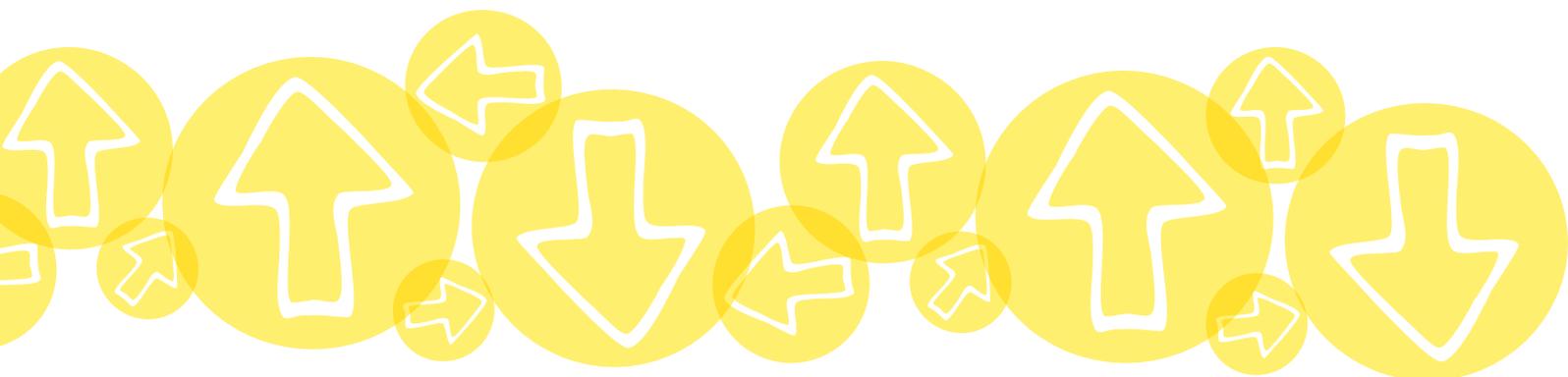


GOING TO BE ALL RIGHT?

**A report on the mental health of
young people in Scotland**

“It’s paramount that young people are made aware of the importance of good mental health and how to access services. If we can normalise discussions around mental health, and the fact that everyone goes through periods of poor mental health in their life, then I think people would be more likely to recognise and admit when they are struggling.”

Chelsea Rocks, who became unwell at age 15



Foreword

This year, SAMH launched our *Going To Be* campaign.

We did this because an overwhelming number of people have told us there is a lack of mental health education and support for young people. They have also told us it is essential for children and young people to learn about mental health at a young age.

Most children will never come into contact with specialist mental health services, yet all children have mental health. Diagnosis of a mental health problem should not be the only mechanism to trigger support, but it's often at that late stage when interventions take place. We need to act faster. Improving the self-esteem, resilience and well-being of all our young people must be a priority.

Going To Be is all about campaigning for the future. It's got to change. We can't always prevent young people from developing a mental health problem but we can give them every chance to understand their mental health and normalise help-seeking without stigma.

As adults we all remember a time when, as a young person, we thought about what we were 'going to be'. We probably chatted with friends about it. It is usually from a place of hope and aspiration for the future. Experiencing a mental health problem shouldn't change that, but it does.

SAMH believes the time is right to review, refocus and invest in early intervention and preventative support for children and young people.

Going To Be is our contribution to achieving this aim.

Billy Watson
SAMH Chief Executive

Foreword from Cara

When Cara was young she had hopes of becoming an artist. This was put on hold as she struggled with an eating disorder and Borderline Personality Disorder throughout school without the support she needed.

“At high school I was perfect, a good student with good grades. I tried to tell my teachers that I didn’t feel the same as my friends. The School could see something was wrong but they didn’t know where to send me or what to do. No one talked about mental health.

“I went to the doctors consistently for 6 months to get the help I needed, but I was told I couldn’t get help.

“Because of my age I was too old to go to children’s mental health services and too young for adult services. I was lost in the system for a year. I felt confused and overlooked.

“I should have received support at a younger age, but it took 5 years until I was 23 for a doctor to diagnose me with Borderline Personality Disorder. Now 25, I have started to piece together my life which is now stable.”



INTRODUCTION

Half of mental health problems in adulthood begin before the age of 14.¹

By the time they're 16, roughly 3 children in every class will have experienced a mental health problem.² And thousands will struggle to get the help they need.

Over 7,000 young people were turned away from CAMHS services in the last year. That's 19 young people every day.³

When it comes to finding help for your mental health, only a quarter of young people know where to go.⁴

There are more than 900,000 children and young people who live in Scotland.⁵ Our mission is to change things for these young people and for generations to come. So we commissioned this report to help us understand the mental health issues children and young people are facing.

It's got to change: our initial recommendations

There is much to do, and over the life of Going To Be we'll be campaigning for many changes. But we think three things need to start happening straight away:

- ✔ **By 2018, create a programme to train all school staff in mental health**
- ✔ **By 2020, provide counselling services across Scotland's secondary schools**
- ✔ **By 2020, let children and young people stay in specialist services till age 25**

Visit www.samh.org.uk to join our movement for change.

EXECUTIVE SUMMARY

SAMH commissioned this report to review published and unpublished evidence from the last five years about:

- the nature and extent of mental health problems, and of mental and emotional wellbeing, in 12-18 year olds nationally in Scotland; and
- what happens when young people, aged 12-18 years, seek help for their mental health from both statutory and non-statutory services in Scotland.

Methods

A rapid review of relevant articles and reports was undertaken in March 2017. This involved searches of published articles and identification of unpublished reports.

This report is not a systematic review. It is a selective account of some recent developments in understanding the nature and extent of mental health problems and mental wellbeing among young people, and their experiences in accessing support from services, in Scotland.

What do recent reports tell us about the nature and extent of mental health problems and mental and emotional wellbeing in 12-18 year olds nationally in Scotland?

