Mental health related contact with education professionals in the British Child and Adolescent Mental Health Survey 2004

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Keywords: survey; all school sectors; inter-agency work; mental health

Abstract

Rationale

Children with mental health problems are more likely to experience adverse outcomes including educational underachievement and psychiatric disorder in adulthood. Policy has increasingly focussed on interventions in schools and contacts with education often constitute a common starting point for other mental health services.

Aims

To analyse mental health related contact with educational professionals amongst children with psychiatric disorders in the British Child and Adolescent Mental Health Survey (BCAMHS) 2004.

Methods

BCAMHS 2004 was a community-based survey of 5,325 children aged 5-16, with follow-up in 2007. This paper reports the percentage of children with a psychiatric disorder that had mental health related contact with education professionals (categorised as teachers or specialist education services) and reports the percentage with specific types of psychiatric disorders amongst those contacting services.

Results

Two-thirds (66.1%, 95% CI 62.4-69.8%) of children with a psychiatric disorder had contact with a teacher regarding their mental health and 31.1% (95% CI 27.5-34.7%) had contact with special education either in 2004 or 2007, or both. Over half of children reporting special education contact (55.1%, 95% CI 50.0-60.2%) and almost a third reporting teacher contact in relation to mental health (32.1%, 95% CI 29.7-34.6%) met criteria for a psychiatric disorder.

Conclusion

Many children in contact with education professionals regarding mental health experienced clinical levels of difficulty. Training is needed to ensure that contact leads to prompt intervention and referral if necessary. High levels of teacher contact also represent challenges in supporting staff with time, resources and access to mental health services.

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Introduction

One in ten 5-16 year olds in the UK have a diagnosable mental health problem(Green et al. 2005). These children are at higher risk of educational underachievement, are likely to be over-represented amongst children excluded from schools (Parker and Ford 2013, Whear et al. 2014)and, ultimately, are more likely to experience poorer mental health as adults(Fergusson et al. 2005, Fergusson and Woodward 2002).

Education has taken an increasing role both in promoting good mental health in children and identifying and managing difficulties. Universal and targeted interventions in schools have an expanding evidence base and incorporate programmes aimed at mental health promotion as well as for the management of disorders such as ADHD (Adi et al. 2007, DuPaul et al. 2012). Teachers, educational psychologists and other education professionals also refer children onwards to other education services and to health and social services, and contribute to multidisciplinary assessment and management. Education professionals are therefore key to the identification and management of mental health difficulties and correspondingly in mitigating the associated potential adverse educational and social outcomes.

Surveys can describe the multiple services children come into contact with and capture data on those who do not use any services at all. Contacts with education constituted over 80% of all mental health related service activity in the US Great Smoky Mountains Study and often represented the common starting point for receiving other mental health services(Farmer 2003). In Britain, the two Child and Adolescent Mental Health Surveys

(BCAMHS) in 1999 and 2004, to date the largest national studies focussing on child mental health, also reported on service contacts amongst children with problems(Ford et al. 2005, Green et al. 2005). Teachers were the most commonly reported professional contact regarding child mental health by parents of children with a psychiatric disorder in the 1999 survey, and a quarter also reported using SEN resources(Ford et al. 2007).

This paper presents data on parent-reported mental health related contacts with teachers and specialist education services amongst children in the 2004 British Child and Adolescent Mental Health Survey (BCAMHS). This is the first paper to report on mental health related service contact with education professionals in the 2004 survey along with its 2007 follow-up. It describes the mental health diagnoses and difficulties of children whose parents report contact with these services, and the other services they use.

This paper addresses the following key questions in relation to BCAMHS 2004:

- What percentage of children with psychiatric disorders have contact with education professionals in relation to their mental health?
- What is the prevalence of specific types of psychiatric disorders amongst children who had mental health related contacts with education professionals?

