Mental health in children and young people

An RCN toolkit for nurses who are not mental health specialists

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Document prepared by Sally Ramsay, Independent Nursing Adviser.

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Contents

1 Introduction

One in 10 children and young people will experience behavioural, emotional and mental health problems at some point in their lives. Twice as many boys aged between five and 10 years are diagnosed, in comparison to girls (Office of National Statistics, 2004). Early recognition and referral can make a positive difference to the child and family, in both the short and longer term (RCN, 2004). However, identifying mental health problems and responding appropriately can prove challenging for nurses working with children and young people.

Most children with mental health problems are managed outside specialised mental health services. Consequently, all staff should have an understanding of how to assess and address the emotional wellbeing of children and young people. They should be able to recognise if a child or young person may be suffering from a mental health problem and liaise with the appropriate services (DH, 2007). Mental health promotion should be an underpinning principle for all who come in contact with children and young people, whether they are well or unwell (Public Health Institute of Scotland, 2003).

2 Our aims

This document aims to assist those nurses who are not mental health specialists who work with children and young people in community and hospital settings. It will help them in identifying the skills and knowledge they need to recognise and, if necessary, refer children who have problems affecting their mental health. It will also help those nurses who provide care in acute hospitals, while waiting for specialist mental health practitioners to attend a particular child or young person, by giving insight into the more common mental health problems and facilitating the development of local guidelines.

In addition, this publication will be of use to those who are preparing education and training programmes to assist nurses in their understanding, recognition and management of mental health problems in children and young people.

3 What this document includes

The document gives brief outlines of the common mental health problems that practitioners may identify in various community or hospital settings, including GP surgeries, school nursing services, looked after children, community children's nursing, accident and emergency departments, outpatient services and acute children's wards.

It gives basic information on the knowledge and skills that nurses need in order to recognise and care for children and young people who present with possible mental health problems.

Further, it includes references, organisations and websites that nurses will find useful for developing their knowledge. Some of these are specific to the four countries of the UK.

It can be linked to the NHS Knowledge and Skills Framework dimensions HWB1 (promotion of health and wellbeing and prevention of adverse effects on health and wellbeing); HWB3 (protection of health and wellbeing); HWB4 (enablement to address health and wellbeing needs); HWB6 (assessment and treatment planning); and HWB7 (interventions and treatments).

Further information can be obtained from www.skillsforhealth.org.uk.

4 What this document does not include

The document is not aimed at nurses working in children and adolescent mental health services (CAMHS) who have specialist expertise. Nor does it replace the need for the inclusion of specific training in children and young people's mental health, in either pre- or post-registration education programmes. However, it will assist nurse educators in preparing programmes.

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5 What nurses should know

The National Service Framework (England), Standard 9 states: *"All staff working directly with children and young people should have sufficient knowledge, training and support to promote psychological wellbeing of children, young people and their families."*

Those nurses at the frontline of service delivery for children and young people are often best placed to recognise when the child or young person is experiencing difficulties. Nurses should be able to offer general advice and treatment for less severe problems; contribute towards mental health promotion; identify problems early in their development; and refer to more specialist services (*Every Child Matters,* DfES, 2004a). With support and training, they will be able to provide screening and some simple interventions with young people and their families.

It is generally regarded as important for all children's health care staff to undergo education and training in how to recognise and respond appropriately to the mental health needs of children, and to be able to support their families. To do this effectively, nurses need to ensure they have good knowledge of how children and young people develop socially, emotionally and psychologically, and the risk factors that can lead to mental health problems.

The skills and knowledge necessary for identifying potential mental health problems are described in document MH14 of competences developed by Skills for Health, the health sector's skills council (www.skillsforhealth.org.uk). In particular, they include the need for a working knowledge of:

♦ how to assess and manage the risks to individuals, self and others

♦ the range of different mental health needs and their effects.

6 What is good mental health?

Good mental health is not simply the absence of diagnosable mental health problems (Mental Health Foundation website www.mentalhealth.org.uk, 2009). It is about physical and emotional wellbeing, living a full and creative life and being able to deal with life's ups and downs. In children and young people, good mental health can be indicated by being able to:

♦ develop emotionally, creatively, intellectually and spiritually

♦ initiate, develop and sustain mutually satisfying personal relationships

♦ face problems, resolve them and learn from them in ways appropriate for the child's age

♦ develop a sense of right and wrong

♦ be confident and assertive

♦ be aware of others and empathise with them

♦ enjoy solitude

♦ play and learn.

(Mental Health Foundation, 2002)

Risk and protective factors

Some children and young people are at greater risk of developing mental health problems than others, whereas certain factors can act as protection. These risks and protective factors can be related to the child's personality, family, socio-economic status and environment.

Children and young people in special circumstances or those with learning difficulties and/or disabilities can be at greater risk. For these children and their parents or carers, the provision of early intervention may make a significant difference (*National Service Framework*, DH, 2004).

Knowledge of the factors that increase the risk of problems developing or being sustained is important when considering how to improve the mental health of children and young people (Townley, 2002).

Child risk factors include:

♦ poverty

♦ family breakdown

♦ single parent family

♦ parent mental ill health

♦ parent criminality, alcoholism, or substance abuse

♦ overt parental conflict

♦ lack of boundaries

♦ frequent family moves/being homeless

♦ over protection

♦ hostile and rejecting relationships

♦ failure to adapt to the child's developmental needs

♦ death and loss, including loss of friendships

♦ caring for a disabled parent.

Family risk factors include:

♦ learning disability

♦ abuse

♦ domestic violence

♦ prematurity or low birth weight

♦ difficult temperament

♦ physical illness

♦ lack of boundaries

♦ looked after children

♦ lack of attachment to carer

♦ academic failure

♦ low self-esteem

♦ shy, anxious or difficult temperament

♦ young offenders

♦ chronic illness.

(Department of Health, 2004a)

External risk factors:

♦ school: unclear discipline, failure to recognise children as individuals

♦ bullying

♦ peer rejection/peer pressure.

Protective factors include:

♦ intelligence

♦ being loved and feeling secure

♦ living in a stable home environment

♦ parental employment

♦ good parenting

♦ good parental mental health

♦ activities and interests

♦ positive peer relationships

♦ emotional resilience and positive thinking

♦ sense of humour.

7 What is mental ill health?

It is now common to differentiate between mental health problems and disorders, the former being regarded as less severe (Townley, 2002). However, mental health problems can be distressing to the child and family, resulting in their seeking help from a health care professional.

Problems may include:

♦ sleeping difficulties

♦ feeding difficulties

♦ unhappiness

♦ bed wetting that does not have a physical cause

♦ faecal soiling without a physical cause

♦ over-activity

♦ tantrums, oppositional and deviant behaviour

♦ psychosomatic symptoms – for example, abdominal pain without a physical cause.

(Kurtz, 1992 cited in Townley, 2002)

Mental health disorders include:

♦ affective (mood) disorders, such as depression

♦ chronic fatigue syndrome

♦ conduct disorders, such as unusually severe and frequent temper tantrums beyond the age that they usually occur

♦ disorders of thought, such as delusions and hallucinations

♦ eating disorders, such as anorexia and bulimia

♦ hyperkinetic disorders, such as attention deficit disorder

♦ post-traumatic syndromes

♦ self-harm and suicide.