- Inequalities are evident, with associations between mental health and gender, age, ethnicity, social position, deprivation and being looked after/accommodated.
- Generally speaking, older boys and girls (S4 pupils) have worse mental health than younger ones (S2 pupils)
- Girls, in particular, those at age 15, experience poorer mental health than boys
- Stresses of school-life feature prominently, with a particular increase in girls reporting high levels of pressure from schoolwork
- Bullying at a young age can affect mental health in later life
- Young people are increasingly experiencing emotional and psychological health problems

What do recent reports tell us about 'what happens' when young people, aged 12-18 years, seek help from services in Scotland?

- While the majority of young people referred to Child and Adolescent Mental Health Services (CAMHS) are seen within 18 weeks, almost 20% experience longer waits.
- Around a fifth of referrals to CAMHS are rejected, with no information provided about what happens next to those young people.
- There are considerable variations across health boards in waiting times.
- Long waits can leave young people feeling anxious about their ability to cope.
- Young people experience a diverse range of barriers to help-seeking including fears about not being taken seriously, being judged, and about confidentiality.
- Young people would welcome better information on where to go for help, and more and better support from non-professionals.
- The importance of prevention, early intervention and trust are recurring themes.



GOING TO BE... ALL RIGHT?

Scope

The researchers were asked to review existing literature on:

- the nature and extent of mental health problems and mental and emotional wellbeing in 12-18 year olds nationally in Scotland; and
- what happens when young people, aged 12-18 years seek help from services (statutory and non-statutory) in Scotland.

For the second question, the interest therefore lay in not only service uptake, but also what supports and hinders such uptake, and views / experiences of accessing services.

In addition, the report was to outline key aspects of the Scottish strategic landscape relevant to these points of interest. More specifically, SAMH's interest was in developments *over the past five years as they relate to young people in Scotland*.

1.1 Methods

In March 2017, a rapid review was undertaken of relevant articles published over the past five years. These were identified via searches of the following databases:

- Applied Social Science Index & Abstracts (ASSIA)
- PsycINFO
- CINAHL
- MEDLINE
- Web of Science (SSCI, SCI)

Appendix 1 provides the search terms that were used to search these databases. Abstracts for each of the identified articles were downloaded, and for those that were directly relevant to the research questions, the full articles were sourced and read. In addition, unpublished reports were identified through:

- the commissioners' knowledge of relevant (Scottish) reports
- contacting selected national statutory and non-statutory in Scotland to ask if they had, or knew of any reports that were relevant to the research questions
- on-line searches regarding young people's mental health in Scotland.

1.2 A note on scope and limitations of methods and this report

While information and findings were distilled for this report, it should be noted that this report is not intended to be, and should not be viewed as, a systematic review. Thus, this report is not a comprehensive account of all evidence (or strategic context) that is relevant to the questions of interest to SAMH. Rather, it is a selective account of some recent developments in understanding the nature and extent of mental health problems and mental wellbeing among young people, and their experiences in accessing support from services, in Scotland.

1

What do recent reports tell us about the nature and extent of mental health problems and mental and emotional wellbeing in 12-18 year olds nationally in Scotland?

‘The extensive inequalities in mental health outcomes by gender, age and SIMD ... demonstrate the need for a range of national policies to give direction to and support this agenda. These include policies on nutrition and physical activity, drugs, alcohol, suicide prevention, poverty, inequality and also many others that less directly shape the context for mental health.’

(Tod et al. 2013, page 97)

This chapter draws heavily and selectively from four key sources of findings regarding the mental health of Scottish young people:

- Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) as reported in Black, C and Martin, C. (2015)
- Children’s and Young People’s mental health indicator data as reported by Tod et al. (2013)
- Scottish Health Behaviour in School-aged Children (HBSC) Study as reported in HBSC briefing papers by Cosma et al. (2016a,b) and HBSC journal articles
- Scottish Health Survey (SHeS) as reported by Brown et al. (2016) in The Scottish Health Survey 2015: main report.

Short descriptions of these four large scale pieces of research are provided in Appendix 2.

Terminology

It should be noted that the term ‘mental health’ is not used in a consistent manner across all research reported. Thus, sometimes the term ‘mental health’ refers to mental wellbeing, whereas at other times, it is used as a general term that can encompass mental health problems. Furthermore, research studies can differ in the terms used to refer to difficulties or distress, variously using terms such as ‘mental health problems’, ‘psychological problems’ and ‘emotional problems.’

Main findings

- Inequalities are evident, with associations between mental health and gender, age, ethnicity, social position, deprivation and being looked after/accommodated.
- Generally speaking, older boys and girls (S4 pupils) have poorer mental health than younger ones (S2 pupils).
- Girls, in particular, those at age 15, experience poorer mental health than boys.
- Stresses of school-life feature prominently, with a particular increase in girls reporting high levels of pressure from schoolwork.
- Bullying at a young age can affect mental health in later life.
- Young people are increasingly experiencing emotional and psychological health problems

2.1 Overview: current mental health and wellbeing among young people

Large-scale national studies of young people in Scotland are in agreement that, generally speaking:

- Mental health and wellbeing worsens with age, and in the case of the Health Behaviour of School-aged Children (HBSC) research which also measures life satisfaction, high life satisfaction also diminishes with age.
- Boys have better mental health and wellbeing than girls (more details on this are provided later).
- Mental health and wellbeing is lower for 15 year old girls than other demographic groups of young people.

Reporting on its most current picture of Scottish adolescents’ mental health (from 2014 data collected in schools), findings from the HBSC survey (Cosma et al. 2016a,b) indicate:

- the majority indicate feeling highly satisfied with their life;
- two fifths responded that they are very happy at present;
- two fifths responded that they felt pressure from school work;
- almost a quarter reported having experienced two or more psychological complaints (e.g. having difficulty sleeping, or feeling low, irritable or nervous) within the previous week;
- less than one in five responded that they always feel confident;
- less than one in five reported that they never feel left out or excluded.

