involvement in effective support for children and young people with emotional well-being and mental health problems, Attride-Stirling et al. (2004) found that parents whose children completed their programme of treatment within CAMHS, when compared to parents whose children had prematurely terminated their involvement, tended to be more focused on their child's difficulties, then broader family problems. Furthermore, those parents whose children had not completed their treatment were more likely to identify the various barriers they had experienced in engaging with CAMHS, rather than the factors they had found facilitative.

Jarvis et al. (2004) evaluated the Parent Consultation Service at Open Door in Haringey, London set up for parents whose children had failed or refused to engage in the psychotherapy service. Twenty-six parents received support from this initiative in the time period studied and completed Problem Perception and the Stress Index for Parents of Adolescent measure before and after the intervention. Parents were offered between four and thirty-nine appointments and scores on both measures were found to have been reduced significantly. As Heywood et al. (2003) concluded, despite a child or young person not engaging in a support service, if parental perceptions of the issue and their interactions with their children could be changed, the difficulties initially presented with can be reduced. No follow-up data were reported in this study.

Vostanis et al. (2006b) reported on a relatively similar programme as evaluated by Jackson (2006) where referrals to CAMHS in one area of children under 12 years of age were initially dealt with by a team of family support workers who aimed to work directly with parents in their homes, using Brief Solution Focused Therapy, offering up to eight sessions of support. Using a CAMHS service in another locality with such an initiative as a comparison group, the researchers found that parents were seen earlier and improvements were noted in child emotional well-being and mental health (using parent-completed Strengths and Difficulties Questionnaires and the Health of the Nation Outcome Scales).

Finally, although Kazdin & Whitley (2003) report on findings from a US study, their results supports the suggestion that very little extra work with parents is needed to have an impact. One hundred and twenty-seven families with children displaying aggressive behaviour were offered a programme - where children received 20 to 25 cognitive behavioural therapy sessions and parents attended up to 16 parent training session. One group of parents received an extra intervention - five sessions on problem solving skills, and it was those families who took part in this extra training who demonstrated the greatest improvement.

5.2.3. Approaches in community and other settings to promoting the emotional well-being and mental health of children and young people with variable or no evidence of success

Summary:

- No positive outcomes were noted among studies evaluating CBT work with foster carer families (Turner et al., 2007).
- Littell et al. (2005) concluded it is too early to suggest multi-systemic therapy may be effective for families with children with emotional well-being and mental health problems.
- Few methodologically rigorous evaluation studies were identified during the literature review which reported on community-based programmes and services aimed at promoting emotional well-being (with the exception of studies which reviewed early and brief interventions with children and their families, and programmes targeting parents).

Turner et al. (2007) sought to assess the effectiveness of cognitive-behavioural training in improving looked after children's relationship problems, foster carers' emotional well-being and mental health, foster carers' overall family functioning, and outcomes of foster care placements. The review evaluated data from six trials. The authors found that evaluated interventions had very little effect on outcomes in looked after children and their foster carers, while the interventions had no effect on foster care placement outcomes.

Littell et al. (2005) reviewed the effectiveness of Multi-Systemic Therapy (MST), which is an intensive, home-based intervention for families of young people with social, emotional, and behavioural problems. The intervention is applied by highly trained therapists who try to influence individual, family, and environmental factors thought to be contributing to the children and young people's emotional well-being and mental health problems. A total of eight randomised-controlled trials of MST were identified. The studies had mainly been conducted in the USA, but also in Canada and Norway. The authors concluded that it was too early to judge the effectiveness of MST when compared to other therapeutic models.

Three individual evaluation studies of community-based services in London were identified during the literature search. All three services are quite different as were the evaluation methods used, so no firm conclusions can be drawn from this work. However, given the focus of the review is on research of relevance to young Londoners, all three studies will be very briefly described. Day & Davis (2006) evaluated outreach clinics run by CAMHS professionals (clinical psychologists and a child and family therapist) in a primary care

or other community setting. Eighty-eight children were seen in the outreach clinics and the outcomes of this intervention compared to a waiting list group of ninety-nine other children/young people. The Child Behaviour Checklist, Parenting Stress Index - short form, Child and Family Impact measures were completed at the point of referral, four months and again at twelve months post-intervention. Compared to the waiting list group, reductions in 'problem severity, distress and impairment' (Day & Davis, 2006: 448) among the children and young people was noted, and were found to be maintained one year on. Despite high levels of parental satisfaction with the service, levels of parental stress showed no change, which led the authors to conclude that 'interventions may need to be specifically aimed at improving parental well-being rather than simply relying upon changes in children's problems' (Day & Davis, 2006: 449).

The ARTService in Brockley, south London aimed to work with young people who were hard to engage in other local services, such as young offenders. Ninety-seven young people were referred to the service during 2000/2001, and one in ten received a 'psychiatric diagnosis' (Hagell & Brazier, 2002: 6). A range of support was offered and the degree of engagement was variable; on average young people attended six sessions. Hagell & Brazier (2002) interviewed the clinicians, who reported that a minority of young people had benefited from the intervention, yet overall the young people assessed the service positively. Programmes by Kids Company, such as the Arches II Drop-In Centre or their work with schools, have been evaluated as taking a child-centred, holistic approach, with high rates of self-referral. However, the evaluations have used mainly interviews and questionnaires, which while reporting high levels of satisfaction from school staff, Kids Company workers and increased 'happiness' and 'confidence' by children and young people, make it hard to set these findings in context with the other studies reported on in this review (Gaskell, 2006; Armitage & Gaskell, 2006 respectively).

5.3. Gaps in what we know about successful approaches

Harden et al. (2001) concluded that there exists a gap in programmes identified as effective in their literature review which actually address those issues identified by young people as being key concerns for them. A similar conclusion could be drawn from the findings of this review - where few or no studies evaluating initiatives aimed at supporting children and young people to deal with family and peer relationships problems, bullying, stress about school among other concerns (identified in section 3.1.2).

A further issue is that only a small number of methodologically strong evaluation studies from the UK can be identified (c.f. Edwards, 2003). Most studies evaluating programmes aimed at promoting childhood emotional well-being and mental health or at targeting those with emotional well-being and mental health problems tend to have been conducted in the USA.

While a reasonably large number of studies were identified which evaluated school-based programmes, those studies which focused on community-based initiatives tended to be concerned with evaluating the effectiveness of cognitive-behaviour therapeutic approaches, early and brief CAMHS intervention initiatives, or approaches to working with parents. Few studies were found which evaluated other types of community-based programmes in tackling the emotional well-being and mental health problems experienced by children and young people.

5.4. Key principles underpinning successful approaches to promoting emotional well-being and mental health

Based on this analysis of relatively successful approaches aimed at promoting the emotional well-being and mental health of children and young people, or supporting those with emotional well-being and mental health problems, four key principles to inform the development of future programmes can be highlighted:

- 1 In schools - whole-school or universal programmes should be complemented by targeted support for those with emotional well-being and mental health problems (Durlak & Wells, 1998). Furthermore, programmes required sustained investment, should be integrated into the curriculum and involve the whole school-community (Durlak & Wells, 1997; Rones & Hoagwood, 2000).
- 2 The involvement of parents and carers is central to effectively meeting the emotional well-being and mental health problems of children and young people: firstly because parents/carers are strongly associated with children and young people's emotional well-being and mental health (Meltzer et al., 2000; Green et al., 2005a); secondly, parents/carers may play a role in facilitating access to support services (Sayal, 2006), and thirdly, because programmes supporting parents alongside initiatives aimed at children

and young people (or even programmes aimed at parents before children and young people are offered support) have been shown to have a positive impact emotional well-being and mental health (Heywood et al., 2003; McTaggart & Sanders, 2003; Dretzke et al., 2005; Harrington et al., 2005; Lovering et al., 2006; Vostanis et al., 2006b).

- 3 Programmes should aim to identify children, young people and families requiring support as early as possible and reducing the waiting time between identification of a problem and first appointment as this not only meets with high levels of parental satisfaction but also with more efficient CAMHS services (Heywood et al., 2003; Clemente et al., 2006).
- 4 A number of service and staff characteristics were identified by children, young people and their parents/carers as facilitating access to mental health support services: confidentiality, trustworthiness, being non-judgemental, listening, kindness, and being given clear information about what to expect (Armstrong et al., 2000; Attridge-Stirling et al., 2001; Smith & Leon, 2001; Buxton, 2002; Baruch & James, 2003; Roose & John, 2003; Curtis et al., 2004; Dogra, 2005; Swales, 2005; Day et al., 2006; Teggert & Linden, 2006; Transitional Years Mental Health Team, 2006; Street et al., 2007).

