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MENTAL HEALTH IN PRIMARY CARE

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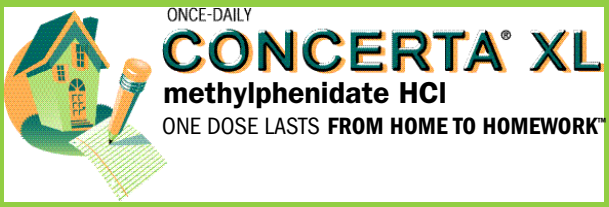

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MENTAL HEALTH
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EDITORIAL

THIS THIRD issue of the journal addresses issues raised in the government's green paper, Every Child Matters, which will also be prominent in the CAMHS part of the NSF, expected next year. The main thrust of these documents will be the need for truly joined up thinking and more importantly, joined up services with good communication. A comprehensive CAMHS "is prescribed".

Panos Vostanis outlines the complex needs of looked after children. Many have significant experience of adversity across the emotional, educational and social range and are at increased risk of mental health and behavioural disorders. Various factors affect their access to healthcare and their health needs may not be addressed. The article stresses the need for a multi-agency approach, underpinned by appropriate staff training.

The theory behind the definition of a 'comprehensive CAMHS' is discussed by Fiona Gale, in particular, that the community version of CAMHS should expand to include all workers who have contact with children from both the statutory and voluntary sectors. It is expected that parents, children and young people using the service will be consulted and involved in planning. This will involve agencies working together, trusting each other and resolving power struggles for the good of the service. Joint planning and budgets should follow. What is not clear is how to work with the increasing number of children and families who will now be seen in services and may well need to stay tracked with resources for the rest of their childhood. This requires a radical rethink, with focused treatment approaches and signposting options, if the outcomes for these children are truly going to improve.

Two specialist ADHD nurses describe how they have developed a role in assessment and treatment of the increasing number of children referred into the service. Cathy Laver-Bradbury discusses her work with children, as well as strategies aimed at improving these children's self esteem. Parenting packages and links with schools and primary care staff are also important, supported by information sheets and treatment manuals. Kelly Osman works in a very similar way and proposes that nurses are particularly useful in working with children who have complex problems. These families require focused work over the long term to sort out their problems and a specialist nurse is ideally placed for this.

Adolescence is a troubled time for many young people and their parents. Services to this age group need to be innovative and delivered in a non-judgemental way in a neutral setting. Anne Percival and Barbara Richardson-Todd outline the factors influencing the emergence of problems and the importance of nurturing strong, supportive and positive ongoing adult relationships to allow safe transition to adulthood. In this vein, Visyon offers accessible services to young people in Cheshire, where group work has provided an ideal setting in which to offer useful and relevant services and service development is informed by service users. Lastly, Nathan's story Illustrates how it is possible to take a different, but equally engaging approach to work with troubled families.

Margaret Thompson
November 2003

Mental health problems in looked after children:

We need a multi-agency approach

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KEY POINTS

- *Looked after children have complex mental health needs, which are interrelated with care issues, developmental, relationship and educational difficulties.*
- *The mental health needs of looked after children cannot be met successfully by any one agency.*
- *Multi-agency partnerships between CAMHS and social services are equally important at strategic and operational level.*
- *Interventions should include consultation, training, assessment and treatment applied to the characteristics of looked after children.*

LOOKED AFTER children and young people have multiple and complex mental health, social and educational needs because of their exposure to a range of vulnerability factors – loss and trauma, as well as the secondary effects of care placements and further experience of adversity. Life events include family breakdowns, rejection, abuse (emotional, physical and/or sexual), loss of attachment relationships within their family and wider community, experience of violence, parental factors such as drug and alcohol misuse and family/school instability which can prevent them from forming and sustaining peer relationships and school attainment. Further losses and experience of rejection are often experienced within the care system, thus maintaining a cycle of emotional distress, behavioural and relationship difficulties, which in turn can reduce the possibilities of successful foster placements or adoption.

These mechanisms and outcomes by no means apply to all looked after children, but they do place them at risk of a range of mental health problems and disorders. A number of studies have found high rates of mental health problems among children in foster care[1] and young people in residential care.[2] Young people leaving local authority care are particularly vulnerable, because of the difficulties in making a smooth transition to independent living and the social consequences of homelessness, lack of educational and employment opportunities and absence of supportive networks. Mental health problems are not different in nature from other groups of the population, but they are more frequently seen and possibly more likely to present with combined behavioural, emotional and relationship difficulties. Looked after children also present with other health and developmental needs.[3]

Longstanding service issues

Descriptive and longitudinal research has established the characteristics of looked after children, their social and mental health outcomes and their poor access to services. The latter is related to children's mobility, disengagement and lack of advocacy, as well as to the fragmented and uncoordinated involvement of agencies. Health records may not be passed on between carers and health checks or immunisations can remain incomplete. Also, there is poor access to health records or liaison between health professionals. Although medical examinations are compulsory, uptake is frequently poor, particularly among older children and there is limited communication between health and social services.[4] The remit of mental health services input is often not clearly defined and inevitably overlaps with placement and care issues. Common causes are discussed below, before considering ways forward.

CAMHS and social services: Different cultures, growing partnerships

In a recent study, we explored perceptions and expectations of CAMHS from social services stakeholders through 13 focus groups with social services staff, foster carers and residential social workers.[5] Several themes emerged, including:

- Difficulties accessing mental health services because of waiting lists
- Children's unstable circumstances and sometimes inconsistent referral criteria
- The need for response and intervention early in a child's experience of care
- Confusion over the concept of mental health and the remit of specialist CAMHS
- The need for flexible and engaging services for young people in transition, in contrast with CAMHS seeking stability before providing any intervention
- The need for good working partnerships and communication
- Consultation and training by CAMHS.
- Other factors which contribute to children's access difficulties include non-detection of mental health problems, referrers' reluctance to pathologise children's behaviour, difficulties in gaining their engagement with therapies and limited resources.[6]

However, it is also important to consider these issues in the light of a 'CAMHS perspective' and to highlight the different pressures, priorities and cultures of local authority and health services.

For CAMHS, a priority of central importance is to ensure that limited resources are employed to maximum effect and in this context, the priorities of CAMHS do not always match those of other stakeholders. For example, distinctions between concepts such as 'mental health', 'mental health problems' and 'mental illness' become crucial in deciding how best to allocate service provision, with specialist CAMHS targeting the more severe problems and disorders. Also, in distinguishing between different levels of therapeutic interventions, it is important for CAMHS to consider what degree of input is going to make the most effective use of limited resources and to resist pressures to offer psychotherapy as a panacea for all problems, particularly in response to serious environmental deficits or externalising (aggressive) behaviours. For example, there needs to be a distinction between psychotherapy for emotional difficulties and therapeutic work for all children who have suffered loss.

Not all children can make use of or engage with one approach, therefore another consideration must be the provision of a range of therapeutic approaches adapted to the characteristics of looked after children (such as cognitive, brief psychodynamic or solution focused therapy).

Requests from CAMHS for a young person to be in a relatively stable placement prior to input often stem from professionals' experience that the effectiveness of psychotherapy can often be compromised by children's difficulties in making sense of their inner world in the middle of major (and often unsafe) life changes. CAMHS also have to resist pressures to provide therapy because 'nothing else has worked', as this is also unlikely to have a positive impact.

Although the previous arguments are valid for both organisations, which have different (but overlapping) priorities and pressures, it is increasingly accepted that looked after children's mental health needs cannot be met with unilateral

Five months after their first attendance, children had improved on emotional and behavioural problems, self harm, and relationship with the carer.

solutions by any one agency. Also, one needs to include the contribution from other health, educational and non-statutory services in order to achieve a comprehensive service. National policies such as Quality Protects[7] have facilitated this process and have been followed by funding streams that require partnership at both strategic and operational level. But what kind of CAMHS provision should we be aiming for?

