NSPCC Scotland response to the Mental Health Strategy for Scotland 2011 – 2015

About NSPCC Scotland

The NSPCC aims to end cruelty to children. Our vision is of a society where all children are loved, valued and able to fulfil their potential. We are working with partners to introduce new child protection services to help some of the most vulnerable and at-risk children in Scotland. We are testing the very best intervention models from around the world, alongside our universal services such as ChildLine[1], the ChildLine Schools Service and the NSPCC Helpline. Based on the learning from all our services we seek to achieve cultural, social and political change – influencing legislation, policy, practice, attitudes and behaviours so that all children in Scotland have the best protection from cruelty.

NSPCC Scotland response

NSPCC Scotland welcomes the opportunity to respond to the Mental Health Strategy consultation, which we regard as a crucial part of the preventative spend agenda.

We recognise the need for the strategy to prioritise particular areas of mental health in order to concentrate on those issues which will have the most significant impact. This is particularly important given the current economic climate. However, we strongly believe that infant mental health should be one of the Scottish Government's priority areas. We feel that this is a significant gap in current mental health provision.

Infant mental health is the fundamental building block of child wellbeing. Yet we are not aware of many mental health services for infants, and none aimed specifically at maltreated infants.

This is despite the fact that:

- **the promotion of good infant mental health is now firmly embedded in Scottish policy** – as reflected in the Early Years Framework[2], Pre-birth to Three[3], and A Pathway of Care for Vulnerable Families[4], which reference the

[1] Until March 2012, ChildLine in Scotland will be delivered by Children 1st, on behalf of the NSPCC.
[2] Scottish Government (2008), *The early years framework (*Edinburgh: Scottish Government). Available at: http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf
[3] Learning and Teaching Scotland (2010), *Pre-birth to three: positive outcomes for Scotland's children and families*,(Glasgow: LTS). Available at: http://www.ltscotland.org.uk/Images/PreBirthToThreeBooklet_tcm4-633448.pdf
[4] Scottish Government (2011), *A pathway of care for vulnerable families (0-3) (*Edinburgh: Scottish Government). Available at: http://www.scotland.gov.uk/Resource/Doc/347532/0115722.pdf

developing evidence base about the emotional, social and cognitive development of infants.

- **The Scottish Government aspires to early intervention and prevention**; yet many abused children identified at the earliest age and stage as in need of help are unable to access the intensive therapeutic services they need.

- **Infants and one-year olds in Scotland are the single largest age group of children who require compulsory measures of supervision for safety and welfare reasons.**[5] According to the Children's Reporter, the reasons are usually complex, but often involve domestic violence, parental substance use and parents unable to provide a safe and stable environment.[6]

The preventative agenda is not only about primary and secondary prevention but also about early tertiary interventions.[7] The emphasis, quite rightly given by GIRFEC to universal services, must not mean we ignore the mental health needs of abused infants and children. Addressing these is also a crucial part of the preventative agenda, as it will help children to recover from the effects of abuse and help prevent abuse reoccurring.

We need to recognise that the effects of early maltreatment can amplify across the lifespan:

- abused or neglected children are at greatly increased risk of mental health problems such as conduct disorder and physical disorders.[8]
- between a third and 90% of children who offend have been found to have experienced some form of past or current maltreatment.[9]
- 'aggressive children' commit more than 50% of violent offences in adulthood.[10]
- early maltreatment is associated with drug and alcohol problems and risky sexual behaviour in adolescence and adulthood.[11]

Early childhood adversity and associated disorders carry a heavy social cost. Mental health services are one of the most cost-effective ways of improving mental and physical health and tackling health inequalities.[12]

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[5] Scottish Children's Reporter Administration (2009) *Children aged under two referred to the Children's Reporter* (Stirling: SCRA), A separate analysis of Child Protection Orders (CPOs) in Edinburgh in 2006-07 found that 60% of all children subject to CPOs were under 2 years old. Just under one third were newborns (30%).

[6] Ibid, 9.

[7] See C. Cuthbert, G. Rayns & K.Stanley (2011), *All babies count: prevention and protection for vulnerable babies* (London: NSPCC), 5-6.

[8] H. Meltzer, et al. (2003), *The mental health of young people looked after by local authorities in England. The report of a survey carried out in 2002 by Social Survey Division of the Office of National Statistics on behalf of the Department of Health*, 1-351 (London: The Stationery Office). C. Coffey et al. (2003) Mortality in young offenders: retrospective cohort study. *British Medical Journal*, 326: 1064.

[9] C. Day, P.Hibbert, S.Cadman, (2008), *A literature review into children abused and/or neglected prior to custody* (London: Youth Justice Board).