These questions are important because answers provide a national snapshot of naturalistic service contact. This paper contributes to an understanding of the extent of potential unmet need amongst children with mental health problems, and the demands placed on education and other services by this group. Furthermore, information regarding common disorders in those presenting to education professionals is relevant in planning training and workforce development and shaping appropriate services.

Method

Structure of BCAMHS 2004-2007

BCAMHS 2004 was a large community-based survey including children aged 5-16 living in private households in England, Scotland and Wales. The target sample of 12,294 was drawn from the Child Benefit Register from 426 postal sectors selected by the Office for National Statistics (ONS). 1,798 were not contactable or opted out. In all, 7,977 (76% of the 10,496 children approached) took part in the survey

BCAMHS used a multi-informant model, involving a face-to-face interview with a parent (and with the child if aged 11-16), plus a teacher questionnaire. The key mental health measures completed were the Developmental and Wellbeing Assessment (DAWBA) and the Strengths and Difficulties Questionnaire (SDQ)(Goodman 1997, Goodman et al. 2000). The DAWBA provides a categorical psychiatric diagnosis and the SDQ provides a dimensional rating of difficulties and impact (see measures section below).The 2004 BCAMHS was extended by follow-up waves at 6 months, 12 months and 24 months that involved parental completion of the SDQ. In 2007, the three year follow up survey repeated interviews with informants, collecting information on mental health and contact with services(Parry-Langdon, 2008).

BCAMHS measures used in current study

Data collected at baseline included: age, ethnicity, gender, child learning disability, housing status, family type, parental education and employment and household income. The McMaster Family Assessment (Miller et al. 1985)was used to assess family functioning and the General Health Questionnaire (GHQ)(Goldberg et al. 1997) to assess parental

psychological distress. Parents were asked whether the child suffered from a list of physical and neurodevelopmental disorders, and which of 10 pre-specified potential stressful life events the child had experienced.

Measures of service contact

Parents were asked in 2004 and at the three-year follow up in 2007 whether they or their child had contact within the past 12 months with education professionals specifically in relation to concerns about the child's mental health in terms of difficulties with one or more of the following: emotions, behaviour or concentration. Education professionals were categorised as teachers (including Head of Year, Head-teacher or Special educational Needs Co-ordinator) or special educational services (for example educational psychologist, educational social worker or school counsellor). The same question was asked about contact with primary care/GP, Child and Adolescent Mental Health Services (CAMHS), paediatrics and social work. Reported contacts could involve the child or parent and encompass telephone advice, meetings, assessment, or interventions received by the child and family. Throughout the paper the term 'service contact' is therefore used to refer to such parent-reported mental health related contacts.

The Developmental and Wellbeing Assessment (DAWBA)

The Developmental and Wellbeing Assessment (DAWBA) was used to determine psychiatric disorder status(Goodman et al. 2000)The DAWBA takes the form of a structured interview with parents based on criteria from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) which can be administered by non-clinical researchers and has demonstrated high levels of agreement

between case notes and DAWBA disorder in both community and clinic samples(Goodman et al. 2000)Where the structured questions identify problem areas, open ended questions and prompts follow to allow the informant to describe the problem more fully – their words are then transcribed verbatim. Computer generated diagnoses arising from the interviews are then reviewed by a clinical rater who has access to all the data plus the verbatim transcripts. The clinician is subsequently able to either confirm or discard the computer generated diagnosis depending on their interpretation and clinical judgement, as would occur in the clinic. DAWBA disorders were grouped into the most common diagnostic categories: anxiety disorders, depressive disorders, Attention Deficit Hyperactivity Disorder (ADHD), conduct disorders/Oppositional Defiant Disorder (ODD) and persistent developmental disorders (PDD) including autism. Less than 0.4% met criteria for rarer disorders such as mutism, tics and eating disorders and, therefore, data on these groups were excluded(Green et al. 2005)