(BMA, 2006)

8 General assessment

Where a practitioner's initial assessment of a child or young person, or their interaction with the parents/carer gives cause for concern, it is important to share information with another professional and to initiate further assessment. In some situations where the child or young person is at immediate risk, involvement of a specialist mental health practitioner may be needed urgently. Local policies should clearly identify these situations.

The common assessment framework (CAF) in England, the integrated assessment framework (IAF) in Scotland and the framework for the assessment of children in need and their families in Wales provide standardised approaches to conducting an assessment of a child's additional needs, before deciding how those needs should be met. For specific mental health problems, other tools may be used to complement these frameworks. These are shown within the section, 'specific problems'.

Here are some situations where a common assessment might be initiated:

♦ missing developmental milestones or, for example, making slower progress than expected at school, regularly missing medical appointments and immunisations

♦ presenting challenging or aggressive behaviours – for example, bringing a knife into school, abusing/misusing substances or committing offences

♦ experiencing physical or mental ill health or disability – either their own or their parents

♦ exposure to substance abuse/misuse, violence or crime within the family

♦ experiencing bereavement or family breakdown

♦ being bullied or bullying

♦ being disadvantaged for reasons such as race, gender, sexuality, religious belief or disability

♦ being homeless, threatened with eviction, or living in temporary accommodation

♦ becoming a teenage mother/father or being the child of teenage parents

♦ persistent truanting.

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Some core themes

There are some situations that can lead a child or young person to experience mental health problems. This section includes some examples that practitioners may encounter.

Bullying

While bullying is common, it should always be viewed as unacceptable as it can seriously affect a child or young person's mental health. Bullying can be physical or psychological. It can take various forms, such as teasing, name calling, hitting, kicking, telling nasty stories or social exclusion.

In a study of bullying in 120 schools in Northern Ireland, carried out in 2000, 40 per cent of primary pupils said that they had been recently bullied. Meanwhile 25 per cent admitted bullying another pupil. When secondary pupils were asked, 30 per cent said that they had been recently bullied, with 28 per cent saying they had bullied another pupil (Department of Education Northern Ireland, 2007).

There are some signs and symptoms that can indicate a child or young person is being bullied. These include:

♦ unexplained scratches and bruises

♦ crying themselves to sleep

♦ nightmares

♦ depression

♦ self-harm

♦ headaches

♦ abdominal pain

♦ fear of walking to or from school

♦ school refusal or truancy

♦ poor school performance.

It is important for practitioners to be aware of these signs and to ask a child directly, either alone or with their parents, whether they have been bullied.

Questions you can ask:

♦ Have you been bullied?

♦ Has anyone at school been horrible to you?

Be suspicious, even if the child says no (Spender et al., 2001).

Although the school should deal with the bullying, the child or young person's emotional or behavioural symptoms may mean referral to a mental health specialist is needed.

Abuse

Child abuse falls into four categories: physical, sexual, emotional and neglect. Children who have been abused can experience difficulties for many years. The behavioural effects of abuse may include:

♦ problems at school

♦ prostitution

♦ teenage pregnancy

♦ suicide attempts

♦ alcohol and drug abuse

♦ eating disorders.

Children and young people with learning disabilities or those who are 'looked after' are particularly vulnerable to abuse. Where abuse has not been previously disclosed it is important to follow local safeguarding policies.

Practitioners have an absolute duty to share any concerns they may have that concern possible abuse. Remember that referral is an obligation, not an option.

Chronic illness

Children with a long lasting physical illness are twice as likely to suffer from emotional problems or disturbed behaviour. This is especially true of physical illnesses that involve the brain, such as epilepsy and cerebral palsy (Royal College of Psychiatrists, 2004a).

Children with chronic illness may show various emotional problems, such as rebellion or withdrawal from social settings. Other problems may include non-adherence to treatment, under-achievement in school and regressive behaviours such as bed-wetting and temper tantrums (Taylor, 1999).

As mental health problems may be overshadowed by the child or young person's chronic health problem, they can be overlooked (Vessey, 1999). Using a common assessment framework can help practitioners to identify problems.

Restraining children and young people

It may be necessary to restrain a child or young person in order to prevent significant or greater harm to the child, practitioners or others. For example, this may happen when de-escalation techniques have been unsuccessful for a young person under the influence of drugs or alcohol.

"The level of force must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum amount of time." (RCN, 2007)

It is important for employers to ensure there are procedures and policies for assessing the risk of violent behaviour. Practitioners should be given appropriate essential training.

10 Specific mental health disorders

Anxiety

Anxiety disorders are the most common mental health problem affecting children and young people. It is estimated that 10 per cent of young people experience this problem. Many children have times when they feel frightened about things and it is a normal part of growing up. Teenagers may be moody and worried about how they look, what other people think of them, and how they get on with people in general, particularly the opposite sex (Royal College of Psychiatrists, 2004b). Although there are many possible causes of anxiety, practitioners should be aware of links with street drugs, such as amphetamines, LSD or ecstasy.

Anxiety is a sense of worry, apprehension, fear and distress. Symptoms can be both physical – for example, a headache or nausea – and emotional – feeling nervous or afraid. The child or young person's thinking, decision-making, learning and concentration can be adversely affected. In addition, anxiety can lead to physiological changes, such as a raised blood pressure and heart rate, vomiting, pain and diarrhoea.

Persistent and intense anxiety that is disruptive to every day life requires attention (Rethink, 2007). Nurses working with children and young people, particularly school nurses, can help by facilitating the child or young person to talk about the cause of their anxiety, teaching relaxation techniques and giving information on further support. It may be necessary to seek a medical assessment.

Depression

It is estimated that one in every 200 children under 12 years old and two or three in every 100 teenagers experience depression. However, they are often unwilling to seek help because of the stigma associated with mental health problems (NICE, 2005a). Signs and symptoms of depression can include:

♦ being moody and irritable – easily upset, 'ratty' or tearful

♦ becoming withdrawn – avoiding friends, family and regular activities

♦ feeling guilty or bad, being self-critical and self-blaming

♦ feeling unhappy, miserable and lonely a lot of the time

♦ feeling hopeless and wanting to die

♦ finding it difficult to concentrate

♦ not looking after their personal appearance

♦ changes in sleep pattern: sleeping too little or too much

♦ tiredness and lack of energy

♦ changes in appetite

♦ frequent minor health problems, such as headaches or stomach pains.

Some young people may express or escape from their negative feelings and thoughts through acting recklessly – for example, taking drugs, drinking too much or getting into dangerous situations. Others who are very depressed can become preoccupied with thoughts of death and may attempt to kill or harm themselves.

Many children and young people can be helped by someone who is willing to listen to their anxieties, such as a family member. In addition, telephone help lines, such as Childline and the Samaritans, are useful.