[10] T.E. Moffitt, et al (2002), Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years. *Developmental Psychopathology*, 14: 179-207.

[11] R.E. Gilbert et al (2008), Burden and consequences of child maltreatment in high income countries, *Lancet* 2008, published online Dec 3.

The evidence suggests that recovery from the effects of early maltreatment can be rapid and remarkable if safe nurturing care is achieved early enough – ideally in the first year of life.[13] Therefore, increased investment in intensive therapeutic interventions designed to improve the infant-parent relationship has the potential to transform trajectories for at-risk babies.

The NSPCC is piloting two such interventions in Scotland, the New Orleans Intervention Model and Minding the Baby. The New Orleans Intervention Model aims to promote permanence and secure attachment for children aged 0-5 who have been removed from their parents because of maltreatment. Minding the Baby is an intensive home visiting programme for high-risk first time pregnant women and their families, developed at Yale University. Our evaluation of these services, involving academic experts, will help to develop the evidence base about infant mental health services.

The remainder of our response addresses the consultation questions most relevant to infant mental health.

OVERALL APPROACH

Given the extensive evidence - much of which has been widely disseminated by the Chief Medical Officer[14] - highlighting the effects of maltreatment on infant development, we are disappointed that little emphasis has been placed on infant mental health within the consultation document. The preparation of a new mental health strategy presents a valuable opportunity not only to highlight the importance of infant mental health, but also to make explicit the linkages between mental health policy and the broader policy agendas of early intervention, the early years and preventative spending to which the Scottish Government is committed. Therefore, NSPCC Scotland would like to see the promotion of infant mental health as an explicit priority area in the strategy.

NSPCC Scotland believes that the key reference points for the new Strategy in terms of child and adolescent mental health must be the 2005 *Children and Young People's Mental Health: A Framework for Promotion Prevention and Care*[15] and the detailed application of this for infants provided by the 2007 *Practitioners' Guide to Infant Mental Health*[16], both commissioned on behalf of Government. This response is framed with reference to these two key documents.

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[12] J.J. Heckman and D. Masterov, (2004), *Skills policies for Scotland*. *IZA discussion paper No. 1444***.** (Bonn: Institute for the Study of Labor).

[13] M.Dozier, et al.(2008), Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Developmental Psychopathology* 20:845-59; A.F.Lieberman, et al. (2005),Towards evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44:1241-8; C.H. Zeanah, et al. (2001), Evaluation of a preventative intervention for maltreated infants and toddlers in foster care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40: 21:4-21.

[14] NHS Scotland (2007), *Health in Scotland 2006. Annual report of the Chief Medical Officer* (Edinburgh: NHS Scotland).

[15] Scottish Executive (2005), *The mental health of children and young people: A framework for promotion, prevention and care* (Edinburgh: Scottish Executive).

[16] C. Puckering (2007), *Infant mental health: a guide for practitioners. a report of the Expert Working Group on Infant Mental Health* (Edinburgh: HeadsUpScotland).

The Scottish Government has committed to implementing the 2005 Framework by 2015[17]. The new strategy must therefore set out the actions needed to achieve this over the next three years**.** We think that an audit would be helpful to assess progress in implementing the 2005 Framework.

Outcome 2: Action is focused on the early years and childhood to respond quickly and to improve both short and long term outcomes.

Q7: What additional actions must we take to meet these challenges and improve access to CAMHS?

To effectively address children's mental health, it is imperative that we recognise the uncomfortable fact that mental health issues arise in infancy as well as in childhood and adolescence. This applies particularly to infants who have experienced maltreatment. The Infants Suffering Significant Harm study found that, by the age of 3, almost half of infants who had suffered maltreatment in the first six months of life had acquired developmental or behavioural difficulties.[18]

The Scottish Government's Mental Health Strategy has to apply at every age and stage of life.

- Infants have an equal right to access the full range of promotion, prevention and intervention. This is not the case at present, despite this age group being the most vulnerable to abuse and maltreatment.

- The current HEAT target for access to specialist CAMHS does not effectively address services for our youngest children, because in most of Scotland there is no service provision for them to access.

There has been a lot of activity around infant mental health in the past couple of years. We would like to make two main points about this:

- The thrust of this work has been about moving the centre of gravity of CAMHS towards universal services and early intervention, in line with GIRFEC.[19] As a consequence, infant mental health policy & implementation has migrated away from mental health and towards Early Years and Tier 1&2 professions. This is reflected in the language now used to discuss children's mental health. An unintended outcome is that it is more difficult to talk about the needs of children who have already suffered abuse or maltreatment. A second is that the lack of CAMHS services for very young maltreated children has fallen from view.