The Strengths and Difficulties Questionnaire

Parents, teachers and children (if aged over 11) were also asked to complete the Strengths and Difficulties Questionnaire (SDQ)(Goodman 1997)a screening tool validated across various populations(Gómez-Beneyto et al. 2013, Stone et al. 2010)which covers emotional and behavioural difficulties and their impact on the child and family. The SDQ asks all three informants about 25 positive and negative attributes across 5 subscales: emotional symptoms, conduct problems, hyperactivity/inattention, peer problems and prosocial behaviour. The items are scored 0 (not true), 1 (somewhat true) or 2 (certainly true). The 20 items spanning the first four subscales are added together to give the total difficulties score (possible range 0 to 40). In addition, there is a brief impact supplement which asks the

respondent whether they consider the child to have a problem and, if so, to rate the level of distress and impairment caused.

It is possible to have high scores on the SDQ total difficulty score but fail to meet full criteria for a psychiatric disorder on the DAWBA, and *vice versa.* Reporting only on the DAWBA disorders of children in contact with services does not capture the level of severity or impact of the child's difficulties, therefore, both were used in the current study.

Data collection

Figure 1 displays the data collection points from 2004 to 2007.

Insert Figure 1 here

Statistical analysis

Categorising psychiatric disorder status

Psychiatric disorder status is reported in two ways in this paper. First, children were categorised as having any psychiatric disorder (in 2004 and/or 2007) or no disorder (neither 2004 nor 2007) as defined by the DAWBA using DSM-IV. Second, they were categorised according to disorder status profile over time: no disorder, resolving disorder (disorder in 04 only) emerging disorder (disorder in 07 only) and persisting disorder (disorder in 2004 and 2007).

For those with a disorder, the disorder types according to the DAWBA are reported (i.e., anxiety disorders, depressive disorders, ADHD, conduct and oppositional defiant disorder and persistent developmental disorders).

Contact with services

The percentage of children who had contact with the six main service types in 2004 and/or 2007 (teachers, special education, primary care, paediatrics, CAMHS and social work) is reported by psychiatric disorder status and disorder type status. Children with more than one disorder type were included under each disorder that they met criteria for. The percentage of children in contact with teachers and special education in 2004 and/or 2007 who also had contact with any of the other four main service types is also reported.

Mental health problems in children in contact with services in 2007

As described in the Measures section, mental health problems were analysed in terms of 'difficulties' using the SDQ, and 'disorders' using the DAWBA. To explore the DAWBA-rated disorders of children in contact with education professionals, the percentage of children who reported contact with teachers or special education at any point (2004 and/or 2007) who had a disorder at any point (2004 and/or 2007) was reported with a 95% confidence interval. To describe the difficulties of children in contact with services in 2007 (chosen as the most recent data point), the mean total difficulties score on the SDQ in 2007 as rated by parents, teacher and children over 11 was calculated for children in contact with each type of service in 2007. This was repeated for the SDQ prosocial scores. For the SDQ impact score the percentage of children in contact with each service with an impact score of two and above (abnormal score) was calculated.

Weights

Weights corrected for slight inequalities in the original sample (created by a number of cases which were considered sensitive by the Child Benefit Agency being removed) and

regional variations in response rate in 2004 and accounted for differential non-response according to age, family type and other factors in the 2007 follow-up sample (Parry-Langdon 2008)

Results

Sample characteristics

Of the original 7977 children originally recruited in 2004, 7329 were approached for interview in 2007; the remainder were excluded for reasons including moving abroad and withdrawal from the study. 5,326 took part in the 2007 interview, and comprise the sample for this secondary analysis. The mean (SD; range) age in 2007 was 13.4 (3.3; 7 to 20). 51.5% of the sample were male. 686 children (12.9%) had a DAWBA disorder at one or both time points (2004 and/or 2007). These children are referred to as the 'any disorder' group.

Missing data

As a completed interview was a prerequisite for inclusion in the sample, all participants had data on the DAWBA (any disorder 2004 and any disorder 2007). Approximately 22% and 41% respectively had missing teacher SDQ scores at 2004 and 2007, but were not excluded as over 99% had no missing data on parental rating of concern or parental SDQ.

