

CHILD MENTAL HEALTH: KEY TO A HEALTHIER SOCIETY

Richard Layard¹

Executive Summary

1. The scale and cost of childhood problems

Scale
Linkage to other problems
Cost to taxpayers
Cost to the economy

2. Effective treatments

3. Existing services

4. A way forward

Delivering NICE Guidelines
Cost

Annex on Cost

Notes

References

¹ Paper prepared for Alan Johnson and Ed Balls. I am extremely grateful to Rachel Smithies for help and to Barbara Maughan, Stephen Scott, Philip Graham, Judy Dunn and Robert Goodman for their tuition as part of the Good Childhood Inquiry, and also to Andrew McCulloch, Angela Greatley and Kathryn Pugh. I have received valuable comments from Bob Jezzard, Greg Richardson, Louis Appleby, James Seward, Di Barnes, Michael Parsonage, Lorraine Khan, Jeremy Clarke and Eric Taylor.

EXECUTIVE SUMMARY

One in ten of our school-aged children have a diagnosable mental problem (causing them major distress or seriously interfering with their development). The shocking thing is that only a quarter of them are receiving specialist care of the kind recommended by the NICE Guidelines.

This situation is totally unfair to the children and their families. A fifth of these children have self-harmed; they are suffering. Mental pain can be as bad or worse than physical pain. But whereas most children with physical illness are in treatment, most with mental problems are not.

This anomalous situation is also completely short-sighted from society's point of view.

- Mental problems obstruct many of our key goals for **children**. They disrupt learning; encourage truancy; increase school exclusion; and encourage drink and drugs.
- Mental problems also generate many of the social problems we experience with **young adults** – crime; teenage pregnancy; continuing mental illness, and benefit dependence.

Thus effective treatments would yield big rewards to society. And effective treatments do exist which can often be shown to repay the taxpayer in full for their initial cost.

So how can we reach a situation where the NICE Guidelines are implemented? The handling of children's problems is extremely complicated involving professionals from education, social care, counselling, psychology and psychiatry in different mixtures. The CAMHS Review is covering the whole complexity of these issues and how they can be better arranged.

But to a relative outsider two specific things are clear:

- (i) Not enough specialist psychological help is available and
- (ii) Much of the help currently provided is not supported by the NICE evidence base.

In this sense the situation is similar to that for adults. For the adult situation the Department of Health has devised an excellent strategy (IAPT) within a devolved NHS.

IAPT for adults consists of

- (i) **A training programme** in NICE-recommended treatments, and
- (ii) A programme for **upgrading services**, so as to provide suitable placements for trainees with on-the-job training in NICE-recommended treatments. Any approved service should provide these treatments and monitor their outcomes. It should accept self-referral.

I suggest that any serious attempt to improve CAMHS should (among other things) include such an IAPT-like strategy. I propose for the next CSR a 5-year plan to train **1,000 evidence-based therapists** (some of whom are currently primary mental health workers) and in parallel to **upgrade the quality of psychological assessment and therapy services**. By 2012/13 this programme would cost £28 million a year but some savings could arise elsewhere.

I also make two other costed proposals.

- (iii) Every child referred to Tier 3 services should receive a **fully professional assessment** and 300 people should be trained to do these assessments (people who are otherwise fully qualified and already employed).
- (iv) A dedicated **research fund** should be set up to research into appropriate therapies for children and to analyse CAMHS outcomes and resource use in the field.

This package would cost £35 million a year by 2012/13. It is only one part of what is needed – the more ‘medical’ part of the package (though of course it has to be presented to children and young people in the least medical way possible). There are other crucial elements of prevention and support which the Review will cover. Let me mention just two changes which are clearly necessary:

- (v) All **GPs** in training should do a placement in community mental health, and
- (vi) All **teachers** in training should be educated to recognise and respond to mental health problems. PSHE should include explicit teaching on mental health, and programmes to promote emotional resilience.

These are all matters of great urgency. For a major push on high-quality psychological help for children in difficulty would over time improve the lives of millions of children and their families. It would produce a better society, in which there was less conflict and less misery.

