

Mental health in Scotland: a 10-year vision

Submission from the Children and Young People's Commissioner, Scotland

My role as the Children and Young People's Commissioner, Scotland is to promote and safeguard the rights of children and young people by promoting awareness and understanding of children's rights, keeping under review law, policy and practice relating to the rights of children and young people, promoting best practice and undertaking research.

In commenting on this proposed framework and on mental health priorities, I will make reference to discussions held with numerous individuals, groups and organisations directly involved in mental health work¹ as well as to the UN Committee on the Rights of the Child; in particular their June 2016 Concluding Observations.

I am pleased that the Government have decided to extend the mental health strategy to 10 years, as this will allow enough time to transform mental health services in Scotland and to make radical changes to the current system. The focus on the 'life course' is also welcome as it provides a structured approach and acknowledges that past and present experiences are shaped by a wider social, economic and cultural context. It also moves away from the age related boundaries which can lead to a fragmented and inefficient system.

¹ In particular, CELCIS the Centre for Excellence for Looked After Children, the Scottish Trauma Advisory Group and the Scottish Youth Parliament.

I appreciate that this 10-year vision is a first step towards a 10-year strategy and, as such, it is rather sparse in detail. It does not set out the policy context or the evidence base, nor does it make links to other strategies or programmes directly relevant to mental health, such as the autism or anti-bullying strategies, poverty related initiatives or GIRFEC. The paper refers to outputs and outcomes – noting that these will be measured – but provides no further detail on how this will happen. A commitment to develop indicators to measure clinical and personal mental health outcomes across the range of services is also referred to on page 8, but there is no reference to the Children and Young People’s Mental Health Indicators for Scotland which were developed in 2011. I am interested to know how they will be built upon.

I also recognise that the framework does not reflect all the activity currently taking place to support mental health and rather focuses on the 8 priorities, early actions and results. However, I find it difficult to make more substantial comment because many of the relevant strands of work have not been pulled together. I look forward to commenting on the full strategy when it becomes available in late 2016.

Questions

Question 1. The table in Annex A sets out 8 priorities for a new Mental Health Strategy that we think will transform mental health in Scotland over 10 years. Are these the most important priorities?

Yes/no. If no, what priorities do you think will deliver this transformation?

Yes, to some extent. Please see comments below.

Priority 1. Focus on prevention and early intervention for pregnant women and new mothers

I am pleased to see this as a priority as the figures around mental ill-health in this group are extremely concerning. One in five mothers suffers from depression, anxiety or – in some cases – psychosis during pregnancy or in the first year after childbirth, and suicide is the second leading cause of maternal death after

cardiovascular disease². Having a mother with poor mental health can have an adverse effect on children growing up if it not treated in an appropriate and timely fashion.³

The Royal College of Psychiatrists Scotland's briefing *Healthy Start, Healthy Scotland: Improving the mental health of mothers and babies for Scotland's future* stresses that untreated maternal mental illness may be associated with problems in the developing relationship between mother and infant and can have longer term effects on cognitive and emotional development as a child grows, reducing a child's ability to manage stress later in life. The College calls for prompt treatment of mental ill-health in pregnancy along with an attachment-based approach to mental health.

This call is also evident in numerous other reports including the Growing Up in Scotland study *Maternal mental health and its impact on child behaviour and development*⁴. This showed that maternal mental health had a significant impact on their child's development by the age of four. Thus, supporting mothers with mental health problems may have a direct impact on young children's development and wellbeing and could enhance children's early school experiences.⁵

It is also worth making the point that some pregnant mothers and parents may also be care-experienced young people, who may not have had the best experiences themselves of being parented. As such, they will require particular support.