‘These findings underline the importance of school-based SSS in adolescence...’

Findings from the NSPCC review of ChildLine 2015–2016 offer another lens through which to consider issues that affect young people and cause them distress and which prompt them to reach out for external support. Such findings may tell us more about (prior or acute) unmet needs than needs generally, but are nevertheless of potential interest here. This review reports that:

- Nationally/UK-wide, young people aged 12–15 were most likely to talk to ChildLine about family relationships, low self-esteem/unhappiness and bullying, whereas those aged 16–18 were most likely to talk to the service about low self-esteem/unhappiness, family relationships, and sex and relationships.
- Looking at Scottish data only, the most common primary concerns were low self-esteem/unhappiness which accounted for 16% of calls and family relationships, which accounted for 12%. Other issues featuring among the ‘top ten’ concerns were: self-harm; suicidal feelings; friendship issues; bullying/online bullying; sex/relationships/puberty/sexual health; problems in school; mental health/depression; and sexuality and gender identity (NSPCC 2016).

2.2 Socio-economic and school-based inequalities

Evidence is inconsistent on whether/how health, (including mental health) in adolescence is patterned by socio-economic position, with ‘several but not all studies suggest[ing] “relative equality” during this life-stage’ (Sweeting et al. 2016, page 8).

Analysis of data obtained from Scottish school-pupils in 2013 has indicated that mental health and wellbeing are poorer for those who live in less affluent circumstances – a finding that is evident when looking at the Scottish Index of Multiple Deprivation (SIMD), receipt of Free School Meals and, most strongly in relation to perceived family affluence (Black and Martin 2015).

Research involving 2,503 Scottish pupils in S2 – S4 (aged 13 to 15 years) points to complexities in the relationship between objective and perceived socio-economic status (SES) and psychological wellbeing, and raises questions about whether other types of social standing are equally, or more, strongly correlated with mental health difficulties⁶. This research looked at two objective SES measures (residential deprivation, based on SIMD, family affluence⁷, one perceived SES measure (subjective socio-economic status)⁸ and three additional subjective social status (SSS) dimensions that related to perceived social standing within the school context: social status among their peer group (‘SSS-peer’), social status in terms of doing well at school (‘SSS-scholastic’) and social status in terms of being sporty (‘SSS-sports’). Analyses found that associations between objective SES and psychological wellbeing were weak and inconsistent. However, there were clear associations (for both boys and girls) between:

- lower subjective SES and increased psychological distress
- lower SSS-peer and increased psychological distress but reduced anger
- lower SSS-scholastic and increased psychological distress and anger
- lower SSS-sports and increased psychological distress.

The school-based subjective social status dimensions were more strongly associated with psychological distress than either the objective or subjective SES measures.

The authors conclude:

‘These findings underline the importance of school-based SSS in adolescence... They also highlight the need for a focus on school-based social status among those working to promote adolescent health/well-being’ (Sweeting and Hunt 2014, Page 39).

2.3 Age: a complex picture

When looking at young people as a group (and not taking gender into account), recent studies suggest that increasing age is associated with poorer mental health and wellbeing in young people. More specifically, studies have indicated that, among young people, with increasing age:

- mental wellbeing decreases (Brown et al. 2016) and mental health problems generally increase⁹ (Tod et al. 2013)
- there are decreases in the percentages who report happiness and high life satisfaction (Cosma et al. 2016a; Tod et al. 2013) and in levels of confidence (Cosma et al. 2016b)
- larger percentages report two or more psychological complaints within the previous week and higher levels of psychological stress (Cosma et al. 2016a)
- pro-social behaviour deteriorates¹⁰ (Tod et al. 2013).

Research has consistently highlighted however that the relationship between age and mental health is not straightforward. Recent analysis (using logistic regression¹¹) has indicated that age alone is not a key driver of mental health and wellbeing but rather reflects other factors which change as pupils get older:

‘While the prevalence of mental health and wellbeing problems has diverged between girls and boys in recent years, the main drivers have not. Pressure of school work and number of friendships are central to mental health and wellbeing’ (Black and Martin 2015, page 51).

Several other factors are also associated with mental health and wellbeing (e.g. family affluence, physical health), although these are not as strong drivers of mental health and wellbeing as factors to do with school and with friendships. Once the diverse range of factors are integrated into analyses, it would appear that age in, and of, itself does not have a large impact on mental health and wellbeing (Black and Martin, 2015). Thus, the picture is a complex one that is characterised by the interplay of many factors.

2.4 A gender perspective

There are marked gender differences in the mental health of young people. The picture is, however, made more complex by some interactions between gender and age (reported below).

Notwithstanding these interactions, identified gender differences have included:

- mental wellbeing being higher in boys than in girls (Brown et al. 2016, Tod et al. 2013)

- overall, boys being less likely to have common mental health problems, emotional symptoms or to report sadness (Tod et al. 2013)
- boys being more likely than girls to report happiness (Cosma et al. 2016a, Tod et al. 2013) and feeling confident ‘always’ (Cosma et al. 2016b)
- girls being more likely than boys to report recent psychological complaints (Cosma et al. 2016a)
- girls scoring better for pro-social behaviour than boys, being less likely to have conduct problems (Tod et al. 2013, Black and Martin 2015), and being more resilient to engaging in violence in late adolescence (McVie 2014)
- boys being more likely to report peer relationship problems than girls (Black and Martin 2015).
- girls experiencing school pressures more than boys (particularly, at age 15 when the gap between girls and boys is at its greatest) (Currie et al. 2015)
- girls being less likely to suffer from drug-related disorders (Tod et al. 2013)
- girls being less likely to complete suicide (Tod et al. 2013).

Thus, while boys are more likely to report behavioural problems than is the case with girls, girls are more likely to report emotional problems than boys.

As Currie and colleagues comment in an editorial in the Journal of the Royal College of Physicians:

‘What is the most worrying are the trends reported on girls’ mental health. These show that the mental health and wellbeing of adolescent girls has been declining over recent years’ (Currie et al. 2015, page 258).