6 Evaluating programmes to promote the emotional well-being and mental health of children and young people



In the penultimate section of the report we draw on the evaluation studies described in previous section to identify research designs and methods that could prove useful in the evaluation of pilot programmes to promote the emotional well-being and mental health of children and young people in London.

Summary:

- Five key principles are suggested which together should form the basis of any evaluation framework adopted by Strand Group-funded programmes:
 - Using a standardised tool for measuring emotional well-being and mental health;
 - Using qualitative approaches to elicit the views of stakeholders in order to explore how and why changes may have occurred as a result of programme implementation and involvement;
 - Collecting data from a number of different stakeholders;
 - Collecting data at a minimum of two points in time; and
 - Using a comparison, control or waiting list group-design.
- Additionally, funded programmes should evaluate how they make a wider contribution to the services and support structures that are already in place in a locality – examining for instance:
 - Whether clear referral protocols and pathways have been established between the funded initiative and other programmes or services;
 - The length of time children, young people and/or their parent(s)/carer(s) have to wait for an appointment with the funded programme from the point of self-referral or referral from another service;
 - Whether the programmes offer consultation and training to other local professionals.
- Finally, a third tier of data collection should be undertaken to explore how funded initiatives contribute to the attainment of local authority-level indicators and targets. This could include examining how programmes have helped to increase access to emotional well-being and mental health support for children, young people and their parent(s)/carer(s) locally; where they fit within a wider system of local support structures; and whether they have increased accessibility of services to those groups considered to have the greatest need.

6.1 Key principles for evaluating programmes to promote the emotional well-being and mental health of children and young people

Below, we outline the five key principles that can be used to guide pilot programmes.

6.1.1. Using a standardised tool to measure emotional well-being and mental health needs

A number of instruments or screening tools exist which attempt to provide a measure of the emotional well-being and mental health needs or problems of an individual. Such standardised tools allow for comparison between the beneficiaries of a programme, but also between studies of similar types of initiatives. A range of standardised tools have been used in studies. Several criteria could inform which instrument might best be used for pilot programmes. These include: evidence of reliability when compared to other measures; frequency with which it is used by other studies; and, ease of administration and scoring.

One such screening tool is the Strengths and Difficulties Questionnaire developed by Robert Goodman. A brief behavioural screening questionnaire about 3 to 16 year olds, the Strengths and Difficulties Questionnaire examines both positive and negative experiences in the following five domains - emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviours. As an approach, therefore, the Strengths and Difficulties Questionnaire is modelled on a framework of risk and protective factors similar to that which appears to underpin the current government agenda for children and young people.

Age-appropriate versions of the questionnaire have been developed for three to four year-olds, four to sixteen year-olds (these are both 'informant-rated' versions, which means that parents, teachers or other professionals complete the 25-item questionnaire from their observations of the child/young person), and finally a self-completion questionnaire for young people aged 11 to 16 years old. Each of these age-appropriate versions is comprised of three components: the actual 25-item Strengths and Difficulties questionnaire; questions to help determine 'caseness' (for further details see below); and questions examining whether and how the emotional well-being and mental health of a child or young person may have changed as a result of a programme.

The original 25-item questionnaire can now be supplemented by a set of questions which assess an informant's view on the chronicity, distress, social impairment, and burden to others of the child or young person's emotional well-being and mental health problems. Goodman (1999) argued that such information could be very beneficial to CAMHS professionals and researchers when examining 'psychiatric caseness' (p. 791) and type of service which would be most accessible. The third component has been designed for use after a child or young person has completed a programme, and focuses on exploring whether the initiative helped to reduce the difficulties previously experienced and how the programme may have helped in other ways as well, asking informants and young people to make their assessment based on the past month. Further details of the questionnaire, downloadable versions, and the scoring system are available at: <http://www.sdqinfo.com/>

A number of studies have examined how the Strengths and Difficulties Questionnaire compares to other measures of emotional well-being and mental health. From the literature identified for this review, the Strengths and Difficulties Questionnaire compares favourably to other standardised screening tools such as Rutter questionnaires to parents and teachers (Goodman, 1997), Child Behavior Checklist (Goodman & Scott, 1999) and the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (Mathai et al., 2002). At a minimum, therefore, programmes which aim to promote the emotional well-being and mental health of children and young people, or support those children and young people with emotional well-being and mental health problems, might usefully use the Strengths and Difficulties Questionnaire when evaluating their provision.

The CAMHS Outcome Research Consortium (CORC) have recommended that two further measures should be completed wherever feasible: the Child Global Assessment Scale (which is completed by professionals) and the Experience of Service Questionnaire (which can be given to children aged over 9 years-old and their parents). These measures can be downloaded from <http://www.corc.uk.net/index.php?contentkey=32>

Further to CORC's recommendations, and given the importance attributed to supporting parents and involving them to improve the impact of any programme, measures that look specifically at parents' experiences and needs may be appropriate. The Problem Perception Questionnaire and/or the Parenting Stress Index are two instruments used with parents. As neither of these tools is available free to download, the cost implications for purchasing these additional measures will need to be included in the funding given to a pilot programme.

6.1.2. Complementing standardised tools with the views of children, young people, parents/carers and professionals

A second principle for a relatively robust evaluation framework is work to elicit the views of a range of stakeholders (third principle) on how the initiative may have contributed to observed changes. Among key stakeholders in this respect are children/young people themselves, their parents/carers, and the professionals involved in the programme (or in the child's life). Interviews and focus groups offer an appropriate method of data collection in most cases.

The use of such methodologies will also allow for unexpected outcomes to be recorded and examined in more detail and to capture the language that programme beneficiaries feel most comfortable with - which can in itself help to develop a more accessible service.

6.1.3. Collecting information at various points in time and using a comparison/control/waiting list group

In order to make judgements about the sustainability of impact, data from a standardised measure (and ideally from the qualitative element of the evaluation) should, at a minimum, be collected before and after completion of the programme, but preferably for a third (and fourth time) at three, six or twelve months after

a child's participation in a programme (the fourth principle of a relatively robust evaluation framework). While a qualitative assessment of stakeholder perspectives would also ideally be carried out at three or four points in time, if time and resources do not permit this, this should as a minimum occur either immediately after the completion of the programme, and at three or six or twelve months thereafter. While collecting data at various points in time will allow those involved in the programme to assess change over time for an individual or a family, in order to assess the extent to which this change can be attributed to the programme, a similarly sized comparison, control or waiting list group of children, young people and/or families should be involved in the evaluation (the fifth principle of a relatively robust evaluation framework).

6.2. Placing programme evaluation in a wider context

Individual intervention programmes do not operate in isolation, and the approach of the current government agenda for children and young people is that tiers of services and support structures should exist to variously engage and support children and young people. Such a combination of service provision will help to ensure the five outcomes set out in Every Child Matters are achieved.

With this agenda in mind, Strand Group members may wish to evaluate how a funded programme contributes to firstly, the network of services and support structures already in place in a specific geographical locality and secondly, to the attainment of local authority level targets and indicators.

6.2.1. How does the programme contribute to the network of support services available locally?

In order to examine the programme's contribution to support services locally, possible measures might focus on whether clear referral protocols and pathways have been established between the funded initiative and other programmes and/or existing services. These could be measured by:

- Administering a short questionnaire or checklist to professionals working in other services or to parents locally to check their knowledge and perceptions of the new initiative, or convening a series of focus groups with professionals and with parents to elicit this information;
- Requesting evidence of formal referral arrangements; and,
- The length of time children, young people and/or their parent(s)/carer(s) have to wait for an appointment with the funded programme from the point of referral from another service.

Contributing to the development of networks of professionals with increased expertise to meet the needs of children, young people and their families is also an important role a funded initiative could play. Measures of this might include:

- How often the funded initiative advises professionals from other services on the appropriateness of making a referral to the funded programme of a particular child, young person or family of concern;
- Keeping a record of the number of training sessions run by the funded programme for professionals from other services on any specific approaches or skills the funded initiative might have an expertise in.