Multi-agency service models

Looked after children should receive prompt and continuing treatment within a comprehensive child and adolescent mental health service. However, this will not be universally possible for several years, until CAMHS are adequately resourced to respond to primary care referrals, i.e. from general practitioners (GPs), schools and community paediatrics, which often take precedence in service referral pathways. For this reason, services have developed alternative and more accessible models for vulnerable and mobile groups of children, for instance through designated sessions for local authority agencies from specialist CAMHS staff,[8] development of jointly commissioned posts, or designated teams.[9,10] Designated posts integrated within generic specialist CAMHS may be appropriate for smaller districts and rural/semi-urban areas, whereas designated teams may be more effective in inner-city areas.

One such service model is described below in more detail. In a health district covering three local authorities, a mental health team was established to provide a service to overlapping groups of vulnerable children, i.e. looked after children, young offenders, refugee and homeless children and families. The team consists of two primary mental health workers (PMHWs) for looked after children, four PMHWs for the two youth offending teams (YOTs), one community psychiatric nurse (CPN) for refugee children, five family support workers for homeless children and their parents, two psychologists and one psychiatrist who work across the four client groups. In this paper, reference to the team will be confined to the looked after children component. The team roles include assessment and treatment; consultation to foster carers, pre-adoption carers, residential staff, social workers, and foster carers' link workers; and ongoing training to the same agencies.

The team is structured according to a tiered model of service provision, with PMHWs (tier 2) covering the interface between primary care professionals (tier 1 – in this case, local authority staff) and specialist (tier 3) CAMHS (the psychologist and psychiatrist in this team). The posts are recurrent, and were funded by CAMHS modernisation monies and local authority mental health grants. The local partnership between health and local authorities prioritised the needs of looked after children, whilst acknowledging the substantial resource issues in the rest of CAMHS. The service is monitored by a multi-agency steering group, thus retaining strong working relationships with both social services and the rest of CAMHS. The role of the steering group is to plan developments in a strategic way, respond to new policies, oversee operation service criteria, and facilitate multi-agency training.

PMHWs receive most of the referrals, provide telephone or face-to-face consultation to professionals and carers, or joint work with local authority professionals. Each residential unit has an allocated PMHW who regularly visits the home, providing consultation and training to staff teams. In fostering, PMHWs work with fostering link workers, social workers and adoption workers. in this way, the PMHW seeks to empower frontline staff and carers with basic mental health skills, in order to improve their identification of young people at risk and to help them build their resilience. In addition to this consultative role, PMHWs provide time-limited direct interventions to young people, and provide direct support to their carers (foster carers or residential workers).

At the second level, mental health assessment is provided by the psychologists and psychiatrist within the team, who also provide direct treatment (cognitive, psychodynamic, systemic or pharmacological), work jointly with the PMHWs, and contribute to consultation and training. If a child requires long-term psychotherapy, s/he is referred to a designated therapeutic social work team that covers the same local authorities. The team is located within CAMHS, and operates as an independent tier 2/3 service, alongside the sector specialist teams, i.e. those that cover geographical areas.

The team provide ongoing training in mental health awareness, basic concepts of mental health problems, rationale for different interventions and staff roles (foundation course), which is an integral component of the service. The one day training predominantly aims at engaging other agencies and carers, and relating to them in a consistent way within a mental health capacity (i.e. distinguishing CAMHS roles from family support, case work, or child protection). The courses are offered separately to local authority staff (residential social workers, foster carers' link workers, or other social workers) and foster carers, because of their different levels of training needs. A second level advanced training programme (eight half-day sessions) was subsequently developed for foster carers, pre-adoptive parents and their link workers, to provide a framework on the relationship between loss, trauma, attachment and behavioural difficulties, as well as management strategies.

The first phase of this service was evaluated by independently interviewing 45 children and their carers, who were consecutively seen for direct work.[11] Five months after their first attendance, children had improved on emotional and behavioural problems, self harm, and relationship with the carer. Carers had significantly increased understanding of the child's difficulties and awareness of appropriate services - an objective of the service was to maximise input from other agencies in a cost-effective and timely way.

The future

The changing context of child and adolescent mental health services is favourable for the improvement of the quality of mental health services for children and young people looked after by local authorities. A number of multi-agency policies and funding initiatives, service standards such as the National Service Framework (NSF) for children and the wide acceptance of a tiered service model are directly applicable to this vulnerable and needy group. Emerging services operate at multiple levels of interventions through consultation, training, assessment and treatment, adapted for the needs of the child in public care.[10] Ongoing dialogue between the key partners at both strategic and operational level and evaluation of emerging models are essential in this process. ◆

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Working towards a comprehensive CAMHS:

Child and adolescent mental health services, the next three years

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KEY POINTS

- *It is expected that comprehensive CAMHS services, including mental health promotion and early intervention will be available nationwide by 2006.*
- *CAMHS will extend to include all agencies, organisations and people that have contact with children and young people in their day to day work.*
- *Partnership and consultation will underpin the development of accessible, coordinated and responsive CAMHS at all levels of need, across the tiers.*

IN PREPARATION for the publication of the CAMHS module of the National Service Framework (NSF) for Children, there have been a number of recent policy developments which will promote the expansion and improvement of CAMHS on a local, regional and national level. The overall aim of these developments is that all CAMHS should be providing a comprehensive service, which includes mental health promotion and early intervention, by 2006.

The forthcoming Children's NSF and the already published Emerging Findings[1] set out standards and milestones for the improvement of CAMHS, including targets that relate to access to services. The DOH circular Child and Adolescent Mental Health Service (CAMHS) Grant Guidance 2003/04,[2] sets out, for the first time, an initial definition of a 'comprehensive CAMHS' and the interim priorities for service development. The Priorities and Planning Framework (PPF)[3] identifies the expectation that a comprehensive CAMHS will be available in all areas by 2006. In any locality there will be clarity about how the full range of user's needs are to be met, which includes a range of provision from services that give advice regarding minor problems to arrangements for admitting a young person to hospital with serious mental illness.

Within the PPF, the Public Service Agreement identifies national capacity assumptions for year on year improvements within CAMHS. As well as the target for all CAMHS to provide a comprehensive service by 2006, there is also the expectation that CAMHS will increase by at least 10%

each year across the whole service, according to locally agreed priorities. This should be demonstrated by increased staffing, patient contact and/or investment.

The broader Government agenda for children will also influence the development of CAMHS, in an integrated and joined up way. Policies such as Shifting the Balance of Power and reports such as the Climbie inquiry[4] and the Green Papers on children at risk,[5,6] and antisocial behaviour[5] will also assist commissioners and providers in taking forward the development of their services and in identifying their local priorities

Do we mean CAMHS or camhs?

The emerging findings document states that children's mental health is everyone's business. This extends the original concept of 'specialist CAMHS' to include universal services (tier 1) or camhs providers with a small 'c' (those services who would not ordinarily say their core business was children's mental health), i.e. all agencies, organisations and people that have contact with children and young people in their day to day work. This, for example, would include schools, playgroups, voluntary organisations, primary healthcare provision, nursery workers, youth workers etc. The document recognises that universal providers may have a varying ability to contribute effectively to children's mental health, depending on their level of training and the support they receive. Such support would include that received from specialist CAMHS. The need to enhance local specialist CAMHS to provide such support for universal services has been recognised in the circular highlighted above, as the criteria for use of CAMHS grants suggests, the recruitment of child mental health workers to provide a range of services including training, support and high quality advice on children's mental health issues. Such support, too, is determined within the initial definition of a comprehensive CAMHS.

The emerging findings: The mental health and psychological wellbeing of children and young people

A chapter of the emerging findings document is dedicated to children's mental health. This chapter introduces the initial framework on which the CAMHS module of the children's NSF will be based and gives some insight into the direction the final version will take. This enables CAMHS to consider current provision, identify areas of success and also priorities and gaps, therefore assisting in the development of a strategic plan for the expansion and improvement of services over the next three years, in order to meet the target of a comprehensive CAMHS by 2006.

The overall aim outlines 'the need to meet the needs and views of children and young people with mental health problems, together with those of their children and families, in order to improve their life chances within the family, social and educational settings.' The document goes on to suggest that this can be achieved by providing access to appropriate, high quality services that respect difference and diversity, take into account best available evidence of effectiveness and are delivered in a timely way, within an appropriate environment. The aim also recognises that services should be provided through a competent, skilled and supported multidisciplinary workforce. The document highlights a number of areas on which CAMHS should focus in developing plans for a comprehensive service.