In what follows I look at

1. The scale of the problem and its consequences.
2. The cost-effectiveness of treatment.
3. Adequacy of services.
4. A proposed way forward for the next CSR.

1. THE SCALE AND COST OF CHILDHOOD PROBLEMS

According to the ONS, 10% of all children aged 5-16 have a ‘mental disorder’. (This is based on a large household interview survey with questions asked to parents, teachers and children over 11.)² The main disorders are emotional disorders (mainly anxiety states) and conduct disorder, but attention deficit and autism are also quite common – see Table 1. Girls are more prone to emotional disorders, and boys to conduct disorders. Older children are more likely to have problems than younger ones.

Table 1
Mental disorder in 5-16 year-old children (2004, %).

Emotional disorders	3.7
Anxiety disorders	3.3
Depression	0.9
Conduct disorders	5.8
ADHD*	1.5
Autistic spectrum disorder	0.9
Eating disorders	0.3
Any disorder	9.6

* Attention Deficit Hyperactivity Disorder. The definition used here is more restrictive than in the USA. NICE’s preferred figure is 2.4%.

Linkage to other problems

One can see straight away how these problems are linked to many of the main **problems which educators worry about**. Quite disproportionate numbers of children with mental health problems are also

² Green et al (2004).

behind at school
 truanting
 excluded from school
 smokers, drinkers and drug-takers.

The figures in Table 2 are extremely striking. These figures do not of course prove causality, but they provide a strong prima-facie case for tackling the mental health problems – not only for their own sake, but to promote other aspects of the child’s well-being.

Table 2
How mental health problems contribute to other childhood problems
Children aged 5-16

Percentage who:	Children with:		
	Emotional disorders	Conduct disorders	No disorder
have marked difficulties in reading and maths	15	21	6
play truant	16	22	3
have ever been excluded from school	12	34	4
have no friends	6	8	1
smoke regularly (age 11-16)	19	30	5
drink at least twice a week (age 11-16)	5	12	3
ever used hard drugs (age 11-16)	6	12	1
have ever self-harmed*	19	18	2
are in a household under £200 per week	33	37	19
have a parent on any disability allowance	20	20	8

Source: ONS Survey of child mental health: Green et al (2005). * Parent’s report

There is of course the view that all of these problems are essentially caused by poverty and the answer is to abolish child poverty. No one believes more strongly than I do in the justice of that cause. But abolishing child poverty will not eliminate the

problems listed in Table 2. For multi-variate analyses of many of the problems listed in the body of Table 2 show that mental health is a more potent influence on the incidence of the problem than income is. Mental health problems are of course correlated with parental income but a careful analysis shows that income plays a quite small direct role in causing mental illness compared with family break-up, family conflicts, the mental health of the mother, and adverse family events.³ So we should be clear in our minds that mental problems are a sufficiently distinct problem to deserve direct treatment.

Table 3
Subsequent outcomes for children with conduct problems at ages 7 - 9

	Children whose conduct is in	
	worst 5%	best 50%
Percentage		
committing violent offences (21-25)	35	3
drug dependent (21-25)	20	5
antisocial personality disorder (21-25)	17	1
suicide attempt (ever)	18	4
teenage parent	20	4
welfare dependent (age 25)	33	9

Source: Fergusson et al (2005), Table 1. Their Table 3 gives comparable figures after adjusting for other co-variates.

The case becomes even more imperative when we consider the consequences for society of untreated illness **when the children become young adults**. In Table 3 we distinguish between children who had conduct problems at age 7-9 and those who did not, and see how differently they behave as young adults. Those who had problems as early as 7-9 continue in early adulthood to have exceptionally high rates of

violent crime
drug dependency
suicide attempts
teenage parenthood and
welfare dependency.

³ Ford et al (2004, 2007)

Indeed the worst 5% at age 7-9 account for more violent crimes than half the rest of the population.⁴ Furthermore, when one looks backwards from adults who have a mental illness in their late 20s, a cohort study has shown that three-quarters already had a diagnosis before they were 18, and a majority before they were 15 or even by the time they were 12.⁵ These extraordinarily high linkages suggest that, if we addressed the problems of young people at age 7-9, we could have a major effect on the quality of our adult society within a generation.