6.2.2. How does the work of the programme contribute to the attainment of local authority indicators and targets?

Developed with the following two government documents in mind (Department for Education and Skills, 2004¹; Office for Standards in Education, 2005), funded initiatives could be asked to report on some of the following indicators in order to support local authorities in the Joint Area Review process.

One key measure might be to evaluate how the programme has helped to increase access to emotional well-being and mental health support for children, young people and their parent(s)/carer(s) locally. This could be done by:

- Recording the number of people who participate in the funded programme over a specified period of time, perhaps distinguished by length and intensity of involvement (for example, number of hours involved in a programme); and,
- Identifying awareness of the service's existence among other professionals, children, young people and their parent(s)/carer(s), and of how to access support from it (already recommended above).

¹ ECM Outcomes Framework, enclosure E4 – accessible version of this table available to download at:
http://www.everychildmatters.gov.uk/_files/F25F66D29D852A2D443C22771084BDE4.pdf

A further area for investigation could be how and where the funded programme fits into the wider system of support structures and services developed within a locality to meet community needs - to demonstrate how it makes a unique but important additional contribution to current service arrangements. This could be measured, for instance, by:

- Providing evidence that information about the programme has been integrated into any information leaflets or flow-charts for children, young people, their parent(s)/carer(s) and professionals on the range of support services developed within the local authority;
- Recording how often professionals working in the newly funded programme are involved in Child Protection Conferences or other locally established systems for identifying children, young people and families 'at risk' or requiring additional support; and,
- Documenting the number of times the new programme or initiative is mentioned as one of the agencies consulted, currently involved with, or part of the future action plan for a child, young person or family in Common Assessment Frameworks completed by the local authority in a specified time period (perhaps in comparison to other services or initiatives of a similar size level of resource).

Finally, as the *Every Child Matters* framework identifies certain groups of children and young people as requiring prioritised and targeted support, the funded initiative may also want to explore recording and categorising the children and young people they work with into these various groups - such as those in public care, those with learning difficulties, young offenders, those on the Child Protection Register and so forth. In this way, the Local Authority can demonstrate how specific services are targeting or demonstrating accessibility to these children and young people considered to have the greatest needs. Data on numbers of children, young people and families who belong to these identified groups who are referred to, and take-up the provision offered by the newly funded initiative could be compared with similar data from other services or expressed as a proportion of the total population of that group within the local authority.

7 Recommendations to the Strand Group



Summary:

- Three further principles to inform the work of the Strand Group are proposed, which should sit alongside the four principles underpinning successful approaches to promoting emotional well-being and mental health detailed in section 5.4.:
 - The need for a common language and shared conceptual framework to be developed among professionals working in different sectors, and between children, young people, parents/carers and professionals;
 - The value of involving potential and actual programme beneficiaries in the development, review and evaluation of any new initiative; and,
 - The importance of developing programmes that take into consideration gender, ethnicity and special needs differences in the emotional well-being and mental health of children and young people.
- Initiatives should aim to meet the immediate needs of children and young people with diagnosable and diagnosed mental disorders, but also broader emotional well-being and mental health needs such as family and peer relationship difficulties, bullying, and stress due to academic pressures.
- Children and young people with learning difficulties, those living in public care, young offenders, those with long-term physical health problems, and those living in households with parent(s) with mental health problems, headed by a single parent; parental unemployment, or reconstituted families should be targeted for specialist support.
- Two main types of programmes could be funded/supported:
 - Universal emotional well-being and mental health promotion work in school settings, alongside targeted programmes for those children, young people and their parents/carers identified as, or likely to be, experiencing emotional well-being and mental health problems.
 - Programmes which aim to improve the early identification of children, young people and families likely to experience emotional well-being and mental health problems and facilitate rapid and effective access to initial support.
- The future evaluation of newly funded initiatives should begin at the same time as work is commissioned.
- Four key areas requiring further research are identified:
 - London borough-based research which identifies levels and types of problems among different groups of children and young people;
 - In-depth qualitative research to examine children, young people's and parents/carers' understandings of emotional well-being and mental health; differences in perceptions of emotional well-being and mental health and service accessibility by gender and ethnicity; views on school-based as compared with community-based services;
 - Research to examine how the skills and capacities of families and friends could be further developed to play a support role; and,
 - How to develop professionals' capacity to identify emotional well-being and mental health problems early and to make appropriate referrals.

The final section of this report offers some suggestions to the Strand Group on the types of initiatives or 'demonstration programmes' they might wish to consider funding, emphasize the importance of evaluating these programmes from the outset, and indicate where further research might help to inform the future direction of work aimed at promoting the emotional well-being and mental health of young Londoners, or supporting those children and young people with emotional well-being and mental health problems.

While the initiatives which will be recommended below will be informed by the four key principles for successful approaches developed at the end of Section 5 of this report, three further key principles are added here to help inform the overall development of accessible and appropriate approaches to promoting the emotional well-being and mental health of children, young people and their parents/carers in London, or supporting those young Londoners with emotional well-being and mental health problems.

A key issue highlighted throughout this report concerns variability and tensions in the language and conceptual frameworks used in the field of emotional well-being and mental health. Common, or at the very least 'shared', definitions are important so as to enable professionals to work effectively across a range of services. Additionally, due to the stigma associated with 'mental health' issues and lack of common understanding between professionals and children, young people and their families in this area, commissioners and service providers need to work with their local communities to identify language which is seen as 'acceptable' and to develop ways of re-framing provision so as to increase accessibility.

A linked recommendation is the benefit of involving potential and actual programme users in developing, reviewing and evaluating any funded initiatives. This will support the development of a service which is more likely to meet the needs and concerns that children, young people and their families have. Involving service users will also support the development of a 'shared' language between the programme providers and beneficiaries. Consulting programme participants in periodic reviews of the programme will help to ensure that other possible problems in relation to referral pathways, staff attitudes or other implementation issues are identified as early on as possible, while at the same time identifying potential solutions.

Thirdly, boys, girls, young men and women appear to experience slightly different emotional well-being and mental health concerns and problems, often at different points in time (boys are more likely to experience difficulties earlier than their female peers). As a result, future initiatives should examine closely how to develop gender-appropriate and accessible programmes (to be informed by the research evidence, but also by consulting those in their locality). Similarly, as recommended by other researchers, developing programmes which take into consideration ethnic, cultural and special needs differences between potential beneficiaries will help to improve an initiative's accessibility and effectiveness.

7.1. Key issues and groups to focus on in London

While a significant minority of children and young people in London experience clinically diagnosable mental health difficulties, a larger proportion of young Londoners have broader emotional well-being and mental health problems, which include family and peer relationship difficulties, bullying or being bullied, and feeling stressed due to academic pressures. Any work plan developed by the Strand Group should aim to address specific mental health problems, as well as broader concerns relevant to emotional well-being.

Certain groups of children and young people are more likely to experience emotional well-being and mental health problems. As a result, the Strand Group should aim to achieve balance between a targeted and more universal approach to meeting young Londoners problems. This can be achieved by focusing targeted initiatives at groups of children and young people who are known to have higher rates of emotional well-being and mental health problems than the general population. These groups include: those with learning difficulties, those in the public care of the local authority, those involved in offending. Additionally, children with long-term physical ill-health should be prioritised for support, as well as children and young people living in households with one or more of the following characteristics: parent(s) with mental health problems, headed by a single parent; parental unemployment, reconstituted families.

Some of these 'priority' groups are much larger than others. Moreover, children and young people with learning difficulties and those living in reconstituted families and single-parent households are less easy to identify than others, who for instance may already be in contact with other services (children and young people in public care, young offenders, children with long-term physical ill-health problems). As will be recommended below, initiatives that improve early identification of, and offer support to, those with emotional well-being and mental health problems, could use these 'priority' groups listed above to partly inform who they target their provision at, and through which routes they encourage referrals to the new service.

7.2. Successful approaches to promoting children's and young people's emotional well-being and mental health

Two main recommendations are made here on potential areas of work which the Strand Group may wish to consider funding or facilitating. These recommendations have been developed in line with the evidence presented in section 5 on the main approaches found to be effective in promoting the emotional well-being and mental health of children and young people, and informed by the four key principles underpinning successful approaches detailed in section 5.4. Recommendations for programmes which could be developed include:

- Universal emotional well-being and mental health promotion work in school settings, alongside targeted programmes for those children, young people and their parents/carers identified as, or likely to be, experiencing emotional well-being and mental health problems.
- Programmes which aim to improve the early identification of children, young people and families likely to experience emotional well-being and mental health problems and facilitate rapid and effective access to initial support.