Findings from calls to ChildLine (NSPCC 2016) tell a similar story. For girls - mental health and wellbeing concerns, including low self-esteem/unhappiness, are the most common reasons for contacting ChildLine. This review also echoes the findings in relation to boys reported above insofar as relationships, and concerns about their own behaviour, feature more commonly than among the girls.

This same ChildLine review also reports that across the UK:

- for girls, suicidal feelings and self-harm are among the most common reasons for seeking help from ChildLine
- for boys, bullying (including online bullying) is the focus of a higher proportion of counselling sessions than for girls.

2.5 15 year old girls

Many studies point to the high levels of emotional problems and low mental wellbeing that are found among girls aged 15 years. For example, 44% of 15 year old girls reported having two or more psychological health issues (including feeling low, irritable, nervous, dizzy, and having sleep difficulties). As a comparison, such difficulties were reported by 21% of boys of this age (Currie et al. 2015).

More specifically, studies highlight that as a group, 15 year old girls have poorer mental health and wellbeing than other demographic groups. For example, compared with other age/gender groups, 15 year old girls have been shown to report:

- a higher rate of emotional problems and of hyperactivity (Black and Martin 2015)

- lower life satisfaction and health-related quality of life (Cosma et al. 2016a)
- higher levels of school pressure and of feeling left out (Cosma et al. 2016b).

It has been further suggested that another factor negatively impacting on girls' mental wellbeing may stem from their self-perceptions of their looks and body size, with 55% of 15-year-olds girls reporting that they are too fat (Currie et al. 2015).

2.6 Pupils in Glasgow

Data from the HBSC survey (2006) were analysed to consider the mental health and wellbeing of pupils (Primary 7, S2 and S4) in Glasgow as compared with those in the rest of Scotland (Levin 2012).

This analysis indicated that the percentages of pupils reporting being very happy, always confident and never left out were greater among pupils in Glasgow compared with pupils in the rest of Scotland.

The author concludes with a comment on potential implications for improving adult health outcomes in Glasgow, and thereby tackling the much disputed notion of a 'Glasgow effect':

'The current study highlights the need for further examination of the health of the population in Glasgow compared with the rest of Scotland during adolescence. The key to understanding the Glasgow effect and to overcoming the associated negative health outcomes in adulthood may lie in this period of transition and development, where many health behaviours are formed and carried through to adulthood.' (Levin 2012, page 102).

2.7 Ethnicity

Scottish pupils with mixed or multiple ethnicities have been reported as being more likely to report poor mental health and wellbeing than those from other ethnicities (Black and Martin 2015).

2.8 Looked after and accommodated children and young people

Children and young people who are classed as 'looked after' (LA) and 'looked after and accommodated' (LAAC), have been identified as being especially at risk of self-harm. An anonymous self-report survey across 10 schools within six local authority regions in West Central Scotland was conducted with 102 pupils, aged 11-17 years old, who were, or had previously been LA or LAAC¹². This study found that 32% of the LA/LAC had self-harmed and/or thought about harming themselves. (Harkness-Murphy et al. 2013). The authors conclude:

'A recent claim by the British Association for Counselling and Psychotherapy (BACP) argues there is a lack of counselling services within mainstream secondary education institutions in Scotland (BACP: media centre, 2011¹³). With a lack of counselling support and no routine screening that is sensitive to detecting vulnerability to self-harm, there is a considerable missed opportunity to respond to the psychological needs of Scotland's young people' (page 298).

2.9 Disability

Ninety-one disabled children and young people in Scotland completed a questionnaire about their quality of life. Respondents were aged between 5 and 18 years of age, with 70% between 13 and 18. Using KIDSCREEN -27, a standardised instrument to assess children's and adolescents' subjective health and wellbeing: 43% reported that their life had been 'extremely' or 'very' enjoyable in the previous week; one in three reported often feeling sad and depressed; 'significant minorities' (20% - 27%) gave negative responses concerning how often they felt lonely, sad, so bad they did not want to do anything, or unhappy with the way they were, with those aged 14 -18 being most likely to feel lonely and unhappy (Sylvester et al. 2014). The authors conclude:

Compared with findings from a larger European study using the same questionnaire with mostly non-disabled children, the Scottish sample scored lower in every area (Sylvester et al. 2014, page 763).

Dramatic increases have been seen in psychological health complaints (including feeling low, irritable, nervous, dizzy, and having sleep difficulties

2.10 Being bullied

Analysis of six sweeps of Scottish HBSC data (over the period 1994 - 2014) involving over 42,000 pupils (aged 11, 13 and 15 years old) show that overall, 10.6% indicated that they had been bullied at least two to three times per month in the preceding two months, and while there were no significant gender differences, bullying victimisation rates decreased with pupils' age (Cosma et al. 2017).

This latter study showed that associations between bullying victimisation and (lowered) mental wellbeing vary by age and gender. Female victims reported less confidence and happiness and more psychological complaints than those who had not been bullied (Cosma et al. 2017).

Using longitudinal data from the Edinburgh Study of Youth Transitions and Crime, a study of around 4,300 young people in Scotland on the impact of bullying (between the age of 13 and 16 years) on negative outcomes at age 17 years concluded that *'extreme bullying as a victim in the early teenage years had a profound effect on long-term mental health'* (McVie 2014, page 12).