Contacts with education professionals amongst children with psychiatric disorders in the BCAMHS 2004-2007

Contact amongst children with any disorder

Teachers were by far the most common service with which parents reported mental health related contact. Two-thirds (66.1% (441/672) 95% CI 62.4 to 69.8%) of parents of children with a DAWBA disorder at either or both time points reported contact with a teacher regarding their child's mental health. In contrast just over two-fifths reported contact with primary care (41.9%, (278/672) 95% CI 38.0 to 45.7%). Approximately a third (31.1%, (205/672)95% CI 27.5 to 34.7%) had contact with special education services – this was the most frequently used specialist service reported by parents in the survey, followed by CAMHS (29.6%, (195/672) 95% CI 26.0 to 33.1%).

Contact by disorder status

Table 1 presents reported contact with teachers and special education services by disorder status profile based on the 2004-2007 data collection points. Teacher contact was highest amongst children with a persisting disorder at 79.1% (95% CI 72.8 to 84.4%). Over half of those with an emerging disorder (58.4%, 95% CI 52.2 to 64.4%) and a slightly higher proportion of those with a resolving disorder (60.9% (53.9 to 67.5%) reported teacher contact. Use of specialist education services was reported less often than contact with teachers but was still common amongst children with persisting disorders - approximately half of children with persisting disorders reported contact, compared to a fifth of those with emerging and resolving disorders.

Insert Table 1 here

Contact by disorder type

Table 2 displays the percentage reporting service contact for each DAWBA disorder type versus those without the disorder. For each type of disorder, children's levels of contact

were higher than for those without the disorder. Mental health related contact with education professionals was highest amongst children with ADHD – almost nine in ten reported teacher contact (86.1%, 95% CI: 78.5 to 91.4%) and over half had contact with special education services (58.9%, 95% CI: 49.7 to 67.5%), followed by children with persistent developmental disorders. Participants with emotional disorders had the lowest levels of reported contact with education professionals – just over half of children with anxiety disorders (58.4%, 95% CI 52.3 to 64.3%) had contact with teachers, and only 28.8% (95% CI: 23.6 to 34.6%) with special education.

Insert Table 2 here

Contact with more than one service

Children in contact with education professionals regarding their mental health were also much more likely to have used other services than those who had no such contact (see Table 3 below). Amongst those in contact with teachers, 30.1% (95% CI: 27.6 to 32.5%) also reported contact with primary care and 22.6% (95% CI: 20.3 to 24.8%) with special education. Under a fifth reported any contact with CAMHS (16.8%, 95% CI: 14.8 to 18.9%).

Unsurprisingly, contact with other services was more common in children using special education services, as referral from other professionals is often required. The majority (82.1%, 95% CI: 78.2 to 86.1%) of those in contact with special education services also reported contact with a teacher, 51.8% (95% CI: 46.7 to 57.0%) with primary care and 39.2% (95% CI: 24.1 to 44.3%) with CAMHS.

Insert Table 3 here

Mental health problems amongst children in contact with education professionals in BCAMHS

Psychiatric disorders amongst children in contact with education professionals in 2004 and/or 2007

Over half of children in contact with special education (55.1% (205/388), 95% CI 50.0 to 60.2%) met criteria for a psychiatric disorder on the DAWBA at one or both points in the study period (i.e. in 2004 and/or 2007) as did almost a third of those in contact with a teacher (32.1% (441/1523), 95% CI: 29.7 to 34.6%). Children in contact with both services were more likely to meet criteria for all the main disorder groups than children without contact.

The most common disorders amongst children presenting to teachers were conduct or oppositional defiant disorder (19.7%, 95% CI 17.5 to 21.9%), followed by anxiety disorders (11.8%, 95% CI 10.1 to 13.6%), ADHD (8.6%, 95% CI: 7.1 to 10.2%), depressive disorders (3.9%, 95% CI: 2.8 to 4.9%) and persistent developmental disorders (2.8%, 95% CI 1.9 to 3.7%).