Well designed, whole school approaches, seeking to modify the school environment and promote pupils' capacity to manage emotions and behaviour and negotiate stress, with the aim of promoting emotional well-being and mental health, have been shown to be demonstrably effective. A 'healthy school' programme may offer a useful vehicle for developing such a programme of work. Targeted work with children, young people and their families may be developed using behavioural and CBT strategies (such as the FRIENDS programme), and all members of the school community should be involved in the wider programme (both in developing it, but also as beneficiaries). School staff should be offered opportunities to develop their knowledge and skills to identify potential emotional well-being and mental health problems early on and there should be clear referral pathways to enable those children and their families to access support early and quickly (either on the school site itself, or in adjacent health and social services settings).

Alongside a focus on work in school settings, initiatives are required to support professionals working in other agencies to identify and appropriately refer children, young people and their families early and quickly. GPs, youth offending service workers and education, health or social care professionals working with children with learning difficulties should be the focus for such capacity development. GPs have been shown to often be the first point of contact for families experiencing difficulties, or may be supporting children and young people with long-term physical ill-health problems. There is strong evidence to suggest that children and young people with learning difficulties and young offenders are significantly more likely to experience mental health problems and difficulties and are also relatively unlikely to be accessing CAMHS. Despite the inconclusive evidence of whether certain minority ethnic groups are more likely to experience emotional well-being and mental health problems, as 'help-seeking' by parents/carers and referrals made by professionals is influenced by ethnicity, training and capacity development with non-CAMHS professionals should also introduce an element of cultural sensitivity and awareness.

Improving non-CAMHS professionals' capacity to identify emotional and well-being problems early on and to make appropriate referrals, should be complemented by CAMHS initiatives which aim to see referred children, young people and their parents/carers as quickly as possible and offer appropriate interventions to children as well as their parents/carers (which can be followed up with more in-depth support work if needed). Such approaches have been shown to reduce emotional well-being and mental health problems, while also increasing the efficiency of CAMHS.

7.3. Developing and evaluating a programme concurrently

Section 6 of the report outlines five principles which should inform the research design used to evaluate programmes or initiatives funded or supported by the Strand Group, as well as a number of other measures which will enable the service provider and Strand Group to assess the wider impact of the initiative within the local authority. In order to be able to implement these evaluation principles, such activities should be planned for and commence at the same time as the programme development and implementation.

7.4. Areas requiring further research

Four key areas requiring further research, relevant to the Strand Group's remit and the recommendations made above have been identified:

- 1 Emotional well-being and mental health needs assessments in London boroughs, so that levels of needs between local authorities can be compared.
- 2 In-depth qualitative research to examine children, young people, parents and carers' understandings of emotional well-being and mental health; differences in perceptions of emotional well-being and mental health and service accessibility by gender and ethnicity; views on school-based as compared with community-based services. Such locally-specifically research would facilitate the development of more appropriate and accessible initiatives.
- 3 Difficulties in family and peer relationships appear to be a central concern for children and young people. At the same time family and friends are seen as a key source of support. Further research to examine how family and friends' capacity and skills could be further developed to play such a support role would therefore help to develop appropriate initiatives. The majority of parenting programmes reviewed in this report were for parents/carers whose children were already experiencing emotional well-being and mental health problems and the only systematic review examining mentoring programmes identified for the report (Dubois et al, 2002) concluded that such programmes may be less effective in promoting emotional well-being and mental health than other types of initiatives.
- 4 Very few, methodologically rigorous evaluation studies were identified on how to develop professionals' capacity to identify emotional and well-being problems early and to make appropriate referrals. Further research is therefore also needed to examine how best to develop such initiatives (which form a core part of the recommendations being made to the Strand Group).

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Appendix One

Emotional well-being and mental health: time trends, persistence and outcomes

Although the 1999 ONS survey was repeated five years later and found no changes in prevalence of diagnosable mental disorders among children and young people, Collishaw and colleagues (2004) examined whether rates of conduct, hyperactive and emotional problems among 15 and 16 year-olds had increased between the 1974 sweep of the National Child Development Study and the 1999 ONS survey. Collishaw et al. concluded that 'conduct scores increased markedly for both genders, for all family types, and across all social class categories over this 25-year period. Overall, each successive cohort had increased odds of high conduct problems of around 1.5.' (2004: 1357). Non-aggressive conduct problems such as lying, stealing and disobedience seemed to have increased more than aggressive conduct problems (fighting for instance).

Emotional problems (such as anxiety and depression) appeared to have increased by 70 per cent for both young men and women, but only between 1986 and 1999. The authors speculate that changes in the nature of the family and socio-economic inequality may be able to help explain the increase in the emotional well-being and mental health problems experienced by young people in the twenty-first century. However, the researchers note that as increases in conduct problems were found across all family types, socio-economic groups, and in both young men and women, 'relatively broad societal changes (e.g., in the media, youth culture or social cohesion) [must also be]... affecting adolescent mental health' (Collishaw et al., 2004: 1360), or that there might be a generational effect.

West & Sweeting (2003) examined data from two cohorts of 15 year-olds in the West of Scotland, surveyed in 1987 and again in 1999, and found that emotional well-being and mental health problems (measured using the General Health Questionnaire, which screens for diagnosable mental disorders such as anxiety and depression) increased significantly for young women (from 19 per cent to 33 per cent), particularly those from non-manual and skilled manual backgrounds (so called 'middle-class'), but not for young men. Worries about educational attainment was marked for young women. It may be that changes in young men's emotional well-being and mental health were not found to be significant in West & Sweeting's (2003) study as the screening tool used did not measure conduct problems or disorders, which have been found to be more common among boys and young men (Meltzer et al., 2000; Green et al., 2005a).

A number of other studies have investigated the continuities between experiencing a diagnosed mental disorder in childhood and adulthood. Maughan and Kim-Cohen (2005), in their overview of the evidence discussed the varied ways in which a diagnosed mental disorder experienced in childhood may impact on adult psychosocial functioning. The authors found evidence that being diagnosed with a mental disorder in childhood increased the risk of having a similar or different diagnosed mental disorder in adulthood, having an antisocial personality disorder, misusing substances, experiencing disrupted interpersonal relationships and so forth. A longitudinal British study of 225 twins by Simonoff et al. (2004) found that childhood hyperactivity and conduct disorder showed equally strong prediction of anti-social personality disorder and criminality in early and mid-adult life (an association between conduct problems at age 15/16 years-old and offending behaviour at age 30 was also reported by Collishaw et al., 2004). Finally, work by Healey et al. (2003), which drew on a prospective longitudinal, locally representative study of 411 boys from a working class area of south London, found that conduct problems or diagnosed disorders between the ages of 10 and 16 years increased the risk of long spells of unemployment, employment in low skilled work (at ages 18 and 32 years) and significantly lower incomes from employment when compared to peers at age 32.

Studies from other countries support these findings, suggesting a persistence of diagnosed mental disorders between child- and adulthood, and an association between childhood conduct problems and impaired psychosocial functioning. Visser et al. (2000) in a study of children and young adults seen by a hospital psychiatric department in Rotterdam, the Netherlands, found that persistence over time was higher for externalising than for internalising behaviours. Fergusson et al. (2005), in a 25-year longitudinal birth cohort study from New Zealand, found that conduct problems identified at 7 to 9 years of age were significantly associated with criminal activity, substance dependence (cigarettes and illicit drugs), mental health problems (depression and anxiety disorders, antisocial personality disorder and suicide attempt(s)), sexual or partner relationship outcomes (such as teenage pregnancy and parenthood, or involvement in domestic violence) in young adults (aged 21-25 years old). Of particular note in the Fergusson et al. (2005) study was that after controlling for confounding factors no statistically significant associations between early conduct problems and poor levels of educational attainment or periods of unemployment was found.