Cost to taxpayers

We could also save ourselves a lot of money. The Inner London Longitudinal Study of 10 year-olds took children at 10 and diagnosed their conduct. It then followed them up to age 28, measuring the (undiscounted) taxpayer costs generated by each type of child – especially to the criminal justice system, but also in terms of foster and residential care, and remedial help at school. The total costs were as shown in Table 4.⁶

Table 4
Costs to the taxpayer - from crime, social care and remedial help.
(from age 10-28)

Children with conduct disorder at age 10	£70,000
Children with conduct problems at age 10	£24,000
Children with none of the above at age 10	£7,000

Cost to the economy and society

In addition, there are massive costs to the economy (output lost) associated with mental health problems which appear in childhood and continue into adulthood. This can be seen from the famous study of South London boys who were followed from age 8 onwards by David Farrington. We can look at their earnings at age 32. For those who were in the bottom quarter of conduct at age 8 and had a criminal conviction by age 16,

⁴ Fergusson et al (2005). This study is from New Zealand, but similar results are found by Farrington (1995) for a South London Borough

⁵ Caspi et al (2003)

⁶ Scott et al (2001). Expert opinion believes that by spending £6,000 per head on children with “conduct disorder” they will on average become children with “conduct problems” – thus saving the taxpayers £46,000.

their annual earnings (adjusted to 2004 values and annualised) were, other things equal, £5,000 lower than for the rest of the sample.⁷ This is the annual economic cost of mental health problems going back to childhood.

But the costs to society go beyond the costs to the economy. For example, one interesting study of child conduct disorder included (besides the economic cost) its impact on the costs of crime and the value of QALYs lost through mental illness, alcohol dependence, drugs and suicide.⁸ The present value of all these costs over a lifetime was £150,000 per child. By contrast the cost of treating conduct disorder in childhood is £6,000. It follows that treatment would be cost-effective, even if the success rate was only 1 in 25. And effective treatments do exist.

⁷ Healey (2005)

⁸ Friedli and Parsonage (2007)

2. EFFECTIVE TREATMENTS

These treatments are spelt out in the NICE Guidelines and Technology Appraisals.⁹ For children with **conduct disorder**, parent training leads to improvement in two-thirds of children under 10, with effects still detectable four years later. For children aged 8-12 with this disorder, problem-solving programmes for children have good effects if combined with parent training. And for adolescents, functional family therapy and (for severe problems) multi-systemic therapy have significant effects in randomised controlled trials for conduct disorder. For ADHD (attention deficit hyperactivity disorder), medication can lead to normal patterns of behaviour in 75% of treated children.

The other main type of mental health problem in childhood is **anxiety disorder** (including generalised anxiety, OCD, PTSD, agoraphobia, social phobia and panic attacks) – which is often mixed with other emotional disorders. Here CBT clears the disorder in 50% of children treated in randomised controlled trials. The effect is still there when they are followed 2 years later.¹⁰

Eating disorders are another set of conditions that currently cost a lot because they are often managed with long and expensive inpatient stays. But focused family therapy on an outpatient basis can be highly effective.

Good outcomes on this scale fully justify the implementation of all the NICE Guidelines. We treat physical illness whether or not the treatment leads to subsequent savings, and we should do the same for mental illness. Nevertheless, it would be highly desirable to follow up children over many subsequent years after treatment – to track not only their mental health, but their employment, criminal behaviour, benefit dependence and so on. In this way we can establish what is the net cost of these treatments to the taxpayer – or whether there are instead net savings overall.

Clearly the Exchequer savings are more immediate in some cases than others – and are generally quicker the older the person who is treated. For example, if we take young offenders and give them effective psychological treatments, a substantial proportion will not offend again, who otherwise would. We can then count up the resulting savings in police and court costs, probation and possible incarceration.