Conduct and oppositional defiant disorders were also the most common type of disorder amongst children in contact with special education services – over a third met criteria for this disorder type (35.4%, 95% CI: 30.4 to 40.4%). The next most frequent types of disorder were ADHD (21.4%, 95% CI: 17.1 to 25.8%) and anxiety disorders (21.2%, 95% CI: 17.0 to 25.5%), followed by depressive disorders (7.8%, 95% CI: 5.1 to 10.7%) and persistent developmental disorder (7.4%, 95% CI: 4.7 to 10.1%)

SDQ scores amongst children in contact with education professionals in 2007

SDQ scores indicate that children reporting contact with education professionals also had greater levels of difficulty and impairment than children not in contact with services. SDQ total difficulty scores for children in contact with teachers or special education in 2007 were higher across all three raters (parent, child and teacher) than for those who reported no service contact. Teacher-rated mean total difficulty SDQ score for the teacher contact group was 9.8 (95% CI: 9.3 to 10.4), which was 5.0 (95% CI: 4.4 to 5.6) points higher than for children without mental health related teacher contact. This score is well above the norm teacher mean of 6.6, suggesting that teachers were aware of difficulties experienced by children in this group. Parent-rated mean total difficulty score for those in contact with teachers regarding their mental health was 12.4 (95% CI 11.9 to 2.9). The mean difference in parent-rated total difficulty score was 5.6 points (95% CI 5.1 to 6.1) higher for children reporting teacher contact compared to those without contact. For children reporting contact with special education services, the corresponding score was 15.3 (95% CI 14.3 to 16.3), within the borderline abnormal range on the SDQ. This was 7.9 points (95% CI: 6.9 to 8.8) higher than the mean score for those without special education contact.

Children in contact with education professionals had higher SDQ impact scores than those without contact, meaning that their difficulties affected their functioning and that of their family. Almost a third (29.9% (271/970), 95% CI: 29.6 to 32.9%) of children with teacher contact had an abnormal parent rated impact score of two or above, compared to only 5.0% (186/4287) (95% CI: 4.3 to 5.7%) of those who did not report mental health related contact. This proportion was even greater amongst children reporting contact with special education services; 49.4% (131/274) (95% CI: 43.2 to 55.5%) had an impact score in the abnormal range.

The education contacts group also scored more poorly on positive attributes than those without contact. Overall these children had lower scores on the prosocial scale of the SDQ in 2007 as rated by both parents and teachers, indicating lower levels of positive behaviours in interacting with others.

Discussion

Contact with education professionals

This analysis of the 2004-2007 BCAMHS found that teachers were the most commonly approached source of help and support for children with mental health problems, which was also one of the key findings of the 1999 BCAMH survey (Ford et al. 2007).The majority of children with a psychiatric disorder reported teacher contact and a sizeable minority had had contact with specialist education services.

Levels of contact with education services regarding mental health appear to have increased since the 1999 BCAMH Survey without a corresponding rise in the prevalence of mental health problems - 9.6% had a disorder in the 2004 survey compared to 10% in the 1999 BCAMHS (Ford et al. 2007, Green et al. 2005)Over two-thirds (70.4%) of parents of children with a DAWBA disorder at baseline reported contact at any stage with a teacher regarding their child's mental health (in comparison to 41% with a disorder in 1999) and 36.2% had contact with special education services (the corresponding figure in 1999 was 25%).

If this represents a true increase it is likely to be due to a combination of changes in demand for help with mental health problems, and changes in supply. The National Service Framework for Children, Young People and Maternity Services explicitly promoted joint working and expanded access to services within educational settings, and the introduction

of specific school based initiatives such as Social and Emotional Aspects of Learning (SEAL) could feasibly have led to increased recognition and help seeking for problems.