My office is currently represented on the Scottish Trauma Advisory Group (STAG) and I support many of the recommendations in their response. In particular, I agree with their call for staff to be trained in the early identification of domestic abuse, particularly in pregnant women. This will allow trauma-informed perinatal

² The Five Year Forward View for Mental Health 'Report from the Independent Mental Health Task Force in England (2016)

³ NICE 'Antenatal and postnatal mental health: Clinical management and service guidance' (CG192), NICE 2014

⁴ Growing Up in Scotland, *Maternal mental health and its impact on child behaviour and development* (2010) (Scottish Government) <http://www.gov.scot/Resource/Doc/310448/0097971.pdf>

⁵ Data was based on natural mothers interviewed at the time of the first sweep of GUS carried out in 2005/6 when their baby was 10 months old, and subsequently re-interviewed annually on three further occasions, until their child was four.

interventions which can link effectively to agencies that can protect women at risk. (I refer to this in my specific comments)

The previous work through the Early Years Framework, Taskforce and Collaborative have provided a strong platform for improving our early years services. Much of this work continues at local level through Community Planning Partnerships and it is vital that the momentum is maintained, because it contributes to the delivery of key elements of mental health and wellbeing in the early years. I expect this to be covered in the strategy.

Priority 2. Focus on prevention and early intervention for infants, children and young people

Current activities

There are a number of issues to comment on in this priority. As noted earlier, I appreciate that not all the current activities are noted in the vision paper, so would wish to underline ongoing support for the Psychology of Parenting Project (POPP) which is helping Community Planning Partnerships to deliver evidence based parenting programmes, such as 'The Incredible Years' and Level 4 Group Triple P.

Half of all mental health problems have been established by the age of 14, rising to 75% by the age of 24⁶. Too often, children and young people are only supported when they are at crisis point, yet all children have mental health which needs to be fostered and nourished. Good mental health in childhood can contribute to – and is a prerequisite for – a healthy and well-functioning adulthood. Whilst most children will not be involved with specialist mental health services, a diagnosis should not be the sole trigger for support. Early intervention and access to good quality care is key and will help to ensure that potential difficulties are spotted quickly and dealt with appropriately.

⁶ The Five Year Forward View for Mental Health 'Report from the Independent Mental Health Task Force in England (2016)

Waiting times

Waiting times should be substantially reduced and inequalities in access should be addressed. The Committee on the Rights of the Child referred to waiting times in its Concluding Observations (June 2016), calling for these to be reduced and for the expeditious prohibition of placement of children with mental health needs in psychiatric adult wards or police stations, while ensuring provision of age-appropriate mental health services and facilities⁷. Whilst a focus on waiting times is of course important, we must also ensure that we pay attention to the quality of the care that children and young people receive and ensure that support is provided while they are waiting for care.

In-service training

Preventing mental ill health through early intervention is an important priority. However, I would like to see this sit alongside in-service training to ensure that professionals working with children and young people can recognise when a child is in distress and act quickly, appropriately and with confidence, deploying the right skills and techniques. In particular, agencies must be able to respond sensitively and appropriately in response to a child's disclosure that he or she is being bullied, an area which is often raised by children and young people.

Schools

Schools have a particularly important part to play in the promotion of good mental health and I was surprised to see no mention of this in the consultation paper, especially given that health and wellbeing is one of the three pillars of Curriculum for Excellence (CfE). CfE is the key delivery framework for learning and, along with the Early Years Framework (2009), is underpinned by prevention and early intervention. I support the Scottish Youth Parliament's call for the development of a Mental Health Standard for schools to increase the focus on mental health education in the

⁷ <http://www.crae.org.uk/media/93148/UK-concluding-observations-2016.pdf>

Curriculum for Excellence.⁸ Counselling services should also be supported and properly resourced, and I would be particularly keen to see a review implemented around the support that is available in schools.

It is estimated that school nurses spend 40% of their time on mental health⁹. The valued role they play in complementing education services is widely recognised and only last week the Royal College of Nursing (RCN) noted that school nurses play a 'key role' in delivering essential sex and relationships education (SRE) and safeguarding children against sexual exploitation and abuse.