This was done for treatments delivered by random assignment in Washington State and followed up over an 18-month period. Functional Family Therapy cost \$2,100

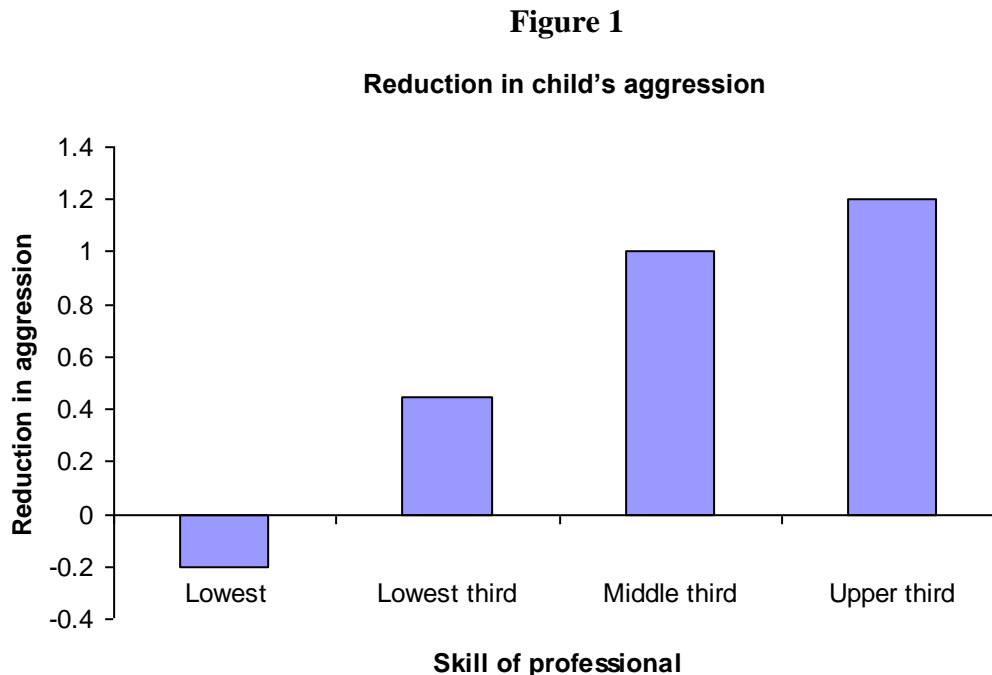
⁹ See Wolpert et al (2006). In 2006 there were ‘guidelines’ on OCD, PTSD, depression, eating disorders, self-harm, substance abuse and ‘technology appraisals’ (which have stronger force) on parent training for conduct disorder, and medication for ADHD.

¹⁰ Dadds et al (1999).

for each young person treated. When competently provided, the resulting taxpayer savings averaged \$9,000. When incompetently delivered, the estimated effects were negative; but averaging all forms of delivery the taxpayer savings were still \$2,500 per person treated – more than the cost.¹¹ A less expensive treatment called Anger Replacement Therapy was also found to pay for itself.

Two important lessons emerge from all studies of treatment effects – the competence of the therapist is crucial, and treatments have bigger effects the worse the child’s problem. The importance of the therapist is illustrated in Figure 1. In a study of a parenting programme for child antisocial behaviour, therapists were independently rated for their skill. The top third of therapists lifted the anti-social children by some 28 percentile points. The least effective therapists actually had a negative effect, as also in both the Washington State experiments already reported. This shows the huge importance of a well-trained workforce – which is central to our proposals in Section 4.

Similarly, the treatment has bigger effects the bigger the problem (provided the problem is not overwhelming).¹² This reinforces the importance of targeting and therefore of assessment – again central to our proposals.



¹¹ Washington State Institute for Public Policy (2004). Exhibits 1 and 23.