Research into the long-term costs to 'society' of childhood conduct disorders makes a strong case for investing funding into early identification and intervention. Knapp et al. (1999) in a pilot study of ten families with children aged 4 to 10 years old who had been referred to CAMHS with conduct disorder, found the average annual cost per child with a conduct disorder was £15,382 (ranging from £5,411 to £40,896), with the largest burden of cost falling on the families themselves (31 per cent) and the education authority (31 per cent). Scott et al. (2001) built on the findings from the above study using data from the inner London longitudinal study which followed children who were 10 years-old in 1970 until age 28 years-old. Compared to children with no emotional or conduct problems or disorders, those with conduct problems (but not a diagnosable conduct disorder) had cost public services 3.5 times more (mean individual total cost £24,324), while those with diagnosed conduct disorders had cost ten times more (mean individual total cost £70,019) than their peers without such problems (mean individual total cost £7,423). The largest proportion of costs fell on the criminal justice system, followed by the education sector and then social care services. Costs to the health sector were comparatively low, but the authors suggest this is because 'only a small proportion of the children reached the mental health services' (Scott et al., 2001: 4).

Appendix Two

Factors associated with emotional well-being and mental health problems

A number of studies have found evidence for the factors which may be associated with emotional well-being and mental health problems. Factors have only been included in the summary account below if the literature search identified at least two references of original research (published between 2000 and 2007) which supported an association between it and emotional well-being and mental health.

Gender:

- In the national ONS study, boys and young men were slightly more likely to have a mental disorder (among 5 to 10 year olds - ten per cent of boys and six per cent of girls; among 11 to 15 year olds - 13 per cent of boys and ten per cent of girls) (Meltzer et al., 2000; also found in smaller studies such as Davis et al., 2000b).
- O'Herlihy et al. (2004) found that young women represented the majority of mental health in-patients on a census day in 1999, especially in those aged over 13 years-old.
- Similarly, the Audit Commission (1999) found that young women were more likely to present to specialist CAMHS among older age groups (15 to 18 years old), while boys were more likely to present among the younger age groups.
- Young women have been found to be more likely to self-harm or contemplate suicide (Hawton et al., 2002; The Priory Group, 2005).
- West & Sweeting (2003) found that young women in the West of Scotland had experienced significant increases in anxiety and depression between 1987 and 1999 (as compared to young men).
- Boys/young men are more likely to experience a diagnosable conduct disorder than girls/young women (Meltzer et al., 2000; Green et al., 2005a).
- Young women aged 13-15 years old are slightly more likely than young men of that age to have a high General Health Questionnaire score (13 per cent compared to seven per cent respectively) while behavioural problems (as measured by the Strengths and Difficulties Questionnaire) are more prevalent among boys aged 4-15 years old (12 per cent) than girls (eight per cent) (Doyle, 2003).

Age:

- Diagnosable emotional disorders and conduct disorders were more likely among older age groups (11 to 16 years old) - Meltzer et al. (2000); Green et al. (2005a).
- O'Herlihy et al.'s (2004) in-patient census study found that among the younger age group (under age 13) there was a wide spread of diagnoses (conduct disorder - 16 per cent; eating disorders - 15 per cent; mood disorders - ten per cent; hyperkinetic disorder - ten per cent; anxiety disorders - eight per cent; encopresis/enuresis - five per cent) while among those aged 14 to 18 years old, three diagnosable mental disorders emerged as being most prevalent: eating disorders (23 per cent), schizophrenia, delusional or psychotic disorders (22 per cent), and mood disorders (20 per cent).
- Emotional well-being and mental health problems are more likely to present among boys and young men at a younger age, while young women tend to report (greater) difficulties a little later on (Audit Commission, 1999; Doyle, 2003; The Institute of Community Health Sciences, 2003; O'Herlihy et al., 2004).

Ethnicity:

- Based on the ONS studies, Meltzer et al. (2000) found that nationally ethnicity was not significantly statistically associated with an increased risk of diagnosable mental disorders among children and young people. However, in the second ONS survey by Green et al. (2005a), children of Black African, Indian or Pakistani ethnic origin were found to have markedly lower odds of having a diagnosable mental disorder than their white peers. Green et al. (2005a) emphasize, however, that the small number of minority ethnic children and young people participating in the surveys made a strong analysis of the association between ethnicity and mental health difficult.
- The Audit Commission (1999) study noted that 'overall, CAMHS is seeing at least a representative number of children from minority backgrounds' (p. 15). However, the research examined in-depth two local authorities (one in Manchester and one in London) where the proportion of non-white children in the

population was higher than the national average and found that non-white children were over-represented in the CAMHS caseloads by between 1.5 and 2.5 times more than the local average might have suggested. O'Herlihy et al. (2004) in their audit of children and young people receiving in-patient care found that those from minority ethnic communities were over-represented among this population (by 1.5 times when compared to the national average proportion of white children and young people and those from minority ethnic backgrounds).

- The Research with East London Adolescents: Community Health Survey (RELACHS) study collected data on mental health using a cross-sectional questionnaire (for further details see previous section). The Strengths and Difficulties Questionnaire was administered to young people. Stansfeld et al. (2004) found that rates of 'psychological distress' (p. 233) were similar to rates found in the ONS survey (Meltzer et al., 2000) but noted that Bangladeshi pupils, although more likely to be 'socially disadvantaged' (measured by indices such as parental unemployment, lack of car ownership and recent migration to the UK), were significantly less likely to be psychologically distressed. On the other hand, non-UK white young women (mainly those of Irish, Turkish or Greek origin) were found to have higher rates of depressive symptoms (further statistical analysis found this was only true for those young women who had recently migrated to this country). In a second paper from the RELACHS study, Fagg et al. (2006) presented data which suggested that 'South Asian' young people had relatively good psycho-social health, and that young white people scored highest on the Strengths and Difficulties Questionnaire than their minority ethnic peers.
- Goodman & Richards (1995) compared second-generation Afro-Caribbean children and young people attending an inner-London child psychiatric unit between 1979 and 1989 with a group of predominantly white co-attenders. The authors found consistent differences in 'psychiatric presentations' (Goodman & Richards, 1995: 362) over time. Psychotic and autistic disorders were disproportionately common among the Afro-Caribbean children and young people and the ratio between emotional and conduct disorders for this group was lower than among their predominantly white peers. Goodman & Richards (1995) argued that demographic differences between both samples could not easily explain these differences. However, Kramer et al. (2000) who examined all referrals to St. Mary's Department of Child and Adolescent Psychiatry in Paddington, London between 1991 and 1992 found no differences between actual compared to expected proportion of attenders by ethnicity. Kramer et al. (2000) also found no evidence for a trend of more conduct disorders amongst children from Afro-Caribbean backgrounds, the only difference noted between ethnicities was among Asian children and young people who were found to have more developmental disorders and fewer 'psychiatric diagnoses' (p. 169).
- In a more recent study of 'psychiatric in-patients' (Tolmac & Hodes, 2004: 428) aged 13 to 17 years old across London, young people from the black minority ethnic communities (Black African, Black Caribbean, Black British) were found to be overrepresented among those admitted with a diagnosis of a psychotic disorder when compared to their white peers (similar to O'Herlihy et al.'s findings in their national survey of in-patients, 2004).

Physical ill-health:

- Meltzer et al. (2000) found that having a physical health condition increased the odds of having a diagnosable mental disorder by 82 per cent.
- Physical illness, alongside age and experiencing a number of stressful events were independently associated with the onset of diagnosable emotional disorders (Meltzer et al., 2003a).
- Ten per cent of the children and young people in in-patient care on the 19th October 1999 were recorded as having a chronic physical illness (O'Herlihy et al., 2004).
- The RELACHS study also found an association between higher Strengths and Difficulties Questionnaire scores (indicating emotional well-being and mental health problems) and a young person having a long-term physical illness (Fagg et al., 2006).

Family and household factors:

- Parent(s) unemployed
 - Of the children presenting at specialist CAMHS, those for whom the 'main breadwinner' in their family was unemployed represented a group 34 per cent above the national average (Audit Commission, 1999: 20).