Commissioning

Commissioning is seen as a high priority, particularly in the planning and development of strategies for improvement and investment, and should therefore be of a high quality. In order to achieve this, commissioners should have the appropriate skills, knowledge, time and authority to commission CAMHS effectively. The commissioning process benefits from operating on a 'joint' basis, with full participation and ownership from key stakeholders within health, education and social care and also includes effective links with, and involvement of, other key partners such as the voluntary sector and users.

The model of commissioning and planning that is beginning to emerge is the development of joint strategic groups, which incorporate all key partners in the process. In a few areas dedicated joint commissioners and strategy manager posts for CAMHS have been developed that can assist in the facilitation of planning and joint use of budgets.

The document also states the necessity for the planning and commissioning of services to be informed by a regularly updated multi-agency assessment of need, which includes the consideration of particular groups where there is currently poor or no provision. All CAMHS development strategies should also be informed by both clinicians' and users' views, and include the whole continuum of CAMHS, from mental health promotion to very specialised (tier 4) provision.

Partnership

Partnership underpins the development of accessible, well coordinated and responsive CAMHS at all levels of need, across the tiers. The emerging findings recognise the importance of integrated partnership working that spans all tiers of provision. Partnership also ensures smooth transitions between tiers and services, in particular at key points, for example, between child and adult services. The findings emphasise particular examples where multi-agency partnership is vital, these relate more specifically to those children and young people whose needs (because of their complexity and/or severity) may span a number of agencies i.e child protection, youth justice or special education needs.

Developmentally appropriate care

The age range for CAMHS, is known to vary on a national basis.[7] The emerging findings emphasise the need to clarify the age range for which it provides, not only to develop a standard and uniform remit across all localities, but also to identify the age range for which it is the most appropriate provider. This should include the interface with adult mental health, the handling of any transition to adult mental health services as well as developing services that cater for the mental health of infants. The expectation is that CAMHS will extend to cover the 0-18 years age group over the life of the NSF (10 years), and have local agreement for responding to referrals for young people in the 16-18 years age group.

Evidence-based practice, training and a skilled workforce

The emerging findings emphasise the need for commissioners to ensure that the CAMHS workforce, at all levels of provision, is skilled and competent in meeting the needs of their population. This includes the requirement for a workforce that is trained to deliver a full range of interventions, including comprehensive mental health assessment and a variety of treatments, based on best available evidence. The importance of training and supporting universal services (tier 1) is also again highlighted. The development of such a skilled workforce, in both specialist and universal CAMHS will require local services to collaborate in terms of training and to link into national workforce development programmes. They will also need to develop creative ways of enhancing and supporting their existing workforce or recruiting into new posts, such as child mental health workers.

Service composition

Although there is as yet no definition available in terms of critical mass of staffing, data from the national CAMHS mapping exercise will assist CAMHS with the planning of services, and will inform the final NSF.
(www.dur.ac.uk/service.mapping/CAMH)

The planning and development of the workforce will need to ensure that it is of an adequate size and skill mix, including professionals with the necessary skills and competencies to deliver a comprehensive CAMHS. It must also be integrated into a network across tiers and agencies, therefore eradicating isolation and supported by an adequate infrastructure i.e. management, administration, IT and appropriate build environment.

Access, users' views, audit and outcomes

Providing services locally and in a number of settings can contribute to an increase in accessibility of provision and serve to reduce the stigma of mental health. When widening accessibility of provision, it is also vital to consider the balance of confidentiality and transparency of services. This can only be achieved though consultation with users. During the development of the emerging findings there was wide consultation with users, who highlighted the need to develop users' fora. The findings also emphasise the importance of ensuring that the views of all users are captured through a variety of creative approaches, including the younger age groups. Young people have identified the desire for as

much transparency in the delivery of services as possible and are keen to be seen as active partners in the process.

Access to tier 4 services that are nearer to home will also require significant investment and collaboration by health, social care, education, youth justice and the voluntary sector. In particular, there is limited inpatient provision in some parts of the country for specific groups of children, for example those who are learning disabled.

The emerging findings also state that all CAMHS should routinely audit and evaluate their work. Such information can be used to develop and improve CAMHS provision, both with the individual and families, and across clinicians and commissioners alike.

The CAMHS financial framework

In 2003-04, a CAMHS grant of £44.1m is being allocated to local authorities to improve CAMHS, according to jointly agreed priorities in local CAMHS development strategies and in local delivery plans (LDPs). The circular mentioned earlier,[2] sets out the funds available to each local authority. It also states that further funds will be available through the CAMHS innovation projects and for the development of treatment foster care. Funds have also been allocated for the development of a National CAMHS support service, made up of nine regional development workers (RDWs), who will support CAMHS locally and regionally to achieve the development of a comprehensive CAMHS.

Total funds available to local authorities (LAs) from 2003 - 2006 are set out in LASSL (2003),[8] Annex A.8 Such information allows LAs, to make projections of funding available by working out their percentage of the overall pot of money, based on their share in 2003/04. In addition to this funding stream, primary care trusts (PCTs) will receive specified funding for CAMHS improvements from 2004-06. The details of this funding can be found in HSC 2002/12 PCT Revenue Resource Guidance: Annex 2 & 3 for Centrally Funded Programmes and Initiatives[9] The funding identified for PCTs within the circular is extra funding each year.

Overall it is anticipated that there will be an increase of 60% on current CAMHS spending nationally by 2006.

The National CAMHS support service

The Department of Health (DOH) has recruited a team of nine RDWs (coterminous with Government Office Regions), who along with a CAMHS Implementation lead will form the National CAMHS support service. The aim of the team is to assist and support local CAMHS staff, services and partnerships in making best use of the new resources to bring each local CAMHS up to a level consistent with the standards to be set by the Children's NSF and the PPF target of achieving a comprehensive CAMHS by 2006. The team will link into the DOH and the wider children's agenda, ensuring a two-way communication on emerging developments and progress in CAMHS.

The RDWs are from a wide variety of backgrounds and organisations, with extensive experience and knowledge of working both within CAMHS and on the strategic development of CAMHS provision and the wider children's agenda.

The team will work locally with CAMHS to support strategy development, quality commissioning and service redesign, as well as developing networks to promote learning and dissemination of good practice. Regionally, they will develop strategic linkage to bring together development activity, establish and support networks and support local leaders and champions for CAMHS. They will also ensure the dissemination of National policy and support local interpretation and implementation. On a National basis, the team will have a role in monitoring progress in service development and ensure local experience informs policy development, milestones and targets. They will also ensure that evidence-based effective practice and innovation is shared and recognised and that the expertise within the team is used effectively to address specific needs and issues.

The challenges ahead

The challenges of developing a comprehensive CAMHS will vary according to the views and priorities of local stakeholders. To overcome this

and achieve a balance of ownership, joint responsibility and agreement it is vital to develop firm partnerships and networks. The effective commissioning and development of strategic plans to achieve the comprehensive CAMHS target will need to be based on a current assessment of need and a baseline position statement of currently available services and resources. Key partners will need to work together within joint strategic partnerships to achieve a shared agenda for development. A comprehensive service can be achieved through a concerted drive by all involved with children and through the recognition of innovative and effective practice. Supporting and nurturing local leadership and the many champions within CAMHS at all levels of provision, as well as involving users in service design is key to the creation a CAMHS that is everyone's business. ◆

The National CAMHS Support Service can be contacted on 0116 295 7574, however, CAMHS regional development workers will be liaising with all relevant partners in their region from August 2003.

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A comprehensive guide to developing integrated services in line with the national service frameworks for mental health.