2.11 Changes over time in Scotland

Analysis of data over a prolonged period indicate:

- Emotional problems, and to a lesser extent peer relationship problems, have deteriorated over time with the main change happening between 2010 and 2013 (Black and Martin 2015).
- Conduct problems and pro-social behaviour have been improving gradually since 2006, and hyperactivity has marginally improved¹⁴ (Black and Martin 2015).
- While mental wellbeing scores (as indicated by the Warwick-Edinburgh Mental Well-being Scale [WEMWBS]) remained fairly stable between 2010 and 2013, there has been a slight decrease in the average mental wellbeing score among 15 year old girls: the findings suggest that, on average, 15 years old girls' wellbeing deteriorated over this time period (Black and Martin 2015).
- An increase in emotional problems from 2010 to 2013 has been evident in 13 year old girls, although this effect was not as strong as in 15 year old girls (Black and Martin 2015).
- Life at school seems to be increasingly stressful in terms of the pressure from schoolwork, with a widening gender gap (Currie et al. 2015). Between 2006 and 2014, the percentage of 15 year old girls reporting high levels of pressure from school work has risen steeply between (Cosma et al. 2016b).

- Dramatic increases have been seen in psychological health complaints (including feeling low, irritable, nervous, dizzy, and having sleep difficulties (Currie et al. 2015).
- Feeling confident 'always' has been decreasing gradually among both boys and girls (Cosma et al. 2016b).
- There has been a widening gender gap in emotional problems, mainly because of the increases in emotional problems among girls aged 15, and to a lesser extent, among girls aged 13 (Black and Martin 2015).
- Bullying victimisation rates have increased between 1994 and 2014 for most age-gender groups (but not among 13-year-old boys and 15-year-old girls) with the steepest increase being evident for 13 year old girls (Cosma et al. 2017).
- The association between bullying victimisation and mental wellbeing has been shown to vary *over time*, with this association becoming stronger over time for those in older age groups, especially among girls. Compared to girls who were not bullied, girls who have been bullied have become increasingly likely to indicate that they have psychological problems (Cosma et al. 2017).
- The most common concerns for children and young people contacting ChildLine remain broadly the same as in previous years, with problems at school, in particular exam stress, showing year-on-year increases (NSPCC 2016).

2

What do recent reports tell us about “what happens” when young people, aged 12-18 years, seek help from services in Scotland?

‘When young people have the courage to speak out and seek help, it’s so important that the right support is there for them.’

(NSPCC 2016, page 5)

This chapter:

- first presents information regarding contact with specialist services. This relates to CAMHS i.e. service support at Tiers 2, 3 and 4¹⁵ and therefore relates to service contact among those with confirmed clinically diagnosed mental health problems; and
- then, presents findings relating to young people’s views and experiences regarding accessing support for their mental health more generally.

Main findings

- While the majority of young people referred to CAMHS are seen within 18 weeks, almost 20% experience longer waits.
- Around a fifth of referrals to CAMHS are rejected, with no information provided about what happens next to those young people
- There are considerable variations across health boards in waiting times
- Long waits can leave young people feeling anxious about their ability to cope.
- Young people experience a diverse range of barriers to help-seeking including fears about not being taken seriously, being judged, and about confidentiality.

- Young people would welcome better information on where to go for help, and more and better support from non-professionals.
- The importance of prevention, early intervention and trust are recurring themes.

3.1 Contact with specialist services

This section reports largely quantitative (numerical) data that relates to CAMHS i.e. service support at Tiers 2, 3 and 4.

This section therefore focuses on service contact among those with clinically diagnosed mental health problems.

CAMHS: waiting times and attendance

‘Health Boards have informed us that they do endeavour to see patients within 18 weeks, however due to circumstances out with their control this is not always possible.’

These include capacity issues and where cases are complex.’

(NHS National Services Scotland Information Services Division [ISD] March 2017b, page 15)

A recent NHS National Services Scotland Information Services Division (ISD) report on CAMHS waiting times (ISD June 2017b) indicates that in the quarter January to March 2017¹⁶:

- There were a total of 8,730 referrals, with 6,892 accepted: 1,838 were therefore rejected, over a fifth of those referred. No information is provided on what happened next to those who were rejected.
- 4,333 started treatment, slightly more than in the previous quarter (4,222) but a decrease when compared with the same time period one year previously (4,436).

- Over eight out of 10 (83.6%) were seen by CAMHS within the 18 weeks target. This means that nearly two in ten were not seen within this time period.
- The 18-week standard was met by ten regional NHS boards¹⁷. This means that the likelihood of being seen within the 18-week target is dependent on where people live. Among those health boards that did not achieve the standard, the shortfall was highly variable, as low as 45.0% in NHS Grampian and 48.3% in NHS Lothian.
- The percentage seen within 18 weeks has been relatively stable over time (with the exception of a slight increase in the first quarter of 2016).
- Half started their treatment within ten weeks (adjusted waiting time). For those NHS Boards able to report unadjusted figures, half started treatment within 12 weeks. (See footnote 17 for an explanation of adjusted and unadjusted figures).
- 74 (1.7%) patients (across Scotland) waited over a year for an appointment¹⁸. Most of these were in NHS Lothian, where 10% of patients had been waiting for over a year.
- Over one in nine (11.8%) of those referred to CAMHS did not attend their first appointment. This is slightly higher than the overall national “did not attend” rate for outpatient services, which NHS Health Scotland put at almost 10% in a 2015 report.
- While most boards are meeting the 18 week standard, there are considerable variations across NHS Boards in their waiting times.

‘Policymakers should consider ways to foster dialogue and collaboration between different groups of professionals...’

The Scottish Children Services Coalition comment:

‘This has led to a “postcode lottery” when it comes to the treatment of those with mental health problems’ (Scottish Children Services Coalition website).

Furthermore, the Coalition has this to say of the target that young people will wait no longer than 18 weeks:

‘This is in itself still far too long and would not be tolerated for those with physical health issues’ (Scottish Children Services Coalition website).

Towards an understanding of factors associated with rejection and waiting times for CAMHS

Policymakers should consider ways to foster dialogue and collaboration between different groups of professionals making and accepting referrals to CAMHS in order to improve timely access to appropriate mental health support services for children and young people.’

(Smith et al. 2017)

A recent study in Scotland (Smith et al. 2017) examined referral forms over a 12 month period (May 2013 - May 2014) to one CAMHS in one local authority area. Of the 476 referrals, approximately half (49%) were young people aged 13 - 18 years of age. The others were under 13.