- Meltzer et al. (2000) found that 'a family with no-one working compared with all adults working nearly doubled the odds of the child having a (diagnosable) mental disorder' (p. 31).
- This association between long-term parental unemployment and the increased odds of a child/young person having a diagnosable mental disorder was further supported by logistic regression analysis of the 2004 ONS survey (Green et al., 2005a).
- Other children living in the family
 - Meltzer et al. (2000) estimated that when compared to a lone child household, the odds of having a diagnosable mental disorder increased by a third and by two-thirds in 4- and 5-children families respectively.
 - Based on the Health Survey for England, a nationally representative survey, living in a family with step-children was found to be independently associated with poorer child psychological health (as measured by the Strengths and Difficulties Questionnaire) in McMunn et al., (2001).
 - Green et al. (2005a) also found that living with a family with step children increased the odds of having a diagnosable mental disorder by 50 per cent (when compared to families with no step children).
- Living in a lone parent household
 - Audit Commission (1999) - 40 per cent of children presenting nationally at specialist CAMHS over four weeks in 1999, came from lone or reconstituted families, compared to 21 per cent of all families.
 - Meltzer et al. (2000) - children were twice as likely to have a diagnosable mental disorder if living with a lone parent than if they were living with married or cohabiting parents. Children were least likely to have a diagnosable mental disorder if living with married parents in a non-reconstituted family (also found by Fagg et al. (2006) in the RELACHS study).
 - Green et al. (2005a) - the odds of having a diagnosable mental disorder increased by 75 per cent if a child or young person was living in a lone parent family, where the parent had been previously married (when compared to living with married parents). However, the authors concluded after logistic regression analysis that 'variations between [types of family] groups were [likely] due to other factors rather than to marital status per se' (Green et al., 2005a: 32).
 - McMunn et al. (2001) using the Health Survey for England found that the association between child psychological health (as measured by the Strengths and Difficulties Questionnaire) and having a lone mother disappeared when socio-economic factors such as benefits receipt, housing tenure and maternal education were taken into account. The authors argued that poverty associated with lone parenthood rather than lone-parenthood alone is the risk factor affecting emotional well-being and mental health.
- Living in a low-income household - Meltzer et al. (2000) found an association between living in a low-income household and having a diagnosable mental disorder. This association was found to be significant by Green et al. (2005a) using logistic regression analysis.
- Children of lower socio-economic status
 - Meltzer et al. (2000) found that children from social class V were three times as likely to have a diagnosable mental disorder than those from social class I, and twice as likely than those from social class II.
 - Green et al. (2005a) found support for 'an overall negative association between the prevalence of mental disorder and socio-economic class' but suggested the gradient 'was not completely smooth' (p. 30).
- Parent(s) with no educational qualifications - in the second ONS survey on children and young people's emotional well-being and mental health, Green et al. (2005a) concluded that 'the odds of having a (diagnosable) mental disorder among children for whom the responding parent had no educational qualifications were one and a half times those of children whose parent had some qualifications' (p. 32).
- Family functioning and parental style - Meltzer et al. (2000) found statistically significant associations between frequent punishment of the child by the parent, 'unhealthy' family functioning as measured by the General Functioning Scale of the MacMaster Family Activity Device (FAD-GFS) (19 per cent of all families were found to be functioning unhealthily in the survey), the experience of a stressful life event¹², and the odds of having a diagnosable mental disorder.

Parental emotional well-being and mental health:

- Nineteen per cent of children presenting at specialist CAMHS had a parent with mental illness (Audit Commission, 1999) - the report estimated this was higher than the total proportion of children living in a family where a parent had a diagnosed mental illness. [Details on how parental mental health was measured were not included in this report].
- In the first ONS study of children and young people's emotional well-being and mental health, children with a diagnosable mental disorder were twice as likely to have a parent (usually the mother) who screened positive on the GHQ12 (General Health Questionnaire) as having a neurotic disorder (Meltzer et al., 2000).
- McMunn et al. (2001), in a national study, found an independent, significant association between child and parent psychological health (the former was measured using the Strengths and Difficulties Questionnaire, while the latter was measured using the GHQ12).
- Using data from the first ONS study on children and young people's emotional well-being and mental health, Meltzer et al. (2003a) found that mother's mental health (measured as having a score of 3 or above on the GHQ12) was the only factor found to be significantly, independently associated with the persistence of diagnosable emotional disorders among children; one of the three factors significantly associated with the persistence of conduct disorders, and one of the four factors significantly associated with the onset of a conduct disorder.
- Derisley et al. (2005) conducted a relatively small study in Norfolk comparing family functioning and parental mental health problems of parents with children who had (measured using the Brief Symptom Inventory) and parents whose children had no known mental health problems. The researchers found that parents with children who had obsessive-compulsive disorder or anxiety disorders had poorer mental health than parents of children with no known mental health problems.

Learning difficulties and other school-based factors:

- Special educational needs
 - The first ONS study on the emotional well-being and mental health of children and young people found that children with a diagnosable mental disorder were around five times more likely to have officially recognised special educational needs; this was higher for boys than girls (Meltzer et al., 2000). Fagg et al. (2006) in the RELACHS study also found evidence of a link between special educational needs and higher Strengths and Difficulties Questionnaire scores.
 - Having special educational needs increased the odds of experiencing a persistent diagnosable conduct disorder three years later, as measured in the follow-up survey conducted by the ONS (Meltzer et al., 2003a).
- Learning difficulties
 - Twenty-seven per cent of children presenting at CAMHS over a four-week audit period had some form of learning disability [not defined in this report] (Audit Commission, 1999).
 - The first ONS study on the emotional well-being and mental health of children and young people found that 22 per cent of children with a specific learning difficulty had a diagnosable mental disorder (Meltzer et al., 2000). Specific learning difficulties were identified through psychometric testing of general cognitive and reading abilities.
 - Analysis by the Foundation for People with Learning Disabilities (2002) of existing literature suggests that child and young people with severe learning difficulties have three to four times higher incidence of diagnosable mental disorders.
 - Based on the 1999 ONS survey, Emerson (2003) found statistically significant differences between children and young people with and without learning disabilities with regard to rates of conduct disorders, anxiety disorders, attention deficit and hyperactivity disorder/hyperkinesis and pervasive developmental disorders.
 - Twenty-three per cent of the children and young people in in-patient psychiatric care nationally on the 19th October 1999 had some form of learning disability [rated by clinicians using the Paddington Complexity Scale] (O'Herlihy et al., 2004).

[A more detailed review of what is known about the association between learning difficulties and emotional well-being and mental health can be found in the next appendix, Appendix Three.]

- Exclusion - onset and persistence of childhood diagnosable mental disorder (over a three year period) increased the odds of experiencing a school exclusion as measured by the first ONS study on the emotional well-being and mental health of children and young people (Meltzer et al., 2003a).
- Age within a school year - younger children in a school year were at slightly increased 'psychiatric risk' (Goodman et al., 2003: 472) than their older peers as measured by the first ONS study on the emotional well-being and mental health of children and young people.

Bullying:

- Salmon et al. (2000) in their literature review on the emotional well-being and mental health impacts of being bullied or being a bully suggested links with depression, anxiety and suicide ideation, especially among those who report having been bullied. Using data from referrals made to an Oxford out-patient CAMHS service and young people admitted to the linked in-patient CAMHS, and a survey of pupils at a secondary school for young people with emotional and behavioural difficulties, the authors concluded that 'bullying [is] a factor in the genesis of mental health problems' (p. 576). Young people with experience of being bullied were significantly more likely to present at CAMHS with depression, while those said to have 'bullied' were more likely to present with externalising disorders such as conduct disorders.
- Wolke et al. (2000) studied much younger children (aged 6 to 9 years old) in primary schools in Hertfordshire and North London. The researchers were examining the association between bullying and emotional well-being and mental health (using the Strengths and Difficulties Questionnaire). Children who both bullied and were 'victims' of bullying, and those who directly and relationally bullied others were found to score highest on the Strengths and Difficulties Questionnaire. (Relational bullying is here defined as 'hurtful manipulation of peer relationships/friendships that inflicts harm on others through behaviours such as 'social exclusion' and 'malicious rumour spreading'', p. 989).