The role of the nurse:

Helping children with ADHD and their families

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KEY POINTS

- *Nurses have a diverse and complex role in the treatment of families whose children have a diagnosis of ADHD.*
- *Children with ADHD often become sad and despondent. Nurses can help the child by teaching them to problem solve and gain a better understanding of their strengths and weaknesses.*
- *Establishing support links with health workers in primary care provides a consistent approach to the management of children with ADHD.*

AS THERE is currently no direct training pathway for nurses leading into a specialist CAMH service, nurses from a variety of backgrounds work within CAMHS.[2] My own interest in behaviour problems surfaced when I was practising as a health visitor (HV) in a rural community in the New Forest. While completing three-year developmental checks, I came across a proportion of children who appeared to have no developmental difficulties but whose parents were expressing concerns about their difficult overactive behaviour and concentration problems, which were demonstrable during the developmental check.

Subsequently, I was fortunate to be employed in a research project identifying children who met the criteria for ADHD, in order to deliver a parent training package.[3] As a result of this project, I developed an interest in helping parents and their children with ADHD and the skills I learnt at that time still underpin my current role in supporting parents and children who have a diagnosis of ADHD.

Since the completion of the research project my role has evolved. Below I have outlined the role of the specialist ADHD nurse and the contribution nurses can make to parents and children who have a diagnosis of ADHD.

The role of the specialist ADHD Nurse can involve the following:

- Assessment of the child and family
- Liaison with schools to facilitate diagnosis
- Parent education
- Parenting strategies – both individually and in groups
- Child education
- Facilitation of further interventions e.g. family therapy, cognitive behaviour therapy (CBT)

- Joint training with educational psychologists to schools, individual advice to teachers
- Ongoing support and advice to parents.
- Medication monitoring and titration of dose within established parameters.
- Training for HVs, school nurses (SNs) and other professionals involved in the care of a child with a diagnosis of ADHD.
- Training for medical students during their psychiatry module.
- Audit and research to enhance knowledge of ADHD and provide the evidence base for treatments.
- Development of protocols and guidelines for the service
- Development of supportive literature and video resources for parents and professionals

Assessment

The development of an assessment tool that can be used by all members of the multi-disciplinary team, ensures that a comprehensive assessment of all the presenting difficulties in the child takes place, in addition to the birth and developmental history. Questions relating to parental mental health, environmental concerns and information about the child's education and time in school form the basis of the assessment in line with the recommendations of NICE guidelines.[4]

In addition to this the assessment tool includes the ICD 10[1] criteria for ADHD and conduct disorder, should symptoms of these be present. To confirm the diagnosis symptoms should be pervasive, present prior to the age of 7 years and be causing significant impairment in functioning both at home and at school. Nurses are ideally placed to carry out the assessment and liaise with the child's school as described below, to find out how the child is progressing.

Following the assessment, letters are written to the referrer with a copy to the parents informing them that the child appears to meet the criteria and further information is sought from the school to confirm this. Contact with the school is established and completed questionnaires and feedback received before confirming diagnosis and commencing parenting strategy sessions.[5,6]

Parental education/strategies

ADHD is one of the most researched areas in children's medicine and this means that there is a plethora of information available, both in literature and on the world wide web. Parents often come across information that can be inaccurate and misleading. Specialist nurses play a vital role in the development of resources for parents and professionals who work with children with ADHD. It is essential to provide parents with up to date information that explains and underpins the work that you as a specialist nurse may offer a child and family. This not only encourages openness but also gives the family background information explaining why we may offer parent training, or play therapy in addition to medication.

The development of appropriate literature and video resources[7,8] for the parent and child can be a challenge, but developing these with the help of parents can be a most useful resource. Giving parents information and advice provides them with the information they need to make informed decisions on behalf of their child. A series of leaflets are used both to inform parents and children and to facilitate an educative role for nurses and doctors. They can be offered at various stages during the intervention to enhance understanding and ensure that most aspects of care are covered.

Three leaflets are currently used within the Ashurst clinic. 'Information for Parents' is given following assessment when the diagnostic criteria for ADHD have been met. At the same time a second leaflet is also given to the child: 'What is it: ADHD?' and provides a simple explanation for children. Following behaviour strategies and parenting advice, medication is often considered. At this point the third leaflet is offered describing the use of medication in treating ADHD. This includes information about how the medication is used and possible side effects. A consent form for the parents to complete is also included, in addition to a final reminder of the contra-indications that need to be considered (e.g. the presence of heart problems or fits in child or family) before the child is considered for medication. Ideally, the nurse gives this leaflet before parents meet with a

doctor, allowing them the opportunity to read and absorb the information and ask appropriate questions before they make the decision for their child to commence medication.

Parenting strategies and support, either individually or in a group setting, can facilitate an enormous change in the way parents manage their child with ADHD and can be of great benefit to the child. We use the strategies as outlined in the 'Information Manual for Parents and Professionals working with Children with ADHD'.[9] The manual gives a descriptive account of either a four or eight week intervention depending on the needs of the parent and child – this package has been adapted for group use, but the principles remain the same. Predominantly, this is carried out by the CAMHS nurses before a child commences medication. This allows an extended period of assessment, advice and enables the parents to spend time exploring the options available for their child and family.

Education for the child

Children can be helped to manage and even to use some of their ADHD symptoms to their advantage. Learning about their strengths and weaknesses and how to solve problems can be helpful to a child throughout their school years and during college. Understanding why parents are concerned and finding ways of communicating in a positive manner require practice and support if they are to be achieved by children with ADHD. In the ADHD nurse role, sharing knowledge of what has helped others can be invaluable, as can seeing someone for a period of time, perhaps in school. Offering regular support sessions if required when the going is tough can ease some of the sadness we see in children with this disorder. The various developmental stages for a child bring their own challenges, with different expectations of teachers and parents, from starting school, graduating to junior school or secondary, right up to GCSE and A' Levels.

Sometimes it is easier to confide in someone outside the family about how you are feeling and when a nurse has worked with a child for a number of years the child learns to trust her or him and recognise that they are trying to help.

Medication

Although primarily the role of the doctor, medication reviews are easily carried out by a nurse both following the initiation of medication and during its maintenance. Titration of ordinary release methylphenidate and dexamphetamine can be agreed at the initial prescribing and then monitored by the nurse within an ADHD clinic setting, or by telephone. Having a tool which prompts the nurse to ask about side effects and which can record important information regarding height, weight, blood pressure and pulse ensures that all relevant questions are asked routinely when a child is seen. Parents or other professionals can phone in with queries in between clinic visits. The medication booklet is also a parent-child booklet which records this information should it be necessary for other health professionals. Ongoing concerns can be discussed with the medical staff and with the doctor seeing the family for the six month review as per guidelines.

Training

The nurse is ideally placed to respond to requests for training for colleagues within primary care and medical students during their CAMHS placement. During my years as a HV, the support I received from the CAMHS service was invaluable, both in terms of supervision and for practical ideas to help children and families.

Training health professionals to use the ADHD manual and supporting them in its use can be rewarding and helps to ensure a consistent approach in the children's care. Most recently, a new training initiative has involved the introduction of medical students from Southampton University on a regular basis. Students rotate through the CAMHS, thereby increasing their knowledge and understanding of child mental health issues including ADHD and emphasising the importance of identifying the condition early to prevent difficult parent-child relationships developing.