There is also much good practice being undertaken in schools across Scotland which other schools can learn from. For example, the *Towards a Mentally Flourishing School* initiative in the Borders¹⁰ came from a school nurse who had recognised that there was a population health need and that there were '*a huge amount of young people who were experiencing social, emotional and wellbeing issues, which were impacting on their personal lives, their relationships and their ability to engage in their education and to attain and achieve a quality of life*¹¹.'

The initiative broadened out to the whole school community who had identified similar issues. What started as an interventionist based approach became a whole school preventative approach, with the pastoral teacher noting a '*huge cultural change in the language of mental wellbeing, used in the school by staff, by parents and particularly by pupils*¹².' Pupil involvement in the project was high. For example, information board resources were gathered with S6 pupil involvement, web based resources were considered by the pupils and identified and feedback from the pupils was gathered to inform evaluation and programme development. Also significant was that an LGBT worker joined the stakeholder group, an acknowledgement of the need for such support.

⁸ Scottish Youth Parliament '*Our Generation's Epidemic. Young people's awareness and experience of mental health information, support and services*' (2016)

⁹ (Jan 2016) *Towards a Mentally Flourishing School* <http://www.qnis.org.uk/wp-content/uploads/2016/03/Mentally-Flourishing-Schools-Report.pdf>

¹⁰ *ibid*

¹¹ Tania Ferguson, Health visitor Nurse <http://www.qnis.org.uk/resources/catalysts-for-change/towards-a-mentally-flourishing-school/>

¹² Scott Fobister, Pastoral teacher, Scottish Borders Council <http://www.qnis.org.uk/resources/catalysts-for-change/towards-a-mentally-flourishing-school/>

The final report to the Borders initiative states clearly that for this to be sustainable it requires a genuine commitment from senior management and recognition for the need to ensure positive mental health is at the heart of the school culture. This is a crucial element of implementation.

Children and young people's awareness of their own mental health

A further area for development which the above initiative highlights is the need to work with children and young people on awareness of their own mental health, so that they can become equipped with coping skills which will help them to build their emotional resilience. This is a fundamental rights issue— the right to acquire knowledge and information in an appropriate form and to be supported in accessing information and support. The Scottish Youth Parliament's report *Our Generation's Epidemic* highlighted that 74% of young people who took part in their research did not know what mental health information, support and services existed in their area. This is a stark figure. There needs to be much better coordination and support for children and young people at risk of developing mental ill-health.

In my foreword to *Our Generation's Epidemic*, I made the point that young people in Scotland are let down by a culture and system which fails to meet their needs, consequently depriving them of their rights. ChildLine and the NSPCC echoed this point last week in their 'spotlight report' on suicide¹³. This report revealed that they had seen a marked increase in the number of children and young people contacting them about having suicidal feelings: in 2015, 934 children in Scotland rang the NSPCC's ChildLine service to say they had suicidal thoughts. The spotlight report stated that 'the stigma of suicide' means that the adults in children's lives (including professionals) are failing to spot the signs, finding it hard to listen to their distress and providing inadequate levels of support. Ten years provides us with plenty of time to change this and to make a real difference to the lives of children and young people in Scotland.

¹³ NSPCC (2014) *On the edge: ChildLine spotlight: suicide*. London: NSPCC

Increase in the prescription of psychostimulants and psychotropic drugs to children

A further area which concerns me and which was raised by the UN Committee on the Rights of the Child in its Concluding Observations of June 2016 is the increased use of certain types of prescription drugs¹⁴. The Committee expressed concern at the significant increase in the prescription of psychostimulants and psychotropic drugs to children with behavioural problems, including for children under 6 years of age, despite growing evidence of the harmful effects of these drugs and has recommended that data is collected on the amount and regularity of psychotropic drugs being prescribed to children. It also recommended that these be used as a measure of last resort and only after an individualised assessment of the best interests of the child and that children and their parents are properly informed about the possible side effects of this medication and about non-medical alternatives¹⁵.

