

2 Child and Adolescent Mental Health

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1 Summary

Introduction

This chapter reviews the need for care and services for children and young people with emotional and behavioural difficulties. Priority is given to considering those difficulties that give rise to substantial disruption of personal and social life. The emphasis throughout is on estimating need in populations, in order to make the data available in a form that will be of use to those professionals in health, social services and education who are responsible for care and service planning in child and adolescent mental health within a defined geographical area.

Health authorities are responsible for identifying the health needs of a geographically designated population and for ensuring that appropriate action is taken to meet them. Although health authorities co-ordinate child and adolescent mental health services (CAMHS), paediatric services and primary health care; other agencies provide complementary services. Social services departments are responsible for the care needs of children and adolescents and education departments provide appropriate educational facilities for all children, including those with special educational needs. Effective care in this field requires provision of services by all three major statutory agencies working in close collaboration with each other and the voluntary sector.

Child and adolescent mental health services aim to prevent, investigate, assess and treat child and adolescent mental health difficulties within the age range 0–16 years. Older adolescents who are still in full-time education may be included.

Some mental health difficulties may be dealt with effectively at the primary care level. However others, which are usually multi-factorial in aetiology and multi-faceted in their manifestations often require skilled assessment and the co-operation of different professionals and agencies for effective treatment. Child and adolescent mental health services therefore work in an interdisciplinary environment which includes professionals in the fields of psychiatry, psychology, psychotherapy, nursing, social work, education, occupational and speech and language therapy.

Epidemiological knowledge of many of the conditions has increased substantially over the past 25 years. From this it is apparent that there is a wide range of predisposing and precipitating factors which can result in an equally wide range of difficulties. Social factors are clearly implicated in the genesis and maintenance of these and in their extension into adulthood.¹ Such factors include characteristics of parents and care-givers; their mental and physical health and personalities; the quality of the parents' relationship; the style of child rearing and the contexts in which it occurs; relationships between the child and other family members; family structure and aspects of family function; life events, such as bereavements; relationships with peers; school experiences and broader environmental circumstances such as adequacy of housing.²⁻⁷ There is also good evidence that childhood difficulties can be the precursors of adult criminality and mental disorder.^{8,9}

Child and adolescent mental health is also directly and indirectly influenced by genetic factors, physical health, developmental status and educational ability. There is increasing evidence of interaction between all of these and other psychosocial factors in the genesis of mental health difficulties.^{10,11}

2 Statement of the problem

Definitions

Children and young people who show patterns of behaviour, emotions or relationships that cause concern to themselves, parents, carers or teachers may be referred to CAMHS, other health services (primary care or paediatrics) or other agencies. The difficulties which precipitate such referral constitute the ‘presenting problems’, which may subsequently be assessed as ‘clinical problems’ requiring intervention. This assessment takes into account ‘severity’, which is a multi-dimensional concept, judged according to the criteria set out in Box 1. It may result in the diagnosis of ‘disorder’. Both problems and disorders may exist in the presence of ‘risk factors’.

Box 1: Dimensions used in assessing the severity of presenting problems

- Impairment: Impact on individual, carers, environment
- Age appropriateness: Departure from expected developmental course or common patterns
- Frequency
- Duration
- Persistence
- Intensity
- Extensiveness/pervasiveness
- Intrusiveness
- Manageability/controllability
- Multiple presenting problems

A **problem** is defined as a disturbance of function in one area of relationships, mood, behaviour or development of sufficient severity to require professional intervention (see Appendix II for a list of individual problems).

A **disorder** is defined either as a severe problem (commonly persistent), or the co-occurrence of a number of problems, usually in the presence of several risk factors.

Problems and disorders can include behaviour patterns and changes which are either quantitatively (e.g. tantrums or stealing) or qualitatively (e.g. autism or psychotic symptoms) different from normal, of which the latter is generally more serious. Both individual problems and disorders vary in severity.

A **risk factor** can relate to the individual child, family, environment, life events and school experience. Risk factors are such conditions, events or circumstances that are known to be associated with emotional and behavioural disorders and may increase the likelihood of such difficulties. (see Box 7 on page 70).

The association of risk factor(s) with problems or disorders implies increased severity. The prevalence of risk factors will vary from district to district (e.g. inner-city versus rural). High levels of any of the risk factors in a given population indicate the need for an increased level of provision of CAMHS.

The terms **care, service, need, demand, utilization,**¹²⁻¹⁴ **professional** and **specialist** which are used in this chapter are defined in Appendix I.

Characterization and classification

Formal characterization and classification schemes for clinical problems and diagnoses in child and adolescent mental health have been developed for different purposes.

The proposed core data set for child and adolescent psychology and psychiatry services¹⁵ is intended for use by professionals involved in direct patient care who are having to identify the characteristics of their patients for recording on computerized information systems. It provides a framework for detailing clinical features (problems), severity of the problems of patients and accompanying risk factors. Box 2 and Appendix II illustrate the data set.

Box 2: A clinically-based classification of child and adolescent mental health problems as derived from the Proposed Core Data Set for Child and Adolescent Psychology and Psychiatry Services

Problems

- Antisocial behaviour e.g. stealing, firesetting
- Problems related to school e.g. school refusal
- Problems of self-regulation e.g. tics, feeding problems
- Problems of social relationships e.g. with parents/sibs, attention seeking
- Self-harm/injury e.g. overdose
- Sexual and sex-related problems e.g. sexual offence, gender identity
- Autistic-type characteristics e.g. autism
- Psychosis-type characteristics e.g. confusion, psychotic symptoms
- Psychosomatic-related illness e.g. hypochondriasis, hysteria

Risk factors

Risk factors in the child

- Problems associated with cognition or academic abilities e.g. reading difficulty
- Personality/temperament e.g. shyness/social isolation
- Problems related to speech and language e.g. mutism, speech delay
- Physical e.g. epilepsy, head injury, chronic illness
- Sensory problems e.g. visual impairment, hearing difficulties
- Genetic condition e.g. chromosome anomaly

Risk factors in the family

- Relationship difficulty involving parent(s)/carer(s)
- Marital difficulties
- Family mental health problems
- Family physical health problems
- Abuse/neglect – physical/emotional/sexual

Risk factors in social circumstances

- Adverse social circumstances
- Life events e.g. bereavement

The tenth revision of the International Classification of Diseases (ICD 10) summarized in Box 3¹⁶ provides a diagnostic classification which concentrates almost solely on disorders and gives indications of probable aetiology, associated factors and prognosis. For a given child or adolescent, the ICD 10 diagnosis usually encompasses several of the problems listed in the Association for Child Psychology and Psychiatric Services (ACPP) core data set (for example 'conduct disorder' might encompass aggression, defiance and truancy) though a single pattern of behaviour such as persistent firesetting may also merit a diagnosis of 'conduct disorder' (F91).

Box 3: Child and adolescent mental health disorders: international classification of diseases (ICD 10) for child and adolescent mental health

F90–F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

- F90 hyperkinetic disorders
- F91 conduct disorders
- F92 mixed disorders of conduct and emotions
- F93 emotional disorders with onset specific to childhood
- F94 disorders of social functioning with onset specific to childhood and adolescence
- F95 tic disorders
- F98 other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- F99 mental disorder, not otherwise specified

F70–F79 Mental retardation

- F70 mild mental retardation
- F71 moderate mental retardation
- F73 severe mental retardation
- F74 profound mental retardation
- F78 other mental retardation
- F79 unspecified mental retardation

F80–F89 Disorders of psychological development

- F80 specific developmental disorders of speech and language
- F81 specific developmental disorders of scholastic skills
- F82 specific developmental disorder of motor function
- F83 mixed specific developmental disorders
- F84 pervasive developmental disorders
- F88 other disorders of psychological development
- F89 unspecified disorder of psychological development

In addition, some adult mental health diagnoses can become apparent in adolescents and younger children. The major groupings for these are:

- F10–F19 mental and behavioural disorders due to psychoactive substance use
- F20–F29 schizophrenia, schizotypal and delusional disorders
- F30–F39 mood (affective) disorders
- F40–F48 neurotic, stress related and somatoform disorders
- F50–F59 behavioural syndromes associated with physiological disturbances and physical factors
- F60–F69 disorders of adult personality behaviour

Comparing the new ICD 10 codes with equivalent ICD 9 codes or the US DSM III – R classification can be difficult but epidemiology based on any of these classifications provides useful guidance for broad categories of disorder and some specific conditions. It should be noted that the US DSM IV has been produced recently and is more comparable to ICD 10

The ICD 10 incorporates findings from recent research and is needed when planning services for populations because epidemiological data are most commonly based on such higher-order diagnoses.

3 Context

There are several clinical and organizational issues which have led to an increase in demand for child and adolescent mental health services over recent years. In young people there has been an increase in the prevalence of mental health problems such as depression, self-injurious behaviour, delinquency and substance abuse.¹⁷ In addition legislative changes affecting social services and education have led to an increased monitoring and assessment role for these authorities. Responsibilities for treatment have increasingly passed to health services.

Other issues include the increasing recognition of the importance of certain diagnoses in this age group (e.g. pervasive developmental disorders, hyperkinetic disorders, post-traumatic stress disorders) and the need to find effective interventions for uncommon and difficult conditions (e.g. self-injurious behaviour in children with severe learning difficulties). The role of prevention has become more important, particularly the recognition of precursors of severe conditions (e.g. psychosocial adversities).^{18,19} All these issues have implications for service provision and should be considered when deriving appropriate models of care to meet the specific needs for this group of children and adolescents.

The Children Act 1989

Any review of child and adolescent mental health services must consider the major service implications of the changes resulting from the Children Act (1989). Essential principles of the act emphasize the welfare of the child, responsibilities of parents and the broad obligations of local authorities to ensure that children's needs are met. The requirements of the act place new, more complex and urgent demands on CAMHS for assessment, consultation and treatment of individuals and families, as well as greater involvement in the associated administrative and legal proceedings. The service implications of the act must therefore be given full consideration in service planning for child and adolescent mental health.

Child protection

Wider appreciation of the range and nature of child abuse and neglect has led to increased pressure on local authority services to carry out monitoring and co-ordinating functions relating to child protection. The Children Act (1989) has given a new range of statutory responsibilities to local authority social services departments and this has further reduced the capacity of those departments to do therapeutic work with individual families.

The increasing demands on social service resources have led to the withdrawal of social workers from collaborative multi-disciplinary work within child mental health services. This has diminished the efficacy of collaboration between child mental health services that is essential for the welfare of children.

The 1981 Education Act

The 1981 Education Act has led to educational psychologists within school psychological services being increasingly engaged in assessments of special educational need and this has been reinforced by the 1993 Education Act.

The integration of children with mental health problems into normal school and limitations on the number of children receiving special educational needs assessments has led to more children being referred to specialist child mental health services because of emotional and behavioural problems associated with educational failure, bullying and other school-related problems. Previously, educational psychologists were more often engaged in schools and clinics in direct therapeutic programmes for individual children. More recently the Department for Education has produced guidance on the assessment of children with special educational needs and the management of children with emotional and behavioural problems in the education system.²⁰

Uncommon and difficult conditions

From time to time children or adolescents require complex, long term and expensive care for uncommon conditions such as severe behaviour disorders associated with epilepsy or challenging behaviour in association with learning difficulties, or autism. There is often confusion or even conflict about the type of service required and failure to agree on the responsible authority, resulting in unacceptable delays in placing the child.

Information

Demographic and related information required to develop services and effective contracts for child and adolescent mental health will need to be obtained from a variety of different sources (Table 1). The task of collecting such data will vary between districts and depends upon quality and accessibility of both computer and library-based information.

Table 1: Source of data for child and adolescent mental health needs assessment

Local data sources	Supplementary data sources
Demographic	Ethnic composition
Ethnic composition	Hospital activity
Mortality	Morbidity
Morbidity	Social Services data
Family and socio-economic data	Socio-economic information
Police and probation	Unemployment
	Family factors
	Criminality

Data are available from a number of written and computer-based sources to provide a background picture of need for services for child and adolescent mental health. This information is by no means comprehensive and will probably require a degree of extrapolation to be used effectively.

The sources of data available can be divided into local data and supplementary data collected at a national, regional or local authority level.

Further details of these data sources can be found in Appendix III. The problems associated with collection and reliability are also identified.

Conclusion

In summary CAMHS deal with a wide range of problems and disorders from minor and self-limiting difficulties through to conditions which result in major disability and may be life-threatening. These conditions occur within a background of individual, family and social risk factors, heightened by disadvantage. There are indications that such problems and disorders are increasing. Adequate management requires a network of multi-disciplinary and flexible services.

Recent legislative and policy changes have resulted in reduced involvement in therapy and care by some professional groups which have traditionally played a major part in this service.

Against this background we proceed to develop the framework for needs assessment for child and adolescent mental health.

4 Sub-categories of child and adolescent mental health problems and disorders

Introduction

There is no single sub-categorization in use in child and adolescent mental health which has been widely adopted and which would be universally accepted by all the professional groups contributing to services. In this chapter we have divided the areas of concern into:

- clinical problems
- disorders
- risk factors.

These terms are defined on page 56.

The decision to seek help is often not taken by children or young people themselves but by parents, care givers or other adults. The type of service needed is indicated by the characteristics of the individual problems and disorders, their severity and the exact nature of the risk factors present. It should be re-emphasized that the relevant service may be required from any or all of the statutory agencies (health, social services and education).

This section describes in more detail the sub-categories of problems, disorders and risk factors. Diagnostic examples which may be of use to purchasers of CAMHS are set out with epidemiological evidence in section 5 (Boxes 5, 6 and 7 provide summaries).

Sub-categorization according to need for service

Child and adolescent mental health problems may be grouped according to whether the individual problem is likely to indicate the presence of a severe disorder. However it should be noted that severity depends not only on diagnostic classification but also on individual case characteristics (Box 1), complexity and risk factors.

Common problems with a low risk for a severe disorder

Disturbances of mood or behaviour which are quantitatively different from normal are not necessarily indicators of a severe disorder if they affect only one functional area (e.g. sleep problems or temper tantrums).

In this case they do not necessarily require management by specialist child mental health services. However if they persist or are associated with other problems such as school non-attendance, poor concentration, being bullied or teased, or multiple risk factors they may constitute a disorder and require specialist assessment or intervention.

Common disorders that are not necessarily severe

These relatively common mood and behaviour conditions usually incorporate problems that are quantitatively different from normal. They can be grouped broadly into:

- conduct disorders (e.g. problems of aggression, stealing, non-compliance)^a
- emotional disorders (e.g. problems of anxiety, depression which do not meet adult diagnostic criteria for mood disorder)
- specific developmental disorders (e.g. problems of language and speech development). A proportion of these disorders are severe and require specialized resources, particularly those persisting beyond five years of age.

These and other disorders not infrequently co-occur in an individual and can often be dealt with satisfactorily by solo professional services. If they are persistent or there are several different risk factors present, multi-disciplinary management will be required.

Less common problems which indicate a severe disorder

Some problems are of particular importance because they point to the possibility of a severe disorder. They will usually require early, specialist CAMHS assessment. These include hallucinations, severe tics, pervasive hyperactivity, symptoms of autism and attempted suicide.

^a Although some can be considered relatively mild, early onset conduct disorders and those associated with hyperactivity and poor peer relationships have a poor prognosis.

Potentially severe disorders

These comprise relatively uncommon disorders where the disturbances of mood and behaviour are qualitatively different from normal. They include:

- pervasive developmental disorders (e.g. autism)
- mental health disorders which meet diagnostic criteria for adult disorders (e.g. eating disorders, schizophrenia and mood disorders).

These disorders need multi-disciplinary specialist CAMHS assessment and may require multi-disciplinary treatment.

Risk factors

The presenting features of mental disorder in children can be associated with one or more risk factors. These add to the complexity of the condition, influence severity and so may determine the nature of the service required. Risk factors can relate to the following.

- **The child** Acute or chronic illness, specific or general learning difficulties, language and other developmental disorder.
- **The family** Parental discord, parental mental health, neglect, child abuse, criminality, economic circumstances.
- **The environment** Overcrowding, homelessness, discrimination.
- **Life events** Parental separation, acute illness, bereavement and disasters.
- **School** Bullying, victimization, inappropriate curriculum.

Multiple risk factors point to the need for specialist assessment and treatment. This is of particular importance in places where the prevalence of risk factors such as unemployment, homelessness, single parenthood and drug misuse are high. Intervention to reduce risk factors (e.g. parental postnatal depression) is an important preventive measure. In the absence of child disorder, some risk factors, such as life events, can be dealt with by the family or in primary care.

When risk factors involve relationship dysfunction, or when they are multiple (e.g. abuse and parental mental illness), multi-disciplinary assessment and intervention are likely to be needed.

Relationship between sub-categories and the Children Act 1989

The Children Act 1989 distinguishes the following.

