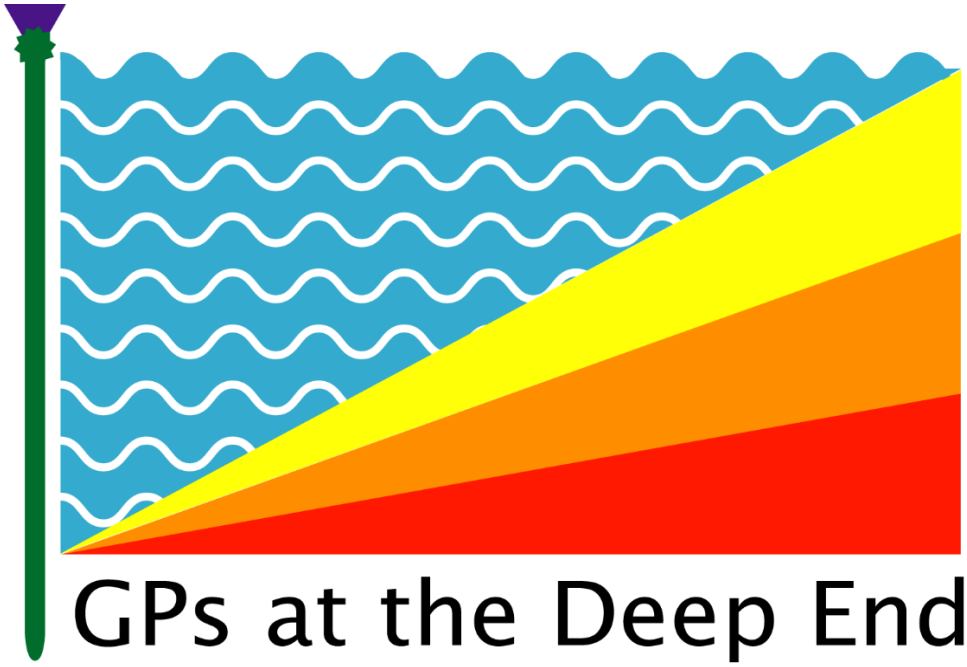

Deep End Report 45

Children and Young People's Mental Health in Deep End Communities.

On Wednesday 17th September 2025, the Deep End GP group hosted an in-person roundtable discussion on children and young people's mental health at the Deep End. The discussion explored the challenges faced by staff – across education and health care – in identifying and supporting children and young people (and their families) experiencing mental health difficulties and challenges related to neurodivergence.

December 2025

EXECUTIVE SUMMARY

Introduction

Mental health difficulties among children and young people in Scotland are increasing, with one in four experiencing challenges weekly and around one in ten having a clinically diagnosable condition but do not have access to the right support. Both General Practice and Education provide universal access for children, and both see higher levels of need in socioeconomically deprived ("Deep End") communities.

Primary and secondary schools operate with differing structures, but both are key first responders for emerging emotional, behavioural, or mental health concerns. CAMHS and Neurodevelopmental (ND) pathways provide specialist support for moderate to severe conditions, but demand on both pathways has significantly increased.

This roundtable, convened by the Scottish Deep End Project, brought together GPs, teachers and CAMHS representatives to explore shared challenges and identify solutions.

Key Themes

1. Growing Need in a Complex Social Context

All groups agreed that children and young people are growing up amid significant social pressures – social media, post-COVID impacts, reduced community cohesion, and rising family stress. These influences contribute to emotional distress, anxiety, and increasing school non-attendance.

Participants emphasised that these pressures affect entire families, and that help is often sought only once families reach crisis.

2. Neurodevelopmental Needs: Diagnosis and Support

The group recognised a growing emphasis on seeking diagnoses to validate needs and access services. While early support should not depend on a diagnosis, participants acknowledged that diagnostic clarity can help young people understand themselves, access resources, and reduce self-blame.

CAMHS noted that most ND referrals appropriately come from schools. Variation in school resources and approaches was discussed, particularly in areas with high levels of trauma or additional support needs.

3. Capacity Pressures and the Emotional Toll on Professionals

Teachers and GPs described working at or beyond capacity, with increasing complexity and limited support services. The emotional impact of "holding" risk was repeatedly raised, particularly where professionals lacked training or time to manage severe distress.

CAMHS staff also described the pressures of high demand, long waiting lists, and balancing clinical risk within a criteria-based service. Unlike CAMHS clinicians, teachers and GPs typically do not have access to formal supervision, despite dealing with significant emotional labour.