While the authors of this study acknowledge that a limitation of their research was that their team developed their own classifications for reasons for referral, they report that:

- the main reason for rejected referral recorded by this CAMHS was ‘not mental health’;
- being male or referrals for hyperactivity/ inattention were associated with longer waiting times;

- referrals of adolescents (13-18) rather than children or for self-harm/eating disorder were associated with shorter waiting times.

The authors go on to conclude:

‘Research is urgently needed to investigate the experiences of children and young people who are either rejected by CAMHS or wait lengthy periods of time before starting their treatment with CAMHS.’

Inpatient provision and age appropriate care

Since 2005, the Mental Welfare Commission (MWC) has monitored admissions of adolescents to non-specialist environments with a view to identifying whether NHS boards are fulfilling their legal duties to provide age-appropriate accommodation and services. The Mental Welfare Commission (2016) report:

- In recent years, the demand for specialist adolescent inpatient beds in the under 18 population has exceeded supply.
- Fluctuations in the number of admissions to non-specialist facilities: in 2010-2011 and 2011-2012, there were drops in such admissions, an ‘all time high’ in 2014-2015, and then a substantial drop the following year (135 admissions, involving 118 young people) (MWC 2016, page 10).

The MWC (2016) go on to comment that:

- There *may* be cases for which admission to a non-specialist ward may be the ‘best option’ for a child or young person e.g. where the admission is only for a very short period, where an admission to a non-specialist facility might make it easier to maintain family contact, and to more effectively co-ordinate local community service support.

- From their recent data, it is not clear for how many of the cases there were positive reasons for the admission to a non-specialist ward.

- It has been concerned about the level of specialist multi-disciplinary support available to children and young people in non-specialist wards.

The MWC (2016) identify current gaps in Scottish provision for young people with significant mental health problems and forensic needs, young people with learning disabilities, and young people being treated in general hospitals who require intensive psychiatric care.

The MWC (2016) report a reduction in the past year in the proportion of admissions for which a young person was described as having access to age-appropriate recreational activity and access to advocacy. The MWC concede that, in cases where there is only a very brief period of admission, there may not be sufficient time to involve advocacy support. Nevertheless, the MWC express concerns about the accessibility of advocacy support as it would expect this to be available and routinely offered to young people.

A national study recently reported patchy geographical provision of comprehensive community forensic CAMH services across Scotland, England and Wales (Peto et al. 2015).

Regional study on impact of an Intensive Treatment Service on admissions

Duffy and Skeldon (2013) report the findings from analysis of 2010/2011 data on referrals and psychiatric admissions following the establishment of a community-based CAMH Intensive Treatment Service (ITS) and service redesign in the South East of Scotland¹⁹. Findings include a reduction in the (median) duration of adolescent inpatient stay (from 28 days to 15 days) and a 65% reduction in admissions to adult wards, with the average length of stay on these adult wards reducing from 6.5 to 1.9 days. However, the number of admissions and readmissions to the adolescent inpatient unit increased. The authors reflect:

Balancing the current financial climate with pressure to meet standards of care is challenging, but planning services imaginatively can be effective and provide more flexible models of care (Duffy and Skeldon 2013, page 120).

3.2 Awareness and experiences of mental health services and seeking help

'When young people have the courage to speak out and seek help, it's so important that the right support is there for them.'

(NSPCC 2016)

This next section focuses mainly on young people's views and experiences when they seek help outwith their immediate and informal networks as provided by their family and friends. This includes (but is not restricted to) views and experiences from young people in accessing and using CAMHS.

To set this section in context, it is notable that findings from the Health Behaviour of School-aged Children (HBSC) in Scotland dataset (i.e. those aged about 13 and 15 years old) have indicated that:

- Approximately three quarters found it easy to discuss things that bothered them with their mother, with a far lower proportion feeling that this was the case when it came to talking about these things with their father.
- Twice as many boys than girls found it hard to talk to their friends about things that bothered them (Levin et al. 2012).

Awareness and experience of mental health information, support and services

Between February and April 2016, the Scottish Youth Parliament (SYP) conducted research to give young people a voice on matters to do with awareness and experiences of mental health services. This research - *Our Generation's Epidemic* - took the form of a survey (available both online and in paper form) and six focus groups. 1453 young people from across all local authorities and aged 12 to 26 years old responded to this survey, the majority of whom were aged 12 to 17 years.

Our Generation's Epidemic found that, of the young people who took part in the research:

- One in five did not know where to go for advice and support for a mental health problem.
- Just over a quarter (27%) did not feel supported to talk about mental health in their school, college, university, or workplace.
- Nearly a fifth (18%) of those who considered that they had experienced a mental health problem had not accessed mental health services.
- In addition, young people participating in this SYP research:

- felt most comfortable talking to a GP or other medical professional, and someone they are close to, about their mental health;
- appreciated young person-specific mental health services as particularly positive examples of mental health services;
- identified some shortcomings with mental health services, including accessibility, lack of confidentiality²⁰, not being taken seriously due to age, and non-person-centred treatment;
- underlined the importance of a human rights-based approach to mental health, and of educating young people about their rights when accessing mental health support, e.g. rights to be listened to, to be taken seriously when accessing mental health support and treatment, and to have confidentiality and privacy upheld.

The ChildLine review - *Always there when I need you* (NSPCC 2015) draws on findings from UK-wide data of calls and online contacts with its services over the period 2014 - 2015. Of the 64% of sessions for which age was given, 87% were with young people aged 12 to 18 years. This review reports that, while anxiety was a common feature (mentioned in a quarter of counselling sessions), young people often found it difficult to articulate the focus of their anxiety. The report states that in some cases this anxiety manifested as a fear or phobia, whereas others talked about feeling anxious most of the time but were unable to pinpoint the reason for this anxiety.

This ChildLine review highlights that children and young people can experience significant challenges in describing to others how they feel and why - important issues when seeking help.