Research and audit

If treatments are to be evidence based it is essential that research and audit form an integral part of an ADHD service.[10]

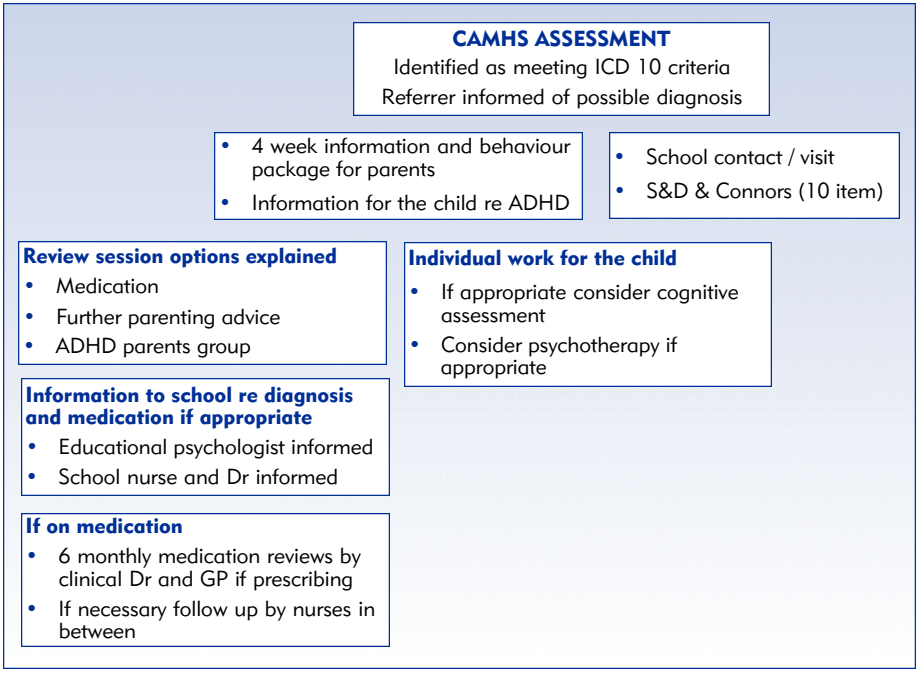

Table 1. *Care pathway for ADHD*

A multidisciplinary approach to research covering qualitative and quantitative methods, adds weight and knowledge to the clinical approach. Establishing a working relationship with the university in the fields of medicine, psychology and nursing in relation to ADHD has been of benefit and information gained from the research is in turn fed back to parents in order to help them and their children. The nurse's involvement in research in terms of feasibility, application and evaluation is invaluable.

Conclusion

The role of the nurse in helping children and their families with ADHD is often complex and diverse. The adaptability of nurses makes them ideally suited to the changing needs of a child with ADHD and those of their family, as well as offering support and information to other professionals. I believe every CAMHS would benefit from having a specialist ADHD nurse working with them. Working with children who have ADHD is both rewarding and enjoyable. ◆

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ADHD:

How are specialist nurses doing?

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KEY POINTS

- *ADHD is a complex neurological disorder with huge implications for children and their families. The number of children referred is also on the increase.*
- *With growing knowledge and evidence for the treatment of ADHD and comorbid disorders, the work undertaken by the specialist nurse has become increasingly complex and specialised.*
- *CAMHS units are currently struggling with large numbers of referrals for ADHD. Average waiting times are between 6 to 12 months.*
- *The need for specialist nurses is likely to become urgent throughout the NHS to meet demand, which is growing at a much faster pace than the medical workforce.*

WHEN I joined this service three and a half years ago, as a nurse to assist with the ADHD clinics, it was initially thought that I would weigh and measure children and escort them to their psychiatrist. Four years later, with the help of my consultant colleagues, my role has developed into that of an ADHD nurse specialist. I have seen so many developments in this field, so I will start by taking a look at how referrals have changed.

When I arrived Dr Weir, child and adolescent psychiatrist, was running two clinics a month to monitor children settled on medication. At that time we were predominantly using dexamphetamine or methylphenidate. The other consultant psychiatrists all had ADHD patients but these were distributed within a generic caseload. Since then we have a developed a service, which I feel, rivals the best in the country. With improved education and increased public and media awareness, we have seen referrals increase and expectations rise, however, resources only trickle in.

Articles discussing methylphenidate, which have appeared in the national and local press, have done little to promote knowledge and understanding of this medication and its use. Unfortunately, a number of these are ill-informed and poorly researched pieces of work that have upset many families whose children already receive medication.

The need to develop an effective service for these children had obviously been identified by my colleagues when they advertised for a nurse specialist to assist in coping with the demand for services in this area. However, I don't think any of us one guessed how much work would be involved.

When I arrived, around 150 children were receiving treatment for ADHD – that figure has now reached approximately 380. Each

consultant now runs regular monitoring clinics and I also run nurse led clinics. I have had the opportunity to develop the role, because the need is there. I feel passionate about the plight of these children and families. Although children with ADHD require monitoring by a specialist, the role for a competent expert nurse is invaluable in freeing consultants to concentrate on the increasing demands for urgent and emergency work. In my own case, it has also allowed me to develop a specialist interest and form good relationship with these clients, who may stay with us for ten years.

ADHD is a complex neurological disorder, which has huge implications for the individual and their family. It is not adequate to define it simply in terms of attention problems and naughty behaviour, although this may still be a broader public perception. It can be treated effectively in many ways, and I feel fortunate to work in a CAMHS service where I am able to offer many treatment packages to help.

Three years down the road, I have written a nurse medication adjustment protocol and attended nurse prescribing conferences, as well as three international conferences on ADHD. Dr Anne Reeve and I have produced an information pack for schools which is currently in press and will be released to all primary schools in Suffolk. No extra funding was forthcoming for this, but we are fortunate to have received help from a pharmaceutical company.

The nurse prescribing debate is ongoing nationwide, but evidence suggests that this will be an area where we could really start making a difference. The nurse role is no longer limited to weighing and measuring. With increased knowledge and evidence for the treatment of ADHD and comorbid conditions, the work is now a great deal more complex and specialised. Recent conferences and research would suggest that 80% of ADHD children have a comorbid condition. These can include autism, conduct disorder, anxiety, dyspraxia, /learning difficulties and Tourette's syndrome to name but a few.

Medication will help with the core ADHD symptoms and we can work well on those, but the gold standard is treating the individual. It is in this area that I feel our service excels. Below I describe a number of initiatives developed and being offered by our service.

Groups

In the past two years I have facilitated a group for teenage boys, and latterly girls, to help with their understanding of this condition as well as looking at medication and impulse control.

In collaboration with Dr Garfield, who was appointed to take a lead with ADHD, we have facilitated a highly successful parents group to improve knowledge and understanding as well as emphasising the most useful parenting techniques.

These groups, along with our excellent child behaviour management group (CBMG), are elements of our service that are the envy of many colleagues in other parts of the country. I can refer to our well developed and specialist CBMG all year round. The groups are now run by individuals with years of experience and a wealth of knowledge. They are not solely for ADHD parents, but the highly packaged programme is as helpful to those parents as to any.

We also have a group for the parents of children with autistic spectrum disorders (ASD), in mild or moderate form, which many of our parents whose children have ADHD and/or an ASD have attended, and a group for children and parents with anxiety called 'Facing your fears'. All of these groups are run in conjunction with our psychologists.

These have been welcome additions to our service, but as all CAMHS are facing another difficult year, how do we sustain these areas of excellence as the pressure of waiting lists and new emergency referrals is on the increase?

CAMHS units nationwide have been swamped - and in some areas crippled - by the growing numbers of children presenting with ADHD. I think it is fair to say that we have also felt that pressure. All our clinicians feel dogged by the current waiting time for assessment of between six months to one year. However, when I attended a

recent conference in London I was reassured and relieved to hear that we are not alone – 12 months is an average waiting time for an ADHD assessment. I was also pleased and interested to hear how other services are managing the difficulties and have since been contacted by several nurses from other regions asking how our service manages. Other services have halted all ADHD referrals, others are paying for out of county assessments and some are developing new services with community paediatricians.

We have coped, if only just, although this may not be of help to those unfortunate families living in with frustration and chaos while they sit on our waiting list. I have many ideas and wishes as to how we could move our service forward, including joint work with community paediatrics, similar to that of our colleagues in the West, however this is not possible until more resources are available across the board to develop this further.

Another ideal would be to employ our pharmacist so that we could begin to think about nurse prescribing issues and together learn more about these stimulant medications, including the sustained release preparations which are now being widely prescribed. We could also explore alternatives not yet in use.

In common with every other CAMHS, we need more staff. Each consultant here does a fantastic job, as do all the clinicians who now have experience of ADHD. They devote as much time as they can to each area of need, yet having a dedicated role can really help. Dr Garfield has put a huge amount of work into producing papers and protocols, at the same time overseeing a county wide clinical group involving CAMHS paediatricians and education for the last 3 years. However, there is still only one of me.

The groups I have been able to work with this this year were a pleasure. The need was clear and I could justly it. However, the clinics remain a priority and if the need for groups changes, the opportunity may not continue. Our CBMG and ASD group for parents group are, we hope, stable, but the groups for ADHD children and parents are elements of our service that I would emphatically like to develop further.