¹² Scott (2005)

3. EXISTING SERVICES

Against this background, how adequate is the existing service? We start from the fact that only a quarter of those with mental health problems have seen any mental health professional in the last year. Most of these children will have been seen in Tiers 3 and 4. There is a strong presumption that many more of them should have been seen, since most of them have problems that will persist.¹³

So, before proceeding, it is helpful to remind ourselves about the structure of CAMHS and the scale of activity involved. Very broadly speaking, the tiers are¹⁴

- Tier 1 Universal services (schools, GP practices social care)
- Tier 2 Specialist individual professionals relating closely to primary care
- Tier 3 Specialist multi-disciplinary teams (secondary)
- Tier 4 Tertiary care

Statistics on CAMHS are relatively scarce, but the CAMHS mapping operation for 2006 covers most of the teams in ‘CAMHS proper’, all of whom are in Tiers 2 - 4.¹⁵ These teams employed 9,700 staff (FTE), detailed below.¹⁶ Of these about 5,800 were in generic Tier 2/3 teams and 2,300 were in Tier 4 tertiary care. Most of the other 1,600 were working in targeted teams.

Table 4
Staff numbers (November 2006, FTE)

Psychiatrists	1,050
Clinical psychologists	1,250
Other psychological therapists	1,000
Primary mental health workers	500
Nurses	2,750
Social workers	600
Admin	1,750
Others	800
	9,700

¹³ Within the total 10% of children aged 5-16, quite a small number have naturally-remitting depression, or adolescent-specific conduct disorder.

¹⁴ See National Service Framework for Children, Young People and Maternity Services (2004), Standard 9.

¹⁵ Barnes et al (2007)

¹⁶ The figure for clinical psychologists includes a small number of educational psychologists. The figure for other psychological therapists includes family therapists, child psychotherapists, and other qualified therapists. The figures for others includes occupational therapists and other staff.

The number of children on the caseload at any one time was 110,000 (60% boys). But the service saw altogether around 300,000 children annually – with treatment averaging 4½ months. Thus, the service saw just under 3% of all our children.¹⁷ Almost half the children at Tiers 2 or 3 have been referred by GPs, but substantial numbers have been referred by secondary child health services or from youth justice. Of the caseload of 110,000

9,300 have learning difficulties
 9,500 are looked-after children, and
 6,200 are youth offenders¹⁸

The waiting list is almost 24,000 (implying an average wait of a month). But this tells us nothing about current demand – since children do not get referred if they are thought to be below the current very high threshold for acceptance.

The annual cost in 2006 (no longer ring-fenced) was £508 million. There has been a recent expansion in expenditure and in the number of primary mental health workers, without concomitant evidence of improvement in numbers treated successfully. This highlights the importance of not only recruiting people but ensuring that they are skilled enough, and trained enough to deliver the therapies that actually work.

¹⁷ This matches the ONS household survey findings (Green et al, 2004).

¹⁸ In the total population there are altogether 75,000 looked-after children, 3,000 children in custody, and 195,000 children who go through the youth justice system each year.

4. A WAY FORWARD

Clearly the capacity of CAMHS needs to be expanded – in order to help more children when they are most vulnerable and also most responsive to the right kind of care. The pattern of expansion will vary from place to place. Complex configurations of services are necessary, involving specialists from education, social care and physical health as well as mental health. But at the centre of the problem is a mental health problem, and no expansion of CAMHS makes sense unless it starts with enhanced capacity to deliver the NICE Guidelines.

Delivering the NICE Guidelines

This requires four things.

1. **A training programme** to produce more psychological therapists able to deliver NICE-recommended treatments.
2. **Development of Tier 3 services** following NICE Guidelines, as training grounds for additional therapists and as suppliers of state-of-the-art treatment to their local population. **Outcome measurement** should be a standard feature of this.
3. **Fully professional assessment** of all children referred to Tier 3, and training of sufficient staff qualified to do this assessment.
4. **Expansion of Tier 2 parent training** and training of practitioners able to deliver it.

Of these, **Tier 2 parent training** is well in hand. Within the next two years the Academy of Parenting Practitioners plans to train 6,000 parenting practitioners to work in Children's Centres and other settings, most of which would be considered as Tier 2.¹⁹ Typical treatments for children with established problems last 10-12 weeks (with 2-hourly sessions each week). Some of the work is in groups.

