TOWARDS A WHOLE SYSTEM APPROACH TO CHILD AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING IN WEST DUNBARTONSHIRE: EXPERIENCES FROM STAKEHOLDERS, PARENTS, AND YOUNG PEOPLE

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INTRODUCTION

Partnership working between services is regarded as one of the key ways to improve service delivery, through sharing of resources, information, and reducing the workload of individual groups. Recently this has been discussed with relation to mental health services, with Dame Coia's Children and Young People's Mental Health Taskforce (2019) commenting that while there is "innovative and effective practice" in terms of child mental health, there was a need to improve delivery of "joined up, multi-agency services that listen to the voices of children and their families" while also tackling barriers within the system. These include the need to strengthen information systems, improve early intervention at community level, and increase capability of workforce to meet the mental health needs of children.

This review begins with a brief overview of partnership working, specifically exploring what is meant by a Whole System Approach, before situating it within current Scottish children's policy. The substantive part of the work provides an account of interviews, surveys, and focus groups conducted within West Dunbartonshire, exploring service delivery, service use, and help seeking within the area. These are organised into three sections: stakeholders and practitioners, parents/carers, and children/young people (CYP). The review concludes with an overview of the key themes from the data collection, and suggested areas of development.

Collaborative working: Whole System Approach

The whole system approach (WSA) is defined by Public Health Scotland as an 'ongoing and flexible approach by a broad range of stakeholders to identify and understand current and emerging public health issues, whereby working together, we can deliver sustainable change and better lives for the people of Scotland'. The WSA seeks to move away from traditional silos of organisational practice, and instead move towards a collaborative model that has a common agenda across stakeholder organisations, creates more opportunities for responsive practice, and shares intelligence and expertise. Both the Children and Young People's Mental Health Taskforce (2019) and Community Mental Health and Wellbeing Supports and Services Framework (2021) comment that this mode of practice will enable a focus on early intervention and prevention, with a reduced stress on tier one services (such as CAMHS).

Relationships and good communication are key to making this approach work, both between the different sectors that work with CYP, but also the children and families themselves. The 2019 Children and Young People's Mental Health Taskforce stressed that any collaborative activities should also have children and their families at the centre to ensure the are 'empowered to express their views regarding needs and services, and to have these views acknowledged and recorded'. Figure one below details an illustration of the WSA.

Figure 1: *Illustration of whole system approach to collaborative working from Children and Young People's Mental Health Taskforce report (2019).*

METHODOLOGY

West Dunbartonshire Health and Social Care Partnership are seeking to move towards a whole system approach to child and adolescent mental health and wellbeing, spanning ages five to 24 (26 if care experienced). The University of Glasgow was hired to conduct a three-phase research programme, to explore current practice in the locality, identify good practice and areas of development. Ethics for this programme of work was approved by College of Social Science, University of Glasgow. Each phase of the research programme focused on a different group:

- Phase one explored stakeholders and practitioners' attitudes and experiences of collaboration
- Phase two explored parents and guardians' attitudes and experiences of help-seeking on behalf of their children
- Phase three explored CYPs experiences of information and support seeking in terms of mental health and wellbeing.

Each phase engaged in a mixed-method approach, detailed in table one below. A more detailed account of demographics of participants can be found in appendix A.

	Online Surveys	Interviews	Other
Phase one	N=37	N=25	2 online focus groups (n=9)
Phase two	N=139	N=15	/
Phase three	N=10	N=0	1 Focus group (n= 7) 2 Participatory action groups (n= 10)

Table 1: Participation rates in study, categorised by method and phase of study

Recruitment was supported by West Dunbartonshire's Health and Social Care Partnership, where existing professional networks and thematic groups were encouraged to support in the drive to recruit participants (both stakeholder/practitioners and general public).

The fieldwork for this piece of work was conducted during COVID-19 and therefore reflected restrictions at the time, with surveys distributed via web-link and QR code, and interviews/focus groups being help via video-conferencing software (such as Zoom, Microsoft Teams, or Google Meet). Other interviews were held via telephone.

The recruitment strategies and uptake were also influenced by COVID-19, which was particularly observed in phase three (young people) as the research team could not attend local schools to organise large scale recruitment for interviews or focus groups. Furthermore, while phase two aimed to achieve a general sample of parents and carers for the qualitative component, it became apparent that the group who opted in for a follow-up interview were those with a lived experience of seeking mental health support for their child(ren).

PHASE ONE RESULTS: PRACTITIONER EXPERIENCS

Phase one was conducted between January and May 2021. The fieldwork explored awareness of collaboration within West Dunbartonshire, examples of good and innovative practice within West Dunbartonshire, how these practices within different sectors complement one another, and whether there were stressors within the system. While acknowledging the fieldwork was being conducted during the COVID-19 pandemic, participants were asked to reflect both in previous practice, as well as how their practice had changed as a result of COVID-19.

NATURE OF COLLABORATION WITHIN WEST DUNBARTONSHIRE

Collaboration can be viewed as a spectrum of activities, including passive activities (e.g. attending meetings) to active activities (co-developing action plans, shared case work). These can be one-off events, such as a knowledge sharing event, or as a continuous production. As collaboration can encompass a spectrum of activities, which may involve (or ignore) different stakeholders at different times, it was crucial to explore both the awareness of collaboration in general but also to unpick what types of collaborative activity were common across the locality.

AWARENESS OF COLLABORATION WITHIN WEST DUNBARTONSHIRE

Survey respondents were asked about their awareness of collaboration between organisations within the locality, both in terms of their general awareness but also in terms of their specific awareness of their organisation's collaborative activities. Table 2 details their responses.

Job Sector	Very Aware		Somewhat aware		Neutral		Somewhat unaware		Very unaware	
	General	Specific	General	Specific	General	Specific	General	Specific	General	Specific
Health	4	6	7	3	0	1	0	1	0	0
Social Work	7	6	1	2	0	1	1	0	0	0
Education	4	5	3	2	0	0	0	0	0	0
LA	1	1	1	1	0	0	0	0	1	1
Third Sector	2	4	4	2	0	0	0	0	0	0
Total	18	22	16	10	0	2	1	1	1	0

Table 2: Participant levels of awareness in collaboration across sectors in West Dunbartonshire

There was a general awareness of collaboration between organisations, with majority of respondents suggesting they were either very aware or somewhat aware (34 of 37 respondents). In terms of specific awareness, we see an increase in the respondents from health, education, and third sector. This suggests that while some respondents may have a general overview of how collaboration works within the wider system, they were more informed of the activities of their organisation.

Given the seniority of many of the respondents, it should not come as a surprise that the awareness of their organisation's strategic collaborative activities was high. However, it could also be suggested that for other participants, their awareness of wider collaborative system could be improved.

COLLABORATIVE MECHANISMS

The different types of collaboration that occur within West Dunbartonshire services were explored in the qualitative work. The participants also discussed the mechanisms through which collaboration could be achieved, including cross-sector meetings, trusted relationships, and the importance of visibility. These are discussed below.

CROSS-SECTOR MEETINGS

Participants described various cross-sector meetings, steering groups, or panels that they were a member of that were seen as beneficial to sharing expertise and knowledge around the system. While some of these cross-sector meetings are seen as useful in terms of information gathering (such as the wider HSCP meeting), participants also mentioned active meetings such as the 'Team Around the Child' or 'Vulnerable Young Persons' meeting where services can put forward a young person as a case for a multi-disciplinary team to discuss.

In the meetings, participants describe being able to share concerns relating to an identified young person, and detail what is already being undertaken. The meeting then focuses on potential solutions with input from multiple sectors such as social work, education and CAMHS. However, this is not limited to statutory services, with several examples from Third Sector organisations of times they either supported a young person who was attending a Team Around the Child meeting, or they put forward a young person to be discussed at these meetings.

This often meant their individual areas of expertise could inform wider discussions. For example, Third Sector youth worker participants described taking on an advocacy role. Working as an advocate in these meetings meant youth workers ensured young people's wishes and feelings were expressed and acted on, and that young people were empowered in the process. This is particularly important when young people are facing issues at home or at school, which may lead to an intervention by education or social work. One youth worker described their role as offering a perspective of the young person that may not be seen by statutory services, with another suggesting their knowledge could offer valuable context regarding why certain behaviours occur. Having this alternative voice around the table emphasises the work undertaken in West Dunbartonshire to move towards a whole system approach and explores the different components of CYP beyond the traditional spheres of influence.

These types of meetings have also been described as potentially being a mechanism to limit the need for additional services to become engaged in a family's life who may already be working with several agencies, but also to identify who is best placed to lead the work.

TRUSTED RELATIONSHIPS

For some participants, they described collaboration as not only existing within the multi-agency teams and the shared case work, but also in the trusted relationships that senior staff develop over time. These personal/professional relationships were discussed as being bolstered by their attendance in the multi-agency or themed groups, whereby individuals were able to make links with their own practice, and interact between meetings. One way this was observed was in the occasional requests for support or advice:

> *[B]ecause we have the relationships, I think that's key, and we're known within the establishments, people will phone up readily and ask for advice in terms of level of need of a young person… I mean, you can have, in theory, the best forum system processes but where people don't talk and pick up the phone, pick up an email. So, I think communication is the key thing, for me. (Education sector)*

The ability to 'pick up the phone' and reach out to key contacts from various sectors was also championed as a reciprocal interaction, where participants describe being able to reach out and ask for help, but are also happy to respond to their colleagues' requests for assistance:

> *I think that probably comes back to that question about accessibility. I think, you know, I don't mind a headteacher phoning my secretary and asking to speak to me, because there's a child in her classroom who she knows attends one of my clinics… I like to think that because they know that they can pick up the phone and call for help, that likewise…I can pick up a phone and say, I'm really worried, or this family are really struggling, and …I'm not in a position to impact any change, but education can then tap into their resources, and do it (Health sector)*

This also corresponded with their ability to identify where expertise and resources lay within the system to support young people. For those participants who were not as knowledgeable about the system, they were then less able to have these useful conversations, but also were less likely to be called upon to offer support in this way. This, therefore, could be described as verifying those well-established services, confirming their place as reliable resources at the cost of engaging with new, lesser known, services.

Discussions of trusted relationships were also raised by Third Sector participants. For more established organisations, they described the importance of their relationships with Social Work, Education, and Health in conducting their work. However, for those organisations recently introduced into West Dunbartonshire, their main relationships existed with other Third Sector organisations, and discussed a challenge of obtaining visibility to enable this cross-sectoral work.

CHALLENGES OF VISIBILITY

In terms of collaboration, visibility was described as a challenge, both for those services that described challenges in being ‘seen’ by the wider system, but also those who were ‘too visible’ in the system. In both instances, visibility posed challenges for collaboration within the system.

Where organisations were in their first or second year of implementation, there were challenges of obtaining this level of relationship, trust, and visibility within the wider system:

> *[W]e’ve got this great buy-in from the council and the department that we work alongside and their staff team as well. I have fortnightly meetings with one of the team leaders in the homelessness service as well just to keep an eye on referrals and make sure that, you know, anything that is coming up…But I don’t know what the story would have been had we not had those kind of relationships built up in the first year where I was, you know, going along to the opening of an envelope to speak about what we were doing (Third sector)*

For this organisation, their workers were proactive in creating opportunities for visibility in terms of relationship building and knowledge awareness. They described the benefits of receiving invitations to attend multi-agency meetings where they could describe what their service offers and the hope that the representative from each organisation would then disseminate what was presented to their wider team.

One of the general challenges for new Third sector services appeared to be ensuring the statutory services understood how their service would fit with their ongoing work. Third sector organisations described it as ‘frustrating’ when statutory services did not understand the remit of the new Third sector organisations, or grasp how collaboration could create new opportunities for early intervention within the system. This was echoed by some statutory service participants, who suggested there was a disconnect which was driven by a lack of understanding and communication regarding how the services could work together.