Clear guidance on managing depression is given in the National Institute for Health and Clinical Excellence document, *Depression in children and young people* (NICE, 2005a). Practitioners working in universal services can care for children and young people with mild depression where the following circumstances apply:

♦ exposure to a single undesirable event, in the absence of other risk factors for depression

♦ exposure to a recent undesirable life event in the presence of two or more other risk factors, with no evidence of depression and/or self-harm

♦ exposure to a recent undesirable life event where one or more family members – parents or children – have multiple-risk histories for depression, providing that there is no evidence of depression and/or self-harm in the child/young person

♦ mild depression, without co-morbidity.

Health care professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression and to assess children and young people who may be at risk. Training should include:

♦ the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, and physical, sexual or emotional abuse

♦ co-morbidity disorders, including drug and alcohol use, and a history of parental depression

♦ the natural history of single loss events

♦ the importance of multiple risk factors

♦ ethnic and cultural issues

♦ and factors known to be associated with a high risk of depression, including problems such as homelessness, being a refugee or living in an institutional setting.

(NICE, 2005a).

Self-harm

Deliberate self-harm is more common among teenage girls. A survey carried out on behalf of Affinity Healthcare in 2008 revealed that 32 per cent of females aged between 11-19 in the UK have tried to harm themselves. However, boys who self-harm must be taken seriously, given an increased risk of suicide. According to the National Children's Bureau, self-harm usually involves cutting, but can include taking an overdose of tablets, scratching or burning. Self-cutting can become habit forming and is often kept secret. Attempted hanging is rare, but clearly very serious.

People who self-injure take care to hide any damage or scars. Acts of self-harm can be impulsive and secretive, and denial is common. Consequently, it can be difficult for health care professionals to identify those who are at risk.

Best practice is that all children and adolescents who have harmed themselves should be admitted to hospital (Spender et al., 2001). The National Institute for Health and Clinical Excellence (NICE) advises that in Accident and Emergency departments:

♦ triage, assessment and treatment should be undertaken

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by children's nurses and doctors trained to work with children and young people who self-harm. It should take place in a separate area of the emergency department for children and young people

♦ all children and young people should normally be admitted into a children's ward under the overall care of a paediatrician, and be assessed fully the following day

♦ those who are involved in the emergency treatment of self-harm by children and young people should be adequately trained to assess mental capacity in children of different ages, understanding how issues of capacity and consent apply to this group. They should have access at all times to specialist advice. In addition, they should understand confidentiality, consent, parental consent, child protection issues, and the use of the Mental Health and Children Acts.

The single most important thing a professional can do after an overdose is to encourage communication between the young person and important others (Spender et al., 2001).

Screening instruments can be useful. 'Pathos' provides several key questions:

♦ have you had **p**roblems for longer than one month?

♦ were you **a**lone in the house when you overdosed?

♦ did you plan the overdose for more than **t**hree hours?

♦ are you feeling **ho**peless about the future – that things will not get much better?

♦ were you feeling **s**ad for most of the time before the overdose?

Using the 'sad person scale' (Patterson et al., 1983) can help to identify risk factors for future suicide. Practitioners should always treat people who self-harm with care and respect (NICE, 2004b).

Good practice for coping with those who self-harm

♦ Admit children and young people to hospital.

♦ Ensure adequate training in self-harm, consent, confidentiality and child protection.

♦ Encourage the young person to talk to important others.

♦ Use a screening tool – for example, Pathos or the sad person scale.

♦ Advise parents to remove all means of self-harm before the child goes home.

(Spender et al., 2001)

Substance misuse

The National Institute for Health and Clinical Excellence (NICE) guidance on substance misuse (NICE, 2007) defines it as: "Intoxication by, or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances)."

Many young people try illegal substances such as cannabis or ecstasy at some stage, but only a small number are regular users (Spender et al., 2001). Other substances used include other hallucinogens, amphetamines, opiates (heroin and cocaine), and prescription only medicines, such as anti-depressants.

In most instances the young person will not seek help for an addiction, but will present with other problems. This may include difficulties at school, signs of depression, inappropriate sexual behaviour or because a parent has become worried.

Some clues may indicate excessive drug use:

♦ changes in attitude or behaviour – for example, lying or stealing

♦ mood changes

♦ deterioration in physical health

♦ sexually transmitted diseases.

(Spender et al., 2001)

It is likely that the young person may not see that they have a problem and seldom want to do anything about their substance misuse. It may be the parents who are expressing concern. In the first instance, 'harm minimisation' to reduce the risks may be the best course of action. This involves giving information to the young person and their family, by providing leaflets, websites and telephone numbers.

Referral to a drug counselling service may be difficult. It will need the young person to be motivated. Services are scarce in some areas.

Vulnerable and disadvantaged children and young people are particularly at risk of substance misuse. Influencing factors may include:

♦ family members who misuse substances

♦ behavioural, mental and social problems

♦ exclusion from school or truancy

♦ young offenders

♦ looked after children

♦ homelessness

♦ commercial sex workers

♦ black and minority ethnic backgrounds.

For these children and young people, NICE recommends the use of screening tools to identify vulnerable and disadvantaged children and young people under 25 who may be at risk of substance abuse. For those at risk, referral to professionals with specialist expertise in delivering community based interventions is recommended.

Screening tools include:

♦ Common assessment frameworks

♦ Drug assessment screening tool (DUST) (www.dfes.gov.uk)

♦ Substance abuse subtle screening inventory – adolescent version (SASSI Institute)

What you can do

As a universal practitioner working with children and young people who may be misusing substances, you should be able to provide:

♦ accurate and age appropriate drug and alcohol information, advice and education

♦ support, advice and information for parents and carers

♦ a referral to another service.

(Britton and Noor, 2003)

Information for parents and young people:

www.rcpsych.ac.uk

Self-help organisations:

www.alcoholics-anonymous.org.uk
www.addaction.org.uk

Conduct disorders

Conduct disorder is the psychiatric label for children and young people who show a repetitive and persistent pattern of anti-social, aggressive or defiant behaviour. In oppositional defiant disorder (ODD) the child or young person has persistently hostile behaviour that is not aggressive or anti-social. Behaviour problems are common complaints and they may be difficult to address.

There are a number of risk factors that can lead to anti-social behaviour. These include:

♦ attention deficit hyperactivity disorder

♦ specific learning difficulties – for example, reading or language delay

♦ poor child-rearing practices

♦ pattern-child interactions that contribute to the persistence of the behaviours

♦ any form of child abuse

♦ losses that the child views as important

♦ school and social influences.

What parents may say:

"He's on the go all the time."

"He won't do as he's told."

"He answers back."

"He hits other children."

(From Spender et al., 2001)

Specific issues in young children include tantrums, aggression and sibling rivalry.

National Institute for Health and Clinical Excellence (NICE) guidance recommends that conduct disorders need to be assessed by a psychiatrist, clinical psychologist or other professional with the necessary competence in the area of children and young people's mental health.

Where problems start at an early age, the long-term outcome is usually poor, unless the child gets early and effective treatment. There can be a detrimental impact on the whole family.

Management for conduct disorders can include behavioural, cognitive and psychosocial skills training, play, music and art therapy. Parent training and education programmes are also beneficial. NICE recommends the development of group-based programmes with individual programmes as necessary. These programmes are structured and based on principles of social learning theory.

Parent training/education programmes should be eight to 12 sessions and delivered by trained and skilled facilitators, with supervision (NICE, 2006).