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[17] Scottish Government (2009), *Towards a mentally flourishing Scotland: policy and action plan 2009-2011* (Edinburgh: Scottish Government), 17.

[18] H. Ward et al., (2010*), Infants suffering, or likely to suffer, significant harm: a prospective longitudinal study* (London: Department for Education).

[19] This approach is embodied in the 2005 *Framework for promotion, prevention & care* and the 2007 *Practitioners' guide to infant mental health*.

- Over the past two years detailed work on infant mental health linked to the *2005 Framework* has been taken forward, for example, by the Maternity Services Action Group, the NHS Scotland Psychology Directorate, the Modernising Nursing in the Community Board, and Education Scotland. However these have been taken forward as largely separate initiatives, under the auspices of a range of different structures, and across a number of different, overlapping policy frameworks. This important work requires careful coordination.

To ensure that action is focused on the early years in the period to 2015, and that the 2005 Framework is implemented, we propose:

1. National leadership and coordination

We would like to see a heightened focus on the direction and coordination of infant mental health services within the existing national monitoring arrangements for CAMHS. This national leadership and coordination role needs to embrace every tier of service provision, spanning promotion, prevention and care, while also linking this activity to the broader agendas of early intervention and the early years. It is particularly important that there is a national lead given the numerous and ongoing processes of change at the moment combined with budget reductions.

Part of this leadership role should be to maintain an overall focus on improvement and outcomes in infant mental health. Infant mental health currently sits within several linked and overlapping social policy frameworks, and within the remit of a range of different Taskforces and Working Groups. Each has its own framework of indicators and outcomes designed to drive improvement and monitor outcomes. We need an overview of where infant mental health sits within existing performance management and improvement frameworks and a way of ensuring that targets, indicators and measures are effective.

2. Capacity of specialist services

As far as we are aware there are no specialist services for the 0-2 age group. Most CAMHS teams do not provide a service to children under five. In addition, as far as we are aware, most operate exclusion criteria for child protection cases, thereby depriving access to specialist services to the most vulnerable children, whose mental health is already compromised or at risk.

We believe that the Scottish Government should encourage improved service provision to the 0-2 age group, for example by introducing performance targets for specialist CAMHS to this group.

3. Relationship with the children's workforce

The *2005 Framework* recognises the essential role of CAMHS specialists in supporting the wider 'mental health capacity' of early years and children's services. [20] We believe it is important that CAMHS professionals are able to provide specialist advice and support to the universal services working with infants and young children, including case consultation, supervision and referral and the provision of learning opportunities. As services are extended to infants and young children, this principle should be at the heart of service design, and the capacity of CAMHS infant mental health specialists must also be sufficient for this purpose.

NSPCC Scotland believes that the Government's stated commitment to integrate health and social care services has the potential to impact positively on infant mental health in Scotland and we commend the shift in focus towards preventative spend.

However, we also need to re-design health and social care services. New models of working should prioritise the needs of high risk groups, with more integrated and multi-disciplinary models of working between health and social work professionals. The supervision model used in two of the NSPCC's services – the home visiting programme Minding the Baby and the Glasgow Infant and Family Team (GIFT – part of the New Orleans Intervention Model) – could be replicated within mainstream services. In both cases an infant mental health service is delivered by multi-disciplinary health and social care professionals.

We would suggest that the Scottish Government considers introducing a target for upskilling social workers in Scotland. We should aim for a proportion of social workers to have advanced clinical post-graduate training. This would allow, for example, infant-parent psychotherapy services to be delivered across every local authority area. This target should be aligned with planning for the roll-out of Children and Family Centres, as set out in the SNP Government's election manifesto. The NSPCC is engaged in early discussion with Scottish universities about the development of advanced clinical skills-based training for multi-agency child protection practitioners.

It is also important to promote the sharing of effective models of practice, such as The Playfield Institute, a partnership between child and adolescent mental health services and public health is one model for achieving this, developed by NHS Fife. The Institute delivers research and information services, as well as dedicated training to the children's workforce about mental health, including infant mental health. The sharing of models of practice could be part of the remit of the national leadership function proposed above.

Q8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

As outlined in our response to question seven, above, we suggest that a HEAT target to encourage the provision of CAMHS services to the 0-2 age group might be beneficial.

[20] Scottish Executive (2005), 52.

We also suggest that the HEAT target for access to specialist services should be revised in relation to children, and with regard to the age of the child. An across the board target of 26 weeks is inappropriate and does not reflect children's needs.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Q19: How do we support families and carers to participate meaningfully in care and treatment?