As well as difficulties in terms of poor visibility, other elements of the system described being too visible, and the impact this has on their workload and ability to collaborate. Participants from CAMHS suggested that given their visibility within the system, they were often viewed as the only destination for young people’s mental health needs:

> *Every parent we refer will more or less tell you that its urgent and that their child needs to be seen, because that’s their first priority but what a lot of the public isn’t aware of is the thresholds …they just see ‘children and adolescent mental health services’ (Health sector)*

Incorrect referrals were seen as stressful for both the CYP and families, as well as for the associated services involved in their care. Incorrect referrals were discussed as being driven by a poor understanding of the other services in the area that could offer support for CYP need, and a lack of communication regarding the referral criteria for CAMHS. The high visibility of CAMHS combined with the low visibility of other services meant for some referring services, they were unsure where else to signpost CYP to if they were found not to meet the criteria for CAMHS support. The communication surrounding support pathways is discussed more in phase two (PAGE), where parents and carers are asked for their experiences of accessing help and information regarding mental health support.

STRENGTHS IN THE SYSTEM

Participants described several elements within West Dunbartonshire that were working well when supporting CYP mental health and wellbeing within the wider system. These included the non-clinical wellbeing agenda of organisations within schools and youth work, the position of non-statutory services within the system, the work already ongoing to support parents in West Dunbartonshire, and the mentoring and buddying schemes that support CYP.

NON-CLINICAL WELLBEING AGENDA

Responsibility for mental health and wellbeing was not restricted to those specialist services who offered clinical support and guidance to CYP in West Dunbartonshire. Instead, it was seen as being part of the broader remit of all services, with the understanding that other elements of a child or young person's life could not be separated from their broader wellbeing requirements. Instead, often the services reflected that their work could not begin until the wellbeing of the young people in their care had been addressed.

A third sector participant whose organisation has a remit for providing sheltered accommodation for young people who are at risk of homelessness described the need to focus on young people's mental health and wellbeing before they support young people in learning life skills such as cooking or cleaning: they can't focus and prioritise things until they focus on their mental health, we are led by what their needs are. There is an expectation that when the young people feel safe and secure in the service, they will be better able to concentrate on the practical skills and support that the workers can offer. In particular, this may be the case for young people who come into the service with a history of adverse childhood experiences. The focus on "being there" for CYP and being a listening ear rather than a clinical intervention appeared to be vital in some youth work relationships. Linked to this is the importance of ensuring that activities developed have a wellbeing focus, either through healthy eating, exercise or creating a safe space for discussions. Some participants did raise examples of staff doubting their capacity to deal with complex cases, and identified a need for additional training to support staff wellbeing.

Recent shifts in practice have also seen schools move from a focus on curricular outcomes to a more holistic nurture and wellbeing focus. While this is particularly strong in nursery and primary schools, participants also discussed the role of guidance teachers in secondary schools. Given the role of the school in the lives of CYP and their families, and how this enables teachers to witness the mental health and wellbeing needs of their pupils on a daily basis, the move towards a nurture curriculum was seen as vital. One educational psychologist referred to this as head teachers being heavily invested in their communities, knowing their pupils, their families and the wider community the school sits within. By building capacity within schools to address low-level problems, it has also enabled the staff to understand how to use their own resources and when to reach out for help. This was reiterated in the group discussion with teachers, where they spoke of the need to look at emotional wellbeing in pupils to ensure they are ready to learn and using mindfulness and growth mindsets to support this goal.

Connected to this was the role of associated professional services (including school nurses, education officers, and educational psychology) in promoting health and wellbeing in schools. For school nurses and educational psychologists, there was a discussion of the importance of early intervention as well as training teachers in techniques such as mindfulness. Also, there was discussion of schools using Pupil Equity Funding (PEF) to fund additional resources that would support wellbeing in schools. Participants in education described referral to CAMHS as being 'a last resort' that schools should do only when they had exhausted other avenues.

POSITION OF NON-STATUTORY SERVICES WITHIN THE SYSTEM

One of the key factors within youth work participants described as being supportive to CYP mental health and wellbeing was the alternative role that youth workers play within the wider system. They are "*treated with less suspicion than statutory services*" (Third Sector) due to the fact they were perceived as having no agenda compared with the other services:

> *…it's really about that power of that one relationship and having that one trusted adult that that young person…that's not got any agenda, you're not a teacher coming from an education perspective or a social worker coming just about the care (Third sector)*

For some Third Sector services, trust with young people was built over time, with participants describing the need to prove themselves to young people who were initially wary of engaging with another service. For one youth worker, who worked with young people with adverse childhood experiences, persistence helped to overcome the wariness, letting them know that they matter. For the worker, finding activities that the young person would like to do helped to develop trust, as did addressing the poverty of opportunity that may exist in the young person's life, and repeatedly showing up even when they were initially rejected by the young person.

As mentioned above, youth workers can act as advocates for CYP in formal meetings such as "Team around the Child". However, they are often not automatically invited to these meetings, and their participation is often based on a request from the CYP. This ability to work outside of statutory services also mean that Third Sector organisations are often exposed to boundary testing conversations, where young people may disclose experiences or thoughts that require risk management discussions:

They kind of test the water. I love that I have that sort of privilege of being able to know our young people, and I feel like it's really beneficial that they know that they have an adult. But also they know that I have boundaries and there are limits to what they can tell me without me doing something (Third sector)

Participants described the person-centred ethos of youth work, and the conversations with young people that sought to acknowledge and build their agency to make decisions, with the knowledge that their youth worker would support them. This relationship also meant that youth workers could respond to conversations or questions raised by their young people, and where appropriate information evenings or harm reduction workshops could be introduced on key issues such as smoking, alcohol and drugs, housing options, homelessness, healthy-eating, and sleep. Similar workshops were also discussed as being delivered in collaboration with local schools or youth groups.

SUPPORTING FAMILIES

Within West Dunbartonshire, there are some examples of multi-agency work surrounding supporting parents. For example, the 'parenting RIG' was, at time of interview, s an active multi-disciplinary team spanning social work, educational psychology, health, etc. This network also provided members with better information of what different agencies do in relation to supporting parents. This was of particular use to those participants who did not have a formal remit to support parents but found it was part of their post. The local authority also use interventions such as Triple P, PoPP, Incredible Years, and Seasons for Growth, with several participants from Educational Psychology, Health, and Social Work serving as trainers in these interventions.

Community nurses, outreach and support workers in West Dunbartonshire exist in several sectors such as education and health and are described as having a key role in providing a vital service as they work closely within the community but were also ‘tuned in’ to the professional networks. They have been described as having their finger on the pulse when linking family need, to professional expertise, and as a key advocate for the child and the parent through different systems. This resource was described as particularly useful for one mentoring group who said they were useful for getting information about the wider context of the young person they support.

Another resource that already exists in the system is the Working4u family support that was established in 2019. The ‘family opportunity hubs’ (Education Scotland, 2020) focus on supporting parents through conducting a needs assessment, confidence building, focusing on ensuring they receive the correct benefits and can access advice regarding debt and career options. This was created through the understanding that to support CYP, you have to look at every element of their life: “you can give a child all the support they need in school, if they go home and it’s chaotic, then you’re kind of fighting a losing battle” (Local Authority sector). By addressing issues that the family may be facing, and any associated stress with unemployment or debt, it will also ensure the CYP benefit from any positive change.

MENTORING AND BUDDYING

Another positive activity within third sector is the work in mentoring and buddying. Often this is delivered by Third Sector organisations in collaboration with sectors such as social work or education. One of these schemes (Care Connections) supports young people under a Compulsory Supervision Order (CSO) who live in the family home, a group identified as ‘flying under the radar’ and as such are a vulnerable group. It is a collaborative piece of work between Y-Sortit, Champions Board and education, and offering mentoring support for young people in primary and secondary schools. The mentors work with young people to locate activities that meet their interests within the local area as well as aiming to broaden the opportunities open to them, for example by paying for membership fees, uniforms, transportation to remove barriers.

Another mentoring organisation in the third sector described the ability of mentors to work with individual young people, or with family groups where individual family members are given support but acknowledging the whole family within this role. Delivery of the service is youth-led, with progress monitored regularly. One of the strengths of having a youth-led approach is that it allows for a different perspective on young people’s issues: sometimes what professionals see as the difficulty is not, and through working with them you can see ‘*actually they’re late in school because they have all of this to do at home, or the reason they don’t do their homework is because they don’t have a quiet place to do it*’. This can then be fed back to services such as social work to bridge communication gaps between the CYP and other services.

Key in the mentoring relationship is consistency, as suggested by one mentoring organisation: what you’re looking for is commitment. This commitment often equates to organisations asking volunteers to sign up to at least one year, to ensure they can build trusting relationships with young people, and to make positive progress with the issues identified by the young people.

BARRIERS TO COLLABORATION

While there is good practice within West Dunbartonshire in relation to using collaborative approaches to support CYP mental health and wellbeing, in addition to the ongoing work within individual organisations to address the needs of young people, there are also barriers and pinch points that create difficulties for organisations to work together or create difficulties for organisations to individually address the needs of CYP and their families.

Barriers to collaboration were explored in the survey and qualitative work. In the question “have you experienced any barriers to working with other organisations when supporting CYP mental health and wellbeing", 32 of the 37 respondents answered yes. Two responded no, two responded don't know. A multiple-choice question followed, asking participants if any of the following had posed a barrier: financial, organisational, lack of resources, lack of time, lack of opportunity, unsure of the remit of other organisations, and belief it could be solved by other organisations. Below is a graph representing overall responses, and appendix two provides a crosstab table reflecting the multiple-choice responses from the different sectors.

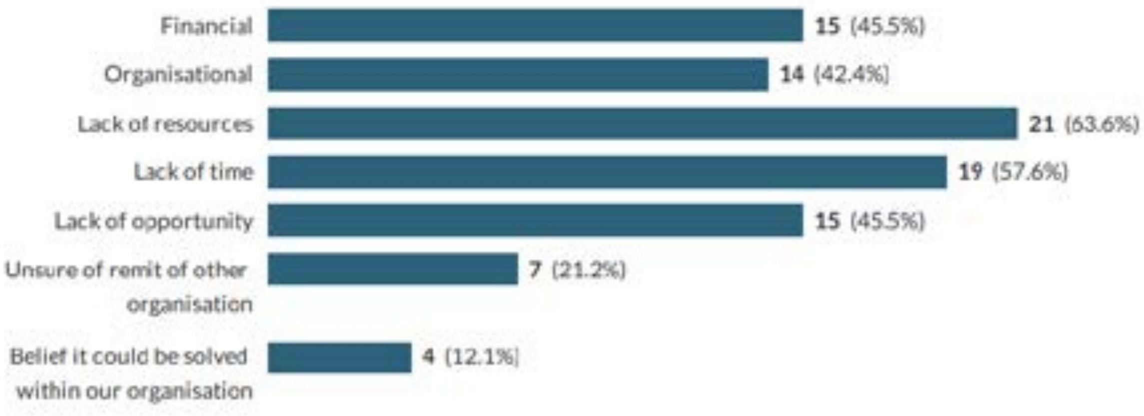

Fig two: Barriers to collaboration

As we can see from the diagram above, the barriers which challenge collaborative work are multi-faceted, including financial, temporal, and organisational. What was of interest were the relatively low scores for 'unsure of remit of other organisations' and 'belief it could be solved internally'. These comparatively low scoring responses may reflect the increasing attention on collaborative responses and information sharing within West Dunbartonshire, and the growing organisational ethos surrounding the importance of a whole system approach. The survey also provided a text box for participants to provide further reflection on the question of barriers. A selection of responses can be found below:

"Day job is a blizzard of fire-fighting, local meetings are useful, other meetings are a struggle to attend as the day job continues to pile up in your absence"

"Many agencies misunderstanding what CAMHS can realistically offer"

"There doesn't seem to be clear pathways from children to adult services... A lack of specialist services for adults with autism means the transition is very unclear"

"Generally there is a lack of money to invest in joint projects long-term"

"Conflicting priorities and a lack of time, very few folk all focusing on broad remits"

"The criteria for accessing mental health input from CAMHS seems to be set very high and more focused on responding to crisis. It seems below this level referrals...placed on a very lengthy waiting list which can allow for problems to escalate"

"Organisations and departments are being pushed to their limits in terms of referrals rates and capacity. This then affects the quality and quantity that can be achieved"

"Multi-agency planning is less robust due to capacity issues in all sectors. The willingness continues, but lack of time, staffing and resources is a huge barrier in recent years"

Some of these themes were followed up in the qualitative interviews. Two topics emerged in the discussions: transitions from child to adult services, and overburdened workloads leading to siloed working habits.