- General needs of children for the promotion of different aspects of their development (emotional, physical, intellectual, social, behavioural and educational).
- Children 'in need' whose development would be impaired without the provision of additional resources by the local authority or health services are thought to comprise some 20% of the population.
- Significant harm which constitutes a threshold for legal action. This comprises either maltreatment by parents or caregivers, or impairment or likelihood of impairment of physical, intellectual, emotional, social or behavioural development that is attributable to the care given to the child. The child may also be beyond parental control.

The act confirms the general need for the support for all children in their development. Any child with significant or long-standing problems or with a recognized mental health disorder is 'in need'. Recent research confirms that services should address children 'in need' and not just those experiencing significant harm.²¹

Relationship between sub-categories and primary, secondary and tertiary prevention

Primary prevention aims to reduce risk factors and prevent the development of problems. This is of potential benefit to all children.

Secondary prevention aims at early detection of problems, with a view to effective intervention and prevention of recurrence or escalation. This is of benefit to children with problems and disorders, or to those exposed to risk factors which are amenable to treatment.

Tertiary prevention seeks to alleviate or minimize the disability associated with a disorder. It is of benefit to children with more serious disorders which cannot be completely eliminated.

5 Prevalence

Introduction

This section reviews the prevalence of child and adolescent mental health problems, disorders and risk factors and is set out in three main groups consistent with the definitions and sub-categories described in sections 2 and 4; clinical problems (Box 5), disorders (Box 6) and risk factors (Box 7). It is important to understand that children and adolescents presenting to services in an average district will have a variety of problems but that the majority tend to fall into two broad groups of conduct or emotional difficulties. The severity of these problems and disorders and the extent to which they are associated with risk factors will determine the level of service required for each child.

General features

Among three year olds in an urban community the prevalence of moderate to severe mental health disorders is 7% and the prevalence of mild disorders is 15%.²² In an older population the overall prevalence of child and adolescent mental health disorders has been estimated at 12% in children aged 9–11 in rural areas (Isle of Wight) and 25% in ten year olds in inner London.²³ Amongst adolescents higher rates have been found. Although these figures seem high, in practice only about 10% of those with disorders are seen by specialist services. Referral levels are influenced by society's and primary health care professionals' perceptions of mental health problems. They are also influenced by the availability of services. As would be expected the highest proportion of referrals are for children with more severe problems.

Differences in overall prevalence between these and other surveys are usually due to the characteristics of the target sample, the sampling method, case definition and assessment procedures.^{24–26}

A broad indication of overall prevalence of symptoms, disorders and risk factors is shown in Box 4.^{27,28} These figures include the full range of conditions from the very mild to severe, not all of which will need specialist care.

These wide ranges of prevalence also reflect differences among populations relating to characteristics such as age, sex, ethnic distribution and whether the population is from a rural or urban setting. Other important associated factors include social class distribution and levels of deprivation. The prevalences act as a broad indication which should be adapted to meet the characteristics of particular local populations.

Box 4: Overall prevalence of child and adolescent mental health problems, disorders and risk factors

Problems	5 – 40%
Disorders	5 – 25%
Risk Factors	5 – 40%

Age and sex

In general, the prevalence of disorders is lower in the younger age group than in the older group and higher in boys than girls, although girls begin to overtake during adolescence.²⁹

Ethnic differences

Data from various studies show that the prevalence and presentation of child psychiatric disorder varies between ethnic groups.^{30–32} The presence and pattern of variation is not constant across subgroups or across individual disorders.

Culture can influence the presentation of psychiatric disturbance in a number of ways. Idioms of distress appear to be culturally determined in adults, such as reactive excitation in Afro-Caribbean people³³ and somatization in people of Pakistani origin.³⁴ Culture may also affect the presentation of emotional disorders in children and influence the way parents interpret their children's behaviour and what action they take when they consider it abnormal.

Studies in the UK suggest that children of Asian origin appear to have comparable or slightly lower rates of psychiatric disorder than white children.^{31,32,35,36} There are no recent studies giving adequate estimates of prevalence across all ages in the different ethnic groups in the UK.

Incidence

Assessing incidence in child and adolescent mental health is difficult as the majority of disorders that are sufficiently severe to be dealt with by specialist services are long standing and chronic. However there are some circumstances which require an acute response (e.g. attempted suicide, drug overdose, acute psychosis and reactions to life and traumatic events, and children refusing treatment on paediatric wards). Self-harm, anorexia and child abuse carry the greatest threat to life. As numbers for suicide, death from anorexia, abuse and undetermined death are small, mortality data are not particularly helpful as indicators of need for services.

Epidemiology of problems

This is summarized in Box 5.

Nocturnal enuresis

Rutter *et al.* found 6.7% of seven year old boys and 3.3% of girls were wet more than one night a week.³⁷ A study of seven year old children found that 8% of children experienced night wetting.³⁸ A study of 14 year olds found 1.1% of boys and 0.5% of girls to be wet at least one night a week.³⁷

Box 5: Prevalence of specific child and adolescent mental health problems^a

• Nocturnal enuresis	8% of seven year old children 1% of 14 year old children
• Sleep difficulties	13% of London three year olds have persistent difficulty settling at night 14% of London three year olds wake persistently during the night
• Feeding difficulties in children	12–34% among pre-school children
• Abdominal pain without organic cause	10% in five to ten year olds
• Severe tantrums	5% of three year olds in an urban community
• Simple phobias	2.3–9.2% of children
• Tic disorders	1–13% of boys and 1–11% of girls
• Educational difficulty	specific reading retardation – 3.9% (Isle of Wight) and 9.9% (London) of ten year olds general reading backwardness – 8.3% (Isle of Wight) and 19% (London) of ten year olds

^aGreater detail can be found in the text. Not all specific problems are represented in this box

Sleep difficulties

A study of three year old London children found that 13% had difficulty settling at night with 14% waking during the night.²²

Feeding difficulties in young children

The prevalence of feeding problems generally among pre-school children is estimated at between 12 and 34%.³⁹

Abdominal pain without organic cause

This is a common complaint in children with one study finding it occurred in 10% of 5–10 year olds.⁴⁰ Another study reported symptoms in one-third of young children persisting into adulthood.⁴¹

Severe tantrums in young children

Severe temper tantrums have been found in 5% of three year olds in an urban community.²²

Simple phobias

Persistent disabling fears of specific objects or situations such as dogs or the dark occur in 2.3–9.2% of children.²⁶

Tic disorders

Transient tic behaviours are commonplace among children. Community surveys indicate that 1–13% of boys and 1–11% of girls manifest frequent ‘tics, twitches, mannerisms or habit spasms’.⁴² Children between the ages of seven and 11 years appear to have the highest prevalence rates (5%) with the male to female ratio less than 2 : 1 in most community surveys (see also page 68).

Educational difficulty

In the Isle of Wight study,⁴³ specific reading retardation (SRR) (i.e. reading performance significantly below what could be expected on the basis of both age and intelligence) was found to affect 3.9% of ten year olds. General reading backwardness (GRB) (i.e. performance specifically below what could be expected on the basis of age) affected 8.3%. In the comparable inner London study the respective rates were double; at 9.9% SRR and 19% GRB.⁴⁴

Epidemiology of disorders

This is summarized in Box 6.

Emotional disorders with onset specific to childhood

These disorders include anxiety and other emotional disorders not fitting adult diagnostic criteria. The estimated prevalence of emotional disorders in population-based studies varies from 4.5% of ten year old children living in small town communities (estimated from Rutter *et al.*²³) to 5.4%⁴⁵ or 8.7%⁴⁶ for anxiety disorders, with rates of 9.9% in inner-city areas.²³ They commonly represent 25–33% of clinic attenders.

Major depression

Uncertainties surrounding the concept of depression in young people and unstandardized methods of assessment led to huge variations in the reported rates of depressive disorder. However by using standard diagnostic criteria together with more comparable methods of data collection, it has been estimated that the point prevalence for major depression is 0.5–2.5% among children and 2–8% among adolescents.⁹

Conduct disorders

The overall prevalence of conduct disorder is 6.2% among ten year olds, with the rate in boys four times higher than that in girls.²³ When similar methods were used in a relatively poor area of London the rate of conduct disorder was 10.8%.²³ 33–50% of clinic attenders have oppositional, conduct or mixed conduct and emotional disorders.

More recently the Ontario Child Health Survey has provided a comprehensive picture of conduct disorder in the general population.^{47,48} The overall rate of conduct disorder in a mixed urban and rural area (5.5%) was similar to the rate reported 25 years earlier in the Isle of Wight study. Although the male to female ratio was similar, no difference between urban and rural areas was found in this part of Canada. This was interpreted as showing the importance of socio-economic status with the effect of geographical area diminishing when the degree of poverty in the different contexts was taken into account.

Box 6: Prevalence of specific child and adolescent mental health disorders^a

• Emotional disorders with onset in childhood	4.5–9.9% of ten year olds 25–33% amongst clinic attenders
• Major depression	0.5–2.5% among children 2–8% among adolescents
• Conduct disorders	6.2–10.8% among ten year olds 33–50% amongst clinic attenders
• Multiple tic disorders	1–2%
• Obsessive compulsive disorder	1.9% of adolescents
• Hyperkinetic disorder	1.7% of primary school boys 1 in 200 in the whole population suffer severe hyperkinetic disorders Up to 17% at least some hyperkinetic problems
• Encopresis (faecal soiling)	2.3% of boys and 0.7% of girls aged 7–8 years 1.3% of boys and 0.3% of girls aged 11–12 years
• Eating disorders – anorexia nervosa	0.2–1% of 12–19 year olds
– bulimia nervosa	8–11 times more common in girls 2.5% of 13–18 year old girls and boys
• Attempted suicide	2–4% of adolescents
• Suicide	7.6 per 100 000 15–19 year olds
• Substance misuse	no figures available for effect on mental health. See text for level of use

^aGreater detail can be found in the text. Not all disorders are represented in this box

Multiple tic disorders

Many children have simple tics (page 67) although when they are multiple and persistent, they have a serious impact on the child's education and social life. The prevalence has been estimated as 1–2% of the general population.⁴⁹

Obsessive compulsive disorders

Figures from recent studies suggest that the weighted prevalence of obsessive compulsive disorder among adolescents is 1.9%.^{50,51}

Hyperkinetic disorders

The reported prevalence of hyperactivity varies greatly. This depends predominantly on whether the problem is confined to one setting such as school or is pervasive across settings. Surveys of teachers or parents suggest figures of 17% in primary school boys.⁵² The International Classification of Diseases (ICD) definition for hyperkinetic disorder includes pervasiveness and for this the prevalence is 1.7% among primary school boys. After allowing for gender differences and geographical variation, these figures imply a prevalence of one in 200 in the whole population for severe hyperkinetic disorders, with situational hyperactivity which may be part of a conduct disorder, being much more common.

Encopresis

Encopresis (faecal soiling) is found in 1.5% of children between seven and eight years of age, (boys 2.3% and girls 0.7%).⁵³ Rutter *et al.* found that 1.3% of boys and 0.3% of girls aged 11–12 soil at least once a month.⁴³

Eating disorders

Incidence and prevalence figures for anorexia nervosa and bulimia nervosa vary among studies due to different case definitions and diagnostic criteria, as well as a lack of homogeneity among the groups surveyed.⁵¹

For anorexia nervosa the majority of studies reporting prevalence figures suggest that 0.2–1% of the 12–19 year old population is affected. It is 8–11 times more common in females than males.⁵⁴

For bulimia nervosa one study suggests a reported lifetime prevalence of 2.5% among 13–18 year old boys and girls. It is more common than anorexia nervosa, peaks at about 19 years of age and is far more common in girls than boys. Bulimic patients are under-represented in clinical samples of eating-disordered adolescent patients.⁵⁵

Attempted suicide

In US studies reported lifetime suicide attempts have been estimated at 9% of adolescents and 1% of preadolescents.^{56–58} The figure for French-Canadian 12–18 year olds is 3.5%, for Dutch 14–20 year olds 2.2% and Swedish 13–18 year olds 4%. The figure for adolescents in the UK is likely to be about 2–4%.

Suicide

Suicide in childhood and early adolescence (up to the age of 15) is uncommon⁵⁹ but it increases markedly in the late teens and early twenties. In 1989 in the UK the suicide rate for children aged 5–14 years was 0.8 per 100 000 and among 15–19 year olds, 7.6 per 100 000, with suicide being more common in boys.⁶⁰

Substance misuse

There is little information on the effect of substance misuse on the mental health of children and adolescents. Figures are generally related to the level of use of different substances. In the UK just over one-fifth of 11–15 year old children said that they had an alcoholic drink in the previous week.⁶¹ There are high levels of regular consumption and experimentation with solvents, cannabis and more recently hallucinogens. 16% of 16 year olds regularly use solvents and illegal drugs.⁶² 3–5% of 11–16 year olds have used cannabis with this figure rising to 17% in older teenagers.^{63,64} However very few have been involved in regular consumption of minor tranquillizers^{65–67} with less than 1% having used heroin and cocaine.^{68,69}

Epidemiology of risk factors

It should be noted that overall prevalence rates for disorder reflect the impact of risk factors in individual cases. Some of the risk factors are summarized in Box 7.

Box 7: Prevalence of specific child and adolescent mental health risk factors and impact on rate of mental disorder^a

<p>Risk factors in child</p> <ul style="list-style-type: none"> ● Physical illness – chronic health problems – brain damage ● Sensory impairments – hearing impairment four per 1000 – visual impairment 0.6 per 1000 ● Learning difficulties ● Language and related problems – 2%, but better methods of identifying required 	<p>Impact on rate of disorder</p> <p>three times increase in rate 4–8 times increase in rate of disorder in youngsters with cerebral palsy, epilepsy or other disorder above the brainstem 2.5–3 times more disorder</p> <p>no figures but rate of disorder thought to be raised</p> <p>2–3 times increase in rate, higher in severe than moderate learning difficulties four times rate of disorder</p>
<p>Risk factors in the family</p> <ul style="list-style-type: none"> ● Family breakdown – divorce affects one in four children under 16 years of age – severe marital discord ● Family size ● Parental mental illness – schizophrenia – maternal psychiatric disorder ● Parental criminality ● Physical and emotional abuse – of those on child protection registers, one in four suffer physical abuse and one in eight neglect ● Sexual abuse – 6–62% in girls and 3–31% in boys 	<p>Impact on rate of disorder</p> <p>associated with a significant increase in disorders e.g. depression and anxiety</p> <p>large family size associated with increased rate of conduct disorder and delinquency in boys eight to ten times rate of schizophrenia 1.2 to four times the rate of disorder</p> <p>two to three times rate of delinquency twice rate of disorder if physically abused and thrice if neglected</p> <p>twice rate of disorder if sexually abused</p>
<p>Environmental risk factors</p> <ul style="list-style-type: none"> ● Socio-economic circumstances ● Unemployment ● Housing and homelessness ● School environment 	<p>Impact on rate of disorder</p> <p>(see text) (see text) (see text) 9% in grades one to nine are victims of bullying 7–8% of children have self-reported bullying of other children</p>
<p>Life events</p> <ul style="list-style-type: none"> ● Traumatic events 	<p>Impact on rate of disorder</p> <p>three to five times rate of disorder. Rises with recurrent adversities</p>

^aNot all specific risk factors are represented in this box

*Risk factors in the child***Physical illness**

- **Chronic health problems** A consistent finding in general population surveys is the increased rate of mental health and adjustment problems in children with chronic health problems, as compared with their healthy peers.^{70–72} Children with chronic medical conditions and associated disability (limitations of usual childhood activities) are at more than three-fold risk for disorders and at considerable risk for social adjustment problems. Children with chronic medical conditions but no disability are at considerably less risk.⁷³

Knowledge about the causal mechanisms involved in producing the association between chronic health problems and psychological and social morbidity is incomplete. Possible mediating factors include low self-esteem, poor peer relationships and poor school performance.⁷³

- **Brain dysfunction** In the Isle of Wight study the rate of disorder was increased four to eight times in youngsters with cerebral palsy, epilepsy or some other disorder above the brainstem.^{74,75} Several studies indicate that brain damage or dysfunction puts children at risk for disorder in general with some increased association with hyperkinetic and pervasive developmental disorders.^{74,76,77}

Sensory impairments

- **Hearing impairment** Approximately one in 1000 children has moderate to profound congenital and bilateral early onset hearing impairment,⁷⁸ rising to four in 1000 if acquired losses are included.⁷⁹ The prevalence of disorder in this group is 2.5–3 times that seen in a control group.^{80–82}
- **Visual impairment** 0.3 per 1000 blind and partially sighted children at six years and 0.6 per 1000 at 11 years have been recorded in the 1958 National Child Development study. This is often compounded with additional impairments such as cerebral palsy, epilepsy and hearing impairment.⁸³

Specific and general learning difficulties

The needs of children with learning difficulties have been assessed in a separate report.⁸⁴

Children who do poorly at school, whether because of low IQ or a specific learning disorder, are at increased risk of disorder. This may be as high as 40%.⁸⁵

The increased risk applies for a wide range of conditions, including conduct disorder,⁴³ delinquency,⁸⁶ hyperactivity,^{87,88} depressive symptoms in adolescents,^{89–95} child-reported anxiety disorders, over-anxious disorder⁹⁶ and self-reported anxiety symptoms in 11 year old girls.⁹⁷ The mechanisms by which poor school performance leads to increased rates of disorder have been investigated most fully in conduct disorder.