Eating disorders

Eating disorders can manifest themselves in a variety of ways. The most serious are anorexia nervosa and bulimia nervosa. Obesity is also an eating disorder, but this is not usually regarded as a specific mental health problem.

Anorexia nervosa is determined food avoidance resulting in weight loss, or failure to maintain a steady weight gain related to increasing age. The child or young person is preoccupied with their weight and shape and has a distorted body image. While it has traditionally been seen as affecting mostly teenage girls, the incidence in younger children and boys is increasing.

The young person experiencing bulimia nervosa will have recurrent food binges followed by compensatory behaviour, such as vomiting, laxative use, excessive exercise and fasting.

Eating disorders can cause severe physical and psychiatric problems and occasionally death. Intervention in the early stages of the illness is more likely to be successful.

A person with an eating disorder usually keeps their behaviour secret and may deny the problem if confronted. While eventually someone notices or the person realises they need help, this can take months or even years.

The 'scoff' questions can be helpful for identifying possible cases of eating disorder.

♦ Do you make yourself **s**ick because you feel uncomfortably full?

♦ Do you worry you have lost **c**ontrol over how much you eat?

♦ Have you recently lost more than **o**ne stone in a three-month period?

♦ Do you believe yourself to be **f**at when others say you are too thin?

♦ Would you say that **f**ood dominates your life?

Score one point for every 'yes'. A score of two or more points indicates a likely case of eating disorder.

Children and young people with an eating disorder will need specialist care and should be referred to a child and adolescent mental health service as soon as possible. Continuing care may be within a children's setting, where close links with specialists will be needed. Practitioners should acknowledge that many people with eating disorders are ambivalent about treatment. They should also recognise the consequent demands and challenges this presents.

It is important for patients and, where appropriate, carers to be provided with education and information on the nature, course and treatment of eating disorders.

Psychosis

The term psychosis applies to conditions where people experience hallucinations and delusions. It includes schizophrenia and bipolar affective disorder. The causes are unknown but can be genetic or have their origin in abnormalities in the brain's chemistry.

Mind-altering substances, such as drugs, alcohol, glue and aerosols, can lead to psychotic disorders, while symptoms can be indicative of substance misuse.

11 When to involve a specialist

Supporting children and young people with mental health problems is not the responsibility of specialist services alone (*Every Child Matters,* DfEs, 2004a). However, the term child and adolescent mental health service (CAMHS) is sometimes used narrowly to refer only to specialist child and adolescent mental health services. There are local variations in the services provided and differences in referral procedures. The roles of the different CAMHS tiers in England are shown below. References for the other UK countries are given at the end of this document.

Tier 1

Non-specialists who can:

♦ identify mental health problems early in their development

♦ offer general advice and, in certain cases, treatment of less severe problems

♦ pursue opportunities to promote mental health.

Tier 2

Specialists who offer:

♦ training and consultation for other professionals

♦ consultation for families

♦ outreach to families and children requiring more help, who are unwilling to use specialist services

♦ assessment, which may trigger further treatment.

Tier 3

A specialist service for more complex, severe and persistent disorders, offering:

♦ assessment and treatment

♦ assessment for referrals to tier 4

♦ contributions to consultation and training at tiers 1 and 2

♦ participation in research and development projects.

Tier 4

Tertiary services including:

♦ adolescent in-patient services

♦ secure forensic adolescent services

♦ eating disorders units

♦ special sexual abuse teams

♦ specialist teams for neuro-psychiatric problems.

Local policies should give clear guidance to practitioners regarding referral and the support available to them.

12 Issues for practice

Child and young person focus

Some core elements of practice can assist in promoting the wellbeing of children and young people. It is important that practitioners base their practice on the needs of children and young people and seek ways to ensure those needs are identified. Young people have described some of the barriers to their effective use of services:

♦ lack of information

♦ lack of expertise and continuity of care

♦ failure to respect their views

♦ particular issues of access to services due to disability, poverty, ethnicity, being in care (looked after) and sexual orientation.

Communicating

Successful interaction is important for learning the child or young person's story and for ensuring appropriate care and management. Cooper and Glasper (2001) suggest that when working with and assessing young people, nurses need to find a way of interacting that is more than 'having a chat' but is not 'doing therapy'. To do this, nurses must be aware of how they are influenced by their personal belief system and that of the environment. Similarly, they should be aware of cultural issues that may influence their care and judgements.

Active listening involves:

♦ observing and reading non-verbal behaviour – for example, posture, facial expressions, movement or tone of voice

♦ listening and understanding verbal messages

♦ listening to the whole person, in the context of the social settings of life

♦ tough-minded listening – accepting that a client's feelings and visions of themselves are valid.

Obstacles to adequate listening include:

♦ being distracted

♦ judging the merits of what's being said, using our own value system

♦ filtering the information

♦ using professional knowledge to filter information

♦ fact-centred listening, rather than person-centred.

(Egan 1990, cited in Glasper & Richardson, 2006)

In Wales, attention must be given to the Welsh Language Act (1993) whereby individuals can choose to communicate in their language of choice. Local procedures will advise practitioners on actions that facilitate this.

Where the first language of children, young people and their parents/carers is not English, it is important to ensure their understanding, providing interpreting services and/or written material in an appropriate language.

Confidentiality

The United Nations convention on the rights of the child Article 12 enshrines the principle of self-determination. Nurses should treat any information in confidence, unless the young person consents to it being disclosed. However, the nurse also needs to consider the interests of the young person and where there is significant risk, the information will need to be disclosed. Examples of such situations include:

♦ abuse

♦ if the young person is likely to harm themselves

♦ if the young person may be involved in serious criminal activity.

Confidentiality should not be a barrier to effective communication with families and carers. Often, carers can be given information in general terms, without breaching confidentiality. Similarly, the concerns of carers can be heard whilst maintaining the privacy of the child. Where confidentiality is an issue, every effort should be made to negotiate with the young person about what information can and cannot be shared. If a decision is made to share information, the young person should be told.

Consent

"The same principles which are used when seeking consent for the treatment of children's physical disorders apply when children are suffering from a mental disorder. Once children reach the age of 18, no-one else can take decisions on their behalf" (DH, 2001).

In Scotland, the age of legal capacity is 16 years and is regulated by the Age of Legal Capacity (Scotland) Act, 1991. An important difference is that parents' consent cannot override refusal of consent by a competent child.

Wherever possible, a child or young person should receive treatment for their mental health problem on a consensual basis. This should be either the child's own consent – where the child is deemed competent to give it – or with consent from a person with parental responsibility and the co-operation of the child – where the child lacks capacity in relation to the decision in question. A trusting relationship with the child can help to achieve this. It is important to take the child's view into account, even when you may disagree with them.

Legislation

The Nursing and Midwifery Council's (NMC) Code (2008) states: "You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision-making and are fully safeguarded."

"Not only must young people under 18 suffer with a disorder they usually know little about, but also their parents must know about it for them to receive any professional treatment. If the parent and child have a poor relationship, the experience can be even harder for the child and in some cases treatment may be refused in order to keep the illness from their parents."
(YoungMinds, 2005)

In England and Wales, relevant legislation includes:

The Children Act 1989 – this allows for court involvement in individual treatment decisions and tends to be perceived as less stigmatising than the Mental Health Act 1983, but it does not specifically address mental disorder.