If the problem does not improve or was already serious, the family or young person should be referred to **Tier 3 services**. At that point it is crucial that there is a fully professional **assessment** before anything else. There can be much unnecessary suffering and a huge waste of resources if this is not done. It must be done by a psychiatrist or other mental health professional (eg psychologist) who is fully trained to do it. We estimate this requires 300 more trained people (trained in assessment on top of their other

¹⁹ The shortest courses last three days followed by ongoing supervision for at least a year (the workers already have experience of working with children). The more intensive courses last up to a year (40 days equivalent).

training). The trainees would already be in employment but would need to receive two days a week off-the-job training for a year.

However, a good assessment is useless and utterly frustrating if there are not enough professionals of the right kind to whom children and young people can then be referred. The central bottleneck here is of **psychological therapists**. Building on the existing base of 2,250 clinical psychologists and other therapists, it seems sensible to aim at **training** an additional 1,000 therapists in NICE-recommended treatments. This could be done over a 5-year period.

These therapists would be drawn from those who already have experience of working with children in distress. They would receive a 1-year training while employed in an approved service. The model would be the IAPT training of ‘high-intensity’ workers, meaning 2 days a week in a university training centre (with a nationally-agreed curriculum) and 3 days a week supervised cases while employed in an approved service.

So there have to be enough **approved services**, working according to the NICE Guidelines to provide the on-the-job training of the right kind. These services need to be developed progressively, as in IAPT, with finance provided centrally through SHAs to act as an inducement to produce proposals for truly improved services. A key feature of any approved service would be effective **monitoring** of outcomes, using nationally-agreed instruments. Another key requirement is that they operate on a hub-and-spoke basis, with as much of the therapy as possible close to people’s homes in non – stigmatising environments like GP surgeries and Children’s Centres.

Two other issues need raising. The first is **research**. The range of therapies that have been properly evaluated is much less for children than adults, despite the critical importance of early intervention. Similarly, we have very little understanding of what type of therapies CAMHS is providing, with what results. Finance ought to be nationally organised to plug these gaps, and is included in our costings.

Second, there are key issues of **prevention, identification and early response in Tier 1**. The key participants are GPs, teachers and social workers.

- Since **GPs** spend 1/3 of their time on problems of mental health, their training should surely include a placement in a community mental health team.
- Even so, many families in difficulty do not want to go to the GP.²⁰ They should be able to **self-refer** to CAMHS.
- Preventive mental health education in schools is vital. **Personal, Social and Health Education** should include explicit teaching on mental health and

²⁰ In the IAPT demonstration site at Newham it was found that those who self-referred had greater problems than those who were referred by the GP.

courses to promote resilience.²¹ And **teachers** should be trained to recognise and respond appropriately to mental health problems in their pupils.

- **Screening** is a major issue. If so many troubled children go untreated, this is often because their problems go unidentified. Parents or teachers may have an idea that something is wrong, but society and schools are too psychologically unaware to realise that these are problems which can be identified and helped. If we used standard assessment tools (like the Strengths and Difficulties Questionnaire) on every child at, say, 5, 11 and 16, there is a better chance of getting help to all who need it. This needs very careful handling and piloting. It is crucial that the tools used make sense to the workers at Tiers 2 and 3 who would have to provide the help. I do not include any of these Tier 1 issues in the following costings.

Cost

The cost of what I have proposed is small relative to the NHS budget for mental health which was £9.1 billion in 2006/7. The cost of training, employing and supervising 200 trainee therapists a year is £14 million. The cost of subsequently employing those workers would build up over time. After adding in an allowance for training assessors plus a budget for additional research (covering trials and service monitoring) the total cost of the proposals is **£35 million a year by the end of the CSR period** (see Table 5).²²

Table 5

Total cost of proposals (£m p.a.)

2010/11	21
11/12	28
12/13	35
13/14	42
14/15	49

²¹ The Penn Resilience programme is now being piloted in 22 schools in England.

²² See Annex. The scale of this proposal is less than IAPT for two reasons (i) fewer children than adults have neurotic problems, (ii) existing services for children are on a larger scale than for adults – costing around £500 million compared with £75 million or so on primary care counselling and psychology services. Comparable numbers of staff (FTEs) are roughly 10,000 and 2,500.