Language and related problems

In a longitudinal study conducted by Fundulis *et al.* the prevalence of developmental language disorder was estimated at 2%.⁸¹ They varied in complexity and severity, the most severe requiring specialist teaching and speech therapy during school years.

However better ways of identifying children whose language impairments are truly handicapping are required. In three year olds the prevalence of behaviour problems amongst those with language delay was four times that of the general population and predicted educational difficulty at age eight.⁹⁸ Other studies have produced comparable estimates across a wide age range.^{99,100}

Risk factors in the family

Family breakdown

Poor parenting, marital discord and family dysfunction have all been associated with an increased rate of disorder in children.¹⁰¹ For example harsh and inconsistent parenting,¹⁰² coercive interchanges between parent and child¹⁰³ and marital discord^{104–106} are all associated with antisocial behaviour in children.

Many different factors and processes contribute to higher rates of disorder among children whose parents have separated or divorced. These include exposure to parental discord both before and after the family break up, involvement in parental disagreement and changes in family circumstances. For example if the parent with custody is emotionally distressed following the separation, then the child's behaviour may lead to critical and hostile parental responses that only serve to make the child more disturbed. These processes contribute to a prevalence of disorders as high as 80% in the first year after divorce. A US national survey showed that adolescents whose parents separated and divorced by the time the children were seven years old were three times as likely to have received psychotherapy as those from an intact family.¹⁰⁷

A recent community survey of 15–20 year old girls in London confirmed that parental separation/divorce was associated with increased risk of psychiatric disorder¹⁰⁸ and that the quality of a mother's marriage was associated with the presence of depression and anxiety disorders.¹⁰⁹

According to the General Household Survey divorce rates in England and Wales have increased markedly in the last few decades, partly as a result of legislation changes.¹¹⁰ The number of persons divorcing per 1000 married people per annum rose from 9.5 in 1971, to 12 in 1980, to 13 in 1990. Haskey has estimated that if the divorce rates stabilize at the current levels, 37% of marriages will end in divorce.¹¹¹ Kiernan and Wickes suggest that divorce now affects one in four children before the age of 16.¹¹²

Family size

Large family size (usually four or more children) has been associated with increased rates of conduct disorder and delinquency in boys,^{80,102} but not in girls.¹¹³ The results of the Farrington and West study of inner-city boys indicate that large family size is related to antisocial behaviour and delinquency, independent of sociodemographic and parental factors.¹⁰²

Parental mental illness

Evidence suggests that mental disorder, particularly personality disorder in either parent, is associated with increased rates of child psychopathology.¹¹⁴ There is emerging evidence that specific parental psychiatric disorders are associated with increased rates of particular childhood disorders. For instance parental alcoholism and antisocial behaviour are associated with increased rates of conduct disorder and depressive symptoms and disorder (especially in the adolescent age group). Also parental anxiety disorders are associated with increased rates of anxiety disorders, particularly separation anxiety disorder (SAD).^{115,116}

From a genetic perspective, children born to a schizophrenic parent have an elevated and specific risk of approximately 8–10 times for developing the disorder during their lifetime.¹¹⁷

Children whose mothers suffer from a psychiatric disorder have a 1.2–4 times increased risk of mental health problems (estimated from Rutter *et al.*²³).

Parental criminality

Evidence suggests that parental criminality is particularly associated with disorders of conduct and delinquency in children.^{101,118} The strength of the association increases if both parents have a criminal record, if they are recidivist and if their crime record extends into the period of child rearing.^{119,120}

The association may be contributed to by personality abnormalities in parents such as excessive drinking or persistent aggression, modelling of deviant behaviour and child rearing that is neglectful, lacking in supervision or includes cruelty or hostility towards children.^{86,119,121,122} A genetic predisposition is considered to be at least a partial explanation.¹²³

Rutter has estimated that children of parents involved with crime have a 2–3 times increased risk of delinquency.³

Abuse/neglect

- **Physical and emotional child abuse** 4% of children up to the age of 12 are brought to the attention of professional agencies (social services departments or the National Society for the Prevention of Cruelty to Children) because of suspected abuse each year. In England in 1988, 3.5 per 1000 children below the age of 18 years were on child protection registers and more than a quarter of these were in the care of local authorities.¹²⁴ There were 24 500 additions to the register in England in 1992.²¹ About one in four of those on child protection registers had suffered physical abuse and one in eight neglect. The largest proportion – one third – were subjects of grave concern, a term that often indicates another child in the family is known to have been abused. Exact figures on mortality from child abuse are unknown in the UK; a figure of at least one in 100 000 may be an underestimate.

Young children who have been exposed to physical abuse and those exposed to neglect have twice and three times the risk of mental health problems respectively.¹²⁵

- **Sexual abuse** The incidence of child sexual abuse is defined as the proportion of a population that has experienced it at any time during childhood. There is wide variation – from 6 to 62% in females and 3 to 31% in males – in quoted rates.¹²⁶ Categorization of sexually abusive experiences according to their severity (e.g. whether involving sexual contact) indicates that severe abuse has been experienced by 5% of women and 2% of men.¹²⁷ Children who have suffered sexual abuse have twice the risk of mental health problems.¹²⁵

Environmental risk factors

Socio-economic circumstances

The strength of the relationship between social class and child disorder is dependent on both the measurement of social class and the measurement of disorder. If occupational prestige is used to operationalize social class, then there is a weak or non-existent relationship between it and child disorder.^{22,80,128,129,130} In contrast when social class is measured in terms of economic disadvantage, then there is a strong and consistent relationship between it and child disorder.^{47,48,131,132}

Unemployment

Banks and Jackson have shown that in the years after leaving school, older teenagers who had failed to find a job showed more psychiatric symptoms than those in employment.¹³³ The specific risk in crimes involving material gain among the unemployed suggests that the relative poverty associated with unemployment is an important mediating factor.¹³⁴

Housing and homelessness

The links between quality of housing and child mental health has been reviewed by Quinton.¹³⁵ Living in the upper floors of high-rise accommodation, where supervision of the child's play is inevitably more difficult, is associated with depression in the mothers of young children.¹³⁶

The deleterious effects of homelessness in families with children have been reviewed by Alperstein and Arnstein.¹³⁷ Uncontrolled studies of children living in homeless families accommodation (hotels, hostels, etc.) have revealed very high rates of developmental delay as well as emotional and behavioural problems.¹³⁸ Parents have high rates of depression.

School environment

Children spend a minimum of some 15 000 hours in school. It is therefore not surprising that experiences in school, such as bullying and pressure for academic achievement together with overall school ethos can influence the rate of childhood disorder.

Wolkind and Rutter have summarized three major aspects of schools which influence behaviour: the composition of the student body; the qualities of the school as a social organization and the efficiency of classroom management techniques.¹³⁹ If many children in the school have poor behaviour and attainment this is likely to be a consequence of poor organization and unclear discipline, lack of recognition of children as individuals, high teacher turnover and low morale.

One problem faced by children at school is bullying. A study from Norway suggests that 9% of children in grades 1–9 are victims of regular bullying and that 7–8% self-reported bullying other children.¹⁴⁰

Life events

The impact of certain life events on a child or adolescent can have a varied effect on psychological well-being. Not all life events are stressors. This depends on characteristics of the event such as the social context and on the child's previous experiences.

Single traumatic events

There is evidence that life events can play a significant part in precipitating a wide range of childhood disorders.^{6,7} Studies of one-off disasters which are outside normal experience indicate that they can result in reactions which are the distinctive manifestations of post-traumatic stress disorder but other disorders such as depression may also be precipitated.^{2,141–143} The risk of disorder may be increased 3–5 times and rise to 100 times if there have been three recent adversities.¹⁴⁴

Other life events include bereavement. In 1984 it was estimated that 3.7% of US children under the age of 18 had lost a parent.¹⁴⁵ Adults bereaved as children approximately double their risk of developing depression, especially if they experience a subsequent loss.^{146,147} Factors that modify the outcome are reviewed by Black and include age (younger is worse), sex (girls seem more vulnerable), mode of death (sudden deaths and violent ones such as suicide or murder are associated with worse outcome) and subsequent experiences (good care lessens the risk).¹⁴⁸ It was concluded that bereaved children are more likely to develop disorders in childhood and in adult life, although the risk is small. Children most at risk are those bereaved young and those whose surviving parent has a prolonged grief reaction.

6 Current child and adolescent mental health services

Introduction

In this section the current variety of services available for children and adolescents with mental health problems is described. This is quantified using information from a recent national survey and highlights the different types of services available and the present staffing levels of relevant professionals.¹⁴⁹ There is considerable variation in available CAHMS resources in different districts.

The main service activities involve assessment, treatment, consultation/liaison, training and research. These are undertaken in community clinics, child guidance, adolescent and 'drop-in' clinics, outpatient, day-patient and inpatient services. Five types of response to child and adolescent mental health problems are described. These are:

- informal care
- primary care
- the child and adolescent mental health service: care by solo professionals
- the child and adolescent mental health service: multi-disciplinary care
- supra-district specialist multi-disciplinary care.

The pattern of care is variable across the country and several extremely successful models exist. For example solo professional care may be delivered from a unidisciplinary service or from a multi-disciplinary team. It should be noted that it is usual for any one specialist child and adolescent mental health professional to contribute to several types of care, e.g. supporting primary health care, solo, multi-disciplinary and supra-district care.

All specialist CAMHS involve professional activity outside the main professional base. This includes home and school visits for assessment or treatment purposes, attendance at child protection case conferences convened by social services and attendance at court.

It must be remembered that most child and adolescent mental health difficulties are dealt with through informal or primary care. These two areas are not covered in the recent survey and there is little additional information available from other sources.

Informal care

Single problems which are short-lived, mild and produce minimal social impairment are often dealt with entirely informally by family, friends or teachers. Examples include emotional reactions to life events, such as school entry or minor illness.

Primary care

Single problems with a low risk for severe disorder (with or without minor risk factors, see page 62) are dealt with by primary care professionals. Such problems include uncomplicated nocturnal enuresis, some general behavioural problems, feeding and sleep problems. Risk factors include overcrowding, isolation, mild parental mental health or relationship difficulties. Some general practitioners (GPs), paediatricians and health visitors have had additional specialist training in child mental health and are able to provide a service

intermediate between that generally available in primary health care and specialist child mental health services.

Current status of services in primary care

Existing services vary widely across the country. Primary health care services exist in all districts, but there are often unfilled posts amongst health visitors, school nurses or community medical officers, especially in inner-city areas. Health visitors or community paediatricians with additional training in assessment and treatment of child mental health problems are present in some districts. Pilot programmes, often supported by research funds, have not always been sustained following the cessation of start-up or research funding.¹⁵⁰ A child development programme from Bristol is being used by many health authorities in the UK.¹⁵¹ It involves a training programme for health visitors to become more aware of mental health and social problems of families they see and to help parents find their own solutions to their child rearing problems. A booklet on child mental health problems has recently been made available to all GPs in England and Wales.¹⁵²

The child and adolescent mental health service for a population of 250 000

Solo professional care

Children with common disorders that are not necessarily severe (page 62) occurring in association with one or two risk factors need specialist care. This is often dealt with by a specialist professional (who need not be a psychiatrist) acting alone or in collaboration with primary or general paediatric care, provided that the risk factors fall within the professional's specific expertise. Examples include some children with emotional and behavioural disorders or those associated with acute and chronic physical illness, feeding difficulties and specific educational difficulty. Services may be provided by child mental health service professionals, educational psychologists and social workers or by adult psychiatrists and paediatricians who have received additional relevant training, particularly those working in the community. Solo professional care may be provided by professionals based in a multi-disciplinary group or based on a unidisciplinary service that works in a co-ordinated fashion with the multi-disciplinary service.

A less common problem which indicates a severe disorder (page 62) and common disorders that are severe and/or with multiple risk factors (page 62) will require multi-disciplinary assessment.

Multi-disciplinary care

Children with disorders comprising particularly persistent single problems, or multiple problems with several aspects of dysfunction (page 62) commonly need multi-disciplinary specialist assessment and treatment (including a child and adolescent psychiatrist), with outpatient or sometimes day unit treatment provision. Such care is also needed for children and adolescents with less common problems which indicate a severe disorder and those with potentially severe disorders (page 62). These disorders will usually be associated with major risk factors and be of long duration (three months or more). They are likely to continue if there is no intervention. For example a child with a hyperkinetic conduct disorder, who is not compliant, shows aggression to peers, has educational problems and experiences family discord, would need such management. Other examples include children and adolescents with schizophrenia or obsessive-compulsive disorders, who will require such care at some stage.

Some services run by education and social services (special schools and family units) also aim to meet this type of need. They are usually supported by specialist child mental health professionals.

Range of child and adolescent mental health services: solo professional and multi-disciplinary care

Dedicated child and adolescent mental health services within districts can include the following.

- A full range of non-residential solo professional and multi-disciplinary assessment and treatment services, including emergency cover for self-harm and other urgent conditions.
- Health day-patient facilities for children with mental health problems to complement facilities provided by educational and social services.
- A service for adolescents which may include a more directly accessible and age-appropriate component, e.g. a walk-in facility.
- Consultation and liaison services for other agencies concerned with children and adolescents. Examples include:
 - a) schools, including special schools
 - b) social services, especially observation and assessment centres, day nurseries and child protection services
 - c) primary health care, including general practice, health visitors and school nursing
 - d) specialist health services: adult psychiatry, adult clinical psychology, paediatrics including community paediatrics, child development teams and learning difficulty services
 - e) voluntary agencies, e.g. NSPCC, Newpin and Home-start, and in particular, any residential or day care establishment for children and adolescents.
- Facilitation, support and training for voluntary organizations, e.g. befriending schemes and self-help groups.
- Training and collaboration with agencies listed under consultation and liaison services (a)–(e) above) and to the general public.
- Administration and monitoring of the service using appropriate secretarial staff and computing.
- Admission of some children and adolescents with mental health problems to health facilities for assessment and/or treatment, e.g. paediatric wards.
- Access to services appropriate to meet the need for specialist multi-disciplinary care for populations of around one million in national centres.

Multi-disciplinary services involve closely co-ordinated assessment and treatment by fully trained child and adolescent psychiatrists, child and adolescent clinical psychologists, child psychiatric nurses, social workers and child psychotherapists, with ready access to other professional colleagues such as paediatricians, speech and language therapists, occupational therapists and teachers.

Figures for these services and the present recommended staffing levels are described on pages 78, 95 and 113.

Supra-district specialist multi-disciplinary care

Children with major mental disorders such as schizophrenia, bi-polar affective disorder, obsessive compulsive disorder, anorexia nervosa, bulimia and complex cases of autism receive care in specialist inpatient units or tertiary outpatient referral centres, with moderate to close geographical accessibility.

Severe conduct disorders also receive this provision if there is an associated mood disorder or self-injurious behaviour or factors such as epilepsy, requiring inpatient assessment. However children with uncomplicated severe conduct disorders requiring residential provision may be placed in a residential school or social service units with education.

National centres

Highly specialized services based around multi-disciplinary assessment and treatment are used for a small number of children with complex neuropsychiatric problems associated with severe behavioural disturbance, those with severe behavioural disorders who require containment within secure units and those with certain rare conditions such as gender identity problems or profound sensory problems with associated psychiatric disorders.

Current service status for child and adolescent mental health services

The following information is a summary of the findings from a recent survey of services for the mental health of children and young people in the UK.¹⁴⁹ It looks at purchasing authorities and the various aspects of child and adolescent services, including community-based care, inpatient and special units, day treatment services, clinical psychology services, paediatric services, social services, education and the non-voluntary sector. Further details including figures from the survey are described in Appendix IV.