4. Considering an "Inverse Education Law"

The group explored the idea that education – like healthcare – may be subject to an "inverse care law," where schools with the greatest levels of need have the least resource relative to that need. Examples included:

- High levels of ASN in mainstream education without commensurate staffing.
- Depute headteacher allocations based on school size rather than complexity.
- Greater challenges engaging parents facing multiple stressors.
- Increased demands around safeguarding and low attainment.

Resources like the Pupil Equity Fund help but do not fully address the scale of need.

5. The "Missing Middle": Lack of Mid-Tier Supports

All groups identified a significant gap between early universal support (e.g. school counselling) and specialist CAMHS. Many children present with moderate anxiety, depression or trauma-related difficulties that exceed the scope of current low-intensity support but do not meet criteria for CAMHS.

This gap can inadvertently shift children into crisis – sometimes resulting in A&E attendance or high-risk behaviour becoming a de facto route to support.

CAMHS staff highlighted that referrals are carefully reviewed and that many are redirected to more appropriate supports. However, GPs and teachers reported that limited availability of those services can leave families feeling stuck.

6. Referrals and Information Sharing

Different professional perspectives on "moderate" mental health need contributed to misunderstandings around referral thresholds. Participants agreed on the need for:

- Clearer communication
- Opportunities for discussion around rejected/redirected referrals
- More consistent information sharing
- Practical mechanisms for joint problem-solving

CAMHS emphasised that redirection decisions are made carefully, based on the information available, and that consent and engagement from the young person are crucial.

Proposed Solutions

1. Resources

- Resource universal services (education and primary care) proportionate to need.
- Support third sector and community organisations to absorb increased demand.
- Enable local autonomy in commissioning support (e.g., flexible counselling procurement).
- Strengthen and stabilise staffing to prioritise relationships.

2. Referrals

- There is a need for high-quality referrals, with sufficient information to support appropriate triage decisions.
- Services should produce clear, kind, and consistent communication in acceptance/rejection letters.
- Share letters (with consent) with schools and GPs to reduce gaps in understanding.
- Pilot options such as brief follow-up phone calls for redirected referrals.
- Explore a navigator role to help families with language, literacy or logistical barriers.
- Provide mechanisms (e.g. an advice email address) to query redirected referral decisions to aid understanding, support interprofessional relationships across the interface, and build knowledge about the alternative options to CAMHS that are available locally.

3. Responsive, Preventative Services

- Commission mid-tier therapeutic services (e.g. CBT, family support, trauma-responsive practice).
- Develop multi-agency community support hubs, co-located with or near schools.
- Expand primary care mental health capacity for young people.
- Recognise non-attendance at school as a key indicator requiring early intervention and support, similar to how "missingness" is increasingly viewed in healthcare.

4. Relationships

- Foster regular interface meetings between education, primary care, CAMHS, social work and third sector partners.
- Improve practical communication channels (secure email, advice lines).
- Promote job shadowing and cross-sector learning.

5. Reflective Practice

- Provide structured supervision for teachers and GPs, mirroring valued CAMHS models.

- Explore the development of a “Teachers at the Deep End” group to build collective voice and peer support.

Conclusion

Despite different roles and pressures, all groups shared a deep commitment to improving outcomes for children and young people. The discussion highlighted a shared sense of responsibility, frustration at system gaps, and recognition that no single service can meet the scale of need alone.

The overarching themes – growing need, stretched capacity, missing middle services, and inequitable resource distribution – point toward the importance of strengthened collaboration, earlier intervention, and proportionate resourcing based on population need.

Introduction/Background

Mental health difficulties among children and young people in Scotland continue to rise. Around one in four young people face mental health challenges weekly, and nearly one in ten 5–16 year-olds have a diagnosable mental illness but do not have access to the right support (Human Development Scotland, 2025).

Pathways to support

Schools and general practices are key universal services that frequently encounter these needs first, particularly in "Deep End" communities where socioeconomic disadvantage is concentrated.

GPs act as the main healthcare contact for families, with practices experiencing very different levels of deprivation and therefore different levels of need. Schools also vary widely in pupil demographics depending on catchment areas. Primary schools rely on class teachers as the first point of contact for wellbeing concerns, while secondary schools use a structured pastoral system. Both sectors have statutory roles in education and safeguarding.

Child and adolescent mental health service (CAMHS) provides specialist assessment and treatment for moderate to severe mental health problems (Scottish Government, 2020), alongside separate neurodevelopmental (ND) pathways (Scottish Government, 2021). Tier 1 and 2 supports, often commissioned by Health and Social Care Partnerships, provide early intervention and counselling within communities and schools. While ND and CAMHS pathways are distinct, the needs of children often overlap, and the demand on both systems has grown substantially.