TRANSITIONS

The five to 24/26 age bracket encompasses several transitions, with health, education, and social work all containing key moments of transition occurring at different ages in the young person's life. From primary to secondary school, or from secondary to post-school destinations, and from specialist youth services to adult services. For this report, the participants' views mainly reflect those of youth centred services, with limited insight from adult services regarding their role.

There was an acknowledgement of the holistic life of the young person, that at any one point, they may experience several transitions at the same time: the move from school to further/higher education or work, the move from youth to adult services, and maybe moving out of the family home, and other interpersonal changes. The need to be aware of these different elements of transition and acknowledge the complexity within young service-users' lives was key to ensuring the smooth transfer of services. Given this complexity, transition meetings may involve several stakeholders, the family and the young person. Where transition was seen to work well, there were several collaborative meetings and collaborative planning between child and adult services, with one healthcare professional suggesting a good transition was where: that team around the child and family have a reasonable understanding about where they're going and that there's a good flow of information. Crucial to this was the ability for information to be shared, and expertise reflected upon. For example, another healthcare participant described a 'transitional group' that is attended by health, social work, and education to alert each other to those young people who will be transitioning to adult services within the next few months. However, where these conversations are not happening, descriptions of the transition process were described as more negative.

For some participants who were involved in periods of transition to adult services, there was sometimes a concern regarding finding a 'best fit' in adult services, particularly where there was not a replication of what the young person had previously had in child services. This, one healthcare professional described, required adult services to 'get their head around young people's complexity' and work with agencies to find a way to support the young person. Where support was offered in school, there were questions regarding how to ensure that support was not lost when young people move to post-school destinations.

Transition periods for young people who are looked after and accommodated also pose additional challenges, particularly surrounding the rights of young people at 18 to continue care in a placement (either residential or fostering) until they are 21:

> *"what we're experiencing just now is children's houses becoming adult houses, quite a significant change… all of our children's houses all have children over 18 in them" (Social work sector)*

This was identified as an issue that will increase in prominence over the next few years in West Dunbartonshire, particularly when there are less foster or residential places available for younger people who may require support. But it also raises a training issue in the workforce supporting young people who are opting to stay in placement longer. Given the different periods of transition that young people experience between 12 and 21, there is a need to ensure the workforce can work in an inclusive and empowering way for these young adults who are in their care. Part of the solution suggested was the need for more collaboration in early intervention at community level, to ensure that issues can be identified and addressed at an early stage, meaning residential allocation is for those young people with a 'higher tariff' of need.

The issue of housing and transition was also raised by a third sector participant who has a remit regarding homelessness and supported accommodation. Their service provided supported short-term (6-9 months) accommodation to 16–21-year-olds, with another offering shared accommodation for young people 16 years and over:

> *"[other service] isn't always appropriate for young people, they support a lot of people with drug and alcohol addictions and for young people who aren't going through that, it's not appropriate for them to be in that service." (Third sector)*

The participant goes on to describe experiences of young people being placed in flats, but without appropriate support in place to support this transition into independent living. This may include advice on money (applying for Universal Credit, ensuring they have a National Insurance Number so they can apply for work, how to set up direct debits to pay bills, etc.) and wellbeing (managing feelings of anxiety or stress). For the participant, there was a need for more collaborative working between agencies, but also a need for outreach support to ensure young people are coping with both the practical elements of having a home. The involvement of outreach workers may enable a wider geographic spread of resource across the local authority, enabling young people to stay near to their support networks.

SILO WORKING AND WORKLOADS

There was a consensus across participants that social work and CAMHS were stretched and overburdened, and that this culture was creating a barrier to some of the key components of early collaboration with third sector organisations (e.g. answering emails/telephone calls, attending meetings). Some within social work and CAMHS describe their current activities as 'firefighting', in that they are reactive in responding to high tier, high need cases and have less capacity for proactive collaborative work:

> *People are so busy firefighting within their own narrow service, that we just pull all the resources in. And one of the obvious places you pull from is collaborative set-ups. So whether that be, you know, triages, or vetting meetings, or where you're discussing clinical care plans, you just pull people out of it, as well. And I think that's one of the barriers, everyone just siloes, and protect their resources, just so that they can fight their own little battle (Health sector)*

There was a discussion within the social work group discussion of the rise of high-tariff cases, where the young people have more intensive mental health issues than previously. As a result, there was a perception that there was less opportunity for third sector or community involvement from the current supports available, as their young people and families required a higher tier response. This increase in high-tariff cases was described as having a knock-on effect on workers being able to do early preventative work which would stop as many cases getting to crisis point.

Within CAMHS, there was a discussion that many of the allocated times during the day where workers would have attended meetings, have now been taken over with casework, and focusing on the immediate demands facing their service, with pressures to reduce waiting times, and to attend to the levels of clinical need within West Dunbartonshire. The need to 'protect their resources' threatens whole system approaches to working, as organisations look inward to solve problems and rely on traditional ways of working with fixed lines regarding ownership.

When asked how they would imagine a system with reduced pressure, participants highlighted the need to focus on early intervention, hiring more staff to address long waiting lists and large case files, or introducing specialist areas where individuals within the team could take on more focused work that reflects their interests and existing training skills.

IMPACT OF COVID-19

As discussed above, the fieldwork for this report took place during COVID-19, where stakeholders and practitioners all saw a change in how their service was delivered, and on their interactions with CYP and their families. Some of the key lessons learned are explored below.

IMPACT ON CYP

For some of the participants, particularly those who work with vulnerable families or have a child protection remit, there were discussions of the increased vulnerability of children and families. This vulnerability may be through the risk behaviours of a parent (e.g. increased alcohol or drug use around the child) or exposure to domestic violence at home. For others, they suggested that where there was previously a support need for the child, such as a communication disorder that would have been supported in a specialist education setting, were described as losing "*pretty much their entire care package overnight*" (Health sector) as parents would not be able to provide the same level of support.

One issue raised regarding the impact of COVID-19 on CYP mental health and wellbeing is how the lockdown and closure of schools has reduced the visibility of young people to appropriate professionals. This was noted in the reduced referrals to CAMHS as CYP were not attending GP surgeries or schools, where referrals would traditionally be generated, with several participants questioning whether there may be a 'surge' in referrals or issues when services begin to open, and the impact of COVID-19 becomes more visible. This was echoed in the education focus group, where they discussed the limitations of online learning. While it enabled teachers to gauge participation, it was not always possible to pick-up on the non-verbal cues that would suggest their pupil was struggling. Given the key role of education within the child's life, and the professional judgements that may often lead to an early identification of an issue at home, the removal of this aspect of classroom teaching stressed teachers. Non-attending pupils, they said, would be one of the key groups to be monitored when schools return.

IMPACT ON SUPPORT OFFERED TO CYP AND FAMILIES

All sectors discussed developing processes to swiftly identify those families and young people who require additional support. One participant described this as a "baptism of fire" (Health sector) as they had to "put our heads together to categorise children in terms of risk and very quickly get ourselves in a position where we could get access to [them]". This idea was echoed in several interviews across several sectors, where participants described needing to use innovative and creative ways to negotiate the challenges posed by COVID-19 including learning new tech with Zoom, Teams and Hangouts. One participant suggested the past year had transformed their role completely, and that there was now "nothing in my job and work that resembles remotely what I used to do a year ago" (Health sector). Many reflected the need to create a traffic light system to ensure that the most vulnerable in West Dunbartonshire were being supported. For healthcare and social work settings, this required stakeholders and practitioners to review caseloads to assess need:

> *"All of us had to sit and look at our entire caseload to see 'who do we need to see and who can we safely phone', like 'who can I just check in with' and know they're okay and can wait, but then who do I really need to see regardless of what's happening, bringing that family physically into the space because we can't leave it" (Health sector)*

Assessing need sometimes also required a collaborative response, for example the Hub Schools had professional input from social work and educational psychology regarding who were known to their teams that may be eligible for additional support.

Aside from those CYP and families seen as most vulnerable, the support for CYP during this time was mainly online. For example, in statutory services such as healthcare, this involved Near Me to limit the footfall in the waiting rooms of surgeries, and in education this was through online classrooms where teachers were able to upload classwork for pupils. The need to address the digital divide was also spoken about, whereby there are barriers to online participation caused by inability to access a reliable or cheap internet connection, laptop or tablet or that this device was shared between several people. However, there was also a discussion of moves to remedy this, such as the education department supplying internet dongles or laptops to young people.

For statutory services, the move to online was particularly useful when supporting families, with some reflecting on how disruptive an appointment with specialist services could be when parents are required to book time off work and arrange childcare to attend a 30-minute meeting. The quality of the interaction was also seen as a benefit:

> *I used to think it was second rate to have a phone call, but if you think of the time and comfort they have… it can actually be more intimate… as a result schools are often asking me to have more phone calls with parents. (Education sector)*

In terms of the Third Sector, there have been a series of innovative activities designed to ensure continued engagement of young people including dance classes, cookery workshops, makeup tutorials where the organisations also had to address any barriers to participation (e.g. purchasing cosmetics, buying ingredients and utensils to chop and prepare ingredients). However, there was also an acknowledgement of the limitations of the online approach:

> *"there was a big push to move everything digitally, but you need to understand that young people have got digital fatigue, they're being asked to look at a computer screen all day during the day. You've got young people who aren't participating in education, so why would you expect them to log onto a computer in the evening to log into a youth provision?"*
>
> *(Third Sector)*

This digital fatigue, and the digital divide, meant that the different sectors had to become creative with regards to how they continued to engage with young people. Some Third Sector participants described dropping off food parcels, takeaways, and wellbeing packs to young people to ensure they have had some face-to-face contact with them. Others described conducting outreach work with young people on the street providing support and a listening ear if young people wanted to talk about how the past year had been for them. Going outside was also discussed by a health sector participant:

"I've known school nurses during this period of time to go to parks and sit and talk with young people that don't like the Near Me and the computer and if they don't have the IT supplied…it's about being creative in terms of what you've got in front of you" (Health sector)

Being able to provide a listening ear outside was also discussed as not being a safe space for discussion of sensitive topics, but instead was seen as a social support and for the young person to know there was someone they could talk to.

ORGANISATIONAL CHANGE

As well as acknowledging the change in how different organisations pivoted from mainly face to face to online interactions with CYP and families, many discussed the organisational changes brought about in the past year- moving from office based, to working from home. This was particularly discussed by participants who had jobs that required site visits, either to homes, or to community locations such as schools:

> *"I've been able to go to more child protection meetings because you just phone in, you don't have to drive down to social work offices, find somewhere to park, sit and wait… it's probably more focused, they were always fairly good at that anyway but there's less*

> *hanging about" (Social Work sector)*

Several participants discussed the time wasted where different meetings required travelling to different locations, with one reflecting 'there was no way I could drive round and sit in all those meetings but now if it's done on telephone or Zoom its easier for me to access and feed into a review. It has really made a difference" (Health sector). It was acknowledged across several sectors that working patterns in the future could become more flexible, particularly in relation to non-contact work with young people.