The planned National Parenting Strategy is an opportunity to embed maternal and infant mental health in a Scotland-wide approach to parenting support. The national survey of parenting programmes conducted in 2008 by the Early Years Parenting Task Force found that a variety of parenting programmes were in use in various parts of Scotland, but that *very rarely was infancy the primary focus* for parenting support. In addition, at that stage very few areas of Scotland had a coherent multi-agency approach to supporting parents from family planning through conception, pregnancy, birth and beyond. [21]

We would like to see the promotion of infant mental health placed at the heart of the National Parenting Strategy, ensuring there is a focus on positive parent-child attachment.

It is also vitally important that adult services and children's services work together to identify and address child mental health. In particular, in families where there are parental mental health issues; domestic abuse; or substance misuse, these issues act as stressors which can impact negatively on infant and child mental health. Therefore it is imperative that adult services are alert to the needs of children in these families (including infants), and that, where necessary, services are provided which specifically look at parent-child attachment and the promotion of health infant mental health and development.

The impact of the new Antenatal Parent Education Pack should be evaluated. We would also welcome investment to develop the evidence base around psychosocial antenatal interventions.

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Q28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

[21] Scottish Government (2008), *Final report from the Parenting Task Group for the Early Years Framework* (Edinburgh: Scottish Government). Online at http://www.scotland.gov.uk/Publications/2008/07/parenting-report)

We welcome the proposed survey to be carried out in support of the psychological therapies HEAT target. This will help to assess progress and identify outstanding action needed to implement the *Framework.* We would like to see this specifically address specialist training needs and capacity in infant mental health CAMHS.

In addition we would suggest an audit of the position of infant mental health as a core topic within the curriculum and post qualification training of children's services occupations.[22]

We would also like to see an audit or survey of training received by Tier 1 & 2 universal services staff in infant mental health, as recommended by the 2007 *Practitioners' Guide*. This should identify the types of training received, and workforce number involved.

Q29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

Primary care practitioners play an extremely important role in early identification of mental health issues, particularly in children under 3. Besides the inclusion of infant mental health as a core topic in the basic training of these occupations, we are aware that more specialised training is needed, for example, in the use of structured tools for identification, and in the evaluation of the parent-child relationship, using a variety of means, as set out in response to question seven, above. We would suggest that the meta analysis of effective interventions in infant mental health by Bakermans-Kranenberg (2003) gives good guidance as to what is likely to be effective.[23]

The *2005 Framework* seeks to shift the focus of CAMHS towards universal services. However we know that primary care staff working with infants and parents are stretched. The *2005 Framework* also highlights that time for staff to support new parents and babies is an important factor, in addition to competencies, in achieving desired outcomes. More recently, the 2011 *National Guidance on Reducing Antenatal Health Inequalities* recognises that staff need support, supervision, time and resources to enable them to work effectively with women who have multiple and complex health and social care needs. It is important that this principle is built into workforce planning as we redesign and modernise services.

It is important that the same principle applies to the development of specialist CAMHS infant mental health services, as mentioned in our response to question seven.

Outcome 12: We know how well the mental health system is functioning on the basis of national data on capacity, activity, outputs and outcomes.

Q31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to help us meet this challenge?

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[22] Recent research (Ward et al., 2010) found that decision-making by child protection social workers is insufficiently informed by current knowledge of attachment, early childhood development, and the long term impact of maltreatment on life chances.

[23] J. Marian, M.H. van IJzendoorn, F. Juffer., (2003), Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, Vol 129(2): 195-215.

NSPCC Scotland believes there is a need to think through the effectiveness of existing targets, measures and indicators for driving improvement in infant mental health services. We suggest a possible approach to this in our response to question seven.

We warmly welcome the new forms of data collection being developed to help service improvement, including the Framework of Child Mental Health Indicators. However we are aware that infancy and early years constitute one of the main data gaps in the new Children's and Young People's Mental Health Indicators. We think that addressing this data gap should be one of the main priorities for developing the Child Mental Health Indicators.

Conclusion

NSPCC Scotland welcomes the early publication of a consultation on mental health and believes this demonstrates the Scottish Government's commitment to the issue.

We would urge the Scottish Government to make infant mental health a priority issue in its forthcoming mental health strategy. We believe that investing early to improve the mental health of our youngest children, particularly those who have experienced abuse or neglect, will lead to improved wellbeing and better outcomes for vulnerable children. The development of a new mental health strategy presents a real opportunity to place mental health policy in the wider context of early intervention, the early years and prevention.

We have carried out considerable scoping work in this area, and will soon be delivering services which translate this priority area into practice. We would welcome the opportunity for more detailed discussions with the relevant Government officials about how to promote and improve infant mental health in Scotland.

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