The number, and complexity, of children with Additional Support Needs (ASN) (including neurodevelopmental diagnoses, learning difficulties or trauma) has increased, resulting in an increased complexity of children in mainstream education at the same time cost pressures on local authorities (LAs) are often leading to cuts in ASN provision. This is important as autistic children are twice as likely to be excluded from school (Guldberg et al., 2021), and only 26% report being happy at school (National Autistic Society, 2023). Children in primary school with ADHD are also more likely to report being unhappy and are more likely to fall below expected attainment in school and have unauthorised absences (May et al., 2021).

There are clear socioeconomic gradients in mental health, with those living in the most disadvantaged communities more likely to experience poor mental health (Marmot, 2010, Green et al., 2005, Gutman et al., 2015) - and ND conditions (Sayal et al., 2018) - and at an earlier age (MacRae et al., 2023). Alongside higher prevalence of child mental health, trauma and poor parental mental health in the most deprived areas, there are

more families with English as an additional language, and lower levels of health literacy, making navigating the health and care systems more challenging.

Preparing for this roundtable discussion

Mental health in school-age children was identified by the Scottish Deep End steering group as a priority topic for a roundtable discussion, reflecting concerns that many young people are falling between service gaps. Unlike previous Deep End discussions, responsibility for assessment, referral and ongoing management spans multiple services. The group felt that exploring this issue without key partners present risked reinforcing existing silos rather than improving collaboration.

To avoid this, a roundtable was proposed involving the two universal children's services—primary care and education—alongside specialist child and adolescent mental health services (CAMHS). The aim was to create a collaborative, solutions-focused space to examine the challenges affecting children's mental health in Deep End communities and to consider how the three sectors might work together more effectively.

Recognising the emotive nature of the topic and the different perspectives each service would bring, an initial pre-roundtable meeting was held with representatives from primary care, primary and secondary education, and CAMHS. This group jointly agreed the structure and key areas for discussion.

Participants were then recruited from Deep End schools (with high proportions of pupils in SIMD 1 and 2), Deep End general practice, CAMHS, and the Scottish Government's mental health directorate (children, young people, relationships and families), along with a representative from the Glasgow Youth Health Service (see Appendix for full details). The session was chaired by an experienced health service manager who was independent of all participating groups, enabling a neutral and balanced facilitation.

The discussion centred around five broad themes: referral pathways; neurodevelopmental assessment and support; the lack of mid-tier ("middle range") services; the emotional impact on professionals; and information sharing.

This report sets out the key themes raised in the discussion, followed by the group's agreed potential solutions and next steps.

Key findings from the discussion

"It's a hard time to be a young person"

Participants agreed that the wider social and political landscape makes childhood and adolescence particularly challenging. Young people are growing up amid what several described as "polycrises," alongside pervasive social media pressures, online comparison, and impacts of the "selfie culture," particularly for girls.

The legacy of the COVID-19 pandemic was felt to have affected not only individual wellbeing but also community cohesion. Many families are now more isolated, with less informal support, making parenting harder and increasing the burden on universal services.

Across the group there was a strong sense that these broader societal influences shape much of the distress seen in schools, general practice and CAMHS. While mental health presentations are increasing, not all difficulties reflect mental illness; loneliness, insecurity, and digital exposure also play significant roles. Participants highlighted the need to recognise these contexts without attributing blame to any single service.

There was collective agreement that the ambition should be to help children and young people *thrive*, rather than simply manage risk or prevent crisis, and that the current system often struggles to move beyond crisis containment.

"We want a society where our families and young people thrive… and yet so much of our system is about managing risk… and stopping people from being dead. What kind of aspiration is that?"

Families, not just children

Professionals repeatedly emphasised that they are not just seeing distressed children but distressed families. Many parents find it difficult to ask for help until they are overwhelmed, and families often present to schools or GPs at or near crisis point.

Family therapy and family support workers were described as highly valuable, but availability varies and, in some areas, has reduced due to local authority cuts. Participants reflected on the additional complexities in Deep End communities, where intergenerational trauma, undiagnosed parental mental health conditions or neurodivergence, poverty, and language barriers are more prevalent. CAMHS clinicians noted that parental insight into their own neurodivergence sometimes emerges only when navigating their child's assessment.

Schools and GPs often have long-standing relationships with families, enabling a holistic view of background stressors. However, the work of supporting families through

long waits, referrals and system navigation requires time that universal services rarely have.