- The matching of provision to local needs has hardly begun and purchasers are still dependent on what the local units say they are providing.
- The specialist child and adolescent mental health services are largely delivered from a community base, by means of inter-disciplinary teams. Psychiatrists and psychiatric social workers are almost universally members of these teams, although the number of social workers has reduced in the past three years. In this period there has been both expansion and reduction of services in different parts of the country. However the overall provision of service has remained roughly the same. Changes appear to have been somewhat arbitrary, often based on local enthusiasm or on enforced reorganization in local authority services. Numbers of staff and the range of skills available vary widely. There is little input from the education sector.
- There is major variation in the distribution of child and adolescent psychiatrists across the country and in the type of work they undertake.
- Clinical psychology is a growing profession, working increasingly from an independent base. Clinical psychologists still work mainly with the child and adolescent mental health teams, but they also provide direct solo and consultative services to acute and community services in other parts of the NHS, to social services and other agencies.
- Almost two-thirds of mental health services for children now employ a psychiatric community nurse. However few nurses have training in children's and adolescents' psychiatric care and many seem to rely on skills acquired on short random courses.
- Many inpatient units, including former regional adolescent units, are experiencing problems particularly with respect to the new system of contracting for services.
- More children with emotional and behavioural disorder present to paediatricians than to any other profession. Paediatricians' training in the main does not prepare them for this and they would welcome further opportunities to gain relevant experience.
- Local education authorities are greatly concerned with emotional and behavioural difficulties in their pupils.
- Behaviour support services, as currently provided in three-quarters of local education authorities, include assessment of the educational needs of pupils with severe behaviour problems, but infrequently no relevant medical contribution is included. Special schools for children with emotional and behavioural difficulties report that few pupils have statements in which therapeutic help is specified, although the head teachers consider that nearly half of all pupils would benefit from such help.

- The educational psychology services state that part of their function is to work with individual children whose behaviour is causing concern, but most find that assessment activity takes up most of their time. Although all services agree that joint work should make a major contribution to the management of problems in children, education authorities limit their staff resources for collaborative work.
- Social services departments concentrate resources on children in need, many of whom have serious emotional and behavioural problems. They report unsatisfactory access to specialist expertise in children's mental health from the NHS.
- The voluntary sector plays a large part at primary care level, particularly in providing services such as counselling. They often take self-referrals. Voluntary organizations also act as a filter to specialist mental health and social services. Since the NHS mental health services accept self-referrals less and less, the voluntary services may be filling a gap in provision. Some voluntary services such as the NSPCC, Barnardos and NCH offer particular expertise of value also for secondary and tertiary provision.

Assessment, management and treatment procedures

To respond to the mental health needs of their patients, child and adult mental health services initiate a variety of assessment, management and treatment procedures. The diversity of these activities is illustrated in Box 8 which shows the broad categories of treatment, investigations and case management undertaken by services. Because of the complexity of needs dealt with, several of these investigative, treatment and care-related procedures will be implemented concurrently or sequentially during an individual care episode.

Box 8: Range of assessment, management and treatment procedures

Assessment
Limited involvement
Individual treatments – child/young person
Physical illness management
Group procedures – child/young person
Work with parents
Family/marital therapy
Community visits
Collaborative work (non-team/service member)
Referral out of team/unit for opinion/non-collaborative management during episode
Tests and investigations
Reports
Attending meetings and formal procedures
Consultation
Status change/extension during episode (e.g. switch to inpatient care)
Clinical trial/experimental interventions

Source: ¹⁵

The information in Box 8 does not detail many of the more specific forms of treatment, investigations and other procedures that have been developed, for instance the variety of medications to deal with anxiety or hyperactivity or the variants of family, psychotherapeutic and behaviourally-based therapies among others. Further it does not list the activities aimed at larger scale prevention or those aimed at the enhancement of practice and the quality of services through training of both service staff and the staffs of other agencies.

Finally services are also involved in the conduct of clinical and service-relevant research recognized as important activities for child and adolescent mental health services.

The activities listed in Box 8 can be grouped into a number of major forms of service which are undertaken in fully resourced and staffed services.

Assessment

Child and adolescent mental health services provide a number of specialist assessments as a basis for treatment or for other purposes:

- The establishment of 'caseness'. The referrer wishes to establish whether the individual has problems that constitute a mental health disorder, but does not request the assessor to undertake treatment.
- Second opinion requests. The referrer requests confirmation of a diagnosis and will deal with the ensuing needs.
- Conventional assessments to inform treatment and management within the service. Such assessments can be fairly rapid or may need to develop over time. Sometimes these include the clinical assessment of complex problems such as neuropsychiatric disorders.
- Complex assessments are those usually carried out for the courts, social services or other agencies. They require detailed information, usually culminating in a long report and consume substantial amounts of professional time. These assessments may not lead to treatment by the service. Most commonly requests for such assessments are from social services or the courts and arise because of proceedings under the Children Act. (Adequate assessment involves not just formal diagnostic categorization of the disorder, but full formulation of the problems including establishment of predisposing, precipitating and maintaining factors, prognosis and plans for intervention.)

Consultation/liaison

Parents, carers and agencies involved in looking after children and young people often need to discuss issues related to referral, diagnosis and management with specialist mental health services without wishing the case to be taken on by the child and adolescent mental health service. The processes of consultation are well-established.¹⁵³ In these instances the 'consultant' works with staff who have direct contact with the patient or patients. The individual patient may not be seen during the consultation, although he or she may be known to the service. Such work can be a more effective use of resources in dealing with the individual child or groups of children. In these instances the consultant works with staff (e.g. in schools or children's homes) who have direct contact.

Some services also provide psychiatric, psychological and psychotherapeutic input to paediatric and other wards to assist in diagnosis, management or treatment.¹⁵⁴

Treatment and management

It is not always easy to differentiate assessment and treatment since the act of referral or even the recognition that a referral to specialist services is needed can initiate changes, as can the first meetings with clinic services even when no systematic attempt is made to produce change.

Interventions involve the use of recognized procedures aimed at removing, reducing or containing symptomatology and achieving a more constructive adaptation and healthy development. Since the symptomatology is invariably expressed in or influenced by the family or school, work with other family members and teachers is essential. Other adults and children may also be involved e.g. club leaders and class peers. There are several further goals of intervention as follows.

- To help clients and relevant responsible adults develop an understanding of the problems and the mechanisms of treatment so that they can anticipate and avert relapse.
- To deal with the symptomatology and contributing context in such a way that interference with the ordinary life and on-going functioning of patient, family or other carers is minimized.
- To prevent the emergence of other difficulties.
- To enhance the quality of psychosocial functioning, present and future.

Emergency services

Many child and adolescent psychiatrists and some multi-disciplinary teams provide emergency input to hospital A and E and paediatric departments dealing with psychiatric emergencies in children and young people. Most commonly these are instances of self-harm or attempted self-harm.

Training

Part of the skill and knowledge base of mental health professionals can be taught to individuals (for instance teachers, nursery staff and social workers) who have non-specialist responsibilities for dealing with mental health needs. Requests for training will sometimes emerge following consultation or may arise directly from other agencies such as day nurseries, social services or schools. Training has both a reactive and a proactive intent: to deal with current difficulties and to make those being trained better able to prevent the emergence or recurrence of problems and disorders.

Professional education and continuing professional development

In common with other professional groups, child and adolescent mental health professionals are responsible for training entrants to their and other disciplines through both formal academic teaching and supervised clinical practice. Training schemes are commonly linked with university academic departments.

Professionals with academic posts usually carry responsibility for training in conjunction with honorary NHS sessional contracts.

Research

Many services undertake research into treatment and other aspects of service delivery, both to enhance practice and improve organizational processes. Job descriptions commonly include provision for research.

Academic psychiatry and psychology departments also play a central role in supporting research carried out by NHS staff as well as initiating and undertaking clinical and academic research of direct relevance to NHS CAMHS.

7 Treatment effectiveness of mental health services for children and young people

Treatment and outcomes: an overview

Mental health services for children and young people provide a variety of assessments, treatments and other interventions for individuals, families and groups, as well as teaching, training and research. It is difficult to

demonstrate conclusively a cause and effect relationship between interventions and changes, particularly with children and families with severe or long-standing difficulties.

In the introduction to a recent collection of papers on the topic of 'Psychosocial treatment research' in child and adolescent mental health, Hibbs states that:

... except in the instance of attention deficit hyperactivity disorder (ADHD), there is little research to corroborate the efficacy of well-defined treatments ... behavioural, cognitive-behavioural, and combined pharmacological/psychosocial/parent training... And there is even greater dearth of research for treatments such as psychodynamic, interpersonal, group, family therapy, and eclectic approaches, which are commonly used in clinical settings and by private practitioners. (page 2)¹⁵⁵

The evaluation of treatments for children and young people with mental health needs is probably more complex than evaluations in other conditions. Some of the reasons for this are discussed later.

Evidence is accumulating for the efficacy of a range of treatments and clinicians working in mental health services for children, young people and their families will identify many clients who they feel have benefited enormously from the therapeutic interventions provided by the service. Likewise there will be teachers, social workers, health visitors and other professionals who will attest to the ways in which the advice and support provided by these services have been of benefit to them and their clients. There will also be others whose response will be less positive and yet others where the impact of the service has been negligible or who will report that intervention made things worse. In this respect child and adolescent mental health services are similar to many other clinical services.

The absence of a substantial body of information or strong evidence of the effectiveness of psychological and pharmacological treatments for children and young people is well recognized and of general concern. This has been of such importance as to have led, at the request of the Federal Government in the US, to the establishment of a task group by the National Institute of Mental Health with the brief to expand research on 'psychosocial treatments' of young people.¹⁵⁵ A need for similar action exists in this country.

Consequently what is possible at the present time is a limited evaluation of the effectiveness of the treatments that services offer although, even here it will be seen that while the conclusions provide good grounds for optimism, there is much that still has to be done to establish that treatments meet strong criteria for effectiveness.

This section focuses on treatment outcomes rather than the effectiveness of services. It examines some of the major reasons for the present uncertainty and provides an update of the evidence regarding the treatment of the major psychological and psychiatric disorders and an overview of the current state of treatment research.

Evaluating interventions

Research on the effectiveness of interventions for mental health needs in children and young people is complex. In order to undertake controlled studies with random assignment of cases – the standard methodology – potentially influential variables such as the severity of the condition, economic status of the family, ability, ethnicity, marital status of carers, mental ability of the child, age and sex, all need to be taken into account. Few researchers have the resources to assemble the very large samples of patients needed to achieve such control, so that research on treatment tends to involve small groups with resulting limitations on the generalizability of the findings.

Psychological treatments are also very difficult to standardize: the therapist follows a general approach but has to tailor this to the idiosyncrasies of the individual patient and family. In some cases treatment may be given by the parent on the instruction of the clinician so that procedural uniformity may be difficult to achieve. Added to this is the tendency for placebo and placebo-like effects to be very influential in research

involving psychological or psychopharmacological treatments.¹⁵⁶ Given such complexity and the variety of human individual differences, it is also difficult to mount replication studies to check on initial findings.

These sorts of difficulties are not unique to mental health investigations but are particularly salient and intrusive in research involving multi-faceted social and psychological processes, especially with children and young people.

Consequently evidence for the efficacy of interventions is accumulated through a series of studies, each having some limitations, but each nevertheless contributing to an understanding of treatment effectiveness. Authoritative, independently assessed review articles which contain detailed methodological critiques of a large number of studies bring this together. Examples include the effects of child psychotherapy, as reported in 43 separate studies, and documented by Barnett, Docherty and Frommelt.¹⁵⁷ Pfeiffer and Strzelecki have reviewed the outcomes reported in 34 studies of residential and inpatient psychiatric treatment.¹⁵⁸ Graziano and Diament reviewed 155 empirical studies of the effects of training parents of children presenting with behaviour problems in behaviour management techniques.¹⁵⁹ Allen *et al.* examined 904 child behaviour therapy studies for evidence that the authors had attempted to check that effects generalized beyond the treatment programme.¹⁶⁰

It is from reviews such as these that the emergent views of the effectiveness of different treatment procedures or treatments for particular conditions arise: that is, from publications that have taken due account of the methodological constraints of the contributing studies.^a

Reviews of studies of clinical effectiveness then serve to inform and guide practice. They cannot however either determine what is done or even ensure favourable outcome in the individual case.

Treatment trials and service effectiveness

Controlled trials with random allocation of cases to different treatments require selection of cases, standard procedures and intensive monitoring of impact. Because of these and other special characteristics of the research it is difficult to extrapolate conclusions from such trials to likely outcomes in clinic populations or for clinic services: patients cannot be selected and the therapists are applying a wider range of treatment procedures to a symptomatically and otherwise heterogeneous client group.

Furthermore in clinical trials patients or their carers may be volunteers or agree to participation in research trials. In child and adolescent mental health services the identified patient and family may not have actively sought or even be willing participants in treatment. Children and young people are brought to the service, sometimes reluctantly, by family members or other carers. The family itself may have had to be persuaded or even, on occasion, coerced to attend because of a threat of expulsion from school or the concerns of social services or other agencies.

For these and other reasons, as Weisz and Weiss have suggested, it is difficult to generalize from research treatments to clinic service treatments.¹⁶¹

In a more recent analysis of the limited success of clinic services as contrasted with the outcomes of research treatments carried out in academic centres, Weisz *et al.* found only three of ten possible reasons were supported by their analysis of the research literature.¹⁶² First research therapy that is structured is more successful than the unstructured approaches that tend to be used in clinics. Second the research treatments that are more successful tend to be focused and specific. As such treatments tend to be easier to implement

^a In the main, the information on the effectiveness of mental health interventions in children and young people presented in later sections of this chapter is based on the conclusions drawn from such reviews. In those instances where this is not the case, conclusions are based on the views of clinicians who are themselves commonly involved in treatment research and who would in any event be taking account of the reviews and related literature.

and control for research purposes and may account for the better outcomes of controlled laboratory studies. Third behavioural treatments tend to have greater effect sizes than non-behavioural interventions.

These authors go on to note that if 'effect sizes are generally higher for behavioural methods... and if behavioural methods are more common in research therapy... then the superior effects of research therapy might be attributable to differences in methods of intervention.' (page 96)

Weisz *et al.* in trying to account for differences in effect sizes and noting the limitations of their approach, nevertheless found that the epoch of the study, severity of condition, the clinical setting, therapist experience, training and caseload and the length of therapy did not emerge as significant influences.¹⁶²

Constraints on outcome

Apart from the efficacy of treatments the factors that influence outcome in the individual case are many, some facilitating and others constraining the effectiveness of services. Not all of these are under direct control of the service.

Procedures for management and treatment are in many cases not carried out by health professionals but others, particularly parents and teachers. The impact of interventions is therefore dependent on, among other factors, parent/carer compliance with the regimen. This can involve bringing the child to clinic appointments, sometimes on a weekly basis for therapy sessions; rigorous data collection (for instance on tantrum frequency); carrying out of precise procedures of monitoring and intervention at home. It may require the involvement of the whole family, sometimes over an extended period. The patient may also have several sibs so that the 'parent as therapist' is implementing the treatment in a family context of competing demands.

Apart from the critical role of parents as facilitators of the intervention processes for their children, parents have their own needs. These may require the attention of services and should also be taken into account in the evaluation of treatment outcomes as the unmet needs of parents may prevent effective interventions with their children.¹⁶³

Participants in treatment (children and parents) may have firm ideas about the appropriateness of the treatment proposed which can limit compliance. Treatments that include medication may be resisted, even though there is increasing evidence of efficacy in specific conditions. Carers may have particular expectations, for instance that the child will be offered dynamic psychotherapy and so resist other treatment.

Many external factors confound treatment effectiveness. Concurrent factors such as inadequate housing can indirectly maintain and prolong the child's problems. In this case improvement may depend on external agencies over which health services have little if any control. Similar circumstances arise in the treatment of school phobia where the school for organizational or other reasons may not be able to participate actively in the treatment programme.

It is against this background that we proceed to examine the empirical evidence for treatment effectiveness.

Research and clinical findings

Reviews of treatment research can be major condition-centred (i.e. following ICD categories), problem-centred (e.g. the treatment of aggression), procedure-centred (e.g. analytical psychotherapy), event-centred (e.g. post-traumatic reactions) or quality of life centred (e.g. focusing on impact on family and others as well as the index individual).

As noted earlier there is as yet no evidence of high probability outcomes for the interventions provided by CAMHS. Instead there are individual case reports and a number of controlled studies in the literature on the

effectiveness of psychosocial interventions, the conclusions of which support the use of some of the procedures. The ways in which they are used will be discussed at the end of this section.

While there are many case reports recording the success of specific interventions with children and young people, some of which incorporate methodologies such as single case designs, it is recognized that such studies are limited in terms of the generalizations they permit. For instance a recent report on the effectiveness of cognitive-behavioural interventions with and without pharmacotherapy, in cases of obsessional compulsive disorder supports the effectiveness of this approach but is based mainly on treatment reports of single cases.¹⁶⁴ Single-case studies and clinical reports will not be considered further here, even though they frequently provide an inspiration for clinicians, especially when treatment options are otherwise limited.

This section is based on reviews of empirical research on psychological and pharmacological treatments of child and adolescent mental health disorders, as these are the basis of much epidemiological research. It is intended to provide a broad perspective on psychosocial treatments rather than a detailed review of all studies or all types of intervention for specific conditions.