The Mental Health Act, 1983, amended by the Mental Health Act, 2007 – this has no lower age limit and there are no specific provisions in the Act relating to children. In theory, children and young people may be treated or compulsorily detained under it, but in practice very young children are not detained under the Act, with the majority being admitted as 'informal' patients by their parents.

The Mental Health Act 2007 requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age.

The Mental Capacity Act, 2005 – this does not generally apply to children under 16. Its principles apply to decisions related to the care and treatment of young people who lack mental capacity to consent, including treatment for mental disorder.

Legislation in Scotland includes:

Children (Scotland) Act 1995 – this safeguards children and young people.

Mental Health (Care and Treatment) (Scotland) Act 2003 – this places a responsibility on health boards to provide for children and young people under the age of 18, who are detained under the Act, or admitted to hospital for treatment services accommodation 'sufficient to meet the particular needs'.

The Adults with Incapacity (Scotland) Act 2000 Part 5, Medical Treatment and Research and **The Mental Health (Care and Treatment) (Scotland)** Act 2003 – these both provide for delivering health care to people who lack the ability to make treatment decisions for themselves.

The Age of Legal Capacity (Scotland) Act 1991 – this outlines that someone has the capacity to make decisions about consent from the age of 16. However, even under the age of 16, a young person may have the legal capacity to make a consent decision on a health care intervention, provided that they are capable of understanding its nature and possible consequences.

The Mental Health (Northern Ireland) Order, 1986 currently provides the framework for mental health issues. There is no legislation pertaining to mental capacity.

The Bamford Review of Mental Health and Learning Disability (Northern Ireland) recommended the introduction of a comprehensive legislative framework to include capacity issues and the needs of children and young people; this legislation is being developed.

Culture

Concepts of mental illness and the understanding of the origins of children's emotional and behavioural difficulties vary across cultures. Nurses need to be sensitive to these differences and ensure they are equipped with the knowledge to work effectively with different groups represented within the community they serve.

Positive steps – supporting race equality in mental healthcare (DH, England, 2007) gives the following advice:

♦ be prepared to develop friendships with everyone. Be politically astute and politically balanced. Don't get caught up in race politics. If your own ethnicity differs from that of a client or community member, never feel you have to apologise for that difference

♦ never feel you have to justify who you are. Saying things like, 'I'm not a racist, some of my best friends are black,' will only undermine your position

♦ a white mental health staff worker is no less equipped to provide a culturally responsive service for black and minority ethnic (BME) clients than a black or Asian staff worker. Competency and commitment will cross all ethnic boundaries

♦ be prepared to stop, reflect and even start again if necessary. Keep the bigger picture in mind; a few set backs and defeats don't mean you won't succeed in the long term.

13
Promoting good mental health

Standard 9 of the National Service Framework for Children and Young People (England) concerns their mental health and psychological wellbeing. It recommends that: "All staff who work with children and young people, in any service, are able to recognise the contribution they can make to children's emotional wellbeing and social development and use their own professional skills in supporting children when there is concern about their wellbeing. They understand their responsibilities for supporting children in difficulty."

All children and young people, and their parents or carers, require access to information and supportive environments to ensure that the child or young person's mental health is promoted.

"Two key skills are necessary for positive mental health – learning to cope and even prosper in the face of adversity and the ability to create feelings of happiness through healthy, positive means… If children and young people have pleasure, engagement and meaning in life, they are likely to experience happiness, life satisfaction, wellbeing and lead more flourishing lives." (Ward, 2008)

Good practice towards achieving this includes:

♦ the ability of frontline staff to access support and advice from specialist CAMHS and other children's services to aid the early identification and support of those with mental health difficulties. These include social workers, behaviour specialists, educational psychologists and specialist support staff

♦ local protocols for referral

♦ ensuring that local needs' assessments identify children in special circumstances – including those who are homeless, misuse substances, seeking asylum, in young offenders' institutions and looked after – and that services are in place to meet their needs

♦ an emphasis on children and young people who are vulnerable to mental health problems and on providing focused, structured, proactive programmes which target

risk factors, using a common assessment framework as appropriate

♦ specific activities such as tackling bullying and increasing awareness of mental health issues

♦ promoting lifestyles that protect children and young people from mental health problems.

"School nurses have an important role in the early assessment and increasingly in delivering effective early interventions for children and young people with mental health problems" (DfES, 2001). Examples of interventions by school nurses are given in this document.

14
Parents and carers

Parents whose children have never experienced worries, fears, bullying, sadness, problems with friendships and bereavement are in the minority. Parents whose child has mental health difficulties are often made to feel it is their fault, and as a result they do not tell anyone. It is common for parents and carers to feel isolated and alone in trying to deal with their child's problems.

In some instances, issues such as family breakdown, poverty and parenting difficulties may have contributed to the child or young person's problems. However, practitioners should remain non-judgmental in their approach to parents and carers, aiming to support and assist them. Several charities offer specific help to parents and carers and knowledge of these organisations can be useful.

15 Summary

The mental health of the child or young person influences the adult they will grow to be. By gaining knowledge on issues concerning the mental health of children and young people, practitioners can develop the skills needed for providing effective care and support. In addition, by being well-informed, practitioners can act in their professional and personal lives to break down the stigma that is so frequently associated with mental health problems.

We hope that this document will assist practitioners in achieving these goals.

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References

The Bamford Review of Mental Health and Learning Disability (N.I.) (2006) *A vision of a comprehensive children and adolescent mental health service*, Belfast: DHSSPSNI. Accessible from www.rmhldni.gov.uk (accessed 16/02/09) (Web).

The Bamford Review of Mental Health and Learning Disability (2007) *A comprehensive legislative framework*, Belfast: DHSSPSNI. Accessible from www.rmhldni.gov.uk (accessed 16/02/09) (Web).

British Medical Association (2006) *Child and adolescent mental health – a guide for healthcare professionals*, London: BMA.

Britton J and Noor S (2003) *First steps in identifying young people's substance related needs*, London: Home Office.

Cooper M and Glasper E (2001) Deliberate self harm in children: the nurse's therapeutic style, *British Journal of Nursing*, 10 (1), pp.34-40.

Department for Education and Skills (2001) *Promoting children's mental health within early years and school settings*, London: DfE.

Department of Education, Northern Ireland (2007) *The nature and extent of bullying in schools in the North of Ireland, Co Down*: DE. Accessible from www.deni.gov.uk/rb3_2007.pdf (accessed 16/02/09) (Web).

Department of Health (2001) *Seeking consent. Working with children*, London: DH.

Department of Health (2004a) *NHS knowledge and skills framework (NHS KSF) and the development review process*, London: DH.

Department of Health (2004b) *National service framework for children, young people and maternity services. The Mental health and psychological well-being of children and young people*, London: DH. Accessible from www.dh.gov.uk/en/publicationsandstatistics (accessed 15/12/08) (Web).

Department of Health (2006) *Tackling the health and mental health effects of domestic and sexual violence and abuse*, London: DH.