However, while some participants described the benefits of working at home, the time saved, and the opportunities to participate in more meetings and panels, others suggested there was a negative side to this. The issue of digital burnout was discussed by several participants, particularly as meetings could be scheduled one after another with limited time to relax in between. This was particularly difficult for those front-line workers where they supported families. Previously, they would have had time to process and debrief between meetings, particularly where there were sensitive or emotive issues discussed. COVID has also impacted on the transitions work that has taken place over the past year, including issues of CYP's school transitions, but also from child to adult services. In terms of the latter, there was a suggestion that some of the meaningful meetings regarding young people's transitions that would previously have occurred have been replaced with a 'transfer of care' with limited input from some services.

PHASE TWO RESULTS: PARENT/CARER EXPERIENCES

Phase two was conducted between September 2021 and January 2022. Linking with the findings from phase one, the fieldwork explored parental perceptions and experiences of parents and carers accessing mental health supports and services. Similar to phase one, this includes an exploration of barriers and facilitators to accessing support, as well as the impact of COVID-19 on both the mental health and wellbeing of CYP as well as access to services.

Unlike phase one, the quantitative and qualitative results will be displayed separately.

ACCESSING MENTAL HEALTH SUPPORT (QUANTITATIVE)

Parental survey questions were devised following a rapid literature review of previous research focused on the health seeking behaviour of parents with regards to their child's mental health. A summary of this literature can be found in appendix two,

ACCESSING COMMUNITY LEVEL SUPPORT

Survey participants were asked to indicate from a list where they were most likely to receive information regarding child mental health and wellbeing. School (80; 58.4%), GP (79; 57.7%) and the internet (67; 48.9%) received the most votes. Other answers included 'from another professional' (41; 29.9%), family (43; 31.4%) and friends (38; 27.7%).

Participants in the survey were asked to rate the trustworthiness (on a five point scale) of different community locations in terms of the advice provided. Specialist services such as CAMHS were not included on this list.

	Very bad	Somewhat bad	Average	Somewhat good	Very good
GP	12 (8.9%)	24 (17.8%)	38 (28.1%)	25 (18.5%)	31 (23%)
School	12 (9%)	19 (14.2%)	33 (24.6%)	34 (25.4%)	34 (25.4%)
Youth club	6 (5.5%)	4 (3.7%)	4 (3.7%)	5 (4.6%)	12 (11%)

Table 3: Participants' perception of trustworthiness of key community locations

Other services such as local church, local community centre, and after school received less than ten votes for each column and a high N/A response so are not reported here.

This was followed up with a question regarding where parents access support within the community. 92 (67.2%) of participants indicated their child had received support for mental health. Of the 45 (32.8%) who answered no, they received a follow-up question to explore the reasons. The highest response was that the child does not need support (25; 58.1%). However, other answers indicate a more complex picture: 8 parents (18.6%) stated they did not know what exists in West Dunbartonshire, 7 (16.3%) believed their mental health could be managed at home, and 4 (9.3%) had a bad personal experience with services and do not want to engage.

For those who answered yes to their child receiving support, they were asked to identify types of support, and also who delivered this support:

Type	N	%
School support	56	60.9
Counselling	49	53.3
Books/strategies/resources	35	38
Nurture/emotional group at school	27	29.3
CBT support	19	20.7
Speech and language therapy	14	15.2
Medication	12	13
Mentoring/buddying	10	10.9

Table 4: Types of support offered to children of participants

Who delivered support	N	%
Teacher	42	45.7
GP	37	40.2
NHS professional	37	40.2
Educational psychologist	25	27.2
School counsellor	23	25
Private health professional	13	14.1
Speech and language therapist	13	14.1
School nurse	7	7.6
Social worker	7	7.6
Youth worker	4	4.3
Paediatrician	2	2.2

Table 5: Organisations and stakeholder/practitioners delivering support identified in table 4

Of these participants who received support for their child's mental health and wellbeing, 66 had received a referral for CAMHS.

ACCESSING CAMHS LEVEL SUPPORT

49 participants (74.2%) indicated this was their first referral to CAMHS, and 17 (25.8%) had tried previously. In terms of CAMHS referral, respondents were most likely to report GP)52, 78.8%),

teacher at school (13, 19.7%) and educational psychologist (9, 13.1%) referred their child to CAMHS. Other responses included NHS specialist (5; 7.6%) and social worker (2; 3%).

The status of their referral was at different stages. 23 (34.8%) had now completed support from CAMHS, 16 (24.2%) were currently receiving support from CAMHS; 12 (18.2%) were waiting to attend their first appointment, 6 (9.1%) were waiting to hear if it was accepted, and 9 (13.6%) had received information that their referral was not accepted.

Participants who had experience of CAMHS referral were asked to rate the information provided. Participants were asked to rate the information provided before the referral regarding what CAMHS could offer, information provided after the referral was accepted but before the first appointment about what they could do in the meantime, and the information provided at first appointment regarding treatment pathways and what to do at home.

	Very bad	Somewhat bad	Average	Somewhat good	Very good
Before	18 (27.7%)	15 (23.1%)	19 (29.2%)	8 (12.3%)	5 (7.7%)
After	20 (32.3%)	13 (21%)	20 (32.3%)	7 (11.3%)	2 (3.2%)
Appointment	13 (22%)	9 (15.3%)	13 (22%)	16 (27.1%)	8 (13.6%)

Table 6: Perception of CAMHS support before and after referral confirmed, and after first appointment

The final question regarding CAMHS concerned online consultation. 23 participants indicated that they took part. An open text box was provided for the participants to share their experiences. 19 of the 23 provided a response. Text box one provides examples of the answers provided:

> *“Any contact during lockdown was needed and appreciated but one to one counselling was the only effective treatment”*
>
> *“Experience was fine, probably not great for child though with ADHD”*
>
> *“Appointment was fine with no issues logging in etc however my daughter struggled to engage and it was decided that a face to face appointment would be best”*
>
> *“My child takes part in the online consultations not myself but is happy to do so as a good rapport has been built up with the counsellor”*
>
> *“My son was happy doing the online sessions. It happened during COVID so online was the only way it could be done at the time. But my son was happier doing it online due to his mental health issues and anxiety. The sessions were excellent for my son and I was very pleased with the results”*
>
> *“Good for review and advice but would not be happy to use for diagnosis purposes as I feel the child really has to be met in person for this”*
>
> *“Not helpful, only one appointment my daughter got angry after, not helping her any more, was upset”*
>
> *“Booked in next week but beyond how to access video- I have no idea about format or what to expect”*

EXPERIENCE OF MENTAL HEALTH SUPPORT (QUALITATIVE)

The qualitative component of this phase explored the activities of the community locations, and sought to unpick why certain locations were seen as more trustworthy or more active in supporting CYP mental health and wellbeing.

EXPERIENCE OF COMMUNITY LEVEL SUPPORT

During the qualitative interviews, parents were asked about the services in the local area that support mental health and wellbeing. One of the key community resources was the school.

Schools were mentioned by parents in a variety of ways, from the wellbeing curriculum and seasons for growth that help young people with emotions and grief, to 'active schools' activities that help young people understand the importance of health and fitness. Schools were also mentioned in terms of the support they can offer for neurodiversity, and how both the ethos of the school and supportive professionals ensure that young people can participate in mainstream education. Where schools are supportive, parents described them using phrases such as "*we're all pulling in the same direction" and "haven't needed much prompting, they're usually good to react*".

One example of this was in adaptions to the school day. Three parents described how both primary and secondary schools have responded to pupil need by allowing pupils out of class five minutes early, offering separate changing areas for PE, a quiet room for lunch, go to the office rather than registration class in the morning, or ensure they can sit in separate rooms to do exams. Sometimes these adaptions were arranged in collaboration with educational psychologists, but other times parents described the head teacher as the key decision maker:

> *It was the headteacher that came up with that solution. And the pastoral care teacher was like – but we've never done that before? And she said, just because we've never done it before doesn't mean we can't do it. Something needs to give here and at the end of the day, you know, we need to put something in place. So just because we've never done it before shouldn't stop us from doing it.*

Other examples included provision of a sensory or quiet room, or access to the school library when the pupil is overwhelmed in class. Supportive staff was one of the key elements in the school. By supportive, I refer to staff that are trained in responding to different levels of pupil capability, in neurodiversity, and are open communicators with parents:

> *there's certain teachers in our school who are very, very well equipped and …a great way of articulating themselves, especially to the kids, to help them understand.*

Others describe receiving phonecalls from pastoral care teachers to update parents regarding any change in their child's routine. Another parent suggested that their child's anxiety could be managed in the school due to the responsive nature of the teaching and support staff:

> *because of the relationships, we were able to just kind of maintain that and nurture that and he's fantastic, he's just happy.*

However, this was not the same across West Dunbartonshire, with some schools requiring improvement particularly around neurodiversity. Some parents described feeling frustrated at the lack of flexibility displayed after a plan has been arranged for their child, particularly when the plan is to send the child home rather than support them in school. One parent described the impact this measure has on attendance:

> *it took weeks and weeks to get [their] support plan in place. Which meant [they] missed out on so much school. I think at one point [their] attendance was about 60 per cent and that was just down to the fact that it took them so long to get the support put in place*

Two other parents described witnessing makeshift nurture spaces that included a windowless cupboard with a beanbag chair, and shutting a pupil in an empty classroom until they calmed down. The parent reflected that it made them feel that the school had "washed their hands" of their child. Parents who didn't feel that the school listened to their concerns, or were slow in putting support in place described feeling as though they had to "fight" in order for their child to be seen. Fighting included seeking second opinions to support their case, and arranging meeting with pastoral care, head teachers, and other senior members of the school to voice their opinion and demand action is taken.

Transitions to high school were another factor that showed how schools managed neurodiversity in their pupil population. Where transition was managed well, neurodiverse pupils were given an enhanced transition, where pupil and parents were shown around the school at a quiet time, or during holidays, and shown social areas and classroom layouts. Where transition was handled poorly, there was limited communication between primary and secondary surrounding the identification of pupils who may need more support. One parent reflected the challenge this posed their child:

> *Like his whole class went on a visit, but there was other classes from other schools all on the same visit, so it was like crowds, and he doesn't deal well with crowds. And then they got shown around this school and they got given a map that he can't read, and then when he asked me about it, I goes, well, I'll discuss it, I'll talk to your teacher*

This was rectified by the secondary school, and the pupil was then given a separate tour around the building.

Parents also reflected on the benefits of engaging with other services. In terms of third sector organisations, Y-Sort-It was often mentioned by parents as being a great supporter of children's wellbeing. The group was particularly seen as beneficial for young carers, both when young people had caring responsibilities for a parent or a sibling. It was described as a place for them to offload their concerns regarding caring responsibilities, their mental health and emotions and everyday life. The ability of the group to offer away day trips, which provide respite for the young carers was also described as very beneficial. Other parents suggested there were sometimes issues with timings, with groups ending earlier or later than expected, but any issues were quickly resolved. One parent also discussed the benefits of Scouts for confidence building and providing different experiences for their children. Finally, others discussed the benefits of the summer programme offered in West Dunbartonshire in offering different activities and experiences across the authority. These activities were seen to encourage CYP to be outside, socialise, and promoted positive wellbeing.