General evidence

Overviews of the controlled studies are at present analysed in terms of the effect sizes from meta-analyses. Taken overall the outcomes of psychological treatments (collectively called the psychotherapies, encompassing behavioural and psychodynamic, as well as other approaches) of children and adolescents 'indicate that psychotherapy is better than no treatment, that the magnitude of improvement in juveniles parallels the treatment gains reported in adults, and that differences between treatment tend to favour behaviour therapy', the latter including cognitive treatments.¹⁶³ These outcomes have however to be qualified. First according to Kovacs and Lohr, many of the studies did not include clinically referred children. Second they note that the positive outcomes for behavioural treatments may reflect a form of criterion contamination in that the treatment targets were similar to the outcome measures – when this effect is eliminated, the superiority of behavioural treatments no longer holds.

The meta-analysis studies also mask significant differences in outcomes between younger children (4–12 year olds) and teenagers (13–18 year olds).¹⁶³

Conduct/antisocial disorders

Earls notes that chronic conduct disorders carry a high social cost and are among the most resistant to intervention.¹⁶⁵ Treatment needs to be focused on the individual, family or wider group depending on the outcome of assessment. Individual-only treatment is unlikely to have an impact.

Recent research is beginning to identify successful approaches to treatment.

According to Earls community-based approaches and those that involve social problem solving skills training have been shown to have beneficial effects.¹⁶⁵ Medication has yet to be demonstrated to have any specific value, apart from its use where other conditions coexist with the conduct disorder.

However in aggressive children who are hospitalized, treatment with lithium appears to have some beneficial effects according to the findings of a recent double-blind trial.¹⁶⁶ Alessi *et al.* suggest that there is increasing evidence for the usefulness of lithium in a number of childhood and adolescent disorders.¹⁶⁷

Kazdin *et al.* have demonstrated the usefulness of parent training and problem solving skills training in the treatment of severe antisocial behaviour.¹⁶⁸

Predictors of treatment drop-out have been described.¹⁶⁹ These include having a very severe form of the disorder, a mother undergoing severe stress and high levels of socio-economic disadvantage. This information enables procedures to be developed which reduce drop-out and so increase the chance of improved outcomes.

In their review Offord and Bennett also conclude that there is as yet little effective treatment for these disorders.¹⁷⁰ This is of major concern because of the associations with difficulties in later life.

Affective disorders

The treatment of affective disorders in children and young people tends to follow the pattern of treatment of such disorders in adults, but with greater emphasis on the involvement of the family and less frequent use of medication.

The outcome of treatment for depression has been recently reviewed.¹⁷¹⁻¹⁷⁴ Reynolds has also reviewed studies of depression in adolescents.¹⁷⁵ There is some, albeit weak, evidence that psychological approaches can have a beneficial effect on mild forms of depression, though the main thrust in treatment research has been in the use of anti-depressant medication. To date there is little firm evidence that such medication works better than placebo in children or adolescents with major depression.^{171,175} As depression in children is a recently recognized condition, it is suggested that it is still too early to make firm judgements regarding all forms of treatment.¹⁷⁴

Anxiety disorders

There have been a number of recent reviews and overviews of the treatment of anxiety disorders in children and young people.¹⁷⁶⁻¹⁸⁰ One reviewer¹⁷⁶ recommends the use of pharmacological treatments for these disorders, while others are consistent in the conclusion that as yet, no approach to treatment is well substantiated, other than that for obsessional compulsive disorder (see below). Bernstein and Borchardt discuss treatments for anxiety.¹⁷⁷ They note a number of studies using different forms of medication and suggest the use of, as well as further research into the effectiveness of different medications. Klein believes that behavioural treatments are rational since rapid improvements are noted clinically in many children when such treatments are instituted.¹⁸⁰

Post-traumatic stress disorder and attempted suicide

There is no research involving controlled trials but there are well documented and commonly applied management procedures. In the case of attempted suicide, for example, there needs to be a rapid response from the service in order to engage the young person and family and initiate treatment.

Anorexia nervosa and bulimia nervosa

Anorexia is a life threatening condition.¹⁸¹ A variety of treatment approaches is available and should include family and individual psychotherapy, behavioural treatments, availability of inpatient treatment or occasionally medication.

Bulimia is a more recently studied condition.¹⁸¹ Although there has been a substantial amount of treatment research the reported studies are methodologically inadequate so there is as yet no firm evidence of specific benefits.

Obsessive compulsive disorders

The treatment of obsessive-compulsive disorders in children closely follows that in adults. Although the efficacy of behavioural approaches is well documented in adult patients it has yet to be demonstrated through controlled studies with children.¹⁸² Medication with clomipramine is effective, though it is likely to be

needed for a prolonged period.^{182,183} There are no systematic comparisons of drug versus behavioural approaches. As noted earlier the use of cognitive-behavioural treatments alone or in combination with medication in the treatment of obsessional compulsive disorder is supported by some.¹⁶⁴

Attention deficit and overactivity

These syndromes are characterized by frequent co-morbidity and psychosocial adversity.¹⁸⁴ The most effective symptomatic treatment is stimulant medication,^{184,185} though the benefits are lost on cessation of treatment.¹⁸⁶ Therefore medication should be accompanied by treatment of other difficulties, such as school learning, social relationships and self-esteem. DuPaul and Barkley reviewed the combined use of behavioural and pharmacological therapies and noted the added benefits for some children treated this way.¹⁸⁷

Tic disorders

Psychosocial interventions involving education about the disorder as well as support, form the core of treatment, with pharmacological treatment being used in the more severe cases. While there is consistent evidence of response to medication in the majority of those treated, side-effects can be intrusive. Cognitive, behavioural and other psychotherapeutic treatments show some evidence of effectiveness, but the findings need to be replicated in further studies.¹⁸⁸

Feeding and sleeping disorders in young children

There are well documented procedures for treating feeding difficulties in young children, but as Skuse notes, the main evidence on effectiveness derives from successfully treated single cases.¹⁸⁹

Difficulties of getting to sleep and night waking are the most common forms and tend to be responsive to simple behavioural management.¹⁸⁹ There are well-trying treatments for other conditions that arise during sleep but as yet without documented controlled trials of their effectiveness.

Disorders of attachment

These problems, usually in the relationship between mother and infant or child, have been treated in various ways commonly involving the mother-child pair in the programme. There is however no systematic treatment research that provides a clear basis for specific interventions.¹⁹⁰

Autism, learning difficulties and related developmental disorders

Although the core problems in these conditions are not modifiable to a major extent, they may require long-term intervention from mental health services. Of particular importance are programmes that deal with secondary behavioural or emotional disorders and training in social skills. The needs of individuals with autism and their families have been well documented and the overall management programme involves provision for medical care, appropriate education, family support and where necessary, focused treatment with speech and language, social skills or other therapies. Pharmacological treatments are as yet without major value but are seen as potentially helpful adjuncts to the overall treatment programme.¹⁹¹

Bed wetting and faecal soiling

Nocturnal enuresis has inspired a wide variety of treatments including surgery, medications, night waking and the use of a special alarm which is the only procedure known to cure the condition.⁶⁰ Cure rates average

about 80% using the alarm, but it can be a difficult procedure to maintain. While relapses do occur, they do so with lesser frequency than when cessation of wetting is accomplished by other means. Medication has short-term benefits in nocturnal enuresis. Encopresis requires both medical and psychological management.

Schizophrenia

Schizophrenia is an appropriate diagnosis for a few older children and adolescents. As with the adult form, it is an incurable or recurrent condition, but persistent symptoms can be controlled with appropriate treatment. The major concerns relate to the consequences of the disorder for the child and family. As there is little evidence on the treatment and outcome in children and young people, Werry and Taylor propose that the efficacy of treatment is assumed to be much the same as for adults.¹⁹² Pharmacotherapy is a major component of treatment and there is substantial evidence that it is 'very helpful in schizophrenia in adults'.¹⁹² Work with the child's family may be important for prevention of relapse.

Some psychologically based approaches to management and treatment in adults appear to have value but their efficacy with this group still requires much stronger support from adequate research. Consequently there is little basis for generalizing to younger age groups.

Atypical psychosexual development

There are several treatment approaches for children and young people with atypical sexual development that report some successful results but there are no trials of treatment sufficient to enable firm conclusions to be drawn.¹⁹³

Somatic diseases and disorders combined with chronic physical illness

The risk of psychological and psychiatric disorders is doubled in populations with major chronic illnesses.¹⁹⁴ The nature of the disorders is much the same as in individuals without the illness so treatment approaches follow those adopted for patients without physical illness. There are no controlled trials of treatment procedures for combined psychological and physical disorders. Specific approaches are available for pain management and to help children cope with medical procedures.

Physical and sexual abuse

The treatment of individuals who have been abused is complex and needs to take account of a multiplicity of factors. The aims are to deal with any current disorder resulting from the abuse and to prevent future mental ill-health. Removal of the child to a hospital, residential unit or other place of safety may be required. The treatment approach depends on the extent to which the factors that led to the abuse can be identified and the willingness of the individuals concerned to participate in treatment. Work with parents and families is essential if children are to remain at home. There are indications that successful behaviour modification, such as anger management in the abusers, can be beneficial for some children.¹⁹⁵ Individual dynamic psychotherapeutic approaches are also used.

O'Donohue and Elliott have reviewed reports of studies using psychotherapeutic procedures with sexually abused children.¹⁹⁶ Systematic studies have begun to delineate some of the characteristics of families which are not treatable, so that service resources can begin to be focused more efficiently.¹⁹⁷

Smith and Bentovim note that an increasing number of treatments for sexual abuse are being investigated but there are insufficient controlled studies so that conclusions about the effectiveness of treatments are still premature.¹⁹⁸

Prevention

Prevention of child and adolescent mental health difficulties is important because of the risk of problems continuing into adult life. Recent reviews of prevention are provided by Cox¹⁸ and Graham.¹⁹

While much research has focused on treatment or other aspects of disorders, comparatively little attention has been given to prevention. There is, however, an increasing interest in prevention, particularly on a more 'macro', community level. Conceptual and methodological frameworks for the evaluation of preventive interventions have been elaborated.¹⁹⁹ Systematic studies in the US are also beginning to show that preventive interventions can have a beneficial impact on different aspects of the behaviour and mental health of children and young people. Interventions include helping them to resist drug taking and to deal with such stressful transitions as school transfer.¹⁹⁹ Recent reviews of research on the prevention of physical abuse and neglect²⁰⁰ and sexual abuse²⁰¹ have also shown that some benefits can be achieved through focused prevention programmes. One major study in the UK provided encouraging results for a school-based psychotherapeutic intervention for children with behaviour problems.²⁰²

Preventive interventions are clearly possible and of great potential benefit, and given the assumption that such interventions can lead to the reduction in the prevalence and incidence of disorders, evaluative studies appear to be well worth supporting, particularly in communities or contexts where the risks for emotional and behavioural problems are known and high.

Criteria for judging treatment research in child and adolescent mental health services

Methodological difficulties are common in all clinical research.²⁰³ Since the earlier reviews of treatment for children with emotional and behavioural disorders,²⁰⁴ some of the major advances that have taken place involve methodological refinements and the consequent introduction of new criteria to be used in the evaluation of studies and outcomes.

Criteria for judging the efficacy of treatment have become increasingly sophisticated and complex. Although some of these criteria are condition specific – for instance in autism the underlying problem is not curable but change in major secondary symptoms is a realistic goal – there are general criteria that are now seen as core requirements.

Among the changes and improvements noted by Kovacs and Lohr has been the introduction of treatment manuals which are aimed at clearer specification of how the treatment should be implemented. Criteria to assess improvement 'have become more specific and multidimensional' and definitions solely in terms of clinicians' global judgements replaced by more objective measures involving direct observations and 'operationally defined scales' (pages 14–15).¹⁶³

It is also recognized that it is now no longer sufficient to report statistical significance. Treatment research must also demonstrate that the changes have clinical significance, and that there is an impact on daily life, adaptation and relationships. There is also the need to demonstrate that treated clients move much closer to, or into the 'normal' range on assessment instruments. Other criteria include:

- a range of different methods for appraising outcome, rather than a single procedure (this includes evaluating process or relationships and not just symptomatology)
- a number of judges of outcome, each with a differing perspective
- assessments of functioning, both pre- and post-intervention which monitor 'internal changes' (both physiological – if appropriate – self-perceptions, and behaviours)
- statistical or other controls for co-morbidity

- assessments of stability of changes over time, since benefits are often not apparent for some time after the intervention
- monitoring of generalizability of improvements across situations (e.g. home and school)
- evidence that the intervention is better than no treatment
- evidence that the intervention is more cost-effective than other procedures
- evidence that there are minimal harmful side-effects.

Treatment research and service implications

The clinical and research literature on treatment, consisting of case reports, small-scale studies and controlled trials, constitutes the major resource for innovation and the modification of service interventions and practice. It is however not realistic to assume that favourable outcomes reported in the literature will invariably translate into positive outcomes in practice.

The nature of individual differences in the aetiology, presentation and external circumstances of children and young people, as well as the resources of services, militate against a simple formula for linking need, intervention and outcome in clinical practice. Even impressive interventions such as the use of medication in children with attention deficit and hyperactivity do not succeed in every case: an appreciable number of children are not helped by the treatment. Indeed, prediction of outcome in the individual case, given the complexity of aetiology, presentation and individual circumstance, is hazardous and a challenge for future research.

Furthermore it is necessary for findings to be replicated in independent studies. Much research emanates from the US and differences in the regulation of medication, the contexts of clinical practice, and the clinical populations studied make it hazardous to extrapolate the results to the UK population.

There can also be a major time lag between the identification of a psychological treatment procedure that shows promise and its systematic introduction in services. This is partly because suitable cases appear intermittently in services and the procedures, for instance cognitive-behavioural treatment, can require specialized training and a period of ongoing supervision.

Conclusion

At present there are few examples of child and adolescent mental health treatment that can unequivocally demonstrate their effectiveness. However substantial progress has been made in identifying the range of interventions that have the potential to benefit children and young people with mental health problems and disorders and their families. This range of treatments should be potentially available to all children and adolescents.

Klein has asserted that ‘...clinicians cannot await the scientific verdict to care for children who seek treatment.’ (page 367).¹⁸⁰ The research underlines the importance of careful monitoring of progress in individual cases undergoing treatment. There should be a preparedness to change the approach where the current procedures are ineffective. The critical importance of controlled treatment trials lies in the inspiration, opportunities and direction they give to clinicians in selecting procedures likely to be the most efficacious. The effectiveness of services is then dependent on their having the resources and the skill to exploit the treatment research literature.

8 Models of care

Principles

There are several important principles which need to be accepted in developing models of care in child and adolescent mental health.

The majority of child and adolescent mental health problems can be dealt with in primary care

Many mental health problems in children and young people can be dealt with at the primary care level. As with other disciplines this can only be achieved if the health professionals at this level have adequate training in the subject and maintain their skills through continuing education. This will usually be provided by specialist child mental health professionals. Primary care teams may identify members who will develop particular expertise in this field, though all team members must be able to recognize mental health problems in children at an early stage.

The primary care team should have ready access to colleagues with additional training such as school nurses or community paediatricians, who may be team members.

The primary care team can only function satisfactorily if it is confident that specialist help is readily available when needed through local CAMHS. Primary care staff should recognize the limits of their competence and not retain responsibility for the care of children whose problems are beyond their experience.

Specialists should provide support to other groups

Specialist child and adolescent mental health professionals should support and promote the activities of primary health care, other professionals and of voluntary agencies concerned with the treatment and welfare of children with mental health problems. Support includes consultation and training and requires ready accessibility of the specialist services.

Service should be patient centred

There is inevitably a tension between accessibility and specialist services. When a child's problems cannot be adequately dealt with in primary care, specialist mental health professionals should be readily available. CAMHS require limited use of complex, hospital-based diagnostic facilities: most assessments and treatments can be adequately carried out in clinic or outpatient premises. When it is geographically desirable, the professional member of the solo professional or multi-disciplinary group should work on a sessional basis to cover more than one site. This will improve convenience for patients and relatives and enhance compliance with treatment. It is undesirable for families to travel long distances with disturbed children. Facilities should be convenient and appropriate for children and adolescents.

However if individual professionals work across several sites much time will be wasted in travel and there will be difficulty in forging good working links with other professional colleagues.

There should be patient choice

Wherever possible patients and carers should be informed about treatment possibilities and given a choice of the professions and services from which they would like advice and help.

Specialist services should accommodate the spectrum of need

Not all children and young people with mental health needs require multi-disciplinary resources. There should therefore be a solo professional service provided by child and adolescent psychiatrists, clinical psychologists specializing in work with children and young people, or child psychiatric nurses. This type of care facilitates the geographical spread of provision, whether organized as a uniprofessional service or as solo professionals doing outreach work from a multi-disciplinary base.

Multi-disciplinary resources should include psychiatrists, psychologists, psychotherapists, nurses and social workers, in order to provide for children and families with more complex needs. Speech and language and occupational therapists, and specialist teachers can make a contribution to such resources.