The prevalence of contact was lower amongst children with an emotional disorder, echoing findings from previous community studies(Costello *et al.,* 2014; Ford *et al.* 2005; Zachrisson *et al.,* 2006). This is likely to reflect multiple barriers to identifying and managing internalizing disorders. Young people themselves are often reluctant to initiate help-seeking from professionals for anxiety and depression(Gulliver *et al.,* 2010), whilst teachers have cited obstacles including insufficient training, inadequacy of support, and the more pressing need to manage disruptive disorders in the classroom amongst others (Papandrea & Winefield, 2011). More recently the evaluation of the Targeting Mental Health in Schools (TaMHS) programme failed to find an impact on emotional problems, acknowledging that schools may be better at identifying and addressing externalizing disorders(Wolpert *et al.,* 2013).

Psychopathology and use of other services amongst children in contact with education professionals

Over half of children in contact with special education (55.09%) and almost a third of those in contact with a teacher (32.13%) met criteria for a psychiatric disorder on the DAWBA at one or both time points in the study period. Although not all children in the contact group met criteria for disorders, they tended to have higher total difficulty and impact scores on the SDQ than their peers who were not in contact, and scored lower on the 'prosocial' scale. These results imply a warranted level of concern from parents approaching professionals for help.

Unsurprisingly, given their difficulties, these children were also more likely to be in touch with other services than children without disorders. However, less than a fifth (16.84%) of those with teacher contact and just under two-fifths (39.20%) of those with special education contact also reported contact with specialist CAMHS over the study period. This suggests that a relatively small proportion of those with problems may be referred on for further assessment and management and may signify a heavy reliance on education professionals as a source of help. Farmer in the US Great Smoky Mountain Study also noted that education was the point of entry 'least likely to be followed by involvement by other sectors' (Farmer, 2003).

Why might this be? It is likely that much of the mental health related contact with education professionals was naturally education focussed, and the involvement of other sectors may not have been indicated. However, professionals in both education and health acknowledge limits to joint working – a significant minority of professionals in CAMHS express low confidence in their abilities to identify and offer advice about children's education needs related to their mental health problems – and the majority report having received no training in this area (Vostanis *et al.,* 2011). Similarly, studies have reported teacher preference for exploring educational resources for help rather than refer to health, and uncertainty about what support from health might be required (Andrews *et al.,* 2010; Ford, 2000; Moor *et al.*, 2007; Papandrea & Winefield, 2011). This is likely to be perpetuated by a perceived mismatch between the expectation that schools will address and refer these problems, and the availability of mental health consultation and services(Rothì *et al.,* 2008). Indeed, identification of problems is of limited value without corresponding services to meet the child's needs, as discussed further in Implications below.

Overall strengths and limitations

BCAMHS reports naturalistic patterns of contact with a wide variety of public sector services and is representative of the British population, reflecting the wider range of contacts which families have and their broader needs. In such a large sample it is unlikely that the levels of service contact were a chance finding. The survey employed well-validated measures of psychopathology which are increasingly used in services today.

One of the key limitations is likely to be the reliance on parent reported contact. Validation of the Children's Services Interview suggested that parental recall of service use was moderately reliable, although their recall of which professional/service was seen was less so (Ford et al., 2007b). This was particularly the case for teachers and the voluntary sector, which may have affected these results, especially as the two education categories of 'teacher' and 'special education' were broad and may have been seen as interchangeable. Older teenagers may also attend services on their own or without informing their parents which could lead to underestimation or misattribution of service contact. There is also a lack of detailed data on the nature and duration of contact with education professionals, including whether any interventions or referrals were made, which precluded more in-depth analysis.