CONCLUSION

This is surely the least we owe to our children. There is nothing more tragic than a life which is wasted because help was not provided in time. We owe it to ourselves as well. If we want a society in which there is less misery and less conflict, we should help those whose misery drags down not only them but all around them.

Annex on Costs

There are three elements of cost which I include:

- (i) Therapists. The cost here includes the cost of training extra therapists and subsequently employing them. The training cost includes tuition, trainee wage plus cost of on-the-job training (taken as equal to half a supervisor's wage, in order to reward services which comply with NICE Guidelines).
- (ii) Assessor training.
- (iii) Research.

In what follows

Table 1 gives unit costs

Table 2 gives the total "therapist" costs

Table 3 gives the total overall cost

Table 1. Unit costs

Therapists	£k
Cost per trainee (200 per year)	
1 trainee tuition	9
1 trainee salary (B7 av)	32
1/2 qualified salary (supervisor) (B8)	29
	70
Cost per previously trained trainee	
1 qualified salary	35
Assessor trainees (60 per year)	
Tuition cost only	10
Wage cost (2 days a week)	20
	30

Table 2. Costs of training and employing newly-trained therapists

	Numbers		Costs (£m)	
	Trainees	Trainees previously trained	Trainees	Trainees previously trained
2010/11	200	-	14	-
11/12	200	200	14	7
12/13	200	400	14	14
13/14	200	600	14	21
14/15	200	800	14	28

Table 3. Total costs (£m)

	Therapist training + employment	Assessor training	Research + monitoring	Total
2010/11	14	2	5	21
11/12	21	2	5	28
12/13	28	2	5	35
13/14	35	2	5	42
14/15	42	2	5	49

REFERENCES

Barnes, D. et al (2007). *A profile of child health, child and adolescent mental health and maternity services in England*, Durham University.

Caspi et al (2003).

Challen, A, (2008), A note on the use of the Penn Resiliency Programme in 22 UK schools. Centre for Economic Performance, LSE.

Dadds et al (1999), *Journal of Consulting and Clinical Psychology*, 67, 145-156.

Fergusson, D., Horwood., J., and Ridder, E. (2005). Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood, *Journal of Child Psychology and Psychiatry* 46:8 837-849

Ford, T., Goodman, R., Meltzer, H. (2004), “The relative importance of child, family, school and neighbourhood correlates of childhood psychiatric disorder,” *Social Psychiatry and Psychiatric Epidemiology*, 39, 487-496.

Ford, T., Collishaw, S., Meltzer, H., and Goodman, R. (2007) A prospective study of childhood psychology: independent predictors of change over three years, *Social Psychiatry and Psychiatric Epidemiology*, 42: 953-961.

Friedli, L. and Parsonage, M. (2007), *Mental health promotion: the economic case for investment*. Sainsbury Centre for Mental Health.

Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004), *Mental health of children and young people in Great Britain*, Office of National Statistics.

Healey, A. (2005). “Economic Implications of Psychosocial Development in Childhood; Long-Term Outcomes and the Costs of Intervention”. PhD Thesis, London School of Economics.

Reivich et al (2005), “A Resilience Initiative and Depression Prevention Program for Youth and their Parents”, Penn Resiliency Project, University of Pennsylvania.

Scott, S., Knapp, M., Henderson, J. and Maughan, B. (2001), “Financial cost of social exclusion: follow-up study of antisocial children into adulthood”, *British Medical Journal*, 323, 28 July, 1-5.

Scott, S. (2005), "Do parenting programmes for severe child anti-social behaviour work over the longer term, and for whom? 1-year follow- up of a multi-centre controlled trial". *Behavioural and Cognitive Psychotherapy*, 33, 403-421.

Washington State Institute for Public Policy (2004). *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders*, January 2004.

Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Phillips, J., Pilling, S., Stein, S. and Target, M. (2006). *Drawing on the Evidence*, CAMHS Publications, 2nd edition.