Experiences in accessing and using CAMHS specifically

In 2016, SAMH launched a short online survey to obtain views and experiences in using CAMHS. This survey was completed by 85 respondents, many of whom were parents, to explore experiences in accessing and using CAMHS. A focus group was also conducted with ten young people. Findings from this research - *In their own words: the mental health of children and young people in Scotland* pointed to variable experiences, good and bad, of services. While most felt that they had been treated with respect and dignity, problems were identified, including long waits, inconsistent treatment, and lack of choice. The report highlights the fundamental importance of having 'clear pathways to excellent support' (SAMH 2016b, page 2).

The NSPCC (2015) review of ChildLine reported a 124% increase (across the UK) in young people talking about problems accessing services. Most of these problems were in relation to accessing services for mental health and wellbeing issues, for example:

- long waits for services left them feeling anxious and frightened that they would be unable to cope
- cancelled appointments or unreturned calls to mental health services left them feeling abandoned
- they were concerned about lack of out-of-hours support from services
- they had insufficient information on issues such as what to expect from a face-to-face counselling service or what would happen when they transition to adult services
- when a familiar service came to an end, they felt unimportant, let down, scared and alone.

Help-seeking attitudes and deterrents

The SYP report - *Our Generation's Epidemic*, (described earlier), highlights a range of barriers that young people experience in talking openly about mental health. These include embarrassment, fear of being judged, and a lack of understanding about mental health (the shaded box below provides a fuller list).

The NSPCC review (2015) of ChildLine highlights that young people talk of worries:

- about 'opening up' to their parent or another adult for fears of being a burden to them
- that they might be seen as attention-seeking
- that they might be dismissed as not needing help
- about confidentiality if they talk to someone else, including talking to teachers.

As a consequence, this NSPCC review reports that young people can often feel that they have no one to whom they can turn, and of having to 'put a brave face on it' in order to conceal from others how sad they are feeling.

This NSPCC review also suggests that, in general, girls may be more positively disposed than boys to the notion that it is helpful to talk about problems²¹.

In 2015, See Me (Scotland's national programme to reduce mental health stigma and discrimination) carried out a consultation with young people aged 12-25 years via an online survey. This generated responses from 455 12-15 year olds and 430 16-25 year olds, with 64% identifying as female and 28% as male.

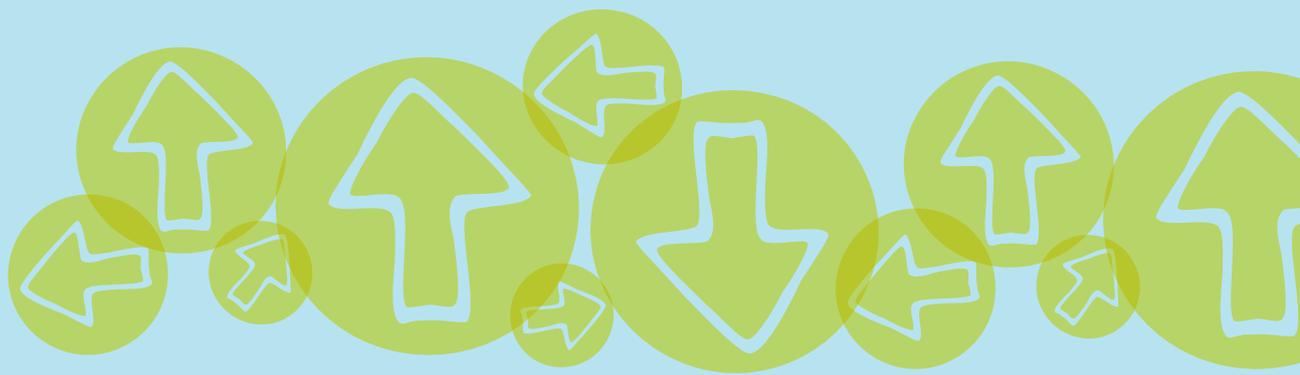
The See Me survey, amongst other things, sought to identify factors that make it difficult for young people to ask for support with a mental health problem.

The report on the survey findings (Griesbach 2015) indicated that the three main reasons that they gave related to:

- 'internal' stigma (i.e. embarrassment or fear about what other people will think)
- other reasons within themselves (e.g. lack of confidence, difficulties in articulating what they are feeling or a feeling that things aren't that bad)
- 'external' stigma (other people's reactions and judgements).

In addition, lack of knowledge or awareness about sources of help, and prior experiences of poor support (including poor services), were identified as issues.

Research funded by the Medical Research Council involving focus groups with 10 to, 13 and 15 year-olds explored their understanding of mental health problems and uncovered how these perceptions affect beliefs regarding help-seeking. This research found that both boys and girls felt that they would be more likely to seek help for symptoms that were physical than psychological. The main deterrent to help seeking was participants' belief that symptoms of mental health problems are rare and, as a consequence, disclosure would elicit stigmatising responses from peers, parents and teachers (MacLean et al. 2013).



BARRIERS TO TALKING ABOUT MENTAL HEALTH AS IDENTIFIED IN OUR GENERATION'S EPIDEMIC (SYP 2016)

An open ended question was posed to ask respondents what would prevent them talking to others about their own, or someone else's mental health. Identified barriers were:

- * **Embarrassment**
- * **Fear of being judged**
- * **Not being taken seriously**
- * **Fear of being a 'burden' to others**
- * **Mental health stigma**
- * **Fear of having confidentiality and privacy compromised**
- * **Fear of possible negative consequences**
- * **Lack of trust in other people**
- * **Lack of understanding about mental health (both that of other people and respondents' own understanding)**
- * **Not knowing who to talk to**
- * **Not knowing how to talk about mental health**
- * **Lack of confidence/shyness**
- * **Shame**

On seeking support for the distress caused by sexual abuse

An analysis of 2986 cases of self-disclosure of sexual abuse from children and young people aged 5-18 years who contacted ChildLine Scotland highlighted barriers to such disclosure. These included: feeling personally responsible for the abuse; feeling ashamed (about the abuse and disclosing this to others); serious concerns about the consequences of disclosure for themselves and/or others about whom they cared; worries about what would happen to the abuser; and fears that they would not be believed (Jackson et al. 2015).