Changes in supply and demand for services are likely to have occurred since 2007, meaning that these results may under- or over-estimate the current extent of service contacts. Programmes integrating mental health interventions into educational settings such as Targeting Mental Health in Schools (TaMHS) and Place2Be may have increased the availability and effectiveness of services and facilitated joint working and awareness of mental health problems in the school environment. Conversely, the impact of austerity from

2010 onwards could have adversely affected access. Nonetheless, whilst the broad configuration of services remains the same, these results serve as a useful benchmark for assessing the impact of changes between 2007 and any future BCAMHS.

Implications

Children in contact with education professionals regarding their mental health experience significant levels of difficulty and impairment. However, a large minority with difficulties do not report any contact with education professionals or other services in relation to their mental health. In particular, some groups such as children with emotional disorders, may be under-served. Such children with mental health problems might feel and function better with integrated support from both education and health, and may be accruing secondary difficulties whilst not in contact with services.

In line with previous research, this study found that education may be the first or only point of contact for many children with clinical and diagnosable levels of difficulty (Farmer, 2003; Ford *et al.*, 2007). Contact consequently needs to lead to prompt and effective assessment and intervention and onward referral if necessary. There are implications both for education professionals themselves and for services working with children with mental health problems. Firstly, there is an ongoing need for awareness and training on the range of disorders which professionals may encounter, and on indicators and pathways for referral, to address the lack of confidence reported by educators in these areas (Andrews *et al.,*2014; Reinke *et al.,* 2011). Secondly, high levels of contact with children with difficulties are likely to reflect a considerable demand on time and resources for staff, potentially contributing to stress and burnout, and competing with escalating pressures to hit academic targets (Kidger *et al.,* 2010; Kokkinos, 2007). Support for professionals should not be only practical, but also

consider emotional wellbeing – in an English study of secondary school teachers, participants highlighted the difficulties in addressing student's mental health where their own needs were neglected (Kidger et al. 2010). Thirdly, parents and education professionals need to have access to wider mental health services where appropriate. Concerns have been repeatedly raised over high barriers for entry to CAMH services and over the impacts of austerity - recent figures from the charity Young Minds (2014) report that 77% of NHS Clinical Commissioning Groups have frozen or cut their CAMHS budgets between 2014/2015 and 2013/2014 (Young Minds, 2014). Fourthly, given the influences described above, there is an urgent need for future surveys to help evaluate the impact of such changes on children's access to mental health support in all settings, as well as to strategically plan services.

In summary, high levels of mental health related contact with education professionals are encouraging in that they represent important opportunities for intervention, but these results also serve to underline the challenges of meeting the needs of children with complex difficulties, and emotional difficulties in particular, within the constraints of current service provision. The messages from the BCAMHS survey further add to the weight of evidence calling for a strategic and integrated approach to child mental health across education and health and for ongoing training and support for professionals.