Participants asked how best to empower parents while also being realistic about what services can offer. Many families want to help their child but face structural and emotional barriers that require dedicated support.

Neurodevelopmental Disorders: Diagnosis and Support

There was broad agreement on the need to shift from a narrow focus on obtaining a diagnosis towards supporting children based on the difficulties they present with. While over-medicalisation of normal distress was raised as a concern, both GPs and educators emphasised that they feel confident in distinguishing distress from mental illness and in providing early support.

CAMHS representatives clarified that although most CAMHS referrals come from GPs, ND referrals are better placed coming from schools given their daily contact with children. GPs agreed with this position.

While early support should not depend on diagnosis, many participants highlighted the practical and emotional benefits a diagnosis can offer – for access to services, validation, and reducing self-blame. Participants also discussed how some young people internalise difficulties as personal failings. In these cases, a diagnosis can be protective by offering an explanation that supports self-esteem. Others noted that diagnostic labels can feel limiting or stigmatising for some young people, highlighting the need for an individualised approach.

Significant variation exists across schools in how ASN and ND needs are supported. In schools with high levels of trauma or ND, inclusive practices are often embedded across the whole school, but the substantial additional work required to do this is not always recognised within existing funding or staffing models.

Capacity and Emotional Impact on Professionals

Capacity issues were raised across all sectors. Universal services described repeatedly absorbing work that sits beyond their remit because there is no clear alternative for families with escalating difficulties.

Teachers gave examples of managing risk, supporting pupils with attendance difficulties, and coordinating multi-agency plans, often outside contracted hours. In secondary schools, high attainment pressures reduce capacity for relationship-based work.

GPs described carrying significant risk and holding complex families across multiple contacts, often without timely access to specialist advice. CAMHS representatives

acknowledged the emotional burden of balancing clinical thresholds within a pressured service and the challenge of wanting to offer more than capacity allows.

Participants agreed that the emotional toll on professionals – feelings of guilt, frustration, helplessness, and moral injury – was substantial. One participant described *"this is worst the start to term we've had… I can't work out why… I am exhausted at the end of the day…. Sensory overload for me with no safe spaces for pupils"*.

Unlike CAMHS clinicians, teachers and GPs typically do not have access to structured supervision despite the high emotional intensity of their work. The group felt that reflective space would be beneficial across all sectors.

An "Inverse Education Law"?

Drawing parallels with the Inverse Care Law in primary care, participants suggested that education may experience a similar pattern – where schools with the highest levels of need have the least resource relative to that need.

"In other [more affluent area] schools, the deputy head teacher is spending their time doing attainment strategies… and I'm turning up at the home of a kid I'm worried about … and the child looks terrible, and the mum looks terrible."

Examples included:

- ASN provision in mainstream settings expanding without matched staffing
- Depute headteacher allocations based on school roll, with no weighting for SIMD or proportion of children with ASN despite these factors heavily influencing workload.
- Lower parental engagement due to structural barriers, not lack of interest
- Greater demands around safeguarding, attendance and crisis management in Deep End contexts
- Fewer opportunities for fundraising, reducing access to enhancements enjoyed elsewhere

The Pupil Equity Fund is valued but cannot compensate for reduced universal or specialist provision, and austerity-related cuts to community services have further increased pressure on schools and GPs.

Participants noted that future legislative or workforce planning should account for the higher intensity of work required in Deep End schools.

“The “Missing Middle” and the Need for Prevention

All participants identified a substantial gap between low-intensity supports (e.g., school counselling) and tertiary CAMHS. This “missing middle” includes children with moderate depression or anxiety, trauma-related difficulties, or significant functional issues such as school non-attendance.

Universal services described a concerning trend whereby crises – including A&E presentations or suicide attempts – risk becoming de facto routes to specialist support. CAMHS representatives emphasised that referrals need to meet set criteria, but acknowledged that gaps in community provision can leave families without accessible alternatives.

Non-attendance at school was highlighted repeatedly as an early warning sign requiring coordinated intervention. Many children who are not attending school due to anxiety are redirected from CAMHS, despite schools and GPs feeling that their level of impairment is significant. Participants stressed that emotionally-based school avoidance requires intervention and this needs to be multi-agency support rather than specialist CAMHS alone.

There was consensus that investing in preventative, mid-tier services would benefit children, reduce crisis escalation and relieve pressure on CAMHS.