If we devote more time and resources to early intervention, this may result in a reduction of such medications. This, however, is currently of deep concern and requires action, perhaps in the form of a review in the first instance.

Funding

I would welcome clarity around how these ambitions will be resourced and more information on how the funding will be spread across the three identified areas. I note that £150m has been earmarked over five years which seems barely adequate given the level of need. It will be important to be clear as to which services are to be given priority at a local level.

¹⁴ <http://www.crae.org.uk/media/93148/UK-concluding-observations-2016.pdf> (para 61)

¹⁵ <http://www.crae.org.uk/media/93148/UK-concluding-observations-2016.pdf>

Specific groups of children and young people

There are specific groups of children and young people who are disproportionately affected by and prone to mental ill-health, and I feel that the needs of these groups should be considered in the development of any strategy. All of these groups have been highlighted in the UN Committee on the Rights of the Child's Concluding Observations (2016) as requiring particular attention (para 60 (b)).

Looked after and care experienced children and young people

My office is a corporate parent under Schedule 4 of the Children and Young People (Scotland) Act 2014. As such, I have a duty to be alert to matters which may adversely affect the wellbeing of looked after children and care leavers and to assess their needs, promote their interests, provide accessible opportunities to participate in activities designed to promote their wellbeing and help them make use of services and access support.

I was surprised to see no mention of looked after or care experienced children and young people in the vision, especially as we know this group of children have much poorer mental health outcomes than other young people. I feel that this needs to be acknowledged in any forthcoming strategy. Some looked after and care experienced young people will require long term, specialist support because of their experience of trauma. Such support must be easily accessible and adequately resourced. There are also specific concerns when young people are placed outside or move outwith the local authority and/or health board area and cannot access appropriate and timely mental health services. I support CELCIS's call for an additional priority area to be focussed on establishing robust data on the mental health and wellbeing of looked after children and care leavers in Scotland. This will help to inform the development of outcome measures, and the development of services at a local level.

Young Carers

My office is currently carrying out research around 'young carers' perspectives of the impact their caring duties have on their mental health and wellbeing'. This work is

being done in conjunction with the Carers Trust Scotland. I hope that the findings will help to provide an insight into the issues facing these children and young people, to allow us to better support this small but oft neglected group in the future.

Deaf children and young people/children and young people with learning disabilities

Research commissioned by my office in 2012 identified two groups of children who are relatively neglected in research and/or policy and are particularly prone to social exclusion¹⁶.

1. Deaf children and young people This research review highlighted the importance of being aware of young deaf people's vulnerability to mental health issues and refers to a consultation undertaken with various groups of children to inform an NHS draft framework for children and young people's mental health indicators¹⁷. The participants felt they were not consistently heard and listened to. They had very clear ideas about what was and was not 'fair' in their lives, with several having experienced bullying and discrimination.
2. The 2012 review also noted that children with learning disabilities have a much higher risk of mental distress than those without learning disabilities (incidence is estimated at 1 in 3). Particularly affected are those from disadvantaged backgrounds, especially those who have additional physical impairments or poor health and those whose mothers may also have learning disabilities and/or mental health problems. These children have often experienced a series of adverse life events, sometimes including community bullying of the whole family. *The Mental Health of Children and Adolescents with Learning Disabilities in Britain*¹⁸ also highlights that children with learning disabilities are likely to have fewer friends than other children in Britain and experience more adverse life

¹⁶ Stalker.K, Moscardini. L, *A critical review and analysis of current research and policy relating to disabled children and young people in Scotland*, (2012) Scotland's Commissioner for Children and Young People

¹⁷ Elsely. S, and McMellon. C *Doing ok? Children and young people's views on what affects their mental health* Centre for Research on Families and Relationship

¹⁸ Emerson. E, Hatton. C, *The Mental Health of Children and Adolescents with Learning Disabilities in Britain* (2007), Institute for Health Research, Lancaster University

events such as abuse, bereavement and health problems. They are also more likely to experience poverty and social exclusion and it is these experiences that lead to a greater risk of mental ill-health. I have received a number of enquiries relating to young people with learning disabilities who have either been in inappropriate care settings or have had no suitable provision found for them in Scotland, resulting in a placement in the South of England. I am considering undertaking further research around these issues.