Department of Health (2007) *The NHS KSF dimensions, levels and indicators (appendix 2)*, London: DH.

Glasper EA and Richardson J editors (2006) *A textbook of children's and young people's nursing*, London: Churchill Livingstone Elsevier.

The Mental Health (Northern Ireland) *Order 1986* (no. 595 (NI 4)). Accessible from www.opsi.gov.uk (accessed 16/02/09) (Web).

Mental Health Foundation (2000) *Pull yourself together! A survey of the stigma and discrimination faced by people who experience mental distress*, London: MHF.

National Institute for Health and Clinical Excellence (2004a) *Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9*, London: NICE.

National Institute for Health and Clinical Excellence (2004b) *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16*, London: NICE.

National Institute for Health and Clinical Excellence (2005a) *Depression in children and young people: identification and management in primary, community and secondary care*, London: NICE.

National Institute for Health and Clinical Excellence (2005b) *Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26*, London: NICE.

National Institute for Health and Clinical Excellence (2006) *Parent-training/education programmes in the management of children with conduct disorders*, London: NICE.

National Institute for Health and Clinical Excellence (2007) *Quick reference guide. Intervention to reduce substance misuse among vulnerable young people*, London: NICE.

NSPCC Northern Ireland Policy and Research Unit (2004) *Assessment of children in need in Northern Ireland*, Belfast: NSPCC. Accessible from www.nspcc.org.uk/inform (accessed 15/12/08) (Web).

Office of National Statistics (2004) *The mental health of children and young people in Great Britain,* London: HMSO. Accessible from www.dh.gov.uk/publications (accessed 15/12/08) (Web).

Patterson WM, Dohn HH, Bird J and Patterson GA (1983) Evaluation of suicidal patients. The SAD PERSON scale, *Psychomsomatics,* 24 (4), pp.343-9.

Public Health Institute of Scotland (2003) *Needs assessment report of child and adolescent mental health,* Glasgow: Public Health Institute of Scotland. Accessible from www.handsonscotland.co.uk/publications/snap%20report. pdf (accessed 15/12/08) (Web).

Rethink (2007) *Childhood mental illness,* Kingston upon Thames: Rethink. Accessible from www.mentalhealthshop.org (accessed 15/12/08) (Web).

Royal College of Nursing (2003) *Restraining, holding still and containing children and young people: Guidance for nursing staff,* London: RCN. Publication code 001 999.

Royal College of Nursing (2004) *Children and young people's mental health: every nurse's business,* London: RCN. Publication code 002 239.

Royal College of Nursing (2007) *Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments,* London: RCN. Publication code 003 017.

Royal College of Psychiatrist (2004a) *Mental health and growing up. Factsheet 27. Chronic physical illnesses: the effects on mental health,* London: RCPSYCH. Accessible from www.rcpsych.ac.uk/publications (accessed 16/02/09) (Web).

Royal College of Psychiatrists (2004b) *Surviving adolescence: a toolkit for parents,* London: Royal College of Psychiatrists. Accessible from www.rcpsych.ac.uk/mentalhealthinfo/youngpeople/adolesc ence.aspx (accessed 15/12/08) (Web).

Spender Q, Salt N, Dawkins J, Kendrick T and Hill P (2001) *Child mental health in primary care,* Oxford: Radcliffe Publishing Ltd.

Taylor SE (1999) *Health psychology,* Boston: McGraw Hill.

Townley M (2002) Mental health needs of children and young people, *Nursing Standard* 16 (30), pp.38-45.

United Nations (1989) *Convention on the rights of the child,* Geneva: UN. Accessible from www.unhchr.ch/html/menu3/b/k2crc.htm (accessed 15/12/08) (Web).

Vessey JA (1999) Psychological co-morbidity in children with chronic conditions, *Pediatric Nursing,* 25 (2), pp.211-215.

Ward S (2008) *Understanding concepts for working with children and young people,* Belfast: Health Promotion Agency. Accessible from www.healthpromotionagency.org.uk (accessed 15/12/08) (Web).

Welsh Assembly Government (2005) *National service framework for children, young people and maternity services in Wales,* Cardiff: WAG. Accessible from www.wales.gov.uk (accessed 15/12/08) (Web).

World Health Organization (2004) *Prevention of Mental Disorders. Effective Interventions and Policy Options. Summary Report* (World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Jijmegen and Maastricht, Geneva), Geneva: WHO.

Useful websites

www.addiss.co.uk
National attention deficit disorder information and support service.

www.alcoholics-anonymous.org.uk
Alcoholics Anonymous.

www.b-eat.co.uk
Understanding eating disorders and how you can help.

www.bmementalhealth.org.uk
Umbrella charity for issues concerning mental health in black and minority ethnic communities.

www.bullying.co.uk
Help and advice for victims of bullying, parents and schools.

www.cafamily.org.uk
Advice and support for all parents of disabled children.

www.childcom.org.uk
Children's Commissioner for Wales.

www.childline.org.uk
Providing a free and confidential telephone service for children. Helpline: 0800 1111.

www.childrenfirst.nhs.uk
Information for children and young people, including mental health issues. The website is run by the Great Ormond Street Hospital for Children NHS Trust.

www.childrenssociety.org.uk
Works with children and young people who are struggling to cope with the pressures of everyday life.

www.childreninscotland.org.uk
National agency for voluntary, statutory and professional organisations and individuals working with children and their families in Scotland.

www.childreninwales.org.uk
National umbrella organisation for those working with children and young people in Wales.

www.deni.gov.uk
Department of Education, Northern Ireland.

www.dfes.gov.uk
Department for Children, Schools and Families.

www.depressionalliance.org
Depression Alliance.

www.everychildmatters.gov.uk
Every Child Matters.

www.funkydragon.org
Children and Young People's Assembly for Wales.

www.fwa.org.uk
Family Welfare Association – support for families with problems.

www.hbsc.org
Health behaviour in school-aged children, a World Health Organization collaborative cross-national study.

www.headsupscotland.co.uk
National project for children and young people's mental health.

www.healthpromotionagency.org.uk
Health Promotion Agency in Northern Ireland.

www.healthscotland.com
Scotland's Health Improvement Agency.

www.hris.org.uk
Health Rights Information Scotland.

www.kidscape.org.uk
Provides advice, training courses and helpful booklets and information about bullying.

www.mentalhealth.org
Mental Health Foundation, a UK charity.

www.mentalhealthcare.org.uk
Institute of Psychiatry, King's College, London, South London and Maudsley NHS Foundation Trust – information about mental health.

www.mind.org.uk
Working to create a better life for everyone with experience of mental distress.

www.mwcscot.org.uk
Mental Welfare Commission for Scotland.

www.nta.nhs.uk
National Treatment Agency for Substance Misuse.

www.nch.org.uk
Support of vulnerable children, young people and families.

www.networks.nhs.uk
All Wales Mental Health Promotion Network.

www.niamh.co.uk
Northern Ireland Association of Mental Health.

www.niccy.org
Children's Commissioner for Northern Ireland.

www.opsi.gov.uk
Office of Public Sector Information.

www.parentlineplus.org.uk
Supporting parents to 'do their best'.