Being in the care of the local authority:

- The Audit Commission (1999) report on children accessing specialist CAMHS over a four week period in 1999 found that nine per cent of children being seen by CAMHS were in local authority care (compared to half a per cent of the general population).
- In 2002, the Office for National Statistics carried out a stratified random sample survey of the prevalence and impact of diagnosable mental disorders in children and adolescents aged 5 to 17 years old who were looked after by local authorities in England (Meltzer et al., 2003b). Almost one in two children and young people in public care were assessed as having a diagnosable mental disorder (45 per cent) - a rate of four to five times higher than the national average. The probability of having a conduct disorder was particularly high among those looked after. While boys in public care aged 5-15 years of age were more likely to have a diagnosable mental disorder than their female counterparts, this gender gap was closed when examining prevalence among 16 and 17 year-olds (likely explained by the fact that emotional disorders among young women increase as they get older, while rates decrease among young men as they get older). Living in residential care was associated with the highest prevalence of a diagnosable mental disorder. The association between a diagnosable mental disorder and physical ill-health found in the 1999 ONS survey was also found among this particular group of children and young people (Meltzer et al., 2003b) and was further supported by research conducted by Hill & Thompson (2003).
- McCann and colleagues (1996) compared a group of young people in public care in Oxfordshire with a matched sample drawn from the community. As concluded by Meltzer et al. (2003b), those children and young people in McCann et al.'s study who were in public care were more likely to have a 'psychiatric disorder' (McCann et al., 1996: 1530) (67 per cent) when compared to their peers not in public care (15 per cent). Also, similar to the ONS findings reported by Meltzer et al. (2003b), conduct disorders was the commonest diagnosis among this group of young people, and those living in residential care had higher rates of psychiatric disorder than those in foster care (96 per cent compared to 57 per cent respectively). Another study, by Blower et al. (2004), in a Scottish local authority, used a two-stage screening process and the same instruments as McCann et al. (1996) and found that 56 per cent of their sample of 48 children and young people living in foster or residential care had 'significant psychological morbidity' and 44 per cent had a 'definite, probable or resolving...psychiatric disorder' (Blower et al., 2004: 117). Similar

rates of emotional well-being and mental health problems (measured using the Strengths and Difficulties Questionnaire, argued to be an improvement on the tools used by McCann et al., 1996 and Blower et al., 2004) were found in a study of one Northern Irish local authority (Teggart & Menary, 2005) with diagnosable disorders found in between three-fifths and two-thirds of children and young people.

- Mount et al. (2004) in a study of young people in the public care system and their carers in one city in the south west of England, explored whether carers' and young people's own perceptions (elicited during semi-structured interviews) of emotional well-being and mental health problems were consistent with a diagnosis of 'mental health need' (p. 368) using the Strengths and Difficulties Questionnaire and two other mental health screening tools. Carers were found to be four times more likely to identify mental health problems than young people. Two-thirds of the residential or foster carers who 'intuitively' (p. 363) identified a mental health problem in the young people they were caring for were shown to have accurately assessed this (using the screening tools mentioned above), however, the authors were keen to stress that this meant as many as 23 per cent of carers failed to identify such problems. Furthermore, fewer than half of those identified as having high mental health problems had accessed a specialist mental health service.
- Blower et al. (2004) undertook a study of children and young people accommodated by one English local authority, to examine the extent of need for CAMHS support by those children and young people who were looked after. The authors found that while many of children and young people's emotional well-being and mental health problems had been identified relatively early on and some had received 'treatment' (p. 117), the persistence of these problems over time meant that interventions were perhaps not as effective as they could be. Nicholas et al. (2003), in their study of children in residential homes across Leeds, however, found that older children especially were less likely to be known to, or be in current contact with 'mental health services' (p. 81). Overall, 64 per cent of the children were known to the CAMHS out-patient team or Therapeutic Social Work team and 27 per cent were in current contact with these services.

Offending:

- Lader et al. (2002) analysed relevant data for 16 to 20 year olds from survey of 'psychiatric morbidity among prisoners in England and Wales' (p. 1), carried out at the end of 1997. They found that young women were twice as likely to have received help or treatment for a mental or emotional problem. Over four-fifths of the young male offenders were assessed to have a personality disorder during a clinical interview, while one in ten had a psychotic disorder, and young offenders were found to be four times more likely than young people the same age in the general population to be experiencing neurotic disorders (Lader et al., 2002). Self-harm, suicidal thoughts and attempts were higher among female than male offenders.
- During structured interviews with 293 young people being supervised by eleven Youth Offending Teams from across England and Wales, Hammersley et al. (2003) found that a quarter of the young offenders responded positively to the 'I have had a mental health problem' option in the section of the questionnaire concerned with 'life problems'. A quarter of the study respondents also said they had thought about suicide in the past two years and over two-fifths reported feeling depressed. Only 17 per cent of the sample agreed they had received 'specialist support' (Hammersley et al., 2003: 32) for their emotional well-being and mental health problems. The young offenders involved in the research (who were predominantly young men) were most likely to say they would share their problems or feelings with others.
- Harrington et al. (2005), in their study for the Youth Justice Board, selected six geographically representative areas across England and Wales which had both a Youth Offending Team and a 'secure establishment' (either a young offender institution or local authority secure children's home). A total of 151 young offenders from secure estate establishments and 150 from the community were interviewed, using the Salford Needs Assessment Schedule for Adolescents (S.NASA) to assess emotional well-being and mental health problems. The main findings of this study in relation to mental health were that one third of young people were assessed as having a mental health problem with close to twenty per cent experiencing depression, ten per cent reporting a history of self-harm within the last month and a similar proportion describing anxiety and post-traumatic stress symptoms. No significant differences were noted between young offenders according to gender and ethnicity. Variable mental health support provision was

noted by Harrington et al. (2005) and concern expressed at the lack of continuous assessment of mental health problems of young offenders, using validated screening tools. Asset forms were often found to be incomplete, and to have only identified half of the young offenders with mental health problems when the Asset forms were compared to the level of mental health problems identified in the study respondents using validated mental health screening tools.

- National studies such as those conducted by Lader et al. (2002) and Harrington et al. (2005), are complemented by more locally-focused needs assessments. Carswell et al. (2004) compared 47 young men under the supervision of the Lewisham Youth Offending Team with the results of another study examining emotional well-being and mental health problems among a sample of 38 randomly selected young men from the same community (undertaken by Attride-Stirling et al., 2001). Carswell et al. (2004) used the same screening tool as Attride-Stirling et al. (2001) - Psychosocial Assessment for Young People and Children (PAYC) which investigated 53 'psychosocial problems' (Carswell et al., 2004: 419) and 44 risk factors associated with such problems. The young men under the supervision of the Youth Offending Team reported 'clinically significant, impairing levels of depression/misery, worry, and problematic substance use' (Carswell et al., 2004: 424) in the three months prior to the interview when compared to their community peers. Nicol et al. (2000) meanwhile assessed the need for 'psychiatric care' (p. 244) among 116 young offenders in Stoke-on-Trent and examined whether their needs were being adequately met. The authors concluded that need outstripped supply and that many of those young people with the most significant mental health problems were not receiving any 'appropriate treatment' (Nicol et al., 2000: 243) for these (Hammersley et al., 2003; Harrington et al., 2005).
- In another study, Anderson et al. (2004) examined the health needs of young people supervised by two Leicestershire Youth Offending Teams, using measures such as the Strengths and Difficulties Questions and The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Using Goodman et al.'s (1998) cut-off scores for the general population, the results of the young offenders' Strength and Difficulties Questionnaires led Anderson et al. (2004) to conclude that 44 per cent of their sample were likely to have mental health problems, 62 per cent hyperactivity problems, 76 per cent emotional problems and 32 per cent conduct (behavioural) problems. Finally, just as some of the longitudinal studies reported above (Appendix One) have found an association between having a diagnosed mental disorder and committing an offence, Wheatley et al. (2004) found that over half of the 80 young people referred from around the UK for medium secure health care had been involved in criminal activity.

Young asylum seekers and refugees:

- It is estimated that London is home to thirty times more refugees and asylum seekers than the UK average and that one in twenty London residents is said to be a refugee or asylum seeker. (Greater London Authority, 2001: 8). Based on 2003 data from the National Association for Language Development in the Curriculum (www.naldic.org.uk), London local authorities with more than 2,000 refugee children in schools are: Barnet, Brent, Camden, Ealing, Enfield, Hackney, Haringey, Islington, Lewisham, Newham, Redbridge, Waltham Forest and Westminster. Newham has the largest population of refugee children in the UK with over 7,000 refugee pupils, while Haringey has the highest proportion, at over 19 per cent.
- Howard & Hodes (2000) undertook a retrospective case-control study of thirty refugee and asylum seeking children and families individually matched with non-refugee immigrant families and white British families, attending a CAMHS Tier 3 clinical service in Paddington, London. Refugee and asylum seeking children and young people were found to present with a wide range of mental health problems, and to have more 'psychosocial disorders' (such as depression, post-traumatic stress disorder, anxiety disorder), but fewer 'neuropsychiatric disorders' (such as pervasive developmental disorders, obsessive-compulsive disorders or hyperkinetic disorders) than their non-refugee immigrant peers using the service (Howard & Hodes, 2000: 368). Refugee and asylum seeking attendees were not found to be more likely to have post-traumatic stress disorder and were less likely to have conduct problems at school. The families in which these refugee and asylum seeking children lived tended to be more isolated than their case-control peers, were more likely to be unemployed and be referred to the clinical service via social services or education (rather than general practitioners). No differences in rates of treatment completion between the two groups were noted.
- Leavey et al. (2004) conducted a similar comparative study, but across a number of schools in London. Using a cross-sectional design and the Strengths and Difficulties Questionnaire, almost one quarter of all

schoolchildren were said to have an emotional well-being and mental health problem. However, refugee and asylum seeking children showed greater psychological distress on a number of the sub-scales of the Strengths and Difficulties Questionnaire. In another, much smaller study of North West London psychiatric clinics by Patel & Hodes (2006) young female asylum seekers were identified as being at risk of violent deliberate self-harm, with higher rates noted than among their non-asylum seeking female peers or their male counterparts (although it is important to note that fewer than one per cent of all attendees to these clinics over a three year period had committed violent acts of deliberate self-harm).