The consultant's perspective

I hope Kelley's story can serve as an inspiration, not only to nurses working in child psychiatry but also those working in any specialised area of medicine. The post was initially advertised because the consultant's felt overwhelmed with referrals. Initially we thought a nurse could do the weighing and measuring of patients, leaving us more time to do the rewarding skilled bits: talking to patients, adjusting medication etc.

Looking back I can see how much we underestimated the potential of Kelley in particular and the specialist nurses in general. In our defence, I think we recognised our mistake early on and have since allowed Kelley a great deal of flexibility in terms of developing her role. It has been a revelation to see how she has made contact with schools, community groups, paediatric nurses, GPs and individuals with whom consultants are often 'too busy' to become involved. The benefits for our service in terms of good will and an increased local understanding of our problems has been huge. There have been no complaints from patients that they aren't seeing enough of their doctor and it has become clear to me that some children and parents find it easier to talk to Kelley than they do to me, and perhaps the other consultants.

In the future we hope Kelley will expand her specialist role even further. She is already altering doses of medication and will soon start carrying out first assessments of patients. Quality of care will be protected by regular audit of her work, something in which can't always be said of doctors (both trainees and consultants). I think the message is that there is no theoretical limit to the role that nurses can assume, providing that role is agreed between the nurse and other clinicians. These initiatives will soon be an urgent requirement throughout the NHS to meet the demand, which is growing at a much faster pace than the medical workforce. I hope this will be rewarding for the nurses involved, not merely personally but financially. Nurses with this level expertise must be rewarded in real terms. ◆

A primary care intervention:

Easing adolescent transition

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KEY POINTS

- *Unresolved emotional and behavioural difficulties in young people tend to resurface with the onset of adolescence.*
- *Various factors can affect a smooth transition to adulthood, including school, home life, peer pressure, parental expectations and growing sexual awareness.*
- *Strong, supportive and positive relationships with adults are significant factors in easing the transition to adulthood.*
- *Young people need information and guidance provided in a non-judgemental setting*

IT IS apparent that an increasing number of pupils at secondary schools are experiencing emotional and behavioural problems. Problems from an earlier age that have not been addressed tend to resurface at adolescence, coinciding with the transition from primary to secondary school. Early intervention is essential.[1] Our study was undertaken in 2000 and involved a written questionnaire completed by 198 primary school children aged 10-11 years, asking what their worries and concerns were regarding transition to secondary school and also their concerns about life in general. This resulted in an intervention, by the school nurse and educational welfare officer in the form of a series of presentations to year 5 and year 6 pupils in primary schools.

The transition from child to adult can be a challenging, exciting, scary, wonderful and emotional time. Coupled with a change in educational establishment, adolescence is often a difficult time for a child who also has to deal with the physical and emotional changes.

Aim and objectives

The aim of the intervention by school nurses is for each child to have a smooth, seamless transition from dependence to independence, which will result in the child developing self-reliance, responsibility, abstract thinking and having his/her own opinions.

The objectives are to help pupils develop their self esteem and confidence, to make informed choices about matters that affect their future, to develop healthy lifestyles and ways of keeping themselves safe, to gain an awareness of the importance of education for their future and for each young person to start taking responsibility for his/her own health.

Factors affecting adolescent transition

Certain factors affect this smooth, seamless transition from childhood, through adolescence to adulthood, not least of these is that the journey often starts at the same time as the child moves from the secure and familiar environment of the primary school to an unfamiliar and much larger secondary school.

In addition to adapting to this new environment, secondary school may present young people with other difficulties, for instance bullying, peer pressure, boredom, examination stress or problems relating to exclusion, all of which can lead to mental distress. Bullying, which may take the form of physical abuse, name calling and teasing is a common form of discrimination causing great distress (www.kidsource.com). Around a quarter of pupils surveyed reported they sometimes felt afraid of going to school because of bullying. Discrimination at school on grounds such as race, gender, sexuality and disability can also cause distress in young people, undermining self confidence and reducing educational, career and social opportunities. Young people excluded from school experience gaps in their education, making them more vulnerable to future unemployment, antisocial behaviour and crime. Exclusion also reduces opportunities for vital social contact with their peer group and makes the transition to adulthood harder.

If parents make the decision to move house, for instance to ensure that their child attends the school of their choice another factor is introduced affecting the transition to adolescence. Again, moving from the safe and familiar can be very unsettling for the child and may lead to feelings of anxiety. Similarly, the move to secondary school often presents a parent (usually the mother) with the opportunity to return to work after a break to raise children; this can leave children with a sense of abandonment and jealousy.

Families are becoming more diverse, with increasing numbers of children and young people experiencing some form of loss through divorce, separation, or bereavement. When parents divorce or separate, the child must become used to living with a single parent/carer. There may be divided loyalties and if one or both parents then enter into a new relationship the child must adapt again. All children and young people need to feel loved, valued and respected, they also need boundaries, a degree of discipline and supervision. It is the task of parents and other significant adults to provide the security of behaviour boundaries and to build self esteem and confidence, however getting this right is not always an easy task.

Poverty can be a major factor in a child's life. New clothes are likely to be an issue, particularly with the dual pressures of rapid growth and the need to dress to emulate peers. Financial difficulties in the family can influence how children progress at school, for example if there is no spare money available for school trips. Although most schools will not exclude children from trips and events on these grounds, many parents either are not aware of this or do not want others to know that they have money worries. Children and young people's mental wellbeing is greatly affected by poverty and social hardship. The economic, social and political context of their lives is largely beyond their control. A reasonable standard of housing and overall standard of living, together with a wider social network beyond the family can help to minimise the risk of mental health problems in young people.

Domestic violence in the home can leave a child frightened, protective and afraid to leave the abused parent, leading to truancy and possible eventual exclusion, not to mention all the emotional problems the child will experience from witnessing domestic violence or also being a victim of abuse. Neglect, physical, sexual or emotional abuse can cause major mental health problems. One study found that almost half of male and female psychiatric inpatients studied had experienced physical and/or sexual abuse. It is estimated that one in ten children suffers some form of abuse and disturbance, and without help, problems often persist into adult life causing serious personality

and relationship problems and in some cases mental health problems

As we all know, adolescence brings great change. Along with the physical changes, there is also the emotional rollercoaster and a growing awareness of sexuality Adolescents experiment with relationships and sexuality, fall in love and experience both the joy and hurt that relationships bring. Ill health or disability can compound the situation further.

Parental expectations may be unrealistic and place undue pressure on a young person. Examinations, SATs, assessments, interviews and comparison with peers can take their toll and a young person may end up feeling a failure and not up to standard.

Finding the right friends can also be difficult; peer pressure can lead to substance misuse and perhaps to dependence on smoking, drugs, alcohol or solvents. For some young people, the use of alcohol, drugs or solvents may be for social reasons, a means of escape or a way of coping with difficulties. At the same time they may contribute to problems such as low self esteem and involvement in crime. Drinking excessively can result in feelings of insecurity, depression and aggression, which, in turn, may lead to feeling isolated, lonely, subdued or hopeless. The effects of different drugs on mental wellbeing vary from one individual to another and depend on the situations in which they are taken. Effects may range from feelings of tension, panic, anxiety, low concentration, confusion, depression and sleep problems. Stopping the regular use of certain drugs may lead to depression or poor health for some time. Young people with a mental health problem are particularly vulnerable to the effects of drugs.

Other issues for consideration include cultural, religious and language difficulties such as those encountered by asylum seeking adolescents.

Rationale for intervention

If this time of transition is successfully negotiated by an adolescent, then coping skills are in place to help overcome difficult or traumatic life events. As children approach adolescence, the problems they experience may cause maladaptive behaviour as a means of communicating emotional pain.

A child needs positive adult relationships that provide stability and are not likely to change. If a child has love and attention from his family, he is more able to cope with external changes. However, this is not always the case as is evidenced by:

- The number of young adolescents attending child psychology clinics[2]
- Medical conditions that affect pupils' academic progress[2]
- Some pupils disregard for their physical wellbeing[2]
- Increasing challenging behaviour[2]
- Traumatic life events, for instance loss, family dysfunction, abuse/bullying[3]
- Disclosures made at 'drop-in' sessions[3]

Other adults need to be in place to fulfil the role of a strong and positive adult relationship in the life of a child and it is important for a child to know that there is help available.