www.rcpsych.ac.uk
Royal College of Psychiatrists.

www.respectme.org.uk
Scotland's anti-bulling service.

www.rip.org.uk
Research in Practice, supporting evidence-informed practice with children and families.

www.ruralwellbeing.org.uk
Health and well-being information service for the people of rural Wales.

www.samaritans.org.uk
The Samaritans.

www.samh.org.uk
Scottish Association for Mental Health.

www.scbnetwork.org
Supporting Carers Better Network.

www.sccyp.org.uk
Children's Commissioner for Scotland.

www.scotland.gov.uk
Scottish Executive.

www.sehd.scot.nhs.uk
Scottish Executive Health Directorates.

www.selfharm.org.uk
National Children's Bureau information on self-harm.

www.sign.ac.uk
Scottish Intercollegiate Guidelines Network.

www.skillsforhealth.org.uk
The health sector's skills council.

www.statistics.gov.uk
The UK statistics authority.

www.talktofrank.com
An A-Z of drugs.

www.thecalmzone.net
Help for young people.

www.thesite.org
Health information for young people.

www.teachernet.gov.uk
The education site for teachers and school managers.

www.welshrefugeecouncil.org
Advice and support for refugees and asylum seekers in Wales.

www.youthaccess.org.uk
Information on youth counselling.

www.youngcarers.net
Princess Royal Trust for Carers.

www.youthinmind.co.uk
Helping stressed children, teenagers and those who care for them.

www.youngminds.org.uk
Provides information and advice on child mental health issues.

www.11million.org.uk
Children's Commissioner for England.

Further reading

Affinity Healthcare (2008) *New survey reveals almost one in three young females have tried to self-harm.* Press release. Accessible from www.affinityhealth.co.uk/news.html (accessed 16/02/09) (Web).

Anderson M, Woodward L and Armstrong M (2004) Self-harm and young people: a perspective for mental health nursing. *International Nursing Review,* 51 (4), pp.222-228.

Barlow JH and Elland DR (2006) The psychological well-being of children with chronic disease, their parents and siblings: an overview of the research evidence, *Child: care, health and development,* 32 (1), pp.19-31.

Blew H and Kenny G (2006) Attention deficit hyperactivity disorder: the current debate and neglected dimensions, *Journal of Child Health Care,* 10 (3), pp.251-263.

Carr A editor (2000) *What works with children and adolescents? A critical review of psychological interventions with children, adolescents and their families,* London: Brunner-Routledge.

Croghan E (2005) Supporting adolescents through behaviour change, *Nursing Standard,* 19 (34), pp.50-53.

Davies J, Huws-Thomas M (2007) Care and management of adolescents with mental health problems and disorders. *Nursing Standard,* 21 (51), pp.49-56.

Department of Health (2001) *Consent. What you have a right to expect. A guide for children and young people,* London: DH.

Department of Health (2002) *National suicide prevention strategy for England,* London: DH. Accessible from www.dh.gov.uk/en/publicationsandstatistics (accessed 15/12/08) (Web).

Dimond B (2008) The Mental Capacity Act 2005: children and young persons, *British Journal of Nursing,* 17 (4), pp.248-50.

Emerson E, Hatton C (2007) The mental health of children and adolescents with learning disabilities in Britain, *Advances in Mental Health & Learning Disabilities,* 1 (3), pp.62-63.

Fox C, Buchanan-Barrow E and Barrett M (2007) Children's understanding of mental illness: an exploratory study, *Child: Care, Health and Development,* 34 (1), pp.10-18.

Gerkensmeyer JE, Janis E, Perkins, SM, Scott L and Wu J (2008) Depressive symptoms among primary caregivers of children with mental health problems: mediating and moderating variables, *Archives of Psychiatric Nursing,* 22 (3), pp.135-146.

Glasper EA, McEwing G and Richardson J (2007) *Oxford handbook of children's and young people's nursing,* Oxford: Oxford University Press.

Glazebrook C, Hollis C, Heussler H, Goodman R and Coates L (2003) Detecting emotional and behavioural problems in paediatric clinics, *Child: Care, Health & Development,* 29 (2), pp.141–149.

Gloucestershire Eating Disorders Project (2002) *Guidelines for the clinical management of eating disorders in primary care,* Gloucester: Gloucestershire Health Authority. Accessible from www.edglos.org.uk/guidance3.pdf (accessed 15/12/08) (Web).

Goodman R (1997) The strengths and difficulties questionnaire: a research note, *Journal of Child Psychology and Psychiatry and Allied Disciplines,* 38, pp.581–586.

Gorman F (2006) Young people who self-harm, *ChildRight,* 226, pp.14-15.

Graham P (2000) Mental health must be 'centre stage' in child welfare, *Archives of Disease in Childhood,* 831; ProQuest Nursing and Allied Health Source Edition 3-4.

Hairon N (2008) Survey finds worrying number of young people self-harm, *Nursing Times,* 104 (18), pp.23-24.

Hall D and Williams J (2008) Safeguarding, child protection and mental health, *Archives of Disease in Childhood,* 93 (1), pp.11-13.

Hamilton JD (2007) Eating disorders in pre-adolescent children, *The Nurse Practitioner,* 32 (3), pp.44-48.

Harden A, Rees R, Shepherd J, Brunton V, Oliver S and Oakley A (2001) *Young people and mental health: a systematic review of barriers and facilitators,* London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Hartley-Brewer E (1994) *Positive parenting*, London: Vermilion.

Hawton K and James A (2005) *Suicide and deliberate self-harm in young people*, British Medical Journal, 330, pp.891-894.

Honeyman C (2007) Recognising mental health problems in children and young people, *Paediatric Nursing*, 19 (8), pp.38-44.

Lau B K W (2002) Stress in children. Can nurses help?, *Pediatric Nursing*, 28 (1), pp.3-20.

Leighton S (2003) School nurses and mental health parts 1 and 2, *School Nursing*, 7, p.4.

Luck AJ, Morgan JF, Reid F, O'Brien A, Brunton J, Price C, Lacey JH (2002) The SCOFF questionnaire and clinical interview for eating disorders in general practice: comparative study, *British Medical Journal*, 325 (7367), pp.755-756.

MacLeod J, Oakes R, Copello A and Crome I (2004) Psychological and social sequelae of cannabis and other illicit drug use by young people (systematic review), *The Lancet* 363 (9428), pp.1579-1588.

Mafe E (2003) Assessing risk following deliberate self-harm, *Paediatric Nursing* 15 (8), pp.32-34.

McDonald G (2007) Guilt and shame: experiences of parents of self-harming adolescents, *Journal of Child Health Care*, 11 (4), pp.298-310.

Mental Health Foundation (2002) *A bright future for all: promoting mental health in education,* London: MHF.

Metzer H, Lader D, Corbin T, Goodman R and Ford T (2004) *Mental health of young people looked after by local authorities in Scotland*, London: TSO. Accessible from www.statistics.gov.uk/downloads/theme_health/Mentalhealth _Scotland.pdf (accessed 15/12/08) (Web).

Miller F G, Lazowski L E (2001) *The adolescent SASSI-2 manual: identifying substance use disorders,* Springville: The SASSI Institute.