- Finally, a survey by the Refugee Council found that of refugee and asylum seeking children and young people identified personal relationships with peers as the key factor, and relationships with their teachers as the second most significant factor, influencing their emotional well-being and mental health, as well as their educational achievement (Refugee Council, 2005).

Being homeless

- In a review of literature to inform work with young homeless people, Stephens (2002) concluded that mental health problems for adults living in hostels and bed and breakfast accommodation were eight times higher when compared to the general population, while rates of mental health problems among adults sleeping rough were up to eleven times higher than when compared to the general population. The increased risk of mental health problems among the adult homeless population are likely to be mirrored in the youth homeless population.
- Craig et al. (1996) found that two-thirds of the young homeless people involved in their study met the threshold for a diagnosable mental disorder, with 70 per cent of these reporting they had experienced their first symptoms before their first episode of homelessness.
- In another London study by Vasilious (2006), 59 young people aged between 16 and 25 years of age were recruited, and almost two-fifths ($N=11$) were found to have received a 'psychiatric diagnosis' (p. 23) before they had became homeless. Based on qualitative data collected, half of their young homeless sample reported regular feelings of anxiety and low mood.
- Craig & Hodson (2000) explored the persistence of diagnosed mental disorders among their randomly recruited sample of 161 homeless people aged 16 to 21 years at two of London's largest services for homeless young people and found that two-thirds of those young people with a 'psychiatric disorder' (p. 187) at the first interview remained symptomatic one year on.

Being gay, lesbian or bisexual

- Remafedi et al. (1998) undertook a cross-sectional survey of young men and women in secondary school in one US state, comparing 212 young men and 182 young women who described themselves as gay, lesbian or bisexual with 336 gender-matched heterosexual respondents. Suicide attempts were reported by 28 per cent of gay or bisexual young men and 21 per cent of lesbian or bisexual women. While 15 per cent of heterosexual young women reported a suicide attempt, only four per cent of heterosexual young men did. The authors concluded that suicidal intent and attempts were strongly associated with gay or bisexual identification for young men, but not for young women.

Appendix Three

Children and young people with learning difficulties

Within the professional discourse of those working in children's services there is not only variation in the language used to describe children's mental health and emotional well-being, the terms used to describe the learning needs of children and young people also reflect differences in underlying philosophy and theoretical orientation. Within health services, for example, the term 'learning disability' dominates and implies a within person deficit model of ability. In education and social care, however, the term 'learning difficulty' is more widely used, which acknowledges that the learning and social context of an individual can have a significant influence on learning. The terms used in this section relate to the terminology and discourse adopted by the relevant agency.

Amongst health professionals a range of terms and definitions exist. The Learning Disability Sub-Group of the Child and Adolescent Mental Health and Emotional Well Being External Working Group (2003) at the Department of Health collected data across a number of health authorities and concluded that some CAMHS services operate services on the basis of a simplistic understanding of intelligence. An intelligence quotient (IQ) score below 70 was found to operate as a cut off point for access to services in some areas. The working group also noted that some specialist learning disabilities teams, for example services for children with moderate or severe learning difficulties and accompanying challenging behaviour, adopted an IQ range of below 50 to as a criteria for access to their services. Arguably, the use of a cut off point for service access based on IQ fails to recognise the complexities acknowledged by others in forming judgements about an individual's circumstances and abilities (British Psychological Society (BPS) 2000). The BPS has recognised that IQ alone will not help determine whether a service will be accessible to an individual and highlight the need to consider wider social and language competency. Research evidence presented by the Royal College of Psychiatrists (2004) and data from Manchester reported by Emerson & Robertson (2002) clearly identified that the presence of an intelligence quotient, under 70, alone is not an adequate means for determining whether an individual should or can access services.

These diverse definitions present considerable obstacles to effective multi-professional communication. The Learning Disability Sub-Group of the Child and Adolescent Mental Health and Emotional Well Being External Working Group (2003) highlighted the potential for confusion between agencies through the different meanings attributed to particular labels: 'moderate learning disability' (a health services term meaning broadly IQ range 40-55) and 'moderate learning difficulty' (an education services term that broadly equates with the IQ range 50-70). They also noted that academics working within the field are increasing using the term 'intellectual disability' rather than learning disability. The outcome appears to be that particular groups can find themselves excluded from the services by inappropriate and narrow measures of ability, conflicting definitions and gaps in services.

The definition of learning disability agreed by the Department of Health White Paper Valuing People (2001) is: the presence of significantly reduced ability to understand new or complex information, and to learn new skills (impaired intelligence); reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development.

Within the Education Act 1996 the term 'special educational needs' (SEN) is used when a child has a learning difficulty, which required special educational provision to be made for him/her - that is provision over and above that routinely available in the school context. The Act recognises that many children have learning difficulties, but the criteria required for formal statutory identification are that:

- a) the learning difficulty must be significantly greater than the majority of others of the same age; and,
- b) the disability prevents or hinders him/her from making use of the facilities provided for other children.

Furthermore, the SEN Code of Practice (Department for Education and Skills, 2001) advocates multi-professional management and liaison to meet children's needs at the school level - 'the objective should be to provide integrated, high quality, holistic support focused on the needs of the child. Such provision should be based on a shared perspective and should build wherever possible on mutual understanding and agreement. Services should adopt a flexible child-centred approach to service delivery to ensure that the changing needs and priorities of the child and their parents can be met at any given time' (Department for Education and Skills, 2001: 135). The need for agreed and shared definitions was further reinforced by Every

Child Matters (Department for Education and Skills, 2004). However, despite calling for shared discourse and integrated services for over ten years, to date, there is little evidence of change.

As early as 1970, Rutter and colleagues reported that children with learning disabilities were three to four times more likely to have behavioural problems than peers without a disability. The Foundation for People with Learning Disabilities (2002) reported a 40 per cent prevalence of diagnosable mental disorder within the learning disabled population of children, young people and adults. Child and young people with severe learning difficulties experiencing an incidence rate that is three to four times higher. Further studies have consistently verified this finding (Einfeld & Tonge, 1996; Cormack et al., 2000; Dykens, 2000).

Increasingly, evidence is being presented which indicates that the learning disabled living in urban and deprived communities are at particular risk emotional well-being and mental health problems (Foundation for People with Learning Disabilities, 2002; Emerson, 2003; Emerson et al., 2005). Data collected by the Learning Disability Sub-Group of the Child and Adolescent Mental Health and Emotional Well Being External Working Group (2003) across a number of health authorities indicated that one in ten of all children with referred mental health problems had a learning disability, and that 50 per cent of those lived in poverty. Emerson (2006) speculated that 25-30 per cent of the increased risk of emotional and behavioural problems among children with learning difficulties was related to households with very low income (Durkin, 2002; Leonard & Wen, 2002; Leonard et al., 2005).

Based on secondary analysis of the 1999 ONS survey, Emerson (2003) found that there were no statistically significant differences between children and young people with or without learning disabilities with regard to rates of depressive disorders, eating disorders or psychosis. However, rates for conduct disorders, anxiety disorders, attention deficit and hyperactivity disorder/hyperkinesis and pervasive developmental disorders were higher among those with learning disabilities. The data suggested that the presence of intellectual disabilities should be considered a highly significant risk factor for the development of some specific forms of psychiatric disorders. Some other research has suggested that the prevalence of intellectual disabilities among South Asian children and young people is three times higher than in other communities of children and adults aged between 5 and 42 years-old (Emerson & Azmi, 1997; Kerr, 2001).

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