3.3 What would help?

From the See Me survey, respondents (nearly three quarters of whom were female) highlighted a number of issues that they felt would make it easier to get help when they needed it. These were:

- if other people were less judgemental
- if the young person himself/herself was more able to articulate how they were feeling
- if the young person had closer, more trusting relationships
- if the young person knew where to get (confidential) support (Griesbach 2015).

The authors of the MRC research (by MacLean et al 2013) highlight the importance of addressing the misconception that symptoms of mental health problems are rare, and educating (children and) young people so that they understand that these are common and normal in the same way as many physical symptoms. They also argue that it will be important to address the perception that suffering symptoms of mental health problems is not a boys' issue. The authors further caution that attempts to normalise mental health problems must,

at the same time, convey the importance of not dismissing such symptoms. They conclude that campaigns and services should aim to improve young people's knowledge and abilities to know when they need help, and their right to seek such support (MacLean et al. 2013).

Last year, in response to the consultation for the revised mental health strategy for Scotland, the SYP (April 2016) recommended:

- a greater focus on prevention and early intervention
- increased mental health support and education in schools
- awareness-raising regarding available mental health services and information
- increased mental health literacy among non-medical professionals
- improved bridging between CAMHS and adult mental health services.
- identifying and sharing examples of best practice
- embedding rights-based approaches to young people's mental health.

In addition, the SYP report - *Our Generation's Epidemic* proposed that:

- all schools should provide high quality information about mental health and direct them to safe online resources
- all GP surgeries and hospitals should provide age-appropriate information about local mental health support and services
- every school should have a Mental Health Action Plan to encourage conversations about mental health
- a resource, in an accessible format, should be produced on young people's rights when accessing mental health support, and all young people should be given this when they first access mental health support

- all GP surgeries and mental health services should display age-appropriate information regarding young people's rights when accessing mental health support. This should include their rights in relation to confidentiality and to independent advocacy.

The SAMH (2016b) research report - *In their own words: the mental health of children and young people in Scotland* recommended:

- better training and support for primary care staff, such as GPs
- training Accident and Emergency (A&E) staff on how to appropriately support young people who present when in crisis, and to be (more) empathic in their response to self-harm
- better communication and support to young people and their parents/carers when they are awaiting assessment and treatment
- making mental health a whole-school priority.

NOTES

- 1 Kim-Cohen et al., 2003; Kessler et al., 2005
- 2 Green et al 2005, Mental Health of Children and Young People in Great Britain 2004, cited in Young Minds key statistics
- 3 ISD, [CAMHS Waiting Times](#), June 2017
- 4 Scottish Youth Parliament, [Our Generation's Epidemic](#), 2016
- 5 Scottish Government, [Scotland's Population](#) 2015
- 6 This research used the 12 item General Health Questionnaire (GHQ). The GHQ is a self-administered questionnaire that focuses on current state and subjects' inability to carry out normal functions and their experience of distressing symptoms.
- 7 Data on family affluence had been collected from each of the participating pupils in a survey the previous year
- 8 This was assessed by asking pupils to think about how Scottish society is set up, and to indicate where on a 10-rung ladder, they felt that their family is positioned, with the top rung representing "the best off people in Scotland - they have the most money, the most education, and the jobs that bring most respect"
- 9 Conduct problems and hyperactivity/inattention decreased with age in children aged 4 to 12 years.
- 10 While pro-social behaviour deteriorated with age in young people, pro-social behaviour improved with age in younger children between four and 12 years
- 11 Logistic regression is a statistical method to enable separation of effects that might be inter-related
- 12 At the time of the survey, 93% were living with their parents, 4% were living with their grandparents, 3% were living with a foster family and 3% did not answer this question.
- 13 <http://www.bacp.co.uk/media/index.php?newsId=2457>
- 14 These findings are drawn from data on the individual scales that form part of the Strengths and Difficulties Questionnaire (SDQ). It should be noted however, that *overall* scores on SDQ have remained fairly constant since 2006 among young people in Scotland.
- 15 Children and young people who are experiencing difficulties that could be related to their mental health are usually first identified within Tier 1 services, or parents, children and young people will usually first seek help from services at that level. Teachers, GPs and health visitors are examples of those working at Tier 1. Thereafter, those with identified mental health needs may be referred to specialist CAMHS which 'fall into' tier 2, 3 and 4. A fuller description is provided at: http://www.icptoolkit.org/child_and_adolescent_pathways/about_icps/camh_service_tiers.aspx
- 16 This report originally used figures for the quarter October to December 2016. To ensure this report contained the most up to date information, SAMH has used figures for the quarter January to March 2017. The researchers have not checked these figures.
- 17 These figures are based on 'adjusted waiting times' where such information was available. Adjusted waiting times take into account any periods for which patients were unavailable, and any appointments that they missed or rearranged. The ISD reports that for those NHS Boards that are able to report unadjusted waits (the total time from the date the referral was received by the CAMHS to the date treatment started) 79.7% were seen within the 18 week target.
- 18 Information Services Division, Child and Adolescent Mental Health Services Waiting Times in NHSScotland, Quarter ending 31 March 2017, Published June 2017. Available at <https://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2017-06-06/2017-06-06-CAMHS-Report.pdf>
- 19 This involved an intensive community treatment in Lothian, an expansion of existing services in the Borders and Fife, and redesign work in the South East of Scotland adolescent Inpatient Unit (SoS IPU).
- 20 This included lack of clarity on boundaries of confidentiality, and feelings that there had been breaches in confidentiality
- 21 Nevertheless, the review indicated that boys were more likely than girls to contact ChildLine about certain issues including gender identity, physical abuse or their own behavior.

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