A few parents also spoke about other therapeutic services that helped their children. For example, Lifelink or Silvercloud (an online support service that offers CBT advice). One parent described reaching out to their own personal network, as they were aware of someone who had retrained as a therapist. This therapist helped the family better understand their child's behaviours and put in place routines and activities that would allow their child to feel listened to and respected. The parent described the whole family approach to therapy allowing them to ask the therapist for advice, or feedback on ideas they have about their child. Other external agencies included tutors to help build confidence for children with dyslexia, and also a worker from the Strathclyde Autistic Society. Similar to the private therapist, the worker was described as "opening your eyes" to what autism means for the family. Finally, parents spoke about national agencies who could offer support. Including LGBTQ helplines to support a parent whose child was considering their gender identity, Sleep Scotland to support a child with disordered sleep, and Tourettes Scotland to provide a case profile for a child to be provided to their school to support their continued engagement with mainstream education.

EXPERIENCE OF CAMHS SUPPORT

Parents experience of CAMHS was mixed, with some parents describing a swift diagnosis and support, and others describing a two year wait, or longer if there were multiple referrals. For a few of the parents, this combination occurred in the same family. For others, they were all at various stages of waiting:

> *My older son…has been going on for a long time. My two girls have been told they're*

> *possible on the spectrum as well, so its all kind of a waiting game because I know the waiting lists are bad*

For some parents that had multiple children known to CAMHS, they described it as useful when the same staff member could assess the children, as it meant they knew the family's background and the difficulties faced by other siblings. One parent described themselves as being lucky, "*because [the worker] knows everything, and seems to have a way of understanding our challenges and our children's challenges and how best to take them forward*". CAMHS was seen as being swift to act where children had neurological issues that had conditions such as ADHD or autism associated with it, but was more of a challenge to be seen when ADHD or autism presented without neurological conditions. One parent described this as having "*nothing wrong with them per se*". Other times, CAMHS was swift to respond if the child was in immediate risk (e.g. hospitalised through self-harm behaviour).

Gathering evidence for CAMHS was often described as being the role of the school, educational psychologist or the GP. These organisations would make professional observations regarding the child's social behaviours, abilities to read and write, and any other communication difficulties. Parents occasionally described services working together, for example a school asking a GP to refer as it was almost the Summer break and it would speed up the process.

CAMHS were also described as being understaffed, which had an impact on parents' perceptions of the service offered. One parent described a situation where they attended an appointment where they felt like "*it does feel like you're not being rushed out the door but they're doing…the bare minimum*", the bare minimum being a check on weight, height, and a check in regarding emotions. The parent felt there was more that could have been asked either to them or to their child as, at the time of appointment, the child was experiencing a difficult time. Parents who offered opinions regarding negative experiences in appointments also made it clear they were sympathetic to the understaffing crisis, and the need to manage large caseloads, but they also felt that more could be done to help their child.

Some parents described experiences where their child was not seen to meet the criteria for CAMHS, this was often described as being "*rejected from CAMHS*". Parents in this group described feeling powerless, particularly if their child was displaying difficult behaviours and parents felt unsure as to where else to turn for support. This was also made difficult when feedback was seen as being unsensitive, with several parents describing hearing that "self-harm is common among teenagers" or that children would not be seen unless they have suicidal ideation or have tried to take their own life. For one parent who had experienced a recent bereavement, this was difficult to process.

For those who were in this group, often they described trying again, with some experiencing three or more "rejections" from CAMHS before their child was seen. Often parents described this in terms of chronological age, with one parent saying "*I've been complaining since my child was eight years old and she's 16 now and this is us just starting to get the help they need*". At times, parents would describe escalating issues with their children:

> *The first time I got involved with CAMHS, he was hearing voices, telling him to do things… CAMHS thought it was natural to hear voices, so that was the first time he was rejected… then it got to the stage where he was self-harming…but that's all natural. I', like, well when does he stop being natural. He's getting older now, and there is only one place. CAMHS is the only place for kids with mental health"*

For these parents, they felt the only thing to do was try again for a referral or pay for private support. However, even when CAMHS saw the young people and received a referral, often this was mixed with feelings of frustration. One parent described it as:

> *I think parents think CAMHS is going to be this big solution and fix everything. But its quite*

> *a short time you're involved with them*

Similar to some of the other parents, the participant described their child receiving a diagnosis and that signified the end of their journey. They then reflected on utilising their professional networks and additional reading in order to support their child's wellbeing, but suggested that for other parents who may not have this advantage, this would be a difficult and isolating experience for them.

IMPACT OF COVID-19

As discussed above, the fieldwork for this report took place during COVID-19, where family access to service and support had changed. Parents also commented on their observations on how COVID-19 had impacted on their child's wellbeing. Some of the key lessons learned are explored below.

IMPACT ON MENTAL HEALTH AND WELLBEING

COVID-19 impacted on young people's mental health in various ways. Some parents described their children being worried about the contagious nature of COVID-19:

> *she's not gone out the door, no. COVID's got a lot to do with it; she's very scared of it and she just hates when people don't wear masks and people don't go by what they should be doing and she feels safer in here which is hard. She's only twelve*

Parents described their children feeling worried about catching it, concerned about people not adhering to the rules, with this concern also increasing after lockdown when social mixing increased. Lockdown was also related to perceived changes in children's mental health, with some parents describing a negative impact of lockdown on routines:

> *the out of school thing has been a huge challenge for the bigger one because of the lack of routine, which he really, really thrives on and he, kind of, has blossomed really with routine through his years. And then to lose that all of a sudden was a huge thing for him.*

The negative impact of the loss of routine was particularly felt by neurodivergent young people. This was further aggravated by lack of private space at home, or lack of garden. One parent who lived in a flat described feeling “trapped” and less able to help her child with ADHD hyperactive behaviours. One of the main issues was the reduced access to social groups, with some parents describing their children feeling isolated. This was often mediated by young people who were able to access online social spaces (such as snapchat or multi-player online gaming).

For those young people who did have an active online social life, parents described lockdown as being “brilliant” for their children. These parents described witnessing a decrease in self-harm ideation, more relaxed behaviours, and being able to keep their own schedule. COVD-19 lockdown was also seen as positive for mental health if young people had previously experienced periods of anxiety linked with the school setting (loud classrooms, large crowds, difficult social relationships).

IMPACT ON ACCESS TO SERVICES

As discussed in the phase one report, service delivery transformed during COVID-19. Parents often reflected that COVID-19 did not create issues in their area, but exacerbated inequalities and issues that were already present. One parent suggested they did not see the easing of pressures on services happening any time soon:

> *I just feel as if like two years down the line, things are worsening rather than improving. And that could just be our experiences. You know, you're still not getting a foot in that surgery door. You're still not getting anybody to fill that room that's been made into an*

> *office in the schools. You know, you've still got your pupil support staff that are just rammed full of things to do, you know. Nothing is easing for any of them*

Others reported that COVID-19 had caused services (such as after school activities or small sports clubs) to be cancelled or postponed. If services went ahead, they could be cancelled due to a positive COVID-19 test result, either within the family or the professional. One parent suggested that due to COVID-19 related staff absences, their child had not received a check-up to monitor the impact of a new ADHD medication, describing that they were "*fighting to get him seen all the time when they should be seeing him*". Comments like this were often said with a combination of sympathy for the pressure services are under, and frustration for their child.

While schools were open to front-line services and vulnerable families, which were described as a "*godsend*" for one parent who described the importance of routine for their neurodivergent son, where services could not be offered face to face, often there was a pivot to online delivery. Parents appeared to be divided in terms of educational online classes, with some parents describing their children enjoying the ability to select their own hours, and work at their own pace without the distraction of a noisy classroom, whereas others found the situation stressful:

> *I can't force him to sit down at a table, do some work that I don't understand, because when he was getting his work, I was Googling it the night before to try and get it in my head how it worked, for me to try and help him. He was so frustrated, he just wanted…I think he just wanted his routine back, he wanted what he knew.*

Online learning was particularly challenging when children had to share devices or work in communal areas, or when they were studying advanced subjects that may be beyond the parents' expertise. The stress of sharing devices to take part in online sessions was also discussed by one parent who participated in a group session in CAMHS:

> *especially at home, everyone's around the same screen or trying to listen in and watching this person online, it's so different than when you can actually see someone in the flesh. Particularly if they're trying to help the whole family, definitely.*

Another parent who engaged with CAMHS online described feeling frustrated that the non-verbal behaviours were not being picked up as easily by the psychologist, giving the example of one session where they were told "your son doesn't look depressed". This was a statement that frustrated the parent as they had been referred three times, and saw a decline in their son's mood over this time.

In addition to education and psychological services, two parents described youth groups offering interactive online activities:

> *They did online sessions so they delivered all the items that you needed. So say it was a baking session, they delivered all the baking items that you needed. So you're not out of any cost, it's all funded. They get a Christmas bag at Christmas and I've got to say, the bag is pretty substantial. They get useful things; hats and gloves, selection boxes, art stuff, sometimes they get make-up items, things like that. Yeah, I can't fault it whatsoever.*

For families that had lost income due to redundancy or ill-health, the ability to receive support packs to engage in fun activities with children was seen as inclusive and useful.

PHASE THREE RESULTS: CHILDREN/YOUNG PEOPLE EXPERIENCES

Phase three was conducted between January and March 2022. Phase three reflects the voices of CYP living in West Dunbartonshire. Fieldwork explored young people's perceptions of the drivers of mental health, and the resources they can access in the local area. It also highlights two case studies which listened to and responded to what young people wanted to see in their local area.

Survey and focus group data will be presented together, followed by the two case studies.

WHERE DO YOUNG PEOPLE GET SUPPORT AND INFORMATION ABOUT MENTAL HEALTH

SCHOOL SUPPORT

Survey respondents suggested they were most likely to get information about mental health from school (4/10). Other responses received one vote, including GP, youth club, family, youtube and social media. Using an open-text box, participants. School was described both as a positive and negative place with regards to mental health by the focus group participants. One participant described their stress approaching examinations at school:

> *R3: It doesn't help as well that every time you have an exam, you get told, oh, these are the most important exams of your life. This sets you up for school. I remember being told that in Primary 7. Oh, this will determine the classes you're in, in the first year of high school. Then the first year of high school, this is the next…you're leading up and up and up to Highers and every year, it's just that escalating amount of stress and pressure.*

Some participants described secondary school as very pressurising, and that the drive to excellence and examination results was impacting on pupils mental health, particularly if they did not see themselves as achieving to the high standards set by the school. Others reflected that while there was a need to have health and wellbeing in the school, this was not suited to some of the teachers' skill sets:

> *R1: I think that people try and expect too much of teachers sometimes. I do think like, yes, they are teachers and they obviously have a role, however, they're not specialised in mental health. They're specialised in a science degree, you know what I mean. I do think there is, kind of, like that balance…*
>
> *R3: It's a balancing act that teachers do need to play, and its hard because its putting them in an unfair position. That's not to give them the benefit of the doubt all the time because, again, they're not mental health professionals. I feel that the school really does need more mental health professionals in the building.*

Some of the participants also mentioned pastoral care support in their school, although a few suggested that the need to fit the pastoral care role to the interests of the professional is very important. Two participants described feeling there was a mismatch between the pastoral care role and the teacher's attitude towards mental health:

> *R1: Personally, I'm not a fan of [my high school]'s pupil support system but there are your pupil support teachers and your pastoral carers…I've never had any issues where I've had to go to pupil supports but I know some of my friends had issues where its like they just dismiss it*
>
> *R4: They just think because they never had it when they were a young person, it never happens*

Later in the discussion, the participants reflected on the needs of pupils with diagnosed conditions:

> *R3: Even if you are diagnosed with ADHD with autism, teachers and that aren't prepared to deal with that properly, especially to help someone that's having a sensory meltdown. In [my school] they've got a pupil support base for that which does provide a bit more hands-on support but there's only so much they can do*