Mind (2006) *How to cope as a carer,* London: Mind. Accessible from www.mind.org.uk/information (accessed 15/12/08) (Web).

Mind (2007) *Understanding self-harm*, London: Mind. Accessible from www.mind.org.uk/information (accessed 15/12/08) (Web).

Morgan JF, Reid F, Hubert Lacey J (1999) The SCOFF questionnaire: Assessment of a new screening tool for eating disorder, *British Medical Journal*, 319 (7223), pp.1467-1468.

Murphy B, Manning Y (2003) An introduction to anorexia nervosa and bulimia nervosa, *Nursing Standard* 18, pp.14-16, pp.45-52.

National Assembly for Wales (2000) *Tackling substance misuse in Wales. A partnership approach,* Cardiff: National Assembly for Wales. Accessible from www.wales.gov.uk (accessed 15/12/08) (Web).

National Assembly for Wales (2001) *Child and adolescent mental health services. Everybody's business*, Cardiff: National Assembly for Wales. Accessible from www.wales.gov.uk (accessed 15/12/08) (Web).

National Assembly for Wales (2001) *Framework for the assessment of children in need and their families*, London: The Stationary Office.

National Institute for Health and Clinical Excellence (2007) *Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people*, London: NICE.

National Institute of Mental Health in England (2003) *Inside outside – improving mental health services for black and minority ethnic communities in England*, London: NIMHE.

National Treatment Agency for Substance Misuse (2007) *Assessing young people for substance misuse*, London: National Treatment Agency. Accessible from www.nta.nhs.uk/publications/documents/nta_assessing_ young__people__for__substance__misuse_yp1.pdf (accessed 15/12/08) (Web).

NHS Direct (2007) *Self-injury. Symptoms*, London: DH. Accessible from www.nhsdirect.nhs.uk (accessed 15/12/08) (Web).

Nursing and Midwifery Council (2008) *Consent*, London: NMC.

Office of National Statistics (2004) *The mental health of young people looked after by local authorities in Wales*, London: HMSO.

Preece P and Jowett S (2007) Why do young people self-harm?, *British Journal of School Nursing*, 2 (1), pp.20-23.

Potts N (2005) Problem drug use and child protection: interagency working and policies in Scotland, *Infant* 1 (6), pp.189-193.

Research in Practice (2006) *Transition of adolescents to mental health services. Champions for children*, Totnes: Research in Practice. Accessible from www.rip.org.uk (accessed 15/12/08) (Web).

Rodrigues VC (2004) Health of children looked after by local authorities, *Public Health*, 118 (5), pp.370-376.

Royal College of Psychiatrists (2004) *Mental health and growing up series*, 36 fact sheets on a range of common mental health problems. Accessible from www.rcpsych.ac.uk (accessed 16/02/09) (Web).

Rutter, M and Taylor E editors (2002) *Child and adolescent psychiatry* (4th edition), London: Blackwell.

Sainsbury Centre for Mental Health (2005) *Feeling good: promoting children's mental health*, London: SCMH. Accessible from www.scmh.org.uk/publications/feeling_good.aspx?ID=510 (accessed 15/12/08) (Web).

Scott A, Shaw M & Joughin C (2001) *Finding the evidence: a gateway to the literature in child and adolescent mental health* (2nd edition), London: Gaskell.

Scottish Government (2006) *National programme for improving mental health and well-being: small research projects initiative. An investigation of the role of school nurses in supporting mental health and well-being,* Edinburgh: Scottish Government. Accessible from www.scotland.gov.uk/Publications/2008/05/22095935/1 (accessed 15/12/08) (Web).

Scottish Government (2007) *Integrated assessment, planning and recording framework,* Edinburgh: Scottish Government. Accessible from www.scotland.gov.uk (accessed 15/12/08) (Web).

Scottish Government (2008) *National delivery plan for children and young people's specialist services in Scotland. Draft for consultation*, Edinburgh: Scottish Government. Accessible from www.scotland.gov.uk/Resource/Doc/213263/0056654.pdf (accessed 15/12/08) (Web).

Scottish Intercollegiate Guidelines Network (2003a) *The management of harmful drinking and alcohol dependence in primary care*, Edinburgh: SIGN. Accessible from www.sign.ac.uk/guidelines/fulltext/74/index.html (accessed 15/12/08) (Web).

Scottish Intercollegiate Guidelines Network (2003b) *The management of obesity in children and young people*, Edinburgh: SIGN. Accessible from www.sign.ac.uk/guidelines/fulltext/69/index.html (accessed 15/12/08) (Web).

Simpson A (2008) Professional backup, *Nursing Standard*, 22(28), pp.62-63.

Spataro J, Mullen PE, Burgess PM, Wells DL and Moss SA (2004) Impact of child sexual abuse on mental health. Prospective study in males and females, *British Journal of Psychiatry*, 184, pp.416-421.

Stanley N (2005) The mental health needs of looked after children: matching response to need, *Health and Social Care in the Community*, 13 (3), pp.239-248.

Street C, Stepelkamp C, Taylor E, Malek M and Kurtz Z (2005) *Minority voices. Research into access and acceptability of services for the mental health of young people from black and minority ethnic groups*, London: Young Minds. Accessible from www.youngminds.org.uk/publications/all-publications/minority-voices/file (accessed 15/12/08) (Web).

Stubbe D (2007) *Child and adolescent psychiatry*, Philadelphia, USA: Lippincott Williams & Williams.

Taylor HC, Stuttaford MC, Broad B and Vostanis P (2007) Listening to service users: young homeless people's experiences of a new mental health service, *Journal of Child Health Care*, 11(3), pp.221-230.

Thambirajah MS (2007) *Case studies in adolescent mental health*, Oxford: Radcliffe Publishing Ltd.

Tipper P (2001) Linking mental health and paediatric services, *Paediatric Nursing* 13 (1), pp.14-16.

Urquhart Law G, Sinclair S and Fraser N (2007) Children's attitudes and behavioural intentions towards a peer with ADHD: does the addition of a label make a difference?, *Journal of Child Health Care*, 11 (2), pp.98-111.

Warne T and McAndrew S (2005) The shackles of abuse: unprepared to work at the edges of reason, *Journal of Psychiatric and Mental Health Nursing*, 12 (6), pp.679–686.

Webster Stratton C (1992) *The incredible years: a troubleshooting guide for parents of children aged 3–8*, London: Umbrella Press.

Welsh Assembly Government (2008) *Working together to reduce harm. The Substance Misuse Strategy for Wales 2008-2018*, Cardiff: WAG. Accessible from www.wales.gov.uk/topics/housingandcommunity/publications/strategy0818 (accessed 16/02/09) (Web).

Welsh Office (1997) *The health of children in Wales*, Cardiff: Welsh Office.

Whyte A (2004) Treating children with ADHD, *Nursing Times*, 100 (21), pp.26-27.

Wilson P, Furnivall J, Barbour RS, Connolly G, Bryce G, Phin I and Stallard A, (2008) The work of health visitors and school nurses with children with psychological and behavioural problems, *Journal of Advanced Nursing*, 61 (4), pp.445-455.

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