Where there are both unidisciplinary and multi-disciplinary groups, they should work in close liaison with each other and with social services and education colleagues to facilitate joint assessment and treatment. Multi-disciplinary resources may work as a team receiving referrals or as independent professional groups who collaborate on individual cases. Where a team organization is used professionals can also work in a solo or unidisciplinary mode. Team organization is needed for day and inpatient services. Inpatient services require educational provision.

Services should be concentrated in areas of greatest need

The prevalence of mental health problems in children and young people is high among those with special educational needs, those with developmental problems and physical illness, those with mental and physically ill parents and those in contact with social services and the law. Efforts should be made to ensure that services are distributed to provide maximum resource at points of greatest need.

Professional isolation should be avoided

It is unsatisfactory for professionals of any discipline to work in isolation. This can lead to undue work stress and idiosyncratic practice, as well as problems with the organization and continuity of service delivery. All services should therefore include at least two members of each professional group, one of whom should be of senior status.

Service organization

Services should have at least one senior member of each profession to organize and be responsible for intra-professional matters e.g. training, supervision, recruitment and service development. There should be clear management structures with lines of accountability for provision of services, incorporated by appropriate contracts or job plans.

Professional accountability

Professional accountability should be to an individual within the same discipline. There will need to be clear distinctions between the spheres of professional (clinical) and management responsibility.

Service isolation should be avoided

Solo professionals should have ready access to multi-disciplinary services, if staff are not also members of such services. There should be agreed procedures to prevent duplication of referrals to different services and mechanisms to distribute resources effectively and appropriately.

Good communication and collaboration are essential

If communication and collaboration are poor, resources will be wasted through duplication, there will be gaps in services and patients and carers will be confused.

Services can only be effective if there are easy and open channels of communication between all parties, independent of their management structure. This does not imply the need for a single management structure, but emphasizes the importance of a co-ordinating structure with shared strategies and policies.

The model of care*Localities*

Each will have a primary care team, with a measure of specialist support from, for example, a school nurse or consultant community paediatrician who may work with several teams. Outreach services from child mental health professionals should be available in primary care as part of the solo professional specialist service.

Communities up to 250 000

Each should have both a solo professional and multi-disciplinary specialist service providing day and outpatient services. They should work closely with co-terminous local authority social services and education teams, preferably with some social workers and/or educational psychologists working from the same base. The model of co-ordination of solo and multi-disciplinary service can vary. What is essential is that the two components are co-ordinated. Two main models exist at the present time.

- Professionals collaborating in a multi-disciplinary service that also provides a solo service.
- Multi-disciplinary and solo professional services that are organizationally distinct but have mechanisms to collaborate effectively. In these circumstances the solo professional is usually a clinical psychology service.

The services will also work closely with the general paediatric and adult psychiatry services at the district general hospital. The specialist services will provide clinics at several sites, with the aim of ensuring that under-fives can be assessed reasonably close to their homes and that distance is not a barrier to care for older children. Intensive day treatment provision should be available for families of under-fives for parenting problems and for school age children. Day units need a range of dedicated staff similar to those in inpatient units. Local services for adolescents can be more concentrated, since this age group is likely to be more mobile and may be encouraged to attend by the availability of an environment which is sensitive to their interests and attitudes. Temporal as well as geographical access is important for this group: services should be available out of school hours. This also helps to ensure the attendance of parents who are working outside the home.

The specialist services should provide concentrated input in areas of high need, such as special schools, local authority family centres and residential homes and paediatric clinics. Joint approaches to funding of staff should be considered.

There should be access to hospital diagnostic facilities and inpatient paediatric beds on an occasional basis.

Communities of 750 000–1 000 000

Inpatient facilities for children and adolescents should be provided. An inpatient unit for younger children may be satisfactorily sited within a district general hospital, preferably close to outpatient and paediatric facilities. Adolescent units are best sited away from the district general hospital: access to investigatory, paediatric and adult mental health services is essential.

The Royal College of Psychiatrists has estimated that for a total population of 250 000 the inpatient provision should be 2–4 beds for children and 4–6 beds for adolescents up to the age of 16 in wards of a minimal size of 15 and 20–25 beds respectively.²⁰⁵

The inpatient facilities should be staffed by a dedicated, multi-disciplinary team which works closely with the community-based specialist services that will normally be the source of referrals. The inpatient team should include the following professional groups, as a minimum:

- child and adolescent psychiatrists
- clinical psychologists
- nurses
- occupational therapists
- social workers
- psychotherapists.

All inpatient units must have proper educational facilities (staffed by the local authority education department) and adequate recreational opportunities.

Adjacent outpatient and day care facilities can be helpful in managing the transition from inpatient to community-based care and eventual discharge.

Communities of 3 000 000

There are some rare and difficult-to-manage conditions for which highly specialist services are required. They can be divided into the following.

- Conditions needing complex assessment. For example:
 - a) pervasive developmental disorders
 - b) neuropsychiatric problems
 - c) gender identity problems
 - d) severe psychoses
 - e) severe obsessional disorders
 - f) complex child abuse
 - g) sensory handicaps.
- Difficult treatment problems. For example:
 - a) severe conduct disorders, including those needing secure accommodation
 - b) other severe disorders not responsive to more local inpatient treatment (e.g. obsessional and mood disorders)
 - c) neuropsychiatric disorders
 - d) post-traumatic disorders
 - e) severe epilepsy
 - f) other brain dysfunction
 - g) complex child abuse, including treatment of Münchhausen Syndrome by Proxy and child/adolescent perpetrators of sexual abuse.

'Regional' centres are needed for these patients. These units are by definition dealing with highly demanding patients. It is essential that their staffing is maintained at a sufficiently high level to promote effective treatment and to prevent stress among staff.

Service targets

In a co-ordinated service for a population of 250 000 no professional should work in isolation. This means that both solo and multi-disciplinary services should have at least two professionals from any discipline, whether child psychiatry, clinical child psychology or community psychiatric nursing.

The targets for individual disciplines outlined below derive from recommendations from professional bodies where such recommendations exist. These recommendations do not take adequate account of the need for solo professional activity. Child psychiatrists and clinical psychologists will be expected to take a leading role in the development of solo and multi-disciplinary outpatient/day patient services, assessment, treatment, teaching and research. The involvement of senior nursing staff is vital for the planning of inpatient and most day patient services.

Psychiatrists

The Royal College of Psychiatrists recommends that there be 1.3 whole time equivalent (wte) consultants in child and adolescent psychiatry per 100 000 total population (for uni- and multi-disciplinary care). In addition to this there should be consultant provision for regional or supra-district services. In centres with a major teaching responsibility, consultant numbers should be increased to take account of teaching and research responsibilities.²⁰⁵ Bridges over Troubled Waters has recommended that there should be 0.8 wte consultants per 200 000 population with a special responsibility for adolescent mental health services.²⁰⁶ Child psychiatrists will usually be based in multi-disciplinary groups although some of their activity will be as a solo professional. All inpatient units need a child psychiatrist who carries appropriate responsibility for leadership and organization in collaboration with senior nursing staff.

Clinical psychologists

The Division of Clinical Psychology of the British Psychological Society recommends that there should be at least one full-time clinical psychologist working with children and families per 75 000 population. A child clinical psychologist at Grade B level with relevant skills and experience should head the psychology services for a given population. There should be at least one child clinical psychologist in all major service segments (e.g. under-fives, adolescents) provided by the unit or hospital trust. In a population of 250 000 a minimum of 3.5 wte posts are required. Additional posts will also be needed to provide specific services to specialist units for children and young people in primary health care.

Solo professional activity (page 76) is often appropriately conducted by clinical psychologists. This solo professional activity may be provided by clinical psychologists working from a multi-disciplinary base or a uniprofessional service.

Nurses

Nurses will usually be based within a multi-disciplinary group or team. They make an essential contribution to inpatient services but require additional training to work in an outpatient service. There are no specific recommendations for the expected levels of staffing for nurses working with multi-disciplinary outpatient groups. It is suggested that there should be a minimum of two community child psychiatric nurses for every consultant child psychiatrist. A day unit working intensively with between 50 and 80 children and their families per annum will require at least three full-time nursing staff of whom one should be at least Grade H. Inpatient units should maintain safe levels of staffing with trained nurses at all times. This may require a nurse: patient ratio of 1 : 1, depending on organizational arrangements in the unit.

Child psychotherapy

Psychotherapists perform a valuable role in both direct work with children and parents and in supporting and supervising intensive individual and group psychotherapy by other professionals. One child psychotherapist is required per 100 000 population with an additional child psychotherapist for every inpatient unit. The Child Psychotherapy Trust has proposed a target of one child psychotherapist for every child mental health team (a total of 660) with additional senior child psychotherapists who can take teaching responsibility.

Occupational therapy

Occupational therapists with specific training and expertise in working with children contribute towards day and inpatient treatment services. A minimum of one occupational therapist is needed per 100 000 population to work in day unit facilities. An additional occupational therapist will be required for every inpatient unit.

Social workers, educational psychologists and specialist teachers

Many children referred to child and adolescent mental health services are involved with social services or have special educational needs. Closely co-ordinated work is required in matters relating to child care, child abuse and educational difficulty. Ideally there should be three whole-time social workers per 100 000 population doing regular joint work with child and adolescent mental health services. There need to be arrangements to co-ordinate assessment and joint work with the school psychological service (educational psychologists). This is sometimes facilitated by co-location of educational psychologists with child and adolescent mental health services. As many children attending these services have specific educational difficulties, there can be significant benefit if some teachers with relevant specialist skills are co-located with the child and adolescent mental health services.

Support staff

Secretarial/administrative support staff are required: a ratio of one per three wte health professionals has been suggested, but this depends on organizational arrangements and office systems.

Range of services

The following range of non-residential services should be available in each district.

Assessment

- child and adolescent psychiatric, including neuro-psychiatric
- psychological including psychometry
- physical
- developmental
- educational
- social, including child protection.

Specific treatments

- cognitive and behavioural therapy
- individual child psychotherapy, including play therapy and art psychotherapy
- family therapy
- parental counselling, including marital therapy and advice on child management
- physical methods of treatment, including drug treatment
- social skills training
- special educational treatment
- day unit services
- consultation.

Group therapies should also be available (e.g. for social skills training or in the treatment of sexual abuse of child perpetrators of sexual abuse).

In addition resources should be available throughout the services for training (including continuing education).

Research

Service-related research is necessary to promote and monitor service developments and sustain the quality of staff activity. Appropriate resources are required.

Physical facilities

Within any district there should be at least one hospital and one community base for specialist child mental health professionals. The hospital base should be within a district general hospital or general teaching hospital, situated to enable satisfactory collaboration with paediatric and adult mental health and A and E services. All services should work in collaboration with community health services. Hospital and community clinic premises need to be dedicated and have:

- furnishing and equipment congenial for children and families
- toys and play equipment
- rooms suitable for the full range of assessments and treatments including physical examination, psychometry, individual psychotherapy, family therapy. Video facilities should be available
- an appropriate reception and waiting area
- clinic premises sympathetic to local culture to promote accessibility
- services for adolescents geared to their sub-culture with easy, direct access.

Contracts for care

Each commissioning authority will wish to ensure access for its population to the following.

- **Locally based specialist CAMHS** Provide regular, accessible solo and multi-professional assessment and treatment services, in liaison with other relevant professional groups. These are the 'core' services.
- **Inpatient units** Clear admission and discharge policies are needed and work in close co-operation with the local community-based specialist team is also needed. Commissioners should consider setting standards for waiting lists for admission to these units.
- **Specialist inpatient units for rare conditions** The patients requiring these services are often 'difficult-to-place' and their care is expensive. Purchasing authorities should decide how such cases will be dealt with and arrangements should be explicit in contracts. This may be done by requiring providers to deal with the matter, or by retaining contingency funds for such cases or by agreements on risk-sharing between purchasers and providers. In all cases a time limit for resolution of difficulties and appropriate placement of the child should be set. Clear arrangements also need to be agreed with local authorities about mechanisms for resolving problems relating to responsibility for care, with explicit systems for ensuring that children and families are not passed from one agency to another with unacceptable delays and deficiencies in care.

9 Outcome measures

Introduction

The general aim of child and adolescent mental health services is to relieve suffering in children with mental health problems, to support their families and promote their development into stable adults who fulfil their potential.

The assessment of outcome for specific problems can address:

- symptomatology
- general development
- impact on others
- long-term personal functioning.

It is nevertheless valuable to consider interim measures of structure and process as well as clinical outcomes.

Structure

Although the level of investment in a service is not in itself a measure of quality, it is clear that a seriously under-resourced service will not be able to provide acceptable care. Commissioners should bear in mind the manpower standards outlined in section 8 when specifying service requirements.

- Each commissioner should ensure that community-based specialist services are available to appropriate population groups (see section 8) and that there are clear systems of access to the service and from the service to inpatient and other specialist units when required.

- Specialist services should be set up in such a way that there are no isolated professionals.
- Services should have appropriate administrative and secretarial support to ensure efficient service provision.
- The level of provision should reflect local needs and take account of factors such as social disadvantage.
- Staffing and facilities should take account of local ethnic diversity.
- All premises should be appropriately equipped and furnished for the service age group (children or adolescents) to maximize acceptability and attendance.
- There should be a realistic quality standards framework and systems for service monitoring.

Process

Accessibility

- Clinics should be held at times which are convenient to school-age children and working parents.
- Clinics should be located in places accessible to parents of young children and individuals with disabilities.
- Clinics should be organized so that referrals are seen promptly for assessment, while the individuals are still motivated.
- Clinics should be organized so that there is minimal delay between assessment and the start of a treatment programme.
- Child and adolescent mental health staff should have regular, mutually agreed meetings with paediatric staff and there should be an on-call service for paediatric inpatients requiring urgent assessment (e.g. deliberate self-harm, abuse, psychosis).
- Specialist advice should be readily available to paediatricians, local authority social services, adult mental health, education and primary care services.

Communications

Explicit arrangements should be established for communications between the following.

- **Specialist professional staff** Especially for the multi-disciplinary assessment and monitoring of patients and co-ordination between solo and multi-disciplinary services.
- **Specialist professional staff and other health professionals** All those with responsibility for the health and welfare of children and adolescents with mental health problems and their families should be kept informed of treatment initiation, programmes and progress, subject where necessary to the normal constraints of confidentiality.
- **Services and clients** All those requiring treatment or support should be given a clear explanation of the nature of the problem, as assessed by specialist services, be informed about possible choices of management and be encouraged to participate actively in treatment. Where possible and in particular where this does not prejudice the welfare of the child assessment reports should be available to parents and care-givers.

Professional standards

The maintenance of professional standards of practice is an important, if indirect, consideration in ensuring satisfactory outcomes of care.

Purchasers should require that:

- all professional staff are qualified and registered with the appropriate body
- all professional staff have access to the time and resources needed for continuing education and professional development. There should be particular attention to training and treatment procedures where effectiveness has been demonstrated
- all professional staff participate in clinical audit, which is reported to the district or trust audit committee in accordance with local arrangements. An example of multi-disciplinary audit has recently been described²⁰⁷
- professional training taking place in the service is monitored by the appropriate professional body
- opportunities are available for research.

Outcomes

Clinical

Symptomatic

Some specific conditions allow direct measurement of outcomes. For example:

- specific phobias – proportion of those treated who overcome phobia
- enuresis – proportion of those treated who remain ‘dry’ for a specific time
- school refusal and truancy – proportion of children attending school regularly
- eating disorders – proportion of those treated who maintain a target weight and normal eating habits.

Goal attainment

In many cases progress cannot be assessed by symptomatic improvement and is measured by attainment of diverse treatment goals which are specific for each patient and include qualitative indicators. These goals should be identified for each referral and monitored at specified intervals. They should take into account the goals of parents, referrers and professionals and should be operationally defined.

Quality of life

The impact of treatment on the child and others can also be assessed by measures such as:

- school progress
- friendships
- family discord
- evidence of repeated abuse
- enjoyment of activity.

In all cases objective measures should be used. The C-GAS has been used in a number of services as a measure of impairment and its reduction.²⁰⁸

Adverse events

There are some adverse events which, though from time to time unavoidable, may require specific investigation through a confidential enquiry. This ensures that there were no service failures and allows procedures to be improved where necessary. These include:

- suicides under the age of 18 (whether or not under the care of mental health professionals)
- death or serious self-harm while under the care of child mental health services
- abuse while under the care of child mental health services
- pregnancy under the age of 16.

There are many other events or circumstances which may give rise to significant concern and could be used as a monitoring tool e.g. running away from home.

The clinical outcome of the treatment of child mental health problems may only become clear in later life. In many instances it is never known whether an apparently mildly successful intervention in reality prevented serious deterioration.

User satisfaction

The views of service users are an important aspect of outcome assessment. If users are unhappy with the service, they are likely to discontinue treatment and hence will not be able to benefit. It is particularly difficult to assess the satisfaction of users of child and adolescent mental health services since the designated patient may not be in a position to give an opinion and the interests and satisfaction of the carer or parent may not be concordant with those of the child. However many services have carried out evaluations of both client and referrer satisfaction. Purchasers should, however, encourage providers to develop approaches to this subject and report regularly on findings.