ONLINE INFORMATION AND SUPPORT

Survey respondents were asked how they can tell if information online was trustworthy. The majority of participants described the importance of using official 'well known and trusted' sites such as NHS or big health charities. Others suggested they would not use online resources to look up information regarding mental health. Reasons included concerns about privacy or concerns that the information on websites is not true:

> *"You want to take it with a grain of salt, as not everything that comes from someone's mouth is fact nor is the source where they got the material from"*

This point was also raised in the focus group, where participants agreed that caution should be exercised when looking online:

> *R1: It should be a licensed website and its not just people writing reviewers. Like 'user 542 said this' and you're like like 'oh, I don't know then'*

Others suggested that online community pages were particularly dangerous for young people looking for information regarding mental health conditions:

> *R3: A lot of times, young people go online for bad mental health and talk to other young people in the same circumstance and that and quite often it's just an echo-chamber of bad thoughts and negative thoughts and that, like eating disorder help groups and that which just glamorise and romanticise it and that. Eating disorder Twitter, for God's sake, like that side of Twitter's absolutely horrific. Tumblr is quite bad for it. It was a whole generation that was just struggling so badly with mental health and that in echo-chambers where that behaviour's encouraged and things like that.*

The focus group participants suggested that one of the reasons people may look online is if there is some embarrassment about saying to other people or asking for advice face-to-face, with two participants suggesting that there are still challenges facing young men in terms of mental health help-seeking:

> *R1: Men just get told to like man up, like*
>
> *R5: Suck it up*
>
> *R1: Yeah stuff like man up and all that like 'you shouldn't be feeling that stuff. Only girls should cry, then obviously like women face issues as well but I feel like with the mental health is quite hidden. Not hidden, but like men get told to hide their emotions.*

While the phase 2 parent report showed parents believing that their young people were part of a generation that were less limited in terms of barriers to showing emotions, these young people believed that gender norms still existed, and still played a big part in the need to address the mental health needs of young men. This may lead young men to prefer to seek help online rather than face to face.

SOCIAL SUPPORT

While only one respondent suggested they would ask family or friends for mental health advice, social support was mentioned in the focus group. While some of the group suggested that parents were more likely to be relied on for advice on physical health, and friends for advice on mental health, others suggested otherwise:

> *R2: I'd go to friends but I prefer sometimes going to adult figures, not just my family, just people who I know that I can trust who are older because I always feel like they're far more experienced and I feel like they're a lot wiser with what to do…I feel sometimes friends, they try and do what's best for you but they don't actually know.*
>
> *R7: Sometimes its good to hear about other people's experiences if they're going through a similar thing at a similar age and stage*

In discussing social support, one participant raised the issue of the context of the other person, and questioned whether their experience and options were shaped by the wider context of their life. For them, this may weaken the offered advice.

However there were seen to be barriers about accessing advice from family or friends. Participants reflected on intergenerational issues, particularly with grandparents who were not seen as 'open' to issues of mental health or issues surrounding LGBTQ+. Participants described grandparents as being "stereotypical" or "traditional" and raised in a culture where it was experienced but not spoken about. While the participants' generation is seen as one where these topics are discussed more openly, some suggested that same age friends may feel competitive, and 'one-up' stories, where the focus shifts from supporting a friend in crisis to comparing who has had the worst experience. However, one participant described a concern of burdening friends:

> *R3: A lot of us do struggle with mental illness, and that sometimes feels like 'oh you're struggling with something, I don't want to burden you as well'*

While this statement highlights the increased awareness of mental health experiences in the school and within peer groups, it also suggests that this awareness may stop some young people from speaking about their issues for fear of being a burden.

YOUTH LED ACTION RESEARCH GROUPS

Two youth led action research groups were created in phase three. Below, we document their activities and summarise outcomes from the groups.

YOUTH-LED ACTION RESEARCH GROUP ONE: SOCIAL ISOLATION AND BULLYING AT SCHOOL

Five young people from a secondary school in Clydebank agreed to take part in the first action research group. The group was facilitated by two teachers. At the first meeting, their suggestions for topics were broad, and included **knowledge gathering** (finding out about causes of mental health, healthy coping mechanisms, and about what services are available in the local area), **creating something** (helping the school support pupils' mental health and wellbeing, creating a poster to advertise services, creating a website), **talking/interviewing people** (interviews with friends, family about their experience of mental health, talking to teachers about their experiences, and approaching professionals to understand how they help others). Initially, the group were interested in combatting poverty, as this was a main driver to mental health. They had ideas like organising a food bank, or offering advice to people about money. By the end of the meeting, they began to look at what they could do to change things, and how things in school could be improved. In the second meeting, the pupils had narrowed their focus to creating an activity to help the school. In particular, they chose to focus on bullying. This was chosen as it would create feelings of anxiety, worry, and poor self-esteem in pupils that were targeted. During the discussion, some of the pupils raised that the topic of bullying was rarely covered in serious depth in school, and while it was on the curriculum, some teachers did not take the topic seriously.

Meeting three began with a discussion of resources from *respectme*, Scotland's anti-bullying charity, including examples of other pupil-led anti-bullying activities around Scotland, and how the school could create a positive and supportive environment so pupils who were being unfairly targeted could feel listened to. The group decided they wanted to create a lunch-club for pupils who felt alone at lunchtime, so they would have a group of peers to eat lunch with and a trusted teacher present who could speak to them. They also decided they wanted to introduce a pupil feedback box, for pupils to post any concerns or worries they have about their mental health.

The meeting ended with a discussion around how to gather opinions and information from their peer group about what the lunch club and feedback box would look like. The research team spoke to the group about ethical consent, and how to design research questions. Meeting four began with the pupils providing feedback surrounding their small research activity. 23 pupils from S1 to S3 completed their survey, with pastoral care teachers uploading the survey to google classrooms and members of the group asking people they know to complete the survey using a QR code on their phone. Questions on the survey included whether pupils thought there were enough social spaces at lunch time, if there was a lunchtime club would they attend, and what types of activities they would want to see at the club. In terms of activities, they received suggestions such as board games, team building exercises, homework help, physical games.

The group then identified teachers who they felt would be able to supervise the lunch club over their lunch time, and would be a friendly and trusted face to attract pupils into attending the lunch club. Two of the group recalled previous groups failing as the supervisory teacher was not friendly or understanding, so there was a small uptake among the pupils. The group also identified a day of the week to run the lunchtime club on, and named it the Chill Zone, and thought about a location within the school to hold the club in. This meeting also saw the group agree to create a timetable for volunteers, including themselves and other young people who they believed would support the club.

The final meeting, meeting five, will be scheduled after the lunchtime group launches, to ask the young people what impact they thought it had on their identified issues of isolation, and anti-bullying.

YOUTH-LED ACTION RESEARCH GROUP TWO: LACK OF SIGNPOSTING FOR MENTAL HEALTH SUPPORTS

West Dunbartonshire Youth Council (WDYC) invited the research team to attend one of their youth group meetings, where findings from the first phase of the West Dunbartonshire research project were presented. This included the suggestions for change as discussed by stakeholders and practitioners. A focus group was organised with the group (see results: focus group). Following a short discussion with the group about their experiences of mental health services and supports, both personally and relating to friends and family, they agreed that there was a need for better signposting to support young people while they were waiting to hear back from psychological services/youth counselling/CAMHS. The need for better signposting and ‘mapping’ complemented ongoing work in the WDYC.

In December 2019-Jan 2020, a local consultation with 600 young people who live, work or are educated in West Dunbartonshire was carried out by WDYC. The findings indicated the key issues facing young people. Based on their findings, the WDYC agreed to focus on a map for their own support and services campaign. The map focused on mental health, employability, LGBTQ+, and online protection and safety. As this was an ongoing piece of youth work, the research team followed the progress of the map with limited input. With their youth worker, they agreed that the map should be visual, and have a strong narrative arc running through it. They employed a local artist to work on the map with them, with the instruction that they wanted to see a character stop at each part of the road (see image one). Important to the group was the need to keep the messaging clear and simple, and not to over complicate the information given. Each “stopping point” is clearly signposted as one of the four information areas. Each area has a QR-code attached. By scanning the QR code, the viewer will be taken to a digital map of supports and services in the local area. For some of the topics, such as LGBTQ+, there was an acknowledgement that there was not a lot happening locally, so groups in Glasgow and Edinburgh were also included. Each point of the map includes a description of the service (opening hours, types of support offered, cost). The need to fill in the map with local services and supports is currently the responsibility of the youth workers.

The group also discussed how to disseminate their completed map to wider West Dunbartonshire young people. Some options include doing a "tour" of local schools where it can be displayed publicly for pupils to scan and try it out for themselves, or to have a series of talks in schools where youth workers and some of the young people can discuss what the map is for and how it can be used. There were concerns raised about ensuring it is not vandalised or stolen if it was displayed on the wall, and also questions about what happens to it after the tour is over.

WHAT DO PARTICIPANTS WANT IN THE SYSTEM?

Bringing together results from the three phases, this section asks what stakeholders and practitioners, parents, and young people want from mental health supports and services in West Dunbartonshire. This will be presented under three headings: training, transitions, and information.

TRAINING

FOR PARENTS

In phase one practitioner interviews, there was a suggestion that it would be beneficial to create opportunities for knowledge sharing with parents, both in terms of general knowledge (e.g. creating structure, good sleep hygiene, managing challenging behaviour) as well as offering more tailored support for parents who were either waiting for, or recently received, a clinical diagnosis for their child. There were examples of knowledge and training possibilities that could provide a useful support for families (e.g. individuals trained by Sleep Scotland). But where the parental focus was clinical, these resources may be underutilised.

This may involve challenging the diagnosis, or medical model, focus of some parents, and instead engaging in wider conversations surrounding managing routines, and building resilience and skills within the family to manage everyday life. This was discussed by one participant who described the challenges of talking to parents who were seeking an autism diagnosis for their child, and the wider need to engage them in conversations about the specific young person's "*expression of challenging behaviour*", exploring whether this was neurotypical or a reaction to circumstances within family life. Crucial in this training offering was engaging parents as active partners in the process, rather than passive audience members. One social work participant described this challenge as: *if we don't have parents on board, there will be no change for CYP*. A health sector participant suggested that by providing parents with strategies they would feel empowered rather than frustrated, and could reduce their concerns and anxieties.

This was followed up in phase two parent/carer interviews. Parents described the potential benefit of having group information/training. Similar to the practitioner interviews, these groups could cover training in terms of age/stage, but also diagnosis-based groups. The purpose of the groups also differed, with some suggesting a group that offered professional advice and workshops, and others wanting a supportive social space. The parents who mentioned these elements also referred to the need for young people and parents to access the groups.

AGE/STAGE TRAINING

For the parents who suggested the introduction of age/stage workshops for parents, they reflected on the usefulness of attending baby classes, Triple P, and the need for something similar for older age ranges:

> *"The most important thing I wanted to tell you was there was something missing between*

> *primary five and seven"*

For this parent, they felt that while their child may have continued to receive an education about their wellbeing in this period, there were few activities for them to attend or follow along with. This meant that they felt uninformed about what was happening in school, and how to best support their child. For others, the need for age/stage workshops was to have access to likeminded people that "*make you feel that you're not doing anything wrong, and your kids are going to be alright*". They reflected that the pressures on young people are much higher than they were when they were young, and that they would like the chance to learn about how to support their young people, but also to vent to others if they are having a bad day. Age/stage workshops for young people were mainly spoken about in terms of confidence building classes or general wellbeing.