Figure 1: Data collection points

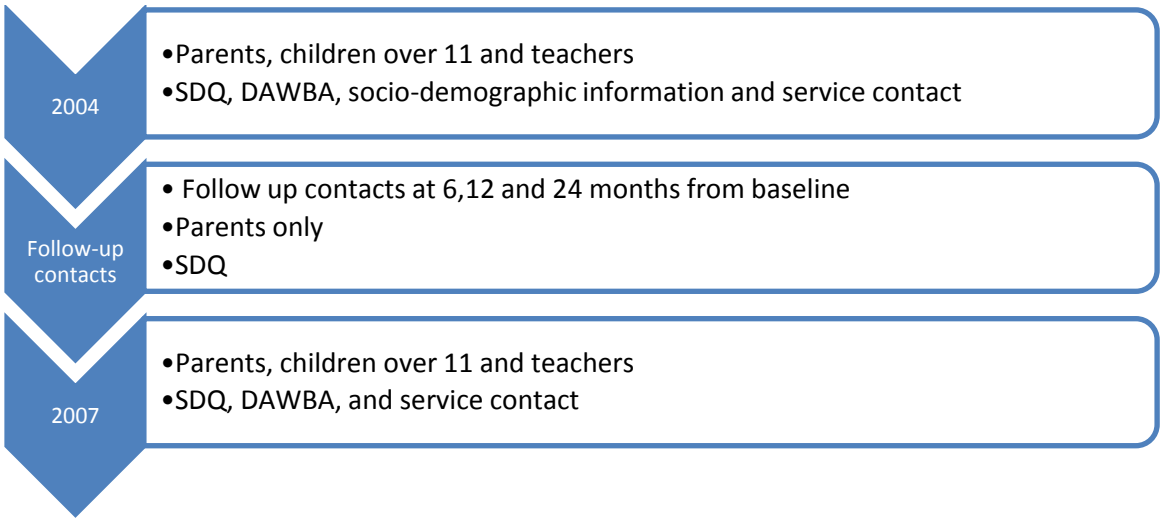

Table 1: Percentage of children in contact with teachers and special education services by disorder status, 2004-2007

Disorder status	N	Percentage in contact with service 2004 and/or 2007 (95% confidence interval)	
		Teacher	Special education
No disorder	4,585	23.8(22.6 to 25.2)	4.3 (3.7 to 5.0)
Resolving disorder (04 only)	203	60.9 (53.9 to 67.5)	19.6 (14.6 to 25.7)
Emerging disorder (07 only)	262	58.4 (52.2 to 64.4)	22.2(17.5 to 27.8)
Persisting disorder (04 & 07)	207	79.1 (72.8 to 84.4)	51.5(44.5 to 58.4)

Table 2: Percentage of children with each disorder type in contact with teachers and special education services, 2004-2007

Disorder type (rated by DAWBA)	Disorder status	N	Percentage in contact with service 2004 and/or 2007 % (95% confidence interval)	
			Teacher	Special education
Any anxiety disorder	**Any (2004 and/or 2007)**	**279**	**58.4 (52.3 to 64.3)**	**28.8(23.6 to 34.6)**
	Never	4978	28.2 (26.9 to 29.5)	6.9 (6.1 to 7.7)
Depressive disorder	**Any (2004 and/or 2007)**	**83**	**63.0 (51.8 to 73.5)**	**35.0(25.2 to 46.3)**
	Never	5174	29.4 (28.1 to 30.7)	7.7 (6.9 to 8.5)
ADHD	**Any (2004 and/or 2007)**	**129**	**86.1(78.5 to 91.4)**	**58.9(49.7 to 67.5)**
	Never	5128	28.3 (27.0 to 29.5)	6.7 (5.9 to 7.4)
Conduct disorder/ODD	**Any (2004 and/or 2007)**	**354**	**74.4(69.4 to 78.8)**	**36.7(31.6 to 42.0)**
	Never	4903	26.2 (24.9 to 27.4)	5.8 (5.1 to 6.5)
Persistent Developmental Disorder	**Any (2004 and/or 2007)**	**46**	**79.6(62.7 to 90.1)**	**58.6(42.8 to 72.9)**
	Never	5211	29.5 (28.2 to 30.8)	7.7 (6.9 to 8.5)

Table 3: Percentage of children in contact with other services by contact with education professionals 2004-2007

Contact with education professionals: 2004 and/or 2007	**N**	**Percentage of children in contact with other services: 2004 and/or 2007 (95% confidence interval)**					
		Teacher	**Special education**	**Primary care/GP**	**CAMHS**	**Paediatrics**	**Social worker**
Children in contact with teachers	1,523	n/a	22.6 (20.3-24.8)	30.1 (27.6-32.5)	16.8 (14.8-18.9)	10.7 (9.0-12.3)	8.1 (6.6-9.7)
Children in contact with special education	388	82.1 (78.2-86.1)	n/a	51.8 (46.7-57.0)	39.2 (34.1-44.3)	24.3 (19.7-28.8)	17.4 (13.3-21.5)
Children not in contact with teachers or special education	3664	n/a	n/a	4.1 (3.4-4.8)	1.4 (1.0-1.8)	1.3 (1.0-1.7)	0.7 (0.4-1.0)

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