My view is that the needs of these particular groups of children and young people warrant specific attention, and I would like to see any forthcoming strategy recognise this. I also feel that the strategy should link to other Scottish Government strategies and legislative developments, such as that on autism, the provisions in the Children and Young People (Scotland) Act 2014 around corporate parenting, aftercare, continuing care and services in relation to children who are at risk of becoming looked after and the requirement on the Scottish Government and other local bodies to publish and implement BSL plans.

Children and Young People in the Youth Justice system

A further group I wish to highlight is young people involved in violent offending. In so doing, I will refer to the Edinburgh Study of Youth Transitions & Crime (the Edinburgh study) and the findings from the IVY project (interventions for vulnerable youth) based at the Centre for Youth and Criminal Justice at Strathclyde University.

The Edinburgh study involved 4,300 children who started secondary school in Edinburgh in 1998. At 15, 23% reported involvement in violence and these also happened to be those who were the most vulnerable and victimised. What was striking about the study was that violent offenders were significantly more likely than non-violent youths to be victims of crime and adult harassment and have self-harming and para-suicidal behaviour, problematic health risk behaviours and weak bonds with both their parent/carer and the school. The study also showed that these young people had personality traits such as impulsivity and risk-taking and, significantly, also suffered from family turbulence and social deprivation.

A similar profile can be seen in the IVY project, an initiative around young people with severe psychological and mental health difficulties who present a risk of serious harm to others¹⁹. In its first six months, it accepted referrals from 25 young people, all of whom had had input from social work services. 76% of these young people had been exposed to domestic violence and 88% had experienced some other form of maltreatment. All of them had been exposed to adverse childhood experiences (ACE). The figure for boys was 34% 6 or more ACE, whilst for girls it was 50% 6 or more ACE. On admission to secure care, over 50% of these young people had PTSD symptoms.

Significantly, over three-quarters of these young people had experienced traumatic bereavements, such as murder or suicide, and two thirds had suffered from four or more bereavements. This highlights a further area for development as we have, at best, patchy coverage of bereavement services for children and young people in Scotland.

Clearly, working with these young people will require long-term intensive support which involves both managing risk, but also addressing the trauma which underpins the actions. Trauma-informed mental health services are essential to both preventing future victims and providing these young people with the chance of flourishing.

Priority 3. Introduce new models of supporting mental health in primary care

The Scottish Government should consider models of care that support an attachment-based approach. Although this approach was developed initially around the observations of infants and their caregivers, attachment relationships and styles are relevant across the life course (Bowlby 1982). STAG advocates such an approach that allows the relationship between patient and practitioner to develop over time. For looked after children and care experienced children, this approach is essential, as their emotional and mental health needs must be understood within this context.

¹⁹ Mental Health Difficulties in the Youth Justice Population: Learning from the first six months of the IVY project, www.cycj.org.uk/wp-content/uploads/2014/07/Briefing-Paper-5-final.pdf

STAG also advocates a move towards person-centred care which aims to match the individual to the resources they need as early as possible. Their view, which I support, is that models that promote an early psychological formulation of mental health problems are most likely to facilitate this, particularly where the formulation is used effectively to inform a matched-care process. This ties in well with a human rights based approach which places the needs of the person at the centre (see answer to Q.4)

I also support STAG's view that the adoption of a bio-psycho-social model should be promoted. This is a more holistic approach that takes into account the interplay between the biological, psychological and social (and cultural) determinants of mental health.

Priority 4. Support people to manage their own mental health

Young people who use mental health services should be at the centre of service development and delivery, helping to design new models and contributing to the development of operational policies and procedures. Young people have told me that being involved in this way is extremely empowering. This gives young people the confidence to speak out and also helps to reduce stigma.