10 Targets

Introduction

Purchasers should aim for the provision of services and staff as set out in section 8. This would include:

- an adequately staffed solo professional and multi-disciplinary service for each 250 000 population
- geographically and temporally convenient services
- appropriate child-centred accommodation that facilitates the full range of assessment and treatment
- ready access to more specialist services, on a larger population base
- no isolated professional staff.

Specific targets

Specific service targets might include:

- no child or young person should wait more than four weeks after referral for specialist assessment by a local solo professional or multi-disciplinary team (a multi-disciplinary assessment is not necessary for every case)
- no child or young person should wait more than two weeks for the start of a treatment programme, following assessment
- a child who might require inpatient care should be assessed within 24 hours if the referring professional considers the case urgent
- a child who following assessment is considered in need of urgent inpatient care should be admitted within 24 hours
- a child requiring inpatient care that is not urgent should be admitted at an appropriate time, as advised by the clinician responsible for the case, and the family should be given at least one week's notice
- no child or young person should be admitted to an adult psychiatric inpatient unit unless there is a positive indication. If this is not considered an appropriate setting, the child or young person should be transferred to appropriate accommodation within one week
- in 'difficult-to-place' cases, senior staff in the authorities concerned (usually health and social services) should meet and decide which agency will take responsibility and set a timetable for placing the child in appropriate care
- all children or young people admitted to hospital or seen in A and E departments as a result of actual or suspected physical, sexual or emotional abuse should be referred for assessment. Local child protection procedures should clearly explain the correct mechanism. Social services will normally be the first line of assessment
- all children or young people admitted to hospital or seen in A and E departments as a result of deliberate self-harm should be seen by a child and adolescent psychiatrist before discharge or by a professional with appropriate training and ready access to a psychiatrist
- all provider units should have explicit procedures, copies of which are available to purchasers, for the two situations set out above.

11 Information

Introduction

Though there is considerable epidemiological information on child and adolescent mental health, clinical and management information is inadequate at present, although some services have produced local needs based assessments.²⁰⁹ The situation is, of course, common to many other health services. It is particularly difficult in this service, however, because of the complex nature of some of the problems, the dependence of many of the designated patients on carers or other adults for referral to services, for participation in treatment and the multi-sectoral range of services. Information availability is variable and commissioners should check with professionals and other agencies on their local situation.

Areas for improvement

In order to improve needs assessment for child and adolescent mental health services, better information is needed on the following.

- **Mental health status in the community** This may require the development of instruments or other measures which can be realistically used in particular populations, though several standardized instruments are already available and screening for major disorders is possible.
- **Information on the number and location of high risk groups** These include relatively easy-to-identify groups, such as those in special schools, those in local authority care, or those with serious physical illness. It is also necessary however, to obtain better information on 'hidden' groups – poor achievers at school, children recently bereaved, children suffering following family break-ups, so as to intervene, if necessary, at an early stage and try to prevent the development of possible serious sequelae.
- **Information on the relationships between mental health and various environmental, social and economic factors** These may be useful proxies for health care needs (section 12).
- **Information from other providers** For example voluntary agencies.

Child and adolescent mental health services are essentially interdisciplinary: they involve different levels of health care and different agencies. Information should ideally be available to all professionals involved in care and integrated records of service use and care should be developed. Advances in information technology should enable more sophisticated systems to be used which could meet operational needs as well as service planning, research and monitoring requirements.

A coding framework such as the 'proposed core data set for child and adolescent mental health services' provides one example of the core data requirements for services.¹⁵ In the medium term the read codes are likely to form the basis of an integrated health record of patient characteristics and core events, which will also cover child and adolescent mental health. At present there are very few operational systems that meet the full spectrum of information needs for these services.

12 Research priorities

Introduction

Child and adolescent mental health services share with most other clinical specialties serious omissions in knowledge about the effectiveness of interventions and the optimal organization of care. It is indeed to the credit of the specialty that so much has been achieved in areas fraught with methodological problems which are not encountered in, for example, surgical specialties with relatively clear cut outcome measures and a short time frame. The evidence available at present is sufficient to support purchasing decisions but there are important areas where further research would be valuable. Both the Medical Research Council and the Royal College of Psychiatrists have made recommendations for research priorities which have been taken into account in the development of these proposals.^{210,211}

Research infrastructure

It is vital that appropriate staff and facilities are available within each population of 750 000 if there is to be satisfactory assessment of local needs and evaluated development of treatment and services. Both the Royal College of Psychiatrists and the British Psychological Society require trainees to undertake research. It is difficult for this to be achieved satisfactorily unless senior staff in academic departments engaged in research are available to provide support.

Normal and abnormal development

Research in this field is inevitably long term. Retrospective studies can produce useful and valid data. However prospective and follow-up studies are likely to be more reliable since they are not dependent upon retrospective recall but use information that has been collected for the purpose. The following areas of enquiry would merit further investigation.

Links between child and adult mental disorders

Which developmental characteristics and which mental problems in childhood predispose to which adult disorders? What is the strength and nature of the relationship? How do risk and protective factors during development influence outcome?²¹²

The development of personality disorders in adolescence needs to be better understood.

Cross-generational influences

How do children's experiences of parent care at different stages of development affect their present mental health and subsequent psychological and emotional development?²¹³ It is particularly important to understand the influence of the contemporary changing patterns of family life and child care on child and adolescent mental health.

Genetic influences: interaction between genetic and environmental influences

Genetic influences on development and behaviour are increasingly recognized. The interaction between these and environmental influences need to be better understood. Certain conditions are particularly appropriate for genetic research. These include autism, learning difficulties and hyperkinetic disorders.

Differential response to environmental influences

Children within the same family vary in their mental health. Is this due to differences in individual resilience or vulnerability or in detailed family interactions? Can these be measured and does the evidence provide clues for prevention?²¹¹

Influence of brain dysfunction on mental health, including the interaction between brain function and environment

This is of particular importance for understanding the influence of different types of brain dysfunction on mental health. Increased collaboration between neuropsychiatry, paediatric neurology and child neuropsychology is required in studies of the psychological, social and educational consequences and management of neurological disorders and acquired dysfunction. Biological studies, including brain imaging, are likely to be of particular value.

Socio-economic relationships

The role of socio-economic factors in the genesis and maintenance of mental health problems is unclear. Research should examine the factors and mechanisms which determine why some children survive in conditions of psychosocial adversity while others do not.

Organization and standards of clinical practice

Development and evaluation of treatments

More research is needed across the range of treatments on effectiveness, with particular emphasis on longer term outcomes and the management of specific problems, including management in primary care.^{212,213}

Development and evaluation of services

Studies are particularly needed of the relative merits of different service delivery settings (primary care, special care, special clinic, school) as well as modes of service delivery (direct intervention versus parent training and responsiveness to the needs of different communities and ethnic groups). Studies to improve recognition of mental health problems such as depression in primary care are needed.²¹³

Developmental evaluation of preventive interventions

Examples of such research could include the prevention of conduct disorders and of psychiatric disorders in children with mental handicap.²¹³

Developmental evaluation of specific treatments/interventions

Examples will include treatments for depression and difficulties arising from development characterized by Asperger's Syndrome and drug treatments.

Skill mix

What is the balance of uni- and multi-disciplinary service delivery? What are the costs and benefits of specific service delivery by different professional groups: to what extent is substitution feasible and desirable? Which problems are appropriately dealt with by voluntary agencies or primary health care?

Development of outcome measures

Since the ultimate outcome of child and adolescent mental health services is the child's success as an adult, valid interim measures need to be established. These should include clinical and quality of life measures.

Specific studies of special groups

Evidence on the effectiveness of care of specific groups of children and young people needs to be co-ordinated through broadly based research studies.

Examples are:

- 'hard-to-place' adolescents
- children in social services care
- children who have been abused²¹³
- children and adolescents with challenging and/or persistent self-injurious behaviour
- childhood hyperactivity.²¹³

Epidemiological studies

There would be particular value in local epidemiological studies to clarify service priorities by evaluating need for the different types of care. Some basic epidemiological work remains to be done.²¹² In particular detailed studies are needed of those conditions which are, according to current evidence, increasing in incidence. These include:

- anorexia nervosa
- suicide
- juvenile delinquency
- depression.

Research in the field of child and adolescent mental health should normally be conducted by multi-disciplinary and multi-sectoral groups.

Attention also needs to be paid to the development and dissemination of research findings across the very broad range of professionals involved in the care of children. Research into this field, and the determinants of change in clinical practice would benefit both child and adolescent mental health services and other clinical specialties.

Priorities

Each of these areas for research is important for a number of reasons. There needs to be an overall balance between the more theoretical and academic studies and health services research. Both are needed to inform each other. However in terms of personal and social consequences, the aetiology, development and persistence of conduct disorders as well as their management and treatment in service settings should be given high priority.

Appendix I Definition of terms

- The term **care** is used to cover treatment, rehabilitation, counselling and social welfare.
- The term **service** covers **service agents** (formal and informal carers) and the **service settings**, varying from the domestic home to secure units.
- A **need** for care exists when an individual has an illness or impairment for which there is an effective and acceptable intervention. In this context an 'effective' intervention is one which achieves the treatment objective. It does not necessarily imply 'cure'. There will usually be a hierarchy of methods, from those which produce a complete and rapid recovery with no side-effects to those which achieve amelioration and/or secondary or tertiary prevention.

The fact that needs are defined does not mean that they will be met. Some may remain unmet because other problems must be dealt with first, or because the more effective method is not available locally or availability is limited by rationing, or because the person in need or the carer objects. There are also 'potential' needs for forms of care that do not at the moment exist but which research may eventually provide.

- A **demand** for care exists when the individuals consider that they have a need and wish to receive care.
- **Utilization** occurs when an individual actually receives care.

Need may not be expressed as demand; demand may not be followed by utilization; there can be demand and/or utilization without any need.
- **Professional** is a term used to encompass individuals such as GPs, nurses, health visitors, paediatricians, teachers and social workers who have a recognized professional qualification.
- **Specialist** is a term used to describe someone who has had specific training to work with individuals who have mental health needs. Child psychiatrists, clinical psychologists, psychiatric nurses, child psychotherapists and some social workers and teachers are the main groups with such specialist knowledge and skills.

Appendix II Core data set for child and adolescent psychology and psychiatric services

This list includes both problems and risk factors.

Anti-social (FA)		Social/relationships (FH)		Autistic type characteristics (FP)
1 Tantrums/outbursts		1 Relationship difficulty parent/s/carers		1 Autism/autistic features
2 Non-compliance at home		2 Relationship difficulty other adults		Psychosis type characteristics (FQ)
3 Stealing from home		3 Relationship difficulty siblings		1 Confusion/disorientation
4 Stealing other		4 General family relationships problems		2 Psychotic symptoms
5 Aggressive behaviour		5 Relationship difficulty peers		3 Unusual/bizarre behaviour
6 Cruelty/violent brutality		6 Harassment/persecution victim		'Psychosomatic' (FR)
7 Firesetting/destruction of property		7 'Attention seeking' behaviour		1 Hypochondriasis
8 Bullying/fighting		8 Social disinhibition		2 Factitious illness
9 Substance abuse		9 Social withdrawal		3 Hysteria/conversion
10 Running away/wandering		10 Social sensitivity		4 Pain/discomfort non-organic origin
11 Lying				5 Headache
School (FB)		Context (FI)		Physical illness/general paediatric (FS)
1 School refusal/phobia		1 Marital difficulties		1 Non-neurological physical illness
2 School non-attendance – other		2 Family mental health problems		2 Pain organic origin
3 School discipline problem		3 Family physical health problems		3 Physical disability/deformity
Cognition/abilities (FC)		4 Adverse social circumstances		4 HIV/AIDS
1 Gifted		Life event (FJ)		5 Other deteriorating organic condition
2 General learning disability		1 Bereavement/loss		6 Terminal illness
3 General academic under-achievement		2 Stress reaction/adjustment reaction		7 Anxiety about physical medical procedures
4 Specific reading difficulty		3 PTSD/at risk for		8 Poor compliance with medical management
5 Specific number difficulty		4 Emergency/crisis during episode		Physical/neurological (FT)
6 Specific spelling difficulty		Abuse/neglect (FK)		1 Physical slowness
7 Writing difficulty		1 Failure to thrive		2 Clumsiness/co-ordination difficulty
8 Unusual cognitive pattern		2 Neglect		3 Epilepsy/turns/fits
9 Memory problems		3 Physical abuse		4 Head injury
10 Attention abnormality		4 Emotional abuse		Sensory (FU)
11 Poor self-care skills		5 Sexual abuse		1 Visual impairment
Self (FD)		Self-harm/injury (FL)		2 Blind
1 Self-deprecation		1 Self-harm/overdose		3 Hearing difficulties
2 Self-aggrandizement		2 Self-injurious behaviour		4 Deaf
3 Disability/disfigurement awareness		3 Risk-taking		Genetic condition (FV)
Mood (FE)		Sexual and sex related (FM)		1 Chromosome anomaly
1 Irritability/moodiness		1 Inappropriately sexualized behaviour		2 Dysmorphic features
2 Fatigue/lassitude		2 Sexual misdemeanour/offence		3 Behavioural phenotype
3 Depression/misery		3 Promiscuity/prostitution		Normal limits (FW)
4 Euphoria/expansive disinhibition		4 Unusual/excessive solitary sexual activity		1 Parental concern but no clinical abnormality
5 Mood swings		5 Concern about sexuality		2 Referrer concern but no clinical abnormality
Anxiety-related (FF)		6 Gender identity problem		Local other (FX)
1 General anxiety		7 Pregnancy		1 n (Clinical problems locally specified)
2 Phobias		Personality/temperament (FN)		Clinical features residual (FZ)
3 Separation anxiety		1 Shyness/social isolation		1 Other
Self-regulation (FG)		2 Personality/temperament extreme		2 Not known
1 Tics/habits/stereotypes		3 Inappropriate immature behaviour		3 Not coded
2 Obsessions/rituals		Speech and language (FO)		
3 Overactivity		1 Mutism		
4 Enuresis/wetting		2 Speech delay/disorder		
5 Soiling/constipation		3 Language delay/disorder		
6 Sleep/wake pattern problems				
7 Problems during sleep				
8 Subjective insomnia				
9 Feeding problems/fads				
10 Anorexia				
11 Bulimia				
12 Obesity/overeating				

Appendix III Official statistics

Local data sources

Demographic

Basic demographic data covering the age and sex breakdown of a district population can be obtained from either the Public Health Common Data Set or the 1991 Census. These can be used to calculate the numbers within the 0–16 age group and to estimate the potential numbers of children with mental health problems. However the age bands used in the Common Data Set do not fully match those required to cover the 0–16 year olds as it uses the bands 0–4, 5–15 and 15–24 years. The Census, on the other hand, will allow analysis for single years of age. The Census also provides data on residence at ward level.

Ethnic

Both the Common Data Set and the Census provide data on the ethnic composition of district health authorities. The Common Data Set provides the percentage of heads of households born in the New Commonwealth or Pakistan. The 1991 Census provides data on the proportions of different minority groups within a district. The census also provides data on ethnic group by age categories (0–4, 5–15, 16–29).

Mortality

Deaths as a result of mental disorders classified under the ICD 9 codes for mental illness and suicide are classified by age and sex as part of a district's VS3 mortality statistics from OPCS.

Morbidity

Morbidity data can be obtained from a variety of sources. Hospital activity data on parasuicide and ICD codes for mental disorders can be obtained from the regional information system (RIS) or other relevant hospital administration systems (e.g. PAS). Hospital activity data provide a record of existing hospital service provision using the ICD codes for diagnosis. From this data it is possible to identify the age, admission method, postcode of patient, length of stay, etc. This data source will not include patients who are treated outside a district health authority area and will include patients from other districts who are treated in the provider unit. The RIS data will need to be interrogated by district code and data from the Mersey tapes (data on patients treated outside the relevant district health authority) added to this.

Hospital admission rates are as much a reflection of bed availability, referral rates and admission procedures as an indicator of need, but they can provide a useful guide on how need is currently being met. Hospital admission data also require care with interpretation as it is likely that an individual patient will be admitted more than once in a year and the data available are by admission episode and not by individual patient. This can result in an over-counting of some cases.

Some provider units have good data on attenders of psychiatric services as outpatients, inpatients or day care patients. The availability of data is not uniform or compulsory, however.

As an indicator of potential morbidity in the area of mental illness, disability and long-standing illness can be of relevance. Some health authorities and some local authorities keep a handicap register which holds details of children with either mental or physical disabilities. These are not compulsory and their completeness varies from place to place.

The Common Data Set contains details of selected congenital malformations; however, this only covers those malformations identified at or shortly after birth.