The Intervention

The intervention referred to above consists of three sessions with multi-agency joint working, usually the school nurse with the education welfare officer or youth worker, to year 6 pupils (11 year olds).

The first session

- Ground rules are laid down and confidentiality is discussed.
- The roles of the school nurse, youth worker, and education welfare office are discussed.
- We explain that we all have worries from time to time and encourage the pupils to talk to their parents.
- We ask what sort of concerns children of their age might have, and where they can access help.
- We inform them of the 'drop-in' service which follows the session, where they can speak to the school nurse privately.[4]

The second session focuses on growing up, the physical and emotional aspects of puberty and what young people can expect to happen. The pupils can write down their questions before the start of the session, without identifying themselves, and these are answered during the session.

The third session discusses personal safety, child protection issues, sources of help, good and bad secrets, choices and refusal skills.

The intervention provides a confidential service, followed by 'drop-in' sessions and includes:

- Facilitation of pupil discussion on adolescence in a safe and non-judgemental environment.[5]
- Allowing pupils to discuss worries, concerns or problems, however trivial.
- Advice on where and how to get help.
- Providing health information as necessary.
- Role play of a 'drop-in' session.
- Question time.
- Leaflet distribution.
- Availability of facilitators on secondary school induction days. Attempting to influence behavioural change.
- Monitoring and evaluating 'drop-in' sessions.

How does the intervention help?

This style of intervention is of benefit in a number of ways. It allows for disclosures of unmet health and emotional needs and support is offered and referrals made where appropriate.

The sessions provide information about health and encourage healthier lifestyles as well as raising pupil awareness of how they can find help when they need it and, crucially, that it is OK to so. Attendance at 'drop-in' sessions also increases. ◆

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Visyon:

Accessible services for 11- 25 year olds

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KEY POINTS

- *Mental health services and emotional support for young people should be flexible, accessible and relevant.*
- *Interventions should not be simply reactive, but also include positive models and social support. Group work is an ideal setting in which to offer this.*
- *Working appropriately with other organisations and adopting a multi-agency approach is key to developing an effective service.*
- *Consultation with service users is essential to inform service development.*

VISYON IS a charity that provides emotional support to 11 to 25 year olds in the Congleton Borough. It was established in 1996, in response to the suicides of three local teenagers. Following this, a group of local parents felt that there was a need for a non-stigmatised, easily accessible and flexible service, which could respond creatively to the needs of young people. Anecdotally perceived needs are often the starting point of voluntary initiatives. Research, such as Together We Stand,[1] on which Child and Adolescent Mental Health Services (CAMHS) are based, and the Government consultation document Listen Up 2000,[2] which led to the development of the Connexions service, recognised and reiterated the need for flexible, accessible and youth friendly services such as those provided by Visyon.

This article is an introduction to the services that Visyon offers and explains briefly how Visyon has developed and the model that overarches the organisation. Following this it describes in more detail how individuals come to use the service (through both self and third party referrals) and presents Visyon's views on keeping an adolescent mental health service relevant.

Development of the service

Visyon employed its first full time member of staff in 1997 and began offering a service in Congleton town. Following a Community Fund Grant in 2001, the service extended to the borough (which incorporates four further small towns and a sizeable rural area). From the outset, Visyon offered individual support and informal group work. The organisation has consistently tried to be responsive to perceived local needs and to listen to the views of young people in providing services. Proportionally, the largest part of Visyon's work is individual counselling. The organisation now has five members of staff who provide counselling, supported by a small team of volunteer counsellors and counsellors in training. The counselling offered has its base in the

person centred tradition, but incorporates cognitive elements, particularly with reference to assertiveness, decision-making and stress.[3] All counsellors are trained to (or in the case of volunteers in training, working towards) a minimum of a diploma in counselling. The counselling is offered in all of the local secondary schools and in community venues throughout the borough.

Visyon's view is that good mental health services should not just be reactive, as counselling may be perceived to be, but must include positive models and social support. Group work offers an ideal environment in which to offer this. Visyon's two most long-standing groups are the After schools club and the Guitar group.

The After Schools Club is an early evening group for 11 to 16 year olds. It offers open access and aims to positively promote mutual support, confidence and cooperation. Decisions are discussed and activities planned within the group, involving group members throughout the process. Working in this way is made possible by significant support from volunteers. The intention is that while it is a non-stigmatised service, it is also attractive to, and supportive of those who are perhaps struggling at present, or lack a strong social network.

The Guitar Group was instigated at the suggestion of a group member and offers space for members to play together, learn from and support each other. Significantly, it also attracts a high proportion of young men. Although the mental health message is not overtly stated, the overall ethos of the group is that music, hobbies and learning new skills are good for your mental health. In terms of Visyon's activities it also fits well within the outreach project, which is specifically targeted at young men; a group widely recognised to be unlikely to access mental health services. Another important factor is that the group helps to give Visyon credibility with group members and their peers.

The working model

From a counselling perspective, the person centred tradition provides a base that is an influence throughout the service. To supplement this approach we also recognise that a wider range of tools is needed. Carl Rogers[4] suggests that the lessons learned from working with individuals in a non-hierarchical way, valuing their experience and empowering them to act as agents in their own lives can be extended to the work of the whole organisation. Drawing on this person centred model Visyon seeks to involve potential clients and offer services that meet their needs in ways that they can use effectively to contribute to their own lives. We also recognise that it is necessary to take account of the context in which young people live and to integrate emotional and cognitive strands. To do this effectively with young people it is increasingly being noted that there is a need to adopt a proactive approach to working[5]. A counsellor taking a proactive approach will see the identified 'problem' of the client within the context of a young person's life and seek to offer a framework for exploring the issues.

The referral process

Referral is an important factor in access to services. In an article of this length it could be confusing to detail referral processes for all the services offered by Visyon. Therefore, for simplicity, this article looks solely at referral to the counselling service, which in many services is arguably the least likely to be accessed directly by the young people seeking support.

A large proportion of those who use Visyon's counselling service do so at their own request. Table 1 displays a breakdown of how those using Visyon's counselling service are referred. As it is generally recognised that adolescents who seek help at their own instigation are far less reluctant and distrustful of counsellors than those referred by an authority figure – this is viewed as a positive factor.[6] Throughout its development, Visyon has fostered strong links with both statutory and voluntary services, a factor reflected in the broad range of organisations now making referrals to us. A majority of the third party referrals we receive come through teachers, Connexions workers and support staff in local schools. This high figure reflects the fact that a counsellor from Visyon visits secondary schools in the borough weekly. Working appropriately with other organisations, along with a youth friendly approach to mental

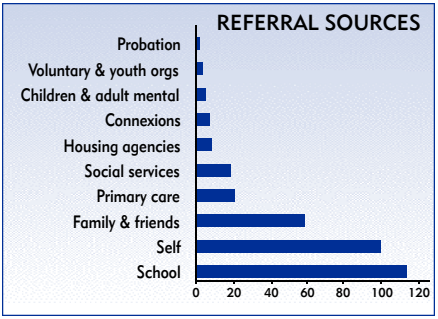

Table 1. *Referral sources*

health, is central to the success of an organisation that aims to create an easily accessible and locally relevant service. In order to maintain and develop good relationships with other agencies, Visyon is active in attending a range of multi-agency meetings and initiatives across the borough. This enables statutory services to get to know and work alongside the agency, raises Visyon's profile and promotes confidence in making referrals. It is important to note here that all referrers are encouraged to both consult and obtain consent before making a referral. Some young people would find it intimidating to make the first contact themselves, so a professional can provide a bridge. The young people however, must decide for themselves on the appropriateness of the service.