DIAGNOSIS-BASED TRAINING

Diagnosis-based groups on the other hand were mostly spoken about in terms of CAMHS, both in terms of the wait between initial referral and first appointment, and also post-diagnosis. Parents were sympathetic about the stretched resources of CAMHS and how stressed the staff were due to heavy workloads. However, they also suggested that more could be done to help them during that initial wait, particularly where children were displaying behaviours that were troubling parents:

> *"it could be somewhere for you to ask questions like, oh, my daughter's saying this or doing this, like how can I help them, what does that mean. It might actually be a place for you to get a wee bit help before an official diagnosis gets made".*

This group was described as a way for initial information to be fed by clinical staff regarding activities to try, but also as a supportive environment for parents to reflect on what worked for them and to reduce feelings of social isolation. One parent described attending a Barnardos course about autism which was described as "lightbulb moment after lightbulb moment" as they broke down what autism was like from the point of view of the young person, and discussed triggers and how to help them.

In terms of post-diagnosis, some parents suggested that they required more information from CAMHS. Particularly when the diagnosis created more questions than it answered with regards to daily functioning, what their diagnosis means for the future, and how to create new supportive routines to help their children. For some, having an information pamphlet wasn't enough:

> *"we just felt let down, because like you're given a booklet and going, there you go, but more communication and support would help parents tenfold"*

For some parents, they suggested if there were support groups that were co-organised by clinicians and also parents who were able to reflect on their own experiences, and lessen feelings of isolation in the early days post-diagnosis, that would be beneficial. Discussion of attending groups also raised questions regarding accessibility, both in terms of managing conflicting demands of childcare, work, and attending group sessions, but also in terms of cost and geography. One parent also suggested ensuring that groups have access to childminding or creche facilities to enable parents who have younger children to also attend.

OTHER TRAINING

Phase two parents also touched on the importance of providing schools with additional training and information, particularly regarding specific neurodiverse conditions. Some parents agreed that there was diversity in terms of how schools manage pupils needs, with some offering adaptions to the school day, training for staff, and a holistic approach to pastoral care, whereas others were described as more "old fashioned" in their attitudes towards mental health and neurodiversity.

TRANSITIONS

In phase one practitioner interviews, there were concerns regarding parents feeling “let down” (Health sector) with regards to CAMHS to adult MH services, particularly with the shift to more independent person-led treatment models. One healthcare professional described the transition as the ‘*difference between school and university*’ in terms of expectation of self-management. As detailed above, there was often not a direct match in adult services for those who had experienced more specialist support in child services. One suggestion was provided by a third sector participant, who suggested the importance of having services that offered support that spanned these transitional years, and could offer some advice and emotional support during times of flux and change. Being able to identify and locate those services within the community that offer these bridging supports would better enable services to include them in their transition planning. This therefore links with issues of information (both creation of road map, and visibility of information).

In phase three’s CYP focus group, participants also mentioned the difficulties of being an older teenager in accessing services, particularly when they fall in between the gap of child and adult services:

> *R7: CAMHS only go up to 16 so as soon as you’re out that, then where do you go? The GP?... Like you are an adults but theres not a stepping stone of how do we support our young people that are at that stage?*
>
> *R3:You just get told, just wait until you’re 18. My pal…was struggling with his mental health and he got knocked back from mental health services because he was 17…he wanted support there like at the most pivotal moment of his life and he feels like hes got no support system there and its just sink or swim*

The young people spoke about the difficulties in transitioning from school to University, College or Work, and that the support offered in school, and the knowledge of their teachers regarding their support needs, does not follow them. The example above (R3) was of a friend who applied for University in another City, and felt that their anxiety began to get worse as their support system decreased. They described feeling like it was “sink or swim”.

Phase two parent interviews also discussed transitions, both in terms of the difficulty of having a child who was about the transition from child to adult services (or categorised as not fulfilling CAMHS criteria as they were 17 at time of referral) but also transition in terms of primary to secondary school. When asked how the transition could be managed better for neurodiverse young people, one parent suggested creating an information video for pupils that could show them around the secondary school, and speak to pupils about their experiences of the difference places and things they do:

> *So they can see how busy the halls are, they can see what the dinner hall’s like, what a class is like, what you’re expected to do…Not all kids are going to sit and watch that entire thing, do you know what I mean? But at least you can maybe fast forward a bit so that you can see the dining hall or just something.*

The ability to rewind, fast forward and watch again was described as one way to potentially alleviate any nerves pupils may have about this transitional period.

INFORMATION

CREATION OF A ROAD MAP

Phase one’s practitioner participants described the need for a tool that visualises available services within West Dunbartonshire from low-level community support to higher-level CAMHS support (described by some as a ‘road map’). The roadmap was discussed in several ways, including to help support CYP if they did not meet the criteria for CAMHS intervention. Currently, there was a sense of the system being ‘reactive’, with different organisations needing to “use their imagination” (Third Sector) or “*scrabble around*” (Education sector) in response to the need to ‘plug the gap’ of support. The roadmap was also discussed as a much needed toolkit to help CYP and families while they wait for their referral to go through.

The roadmap was also described as a useful tool for CAMHS to support knowledge mobilisation throughout the Local Authority with regards to combatting the number of referrals that could be assigned to different services. The idea being that if there was a directory or data visualisation of what services could be accessed, then service users could feel confident they were being seen by the correct service at the correct time. This may also address the concern within CAMHS of the service being viewed as a “destination” rather than as a supportive partner who can facilitate ongoing engagement with other services. If all sectors were to participate in the design of the roadmap, it would also ensure the better visibility of the Third Sector, who have described limited interaction with some services despite having a service that may assist in decreasing waiting times for some of the over-subscribed services.

HOW THE INFORMATION WOULD BE DISPLAYED

In phase one practitioner interviews, there was a discussion of the strengths of link workers as *knowledge brokers* within the system, including mental health nurses, family link workers in education and social work. They were described as providing a vital bridge between families in communities and statutory services. Findings from phase one suggest that the role these individuals play are vital both in developing relationships with families, but also in being agile in their approach to locating information and opportunities that would benefit CYP and their families.

Phase two’s parents described a frustration at what they deemed as the poor visibility of information in West Dunbartonshire. Several of the parents described not knowing what was available in West Dunbartonshire and the need for this to improve. Parents suggested various methods of communication, from social media, websites, noticeboards, GP surgeries and on the back of toilet doors. One parent described that the information could also be made available at the local information days, where there are often stalls related to smoking cessation and recycling. Another described that there should be a named person in the local area who updates the list of services, and can be contacted for advice. This could be coordinated by GP services or the local school. One participant described the school as the best place for information as the teachers know the background of many of the local families, and could offer more bespoke advice. Others described the need for the council to use council-owned building in the area as information hubs (see ‘community located services’ below), that could also offer workshops or classes for parents.

When the advice is available, some of the participants described it as being unclear. For example, leaflets that contain the title of workshops without detailing what happens in the workshop, or who can attend. One participant described feeling that some parents are worried about the stigma of attending a parenting class, and if the descriptions could show it was open to anyone rather than to “problem” parents, it would help accessibility. Another parent commented that the language surrounding mental health could be a barrier for some young people:

> *I think that the language that we use sometimes has to be looked at as well… they don’t understand your terminology and the language of it. I think we have to be more specific, and when we’re speaking to young people*

For the parent, using clinical language or complex terminology may create disengagement for the reader, and risk the positive messages and suggestions being ignored. Another parent said that they felt overwhelmed with the amount of information they found, and they would prefer if they could speak to someone to talk them through what the best places were.

Phase three's CYP survey respondents also suggested information evenings or inviting people into schools to give information and ask students for their opinions. In phase three's CYP focus group, participants were asked how information could be displayed regarding mental health support in the local area. Participants doubted the usefulness of putting more information regarding mental health support on West Dunbartonshire Council's website:

> *R3: If you're putting stuff online, it's the luck of the draw if people find it or not. You can put it out there but whether or not young people find it. We can post it on the council website all you want but realistically how many young people are looking at the council website?*

Some suggested that the information would need to be over a range of sources including in schools, on social media, and on websites, with the acknowledgment that not all young people will be looking specially on local sites for mental health information. The question of a road map of services was raised, particularly where this would be the most visible in West Dunbartonshire. One young person reflected that this would be best placed physically in the school, so young people would see it more frequently. They suggested that by having it online, it risked no one interacting with it or knowing it existed.

COMMUNITY LOCATED SUPPORT

Connected to the need for accessible information, the idea of the community-based hub for CYP and families to access was also discussed by some practitioner participants in phase one. However, the appearance of the hub differed, with some suggesting it would be a resource for information or a tailored search engine for West Dunbartonshire health and social care questions:

> *I would like to see a kind of a, one stop shop, if you like. For, not necessarily of personnel, but a one-stop-shop of information and guidance, about different pathways, you know, and how people can access help… I would like to see it kind of a jointly owned by all the agencies involved (Health sector)*

Whereas others envisioned a physical location(s), positioned in the community and addressed the power-imbalance between professionals and the public, through asking professionals to step out of their clinics and offices and spend time embedded in the communities they serve:

> *My vision is we have one front door and it says mental health, and you walk in and you talk to somebody…this week it might be addictions, and you know, next year it might be primary care mental health, you know, people don't fit into the categories, and this is where we're doing it wrong (Health sector)*

While there were differences in terms of how the one-stop shop would function in practice, there were common thematic threads running through. For example, the ability of CYP and their families to be able to walk into a community space that was not directly associated with one service (such as social work, psychological services, or healthcare) but where these professionals may provide drop-in advice sessions. There were discussions of the public to be able to have a cup of tea and a sit down, without needing to worry about having a 10-minute allocated slot of time, with bookable rooms for smaller organisations to host activities in.

Any new service should also be sensitive to the geography of West Dunbartonshire, and acknowledge the impact inequality has on mobility. One participant described a young person who to attend an appointment in CAMHS would *take her an hour and a half to get there, and need to get two buses, a train, another bus, or walk for twenty minutes, and then the same journey back*. In order for any new service to be accessible for all, it may require thinking regarding how to support equitable access across the various communities that it would serve.

In terms of phase two parents, some qualitative participants suggested that the local authority should re-open or re-purpose existing buildings within the community rather than build new. Other participants suggested a GP surgery, while one suggested that may be too clinical, and instead suggested a school as parents would be used to going along to pick up their children. One participant described their idea of the service:

> *If you could go to one place and there was practical advice covering a range of helpful hints, practical parenting supports or how to access these. If that was in the one place and you were able to go to one place and there was a friendly face there, and other people who were in the same situation as you as well as professionals? I think that would be amazing*

One of the key elements for the parenting group was for them not to be judged for attending, and having no stigma attached to the groups, and instead have a way to build a supportive service that promotes good wellbeing among the parents and young people.

In terms of the phase three CYP survey respondents, they suggested that such a service should be cheap, accessible, and there should be no stigma about attending. In terms of stigma, one participant suggested they would be likely to attend if they knew other people were going and they knew it was trustworthy.

DISCUSSION

This piece of research aimed to provide a snapshot of how supports and services for CYP (aged 5-24 years, 26 years if care-experienced) were provided, delivered, and experienced in West Dunbartonshire. This involved three phases of work, looking at stakeholders and practitioners, parents, and young people.

SUMMARY OF KEY FINDINGS

Phase one reflected the perceptions and experiences of a variety of sectors who had a remit in supporting young people with regards to the collaborative ambition of the locality. This involved the surveying and interviewing of stakeholders and practitioners from fields of education, social work, health, third sector and local authority. While the scope of the work reflected 5-24 years, there were instances where professional reflections focused on older young people (e.g. secondary age), and less about younger children, which may reflect the recruitment of services, or the limited engagement of younger children in youth services outside of school environments. The conclusions therefore reflect this, and acknowledge the limited knowledge of support mechanisms available to the younger children in West Dunbartonshire.