Priority 5. Improve access to mental health services and make them more efficient, effective and safe— which is also part of early intervention

This is an important priority, yet the vision paper fails to mention the many barriers to accessing mental health services, which are fundamental to understanding the causes of mental ill health. Mental health is influenced by socio-economic circumstances and the broader and social environment in which we live, as well as our own characteristics which can determine whether we will be resilient to adverse life events. The root causes must be dealt with: we have much evidence around intergenerational trauma, so programmes that recognise and are responsive to how this can affect children and young people growing up are vitally important.

The recent Care Inspectorate's report on Significant Case reviews is worth referring to in this context²⁰. It examined 20 significant case reviews involving 23 children and young people, of whom 11 had died. It stated that the SCRs indicated that there was not always a collective understanding among the staff and agencies involved regarding the extent or impact of mental health problems. Significantly, in 13 of the 20 cases parental mental health was described as a factor. Eleven mothers and a grandmother caring for a child were recorded as suffering from mental health difficulties. We need to prioritise programmes which support parents, families and carers to deal with their own mental health difficulties.

Transition is also an important area, as this is a time when services drop off for many young people who have been in CAMHs and then move to adult mental health services. This period of transition is particularly challenging for young people, parents and carers²¹. I have received a number of enquiries relating to this issue, mostly relating to care experienced young people.

The UN Committee on the Rights of the Child also called for the prohibition of placement of children with mental health needs in adult psychiatric wards or police stations, while ensuring age-appropriate mental health services and facilities. Although there have been some steps towards ending inappropriate placement of children, this issue should be addressed in any forthcoming strategy.

Priority 6. Improve the physical health of people with severe and enduring mental health problems to address premature mortality

See answer below (to Q. 7)

²⁰ Care Inspectorate (2016) *Learning From Significant Case Reviews in Scotland: A retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015*, Care Inspectorate.

²¹ ²¹ Scottish Government (2013) *Staying Put Scotland Providing care leavers with connectedness and belonging* <http://www.gov.scot/Publications/2013/10/7452>

Priority 7. Focus on 'All of Me': Ensure parity between mental health and physical health

Mental and physical wellbeing are interconnected and an integrated physical and mental health approach is essential, but mental health should be seen to be as + important as physical health. Parity should also be given in regard to the resources committed to delivering the forthcoming strategy and should be transparent. Mental health should be on a par with physical health and be as well resourced.

Priority 8. Realise the human rights of people with mental health problems

It is encouraging to see reference to the human rights of people with mental health problems and the intention to embed human rights across priorities and actions (through a PANEL approach). I would like to see specific reference made to the United Nations Convention on the Rights of the Child as there are very particular challenges in this area for children and young people, not least around access to age appropriate information, support and advocacy, confidentiality and consent. An important right for children and young people is article 12, the right of a child or young person to have (their) views heard in decisions affecting them. An important part of this is being listened to, being taken seriously and being involved.

Question 2. Are there any other actions that you think we need to take to improve mental health in Scotland?

There are a number of actions we should be taking to improve mental health support in Scotland, some of which are already being addressed, others which need prioritising. I have already referred in my response to specific groups of children and young people who warrant additional support. Other actions are bulleted below. I have also indicated my support from calls made by other organisations such as CELCIS and the STAG and make reference to the UN Committee on the Rights of the Child's Concluding Observations in June 2016:

Start well

- There should be more of a focus on creating mentally healthy communities and a recognition that other policy areas can impact on mental health, such as housing, leisure and access to a clean and healthy environment. Recent research has linked air pollution to increased mental illness in children, even at low levels of pollution (another area flagged up by the Committee on the Rights of the Child in June 2016). This research found that relatively small increases in air pollution were associated with a significant increase in treated psychiatric problems. It is the first study to establish the link but is consistent with a growing body of evidence that air pollution can affect mental and cognitive health and that children are particularly vulnerable to poor air quality.^{22 23}
- There must be a shared acknowledgement that services – such as CAMHS and Social Work – will have to work together to deliver the best outcomes possible for children and young people. This has particular resonance around the areas of sexual, physical and emotional abuse of children, to ensure that appropriate support is provided in a timely fashion.
- There should be a continuation of routine enquiry for gender-based violence in maternity, mental health, substance misuse, accident & emergency, community nursing and sexual health settings. This helps to identify issues early to ensure the most appropriate treatment and care.
- There should be a continuation of programmes that alert children and young people to sexual and physical abuse, and help them to protect themselves from harm.
- STAG's call for trauma-informed training and the provision of support for teachers should be heeded, as this would allow them to identify and respond to signs of psychological distress in the classroom
- Early Action 5 refers to plans to improve access to psychological therapies by 'rolling out computerised Cognitive Behavioural Therapy nationally'. CELCIS queries whether this is a suitable approach for looked after children and care

²² Oudin. A et al (Setp 2015), Association between neighbourhood air pollution concentrations and dispensed medication for psychiatric disorders in a large longitudinal cohort of Swedish children and adolescents

²³ <http://bmjopen.bmj.com/content/6/6/e010004.full>

leavers, as it does not allow for the attachment and trauma informed response required by many looked after children and care leavers. There are also issues about accessibility, as some may not have access to the internet on a private computer.

Live well and age well

- Mental health education should be a regular part of CPD for health workers, social workers, teachers, lawyers and police officers, as well as those working in early years provision/care
- Consideration should be given to the times of services which work for children and young people. It would be helpful to think in terms of how young people wish to access services and what the most suitable services to meet their needs and lifestyles are. This should include a consideration of out of hours services.
- This section focuses on individuals managing their own health, whilst receiving support from link workers to remain in employment. CELCIS make the important point that whilst it is important to enable individuals to retain control of their lives, this approach might not respond to the specific need of vulnerable groups, such as care leavers. They note that care experienced young adults may have experienced multiple adversities in their lives, and may not have the informal supports required to manage life with a mental health problem. They may have experienced trauma and loss, and have developed fewer coping skills than other individuals. They rightly point out that link workers (and other professionals) must have an understanding of the particular needs of this group of young people, and be committed to practising in a way that is supportive and accessible to them.
- As the STAG notes, given the evidence links that have been made between early trauma and all forms of mental and physical health difficulties in adulthood, we have a common theoretical framework that should inform our mental health interventions.

3. What do you want mental health services in Scotland to look like in 10 years' time?

- High quality, accessible mental health services for children and young people
- A child centred approach, underpinned by a commitment to children's rights. Children should know about their rights to treatment and care and should be supported to be involved in decisions affecting them.
- Systematic collection of data on child mental health, disaggregated across the life course of the child, with due attention paid to children in vulnerable situations and covering underlying determinants (UNCRC recommendation)
- The removal of barriers between primary, secondary and tertiary mental health care, and a more integrated mental health service.
- A priority given to prevention and early intervention
- A recognition that particular groups may have specific needs which should be prioritised and support provided to these groups
- Mental health at the heart of the school culture. There should be a key role for schools in providing support for this, e.g. through mental health education and counselling services
- Community based co-location of services, from health, education and social care, with a key role for the third sector. This will help to reduce stigma
- Skilled professionals, particularly those working in education. This will ensure that they are able to recognise and respond appropriately to distress and trauma
- A reduction in the amount of prescribed medication (and as a measure of first resort) (UNCRC recommendation)
- Improved bereavement services for young people
- Evidence of a trauma-informed approach across the board e.g. in nurseries, classrooms, job centres, hostels, care homes, courts, prisons and young offenders' institutions, and workplaces. This will include the development of therapeutic community based services

- Strong evidence based practice, based on what works along with a flourishing research community in Scotland in the area of mental health

Tam Baillie

Children and Young People's Commissioner