Staying relevant

Services should be accessible, appropriate, friendly and relevant to young people[7,8] and it is important that the work undertaken is developed with reference to those who use the service.[9] Visyon works hard to take note of both these points. In particular it has developed a consultation network that connects with users and potential users of the service. Broadly speaking, this consists of regular in-group dialogue (both formal and informal), counselling client feedback and a regular open forum. These approaches have proved extremely successful in aiding the development of new initiatives and enabling the organisation to fine-tune those that already exist. Projects that have developed from the consultation process described above, have included camping trips for the After schools club and borough-wide songwriting workshops supported by the Guitar group. Each of these initiatives have embraced the views of local young people and worked with them in order to make them a reality. The process of listening to group members and power sharing with them in developing services promotes confidence and helps to activate the strengths and potential of those taking part.

The willingness of young people to access support using the Internet has been identified.[10] With this in mind, and with enthusiastic support from Visyon's reference group, an online counselling service, 'e-motion'[11] has been developed, launched, and is presently being piloted in the borough. We hope that this service will prove successful in attracting individuals who would not ordinarily access a counselling service for support. It is crucial that organisations working with young people do not become complacent. What was relevant yesterday is not necessarily relevant today.

Summing up

Visyon can most accurately be described as an organisation that seeks to promote emotional resilience in young people. It is proactive in approach, and provides a broad range of support services tailored to the needs of young people. Visyon is flexible, accessible and in a continuous process of negotiated development with service users. Our future aims are to continue creating services in collaboration with local young people and by working with other agencies to develop a comprehensive support network. ◆

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The story of Nathan and the Dandelion Trust for Children

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Nathan is nine years old and was born in Maidstone. His Mum, Shirley, has an alcohol problem and his Dad left home when he was 9 months old. Shirley was depressed for 3 years or more when trying to bring up Nathan on her own. She realises now that she found it difficult then to show him affection or take an interest in his development. As a toddler he was renowned for his temper tantrums and was prone to bite other children. He was apparently devoted to his Mum but found it hard to separate from her for school and other activities. Sadly his Nan, who had given a lot of support to Nathan and Shirley, died of cancer when Nathan was six.

At the age of 8 his teachers were complaining vigorously about him at school. He had outbursts of temper and impulsive, aggressive behaviour, did not concentrate in class and was a loner in the playground. He was always losing things and seemed forgetful. Before long he felt he was being singled out and bullied by other children and moaned at constantly by teachers. He was excluded from school twice for short periods.

Shirley took him to the GP saying he complained of headaches and abdominal pains. His GP recognised a more fundamental problem, and Nathan was referred to the Dandelion Trust and assessed. When Nathan was asked what he wanted to change he said he wanted to control his temper. Shirley wanted him to be better organised, less impulsive and happier in himself. Nathan had few interests at this point and no experience of animals or of growing things.

On his first day at the farm Nathan brought a can of cola, some crisps and a packet soup. Shirley confidently assured us that this was all he would eat. He found the garden boring and played football. However, a trip to the lambing shed sparked some interest in

him, particularly when Pip, the shepherd, told stories about some difficult lambings and Nathan was allowed to help feed an older lamb. After this he seemed contented to plant his broad beans in a pot to take home and water, despite having shown fear at the thought of handling real earth. Shirley enjoyed preparing lunch with other Mums and Nathan helped with making pancakes and ate them with relish, along with the cola and crisps.

Over the next few weeks Nathan overcame his fear of dogs and began to enjoy planting directly into the soil. He allowed our calf, Dandelion to lick his fingers and helped to knead dough for hot cross buns. After a while, he stopped bringing his own food and joined the others in such delicacies as nettle soup and elderflower cordial. On one occasion, Shirley came back from a session of weeding the kitchen garden to find him chopping onions : "I don't know why you've got him cooking onions, he won't touch it" but he ate his stuffed peppers with enthusiasm.

Nathan was fascinated by our baby chicks incubating in their eggs. He was allowed to take them home one day and nurtured them with the greatest care. In spite of his reputation for clumsiness he handled the newborn chicks with great gentleness and reverence. On one occasion he said "...don't speak so loud, he's gone to sleep in my hands." Later when they became more lively, some chicks escaped and flew into a hedge. Nathan charged after them, scattering the flock in a sea of feathers and fluff. He quickly realised this approach was failing and adopted a skillful stalking tactic, engaging the help of another boy and organising a successful recapture. His pride in this achievement beamed from his face.

Shirley reports that he is now happier at school, more confident and much less impulsive. His class teacher is amazed at the change in him, noting particularly his enthusiasm when recounting his experiences on the farm. One day he described in detail the process of extracting honey, demonstrated by Derek, the beekeeper. Shirley is proud of the kitchen garden, which she weeds energetically, wishing she had more space at home. She has enjoyed taking home the products of their labours such as strawberry jam and honey. Shirley has benefited from the input of an art therapist and now feels much more positive towards Nathan. He is no longer expected to be the 'man of the house' although she still feels "men are the lowest form of life". Some more work is needed here.

However, all this has happened after only 14 days on the farm. Shirley thinks it is a small miracle, and even Saskia, the doctor running the project, says she would not have believed it.

So what do we believe are the magic ingredients of the Dandelion experience? Contact with the natural world, space to play and use the imagination, making connections between doing and eating and having a positive male role model all play a part. We are working to analyse just what it is that helps most so that we can develop this for many other children.

Nathan is not our only success – other children attending have had a sad start in life, some much more traumatic, but all have gained a tremendous amount. Two boys who were excluded from school have now returned and we hope that their future now looks brighter.

We know that the burden of illness in the UK is now shifting from physical to mental health problems. Emotional and behavioural problems are now the most significant cause of disability in children and a major contributor to social problems such as crime and addiction. It is predicted that by the year 2020 mental health problems will be the most important cause of disability in adults. More and more children are being prescribed medication to control their behaviour. The Dandelion Trust seeks to address and reverse this trend by focusing on children and families at a young age. ◆

Multimedia resources & links

LOOKED AFTER CHILDREN

Reading:

Promoting the health of looked after children.
Department of Health, 2002.

The mental health needs of looked after children.
Joanna Richardson, Carol Joughin.
Gaskell Publications.
ISBN: 190124248X

A multidisciplinary handbook of child and adolescent mental health for front-line professionals.
Nisha Dogra, Andrew Parkin, Fiona Gale, Clay Frake.
Jessica Kingsley Publishers.
ISBN: 1853029297.

Healthy care. Building an evidence base for promoting the health and wellbeing of looked after children and young people.
NCB Books.
ISBN: 1900990784.

Change, challenge and school nursing.
Nicola Madge, Anita Franklin.
NCB Books.
ISBN: 1900990954.

Web links:

www.doh.gov.uk/qualityprotects
www.nch.org.uk
www.mentalhealth.org.uk
www.childline.org.uk
www.barnardos.org.uk
www.thewhocarestrust.org.uk
Electronic library for social care **www.elsc.org.uk**
www.socialexclusionunit.gov.uk
www.youthinformation.com

ADHD

Reading:

ADHD with comorbid disorder: Clinical assessment and management.
Steven R Pliszka, Caryn Carlson, James M Swanson.
The Guilford press.
ISBN: 1572304782

The ADHD handbook for parents & professionals.
Alison Munden, Jon Arcelus.
Taylor & Francis.
ISBN: 1853027561

Web links:

ADDISS
www.addiss.co.uk

ADDContact
www.addcontact.org.uk

ADDERS
www.adders.org

General web links:

NSPCC
www.nspcc.org.uk

Association of Workers for Children with Emotional and Behavioural Difficulties (AWCEBD)
www.awcebd.co.uk

Royal College of Psychiatry. Faculty of Child and Adolescent Psychiatry
www.rcpsych.ac.uk/college/faculty/child

Mental health & growing up: Fact sheet series.
www.rcpsych.ac.uk

Young Minds Mental Health Network
www.youngminds.org.uk

Sure Start
www.surestart.gov.uk

Department of Health.
The Children's National Service Framework.
www.doh.gov.uk/nsf/children.htm

The Mental Health Foundation
www.mentalhealth.org.uk

Read the signs.
A UK site for young people dealing with a range of mental health problems.
www.readthesigns.org

Kids Company
www.kidsco.org.uk

Kidscape
www.kidscape.org.uk

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