What was clear from phase one, was the clear commitment to collaborative working as a solution to supporting CYP mental health and wellbeing. There was evidence of how collaboration had become embedded in the language of improving outcomes, in the information sharing, and in the collaborative meetings attended. The variety of interventions, both clinical and community based, within West Dunbartonshire highlighted the complexity of the problem facing the stakeholders and practitioners. This included the intensive work offered to support young people who experience family alcohol and drug use, young people who are at risk of homelessness, and the support offered to care experienced young people including those looked after and accommodated as well as those who are looked after at home. The non-clinical wellbeing agenda highlighted the commitment across the authority to supporting CYP, and the vital role good mental health and wellbeing play across all sectors of a young person’s life. Across the services, there was a demonstration of the need to include young people’s voices and the importance placed on consistency and relationships in order to facilitate improved outcomes.

Phase two reflected the perceptions and experiences of parents, carers and guardians who are living in West Dunbartonshire, and had at least one child between 5-24 years (26 if care experienced). While the scope reflected this age range, it was found the majority of parents described children from senior primary or secondary school age. This was despite a broad range of recruitment strategies to capture the parents of younger children, but may suggest that the discussions of mental health and wellbeing supports were more suited to an older child's experience. The conclusions therefore reflect this, and acknowledge the limited knowledge of parental experience of earlier childhood supports.

What was clear from phase two was the breadth of knowledge and experience that parents had of supporting their children, and their recognition of the work that the different supports and services within West Dunbartonshire for young people. Parents described the importance of wellbeing for mental health, and provided examples of the need to exercise, eat healthy and share updates of their lives to ensure communication was always open. Others reflected on their own childhood, and how this shaped their own parenting styles, but also allowed them to reflect on how different environments like the school were in supporting mental health of CYP. For those parents who had accessed CAMHS, they were aware of the enormous pressure CAMHS was under, and shared concerns about how overworked the staff were. Their frustration with the overall supportive systems in West Dunbartonshire could be seen as one of visibility and communication, with the message that if they what was in West Dunbartonshire, or how they could support their children, this would be of great benefit in the long run.

Phase three reflected the perceptions and experiences of CYP in West Dunbartonshire. It involved hearing from young people from 12-17 years. The recruitment for this phase, similar to phase one and two, was restricted by COVID-19 restrictions, as the research team could not do in person contact and instead relied on individuals who from phase one to act as facilitators. Therefore, the conclusions from this phase acknowledge the limited scope and inability to reflect on younger children or those young adults post-school.

The young people described a range of services and trusted adults within the system that they felt respected them, with respect being described as listening without judgement and acting on what they wanted to happen. The young people also described a need to be savvy regarding the information displayed online regarding mental health, with strategies such as using official websites and taking a critical view on internet forums and responses by anonymous users. The young people who participated in the focus group described the stressors of school, particularly with reference to examinations and post-school destinations, as potentially difficult for mental health. They also indicated school as both a supportive environment but also suggested a challenge where the adults responsible for pastoral care did not match the role. Finally, for the youth-led action groups, young people showed their motivation to make a difference for their local area, both in terms of creating a positive environment in the school, but also for helping young people across West Dunbartonshire.

CONCLUSIONS

West Dunbartonshire has shown there is a lot of good practice occurring currently in the field of mental health and wellbeing for CYP. This includes partnership working, information sharing and the team around the child meetings. It is also clear that within West Dunbartonshire, the mission to support young people's mental health and wellbeing is not solely the responsibility of clinicians, but instead has been shifted down, so all stakeholders and practitioners who have a remit for supporting young people acknowledge the need to ensure their mental health and wellbeing is crucial to any work they do. Parents and young people acknowledge that there are people within West Dunbartonshire that listen and respond to their views, and they feel included in conversations that affect them.

Where there is space for improvement, is often based around communication. As West Dunbartonshire moves towards a whole system approach, there is a need to ensure the system does not become cluttered, with services repeating what others are doing, or introducing new services that lack impact due to poor visibility within the system. There was also a need to ensure a shift away from parents and carers seeing clinical services as the only place to support mental health and wellbeing, but for that shift to be complemented by an increase in services who can manage mental health concerns at a community level. This may involve additional training, services, or building capacity for early interventions within the system. This also links with the need to provide a safety net for parents and young people who either did not fulfil the criteria for CAMHS, or recently completed treatment. There needs to be improved communication and signposting to respond to their feelings of anxiety or rejection.

Finally, the findings of this report have shown that some of the parents and young people that were spoken to were eager to remain involved in these discussions. Parents volunteering their time to help out in groups, or share their experience with others, and young people requesting that West Dunbartonshire regularly surveys them regarding what they want to see in the area. Looking back to the 2019 Children and Young People's Mental Health Taskforce figure regarding the whole system approach, we see that success in this approach requires young people and their families at the centre.

SUGGESTED DEVELOPMENT AREAS

SDA 1 : Increase the visibility of services operating at community level. This should take on different forms, but could include information stalls at local community days, the creation of a 'road map' that clearly displays how individuals can contact different organisations and any referral criteria there may be. Wherever possible, this information should be available to young people and their parents.

SDA 2 : Explore more effective communication strategies between statutory and newly introduced services. This should take account of the potential for new services to collaborate with statutory services in creating early intervention opportunities with young people and their family. Wherever possible, any achievement from these collaborations should be broadcast across West Dunbartonshire to promote the visibility of community level services.

SDA 3 : Create training opportunities for parents regarding supporting their young people, and their own, mental health. These training opportunities should take on different forms, including training regarding various diagnosis (to support in the parenting of those children who are either waiting for, or recently received, a diagnosis) as well as general support (e.g. sleep hygiene, setting routines, managing challenging behaviour). Wherever possible, these workshops should be flexible in terms of geographic location and time of day to enable shift working parents to attend.

SDA 4 : Introduce social support groups for families, particularly for those who are facing similar issues with mental health conditions of children. This may involve a buddy or mentoring framework, where some parents may support others who are earlier in their journey. Wherever possible, this should be supported by a practitioner, with a focus on reducing feelings of social isolation and promote a sense of community within the group.

SDA 5 : Explore the potential of a community hub to support families in the local area. This was discussed as a way to locate support in the community rather than in clinical settings, and should involve a range of sectors in the design and delivery. Wherever possible, families and young people should also be consulted regarding the design of the model.

SDA 6 : Continue to consult with young people regularly regarding issues that affect them, and let them know what happened as a result of their responses. This may involve young people discussing issues of health outreach, town planning, service delivery rather than only “child only” questions (e.g. issues pertaining to schooling or play spaces).

APPENDICES

APPENDIX ONE: DEMOGRAPHICS

Phase one: Practitioner work

Stakeholders and practitioners came from a variety of both front-line and managerial positions. All worked with CYP and had some responsibility towards their mental health and wellbeing in West Dunbartonshire.

	Survey	Interview	Focus group
Health	10	9	0
Social Work	9	5	4
Education	7	4	5
Local Authority	3	2	0
Third Sector	6	5	0
Total	37	25	9

Table 7: Phase one participants categorised by sector

Participants who took part in the online survey were involved to take part in the qualitative interview, and therefore represented a subsample of the population.

Phase two: Parents/carers

159 parents/carers responded to the survey, and 15 participated in the qualitative interview. They had a variety of experiences with mental health and wellbeing supports and services for their CYP. These are detailed in the table below.

	Survey	Interview
CYP received community support for MHWB	92	3
CYP referral to CAMHS	66	10
No MHWB support	45	2
Total	139	15

Table 8: Phase two participants categorised by type of support received

Participants who took part in the online survey were involved to take part in the qualitative interview, and therefore represented a subsample of the population.

All participants who consented to be contacted regarding qualitative interviews were emailed with a copy of the information sheet, and asked to indicate a time they could be contacted. If no response was given, a follow up email was delivered after five days. If no response was given, one final email was delivered after 5 days, confirming that no response would indicate they no longer wished to take part.

Phase three: children and young people

	N
Online survey	10
Focus group	7
Youth-led action group	10

Table 9: Phase three participants categorised by method

Survey: Supported by Y-Sort-It, 10 young carers completed the online survey. Age range of participants was between 12 and 17 years, with four young people between 12-13 years, five young people between 14-15 years, and one young person between 16-17 years.

APPENDIX TWO: SUMMARY OF LITERATURE CONCERNING HELP-SEEKING BEHAVIOUR OF PARENTS CONCERNING THE MENTAL HEALTH SUPPORT OF THEIR CHILDREN.

Understanding parental perceptions and experiences of the barriers and facilitators to accessing services and supports for mental health needs in children and young people is a key element of service design. As young people often do not seek services or treatment on their own, they often are directed to services by knowledge brokers/gatekeepers such as parents, teachers or GPs (Stiffman, Pescosolido and Cabassa, 2004, Logan and King, 2006). These adults are often the first people that recognise a child's difficulties (Stiffman, Pescosolido and Cabassa, 2004, Logan and King, 2001).

Evidence shows that a child's use of specialist mental health services is positively associated with parental recognition of their child's difficulties (Teagle, 2002), particularly when communicating this need with services. For example, where parents are in contact with community front-line services (e.g. schools, primary care) in terms of the needs of their child, it is likely that a child's difficulties can be recognised early and referral to specialist services can be made (Crouch et al, 2019, Sayal, 2006, Sayal et al, 2010). Although this also requires the school or GP to also recognise the issue identified by the parent.

HELP-SEEKING

Help-seeking behaviour has been defined as a problem focused, planned beahviour involving interpersonal interactions with selected health-care professionals (Cornally and McCarthy, 2011). This can refer to individuals advocating for themselves, but also for others. A systematic review (Reardon et al, 2017) of 44 international studies (20 quantitative, 22 qualitative, 2 mixed methods) described four inter-related drivers concerning parents' decisions to seek help for their children:

- knowledge and understanding of mental health and help-seeking (understanding severity of need, understanding availability of service)
- parental views towards services (existence/absence of trusting relationship with professionals, feeling dismissed/listened to, stigma around mental health)
- wider systemic and structural issues associated with mental health system (e.g cost, inconvenient appointment times, availability of transport, waiting times, lack of specialist services)
- family circumstance (child care needs, other caring responsibilities, own health needs, work)

  These drivers are inter-related due to the ways in which they inform one another, a parent with low trust in professionals, due to their own mental health help-seeking journey, may be less likely to seek help on behalf of their child. Or a parent may have a trusting relationship with professionals, but may be limited due to poor geographic access, and high care needs and work demands.

COMMUNICATION BETWEEN PARENTS AND SERVICES

Many studies describe parental issues with delays or difficulties in diagnosis process (Kohler, 1999, Reardon et al, 2017, Reardon et al, 2018, Crouch et al, 2019, Hansen et al, 2021), which reflects wider issues of under-funding both of clinical and community services to support families and their children. Crouch et al (2019)'s qualitative study of parents accessing CAMHS commented that there was a "*detrimental impact of waiting for long periods prior to receiving treatment coupled with the 'fight' required to access these services*". Studies have highlighted during this period, it is important to ensure communication is clear and regular, and where appropriate, involves other professionals. Communication may include professional recommended resources, strategies or books, signposting to support groups for parents or young people experiencing similar symptoms, or updates regarding where their referral is in the waiting list.

Where a young person does not have a clinical need for support, it often poses a difficulty for parents in knowing where to ask for help (Reardon et al, 2020). This is exacerbated by the lack of clear communication or signposting as to where they could seek help (Hansen et al, 2021), and information to allow parents to make informed decisions as to what service is best suited for their child (Reardon et al, 2018). This is further complicated by the presence of comorbid conditions (e.g. anxiety and autism). As it asks parents to identify an additional need separate to their child's initial diagnosis and to potentially locate additional support (Crouch et al, 2019).