Details of limiting long-term illness can be obtained from the 1991 Census. The relevant age bands are 0–15 and 16–29. These data are divided into those resident in communal establishments and those resident in households.

Numbers of children with special educational needs and learning disabilities can be obtained from local education authorities. The Education Act of 1981 requires that children with special educational needs are statemented and their special need documented. This provides a source of information on intellectual and physical disability in an area but can be incomplete. Where a local education authority runs special schools, the number of children attending will be relatively easy to obtain.

Family and socio-economic data

Social class, unemployment rate, numbers receiving housing benefit, car ownership level, proportion of homes with basic amenities and housing tenure type can all indicate levels of social deprivation.

Details of housing tenure, dwelling type, access to cars, overcrowding and economic position can be obtained at ward level from the 1991 Census. Composite deprivation scores include the Jarman index and Townsend, both of which are available at ward level. The Common Data Set provides an underprivileged area score based on the 1981 Census; this may be of limited value because the data from the 1981 Census is now out of date. Local town councils can provide regular data on unemployment figures at ward level.

Criminality

Information on levels of crime among young people may be obtained from local police and probation services; however, this would involve requests in writing detailing exactly what data are required and permission will need to be obtained from the Chief Constable. However soft information can often be obtained informally by discussions with officers from these services.

Secondary data – based on national, regional and local authority areas

The following list provides a number of sources of data that provide a background picture of need and may be of value in determining service requirements for child and adolescent mental health.

Ethnic

Details of the percentage population in each ethnic group for 1983, 1989, 1990 and 1991 – *GHS 1991*, OPCS. Available from public or academic libraries.

Detailed information about the ethnic data provided by the 1991 Census and information on the use of the Labour Force Survey to estimate Britain's ethnic minority population – *Population Trends No. 72*, Summer 1993, pp. 12–17, OPCS. Available from public and academic libraries.

Hospital activity

Admissions to NHS hospitals for mental illness and mental handicap by age group (under ten, 10–14, 15–19) for 1978–1990 including age-specific rates per 100 000 population – *Health and Personal Social Statistics for England*, 1992 edition, HMSO. Tables 9.2 and 9.4. Available from public and academic libraries.

Morbidity

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Details of the number of dependent children by family type and marital status of lone mothers – *GHS 1991*, Table 2.20. Available from public and academic libraries.

Criminality

Young offenders found guilty or cautioned by type of offence and age (10–13, 14–16, 17–20) in 1981 and 1991 – data covers different regions of England – *Regional Trends No. 28*, 1993, Table 9.6. Available from public and academic libraries.

Supervision orders and intermediate treatment year ending March 1991. *DoH Personal Social Statistics (A/F9/16)*. Available from: The Statistician, SD3A Room 454, Skipton House, 80 London Road, Elephant and Castle, London SE1 6LW.

Appendix IV Current service status for child and adolescent mental health services

Much of the following information has been derived from a recent survey of services for the mental health of children and young people in the UK.¹⁴⁹ It looks at purchasing authorities and the various aspects of child and adolescent services, including community-based care, inpatient and special units, day treatment services, clinical psychology services, paediatric services, social services, education and the non-voluntary sector.

Purchasing authorities

69 of 121 (57%) purchasing authorities were included in the survey. 52% (36 authorities) had done developmental work on a specific strategy for mental health services for young people and 28% (19) had such a strategy in use. A third had consulted with at least four departments or agencies in developing this strategy. The remaining 33 authorities (48%) reported that they had no specific strategy.

In 62% (43) of authorities included in the study, the current specification was separate from that of adult mental health services. Only nine (13%) purchasing authorities had a basis for their specification that was related to the needs of their population i.e. either a formal needs assessment or at least three other indicators of need.

In 55% (38) of authorities, the current contract was separate from that of adult mental health services. In a fifth of cases a single contract was in place covering community, day and inpatient care for children and for adolescents. Every purchasing authority had contracts with named provider units for inpatient care, or else mentioned that they used extra-contractual referrals (8%), or either a block regional contract or a subscription system (7%).

In 28% of authorities, older adolescents (aged 16 to 18 years) were included in the same contract as younger age groups; in 16% they were included by design in the contracts for adult mental health; in 17% they were included with adults, by default.

In most cases the work of clinical psychologists was included within wider contracts, but separate contracts with clinical psychology were specified by 7% of authorities. In 13% of authorities the main contract included services to be provided in education and/or social services.

Plans for evaluation of the service were largely undeveloped.

Child and adolescent mental health services

The specialist child and adolescent mental health services are largely delivered from a community base, by means of multi-disciplinary teams. Within these teams psychiatrists and social workers are almost universal members, although the number of social workers has reduced in the past three years, mainly as a result of local authority reorganization. Numbers of staff and the range of skills available vary widely between different units. There is little regular input to the service from the education sector.

Community-based care

Of the 151 (81%) departments of child and adolescent mental health included in the survey, 94% provided a service in community clinics; 19% were an integral part of units also providing inpatient care and also 11% provided care on a day basis. 70% provided a community service only. There was a designated budget for child and adolescent psychiatry in 56% of services.

There is major variation in the distribution of numbers of child and adolescent psychiatrists across the country and in the type of work they undertake. 15% of services had less than one wte consultant, 40% between one and two, and 44% more than two. The number of children (aged 0–18 years) per one wte consultant ranged from 6 403 to 244 135. The number of wte consultants per 100 000 child population ranged from 0.41 to 15.62. Child and adolescent psychiatrists provided emergency cover in 69% of districts.

Other professional staff included:

- 58% had junior medical staff in training positions
- 69% had clinical psychologists
- 44% had a psychotherapist
- 17% had a family therapist
- 11% had an educational psychologist
- 63% had a psychiatric community nurse
- 81% had a social worker.

Provision to other professional groups included:

- 36% of departments provided five or more sessions (half-day duration) per month to paediatrics. 27% provided no services to paediatrics
- 11% provided sessions in general practice (majority were one session per week)
- 35% provided more than five regular sessions a month for social services departments
- 28% provided five or more regular sessions a month to schools
- 18% provided occasional sessions for the police and 8% for the probation service
- 37% did sessions for voluntary sector agencies.

Overall 15% provided no, or very limited, services to any other department.

Inpatient and special units

Many inpatient units, including former regional adolescent units, are experiencing problems particularly with respect to the new system of contracting for services.

Of the 37 NHS inpatient units (60%) who replied, 32% had contracts with a single purchasing authority, 22% with two authorities and 41% had multiple contracts.

Staffing revealed:

- consultants – 8% of units had less than one wte while 51% had two or more
- 95% had junior medical staff
- 76% had clinical psychology input
- 65% had an occupational therapist
- all but one had teachers
- 32% of units had psychotherapy
- 70% of units had social work input.

65% had a distinct and separate budget, but only 23% held it themselves within child and adolescent psychiatry.

25% of units catered for both children and adolescents, a further 25% for children only and 50% for adolescents only.

60% functioned on a seven-day basis, while 40% closed at the weekend. 80% provided 24-hour cover for emergencies.

33% provided care entirely in one location.

Innovative or specialist clinics and other services most frequently mentioned included child sexual abuse/post-abuse therapy, parenting and early intervention, eating disorders, early onset psychoses, severe enuresis, communication disorders/neuropsychiatry and autism.

Day treatment services

A quarter of all units (37) replied that they provided treatment on a day basis. Of these 59% also provided inpatient care.

Of these units:

- 95% had at least one wte consultant
- 89% had junior medical staff
- 78% had a clinical psychologist
- 84% had a social worker
- the median number of psychiatric community nurses was four.

33% of units stated that treatment on a day basis was available somewhere within the district. A further 10% used education authority facilities, such as emotional and behavioural difficulty (EBD) units or social services day centres as a base from which to provide day treatment. Facilities in neighbouring districts were often otherwise available.

Clinical psychology services

Clinical psychology is a growing profession, working increasingly from an independent base. Clinical psychologists still work mainly with child and adolescent mental health teams, but they also provide direct and consultative services to acute and community services in other sectors of the NHS, to social services and to other agencies.

Of the 168 (90%, covering 88% of districts) clinical psychology services who replied, 67% provided some care on a multidisciplinary basis and 25% had separate contracts with GP fundholders.

The responses covered 513 clinical psychologists, comprising 156 grade B and 357 grade A. There were 277 trainees and 18% of responses stated that their work was essential to maintain the present level of service. In 13% of services other professional staff were employed, including counsellors.

In the past three years, 44% of the services had seen no change in the numbers of clinical psychologists; in 36% there had been an increase and in 12% a reduction. 30% reported that an increase was planned for next year.

42% received referrals from child and family or child guidance clinics. Many clinical psychologists worked regular sessions with acute paediatrics, on the wards (36% of services) and in outpatients (46%). Sessions were provided as required by 27% in cases of deliberate self-harm and by 29% in cases of emergency admissions for abuse. Even more (61%) did sessions in child development clinics and in 20% of services this amounted to more than 20 sessions a month (the equivalent of a half-time post).

The third most important area of work was for social services, with regular commitment from 57% of clinical psychology departments.

Only 8% of services gave more than the occasional sessions in mainstream schools, but 18% provided regular sessions in special schools for children with learning difficulties, physical disabilities or sensory impairment.

On a smaller scale, sessions were provided for the police and probation services by 10% of services, largely on an occasional basis. Similarly 10% of services provided a small input to drug and alcohol services. 32% worked with the voluntary sector, helping particularly with training and management.

22% of clinical psychology departments were members of a multi-disciplinary group that gave advice to the purchasing authority.

Paediatric services

Data from this survey suggest that more children with emotional and behavioural disorder present to paediatricians than to any other profession. Paediatric training in the main does not prepare them for this and they would welcome further opportunities to gain relevant experience.

Hospital paediatrics

It is estimated that 5–15% of children referred to paediatric departments is due primarily to emotional and behavioural problems. The main conditions were: constipation/encopresis/soiling (54% of directorates), enuresis (42%), headaches/abdominal pain/psychosomatic conditions (34%), sleep problems (34%) and feeding problems (27%).

Paediatricians estimated that 15% (median) of their patients had an underlying or additional emotional or behavioural disorder in addition to the main presenting condition, although 42% of departments suggested a lower proportion (between 3% and 10%).

29% of hospital-based paediatric consultants felt that their training had adequately prepared them for dealing with emotional and behavioural problems, although 46% stated that training was still inadequate in this respect. Junior staff needed regular placements or an opportunity to participate in clinics in child and adolescent psychiatry.

Psychological training and support for nurses and junior doctors was regularly provided in 37% of departments. 70% of departments said they needed more support and training for staff in these types of problem.

48% of paediatric departments held formal planning sessions together with the child and adolescent psychiatry department; 32% were part of a multi-agency group, advising the purchasing authority on children's needs, including those for mental health services.

Community paediatrics

20% of children referred to community paediatricians were referred primarily for emotional and behavioural problems. The main sources of referral were health visitors (reported by 83% of departments), GPs (64%) and educational authority staff such as teachers and educational psychologists (53%).

22% of community paediatricians said that they referred between 40% and 50% of cases for further opinion. The main emotional and behavioural conditions treated were largely the same as those treated by hospital paediatricians.

Community paediatricians, even more so than hospital paediatricians, felt that the resources for child and adolescent psychiatry in their district were quite inadequate. Long waiting lists and frequent personnel changes were described by 75%.

Community paediatricians were involved formally in planning provision with the child and adolescent psychiatry teams in 56% of districts. They were represented on a multi-agency group advising the purchasing authority for these services in 40%.

Social services

Social services departments concentrate resources on children in need, many of whom have serious emotional and behavioural problems. They report unsatisfactory access to NHS specialist expertise in children's mental health.

Social service departments contribute to mental health services by providing social work input to the multi-disciplinary team in 81% of services. Of the 59 (56% covering 62% of health authorities) social services departments who replied, 17% had no formal or written policy on assessment and therapeutic services for children and young people with emotional and behavioural problems. All others had some sort of policy, though often part of a general policy for children in need, based on the Children Act. 46% were either working on, or had already developed, joint policies or joint commissioning with the health service. A further 9% had firm plans to start negotiations in this particular field with the NHS in the coming year. Five departments had also included the local education authority in policy making.

Assessment and therapeutic services for children and young people were mostly provided in social services family or day centres (in 29% of departments), though in 17% child guidance centres were used. 20% negotiated provision of part of the service by the NHS; a very small number stated that they purchased these services.

49% of social services departments were represented on a multi-agency group to advise the NHS purchaser. A large proportion (75%) had representation on a multi-agency group to plan services with the NHS providers.

61% of respondents stated that they had had no staff losses in the last three years and 56% said they had had staff increases during that time. Other changes that might have had an effect on services for this client group included the establishment of new team structures (mentioned by 20%) and this was frequently linked with the need to meet the requirements of the Children Act.

64% of the departments stated that they ran services or programmes specifically for children with emotional and behavioural difficulties, providing group, family and individual sessions. The social services department had a direct input into schools in 54% of authorities. 86% of departments contributed on a regular or occasional basis to health services, with half providing sessions in at least five different health settings. The most common contribution was to child and family (psychiatric) outpatient or community-based clinics (58% of the responses), followed quite closely by work in child development clinics (51%), paediatric inpatient wards (49%) and children's outpatient clinics (42%).

Work with the police and the probation service was carried out by a number of authorities, although 30% did not do anything in this respect.

61% of social services departments had direct input into voluntary or joint SSD/voluntary facilities. 12% stated that they had firm plans to increase work with the voluntary sector in the coming year.

The education sector

Local education authorities are greatly concerned with emotional and behavioural difficulties in their pupils. Behaviour support services, as currently provided in three-quarters of local education authorities, include assessment of the educational needs of pupils with severe behaviour problems, but frequently no relevant medical contribution is included. Special schools for children with emotional and behavioural difficulties

report that few pupils have statements in which therapeutic help is specified, although the head teachers consider that nearly half of all pupils would benefit from such help.

Local education authorities

Of the 29 (27%) local education authorities who replied, 59% had developed a policy for pupils in mainstream education who had, or were at risk of, emotional and behavioural problems. A further 17% were currently reviewing their policy.

Educational psychology services

Of the 47 (44% covering 45% of health districts) educational psychology services who replied, work in this field was specifically included in the job descriptions of 55% of services.

Special schools for children with emotional and behavioural problems

Of the 165 (approximately 55%) special schools who replied, 80% felt that help from the referring agency was token in that children were rarely visited by specialists from home and that the resources available from the referring agencies were inadequate. Similarly 86% did not feel that the NHS provided resources that the children needed.

90% of schools had provided in-service training for teaching staff on emotional and behavioural problems or related issues in the past year.

Non-teaching specialists with a particular role in therapeutic support were not widely or regularly available.

64% of EBD schools had not been visited by child and adolescent psychiatrists in the past year. 36% had been, 68% of them on a regular basis.

The non-statutory sector

The voluntary sector plays a large part at primary care level, particularly in providing services such as counselling, and taking many self-referrals. Voluntary organizations also act as a filter to specialist mental health and social services. Since the NHS mental health services accept self-referrals less and less, the voluntary services may be filling a gap in provision. They offer particular expertise for secondary and tertiary provision.

15% of the child and adolescent psychiatry services stated that they had used private hospitals for inpatients. Several responses mentioned that the major and sole use was for eating disorders, such as anorexia nervosa.

In planning (including health needs assessment), 42% of NHS purchasing authorities said that they had included voluntary organizations in their discussions and several had involved particular organizations in a substantial way.

A detailed study of data for one region (Yorkshire) revealed 154 independent or semi-independent organizations, covering all cities and towns in the region. 42% were classified as providing a service for a range of general problems that were of concern to young people. 18% provided services to help people misusing drugs, alcohol or other substances. 12% provided services for children and young people who had been abused sexually, physically or emotionally. About 8% of organizations helped children or their families with problems related to serious physical illness or disability. Another 8% specialized in problems surrounding homelessness.

25% specifically provided for the 16 to 25 age group and 14% for the under 16s.

The sources of funding were varied and few relied entirely on one source. 51% received some local authority funding, including grants from social services, education and housing departments. 6% specifically mentioned joint funding from health and social services. 8% received some funding from central government. 46% raised at least part of their costs by general fundraising, through appeals, corporate fundraising, grants from trusts and subscriptions. 6% charged for their services, either directly or through contracts.

Psychiatric community nurses

There were 260 wte nurses working in community-based units, of whom 47% had been specifically trained in children's and adolescent's psychiatric care (ENB 603). Of the 87 units who employed a community psychiatric nurse (CPN) only one-third (34%) had a nurse with this qualification. Of nurses working within inpatient units less than one-fifth (18%) had undertaken the ENB course, though there were only four units with no nurse with this qualification.

Child psychotherapy

Child psychotherapists working in community-based units were unevenly distributed across the country with 92% employed in the four Thames regions, Wessex, Oxford and South Western.

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