Referrals, Rejected Referrals and Communication

CAMHS representatives emphasised that many of the referrals they receive are requests for advice, updates, or clarification, meaning rejection rates may appear higher than they are. They noted that considerable thought is given to each referral, with decisions based on the information available and with the intention of ensuring families are directed to the most appropriate support.

Where children do not meet CAMHS criteria, alternative pathways are considered carefully. CAMHS staff highlighted the importance of having comprehensive information at the point of referral, given the need to match children to the right service.

The roundtable highlighted differences in how universal services and CAMHS interpret “moderate” mental health difficulties. This variation often reflects the complex social and contextual factors influencing families. Participants noted that some referrals were rejected despite significant risk factors – such as parental addiction or trauma – and clear functional impacts, including school non-attendance and social withdrawal. These indicators were felt to be markers (or risk factors) for moderate mental health difficulties and are commonly considered reasons for CAMHS involvement. However, inconsistent understanding and application of thresholds can lead to frustration and misunderstanding among professionals.

Participants agreed that CAMHS cannot be responsible for every mental health concern in the community, and that GPs and educators require reliable, accessible mental health supports at a level below CAMHS intensity. Many of the challenges around rejected referrals therefore reflect gaps in community provision rather than shortcomings in CAMHS decision-making.

GPs described limited mechanisms for querying rejected referrals or seeking clarification for children already under CAMHS care. While contact with the CAMHS duty team is possible, this can be time-consuming and may involve speaking with clinicians unfamiliar with the family's history.

Communication was recognised as an area with potential for improvement. All services use secure email systems, but these are not always utilised effectively for timely, practical information sharing. Clearer interfaces could help avoid duplication, delays, and uncertainty.

Participants also discussed the emotional impact of rejected referrals – both on families and professionals. Redirection can feel like "closure" rather than continuation unless there is accompanying support to help families engage with suggested services. Some GPs noted variation in the rejection letters with some feeling clinical at times, while CAMHS staff highlighted the effort they put into making letters supportive and transparent.

Signposting alone is not always sufficient. Families may face barriers to accessing recommended services, including:

- long waiting times
- geographical inaccessibility
- lack of digital access
- literacy difficulties
- unfamiliarity with third-sector organisations

These challenges can erode trust between families and referrers, especially when a young person's difficulties continue to escalate.

Universal service practitioners also described "holding" families for longer than feels safe, sometimes referring later than they ideally would, out of concern about the impact of rejection.

Participants noted that navigation across multiple agencies can be particularly difficult for families in Deep End communities. Schools and GPs often take on significant responsibility for supporting families through these processes, despite workload

pressures. Unlike care for under-5s, where health visitors act as a consistent link, there is no equivalent coordinating role for school-age children.

Potential Solutions

Potential Solutions

The roundtable was explicitly solutions-focused. Participants recognised that many of the challenges described stem from wider structural issues – poverty, reduced community services, austerity, workforce pressures – and that meaningful progress requires action both within and beyond the health and education sectors. With that caveat, the group identified several practical areas for improvement, summarised under five headings: **Resources, Referrals, Responsive Services, Relationships, and Reflection.**

1. Resources

Participants agreed that not every mental health difficulty requires CAMHS involvement, and that third-sector or community organisations are often ideally placed to provide early support. However, these services also have limited capacity and need sustainable funding if they are to operate as reliable alternatives to statutory care. A clearer understanding of how many families successfully access signposted services – and why some do not or cannot – would inform future planning.

Universal services stressed that they are currently at saturation point and cannot absorb additional responsibilities. Increased demand in schools and general practice ultimately places indirect pressure on specialist services. Resourcing universal services proportionately to need would help reduce burnout, improve support for families, and relieve pressure on crisis and tertiary-level care.

- In education, this means recognising both the number of pupils and the complexity of needs. Staffing models for teachers, deputes and senior leaders could be better aligned to deprivation and ASN levels. Head teachers should be genuinely supernumerary, allowing PEF to be directed towards attainment rather than substituting core provision.
- In primary care, the Scottish Deep End's recent recommendations on tackling the Inverse Care Law offer a framework for more equitable resource distribution (Blane D, 2024).

Participants also encouraged local autonomy and flexibility in commissioning support. Examples included avoiding restrictive procurement practices that limit access to local counselling providers. Stability within school and primary care teams – through thoughtful recruitment and retention – was seen as essential to maintaining continuity and relational practice.

Finally, recognising financial constraints, the group encouraged learning from systems where strong outcomes are achieved with modest resources, including international

examples that emphasise family and community support rather than specialist CAMHS capacity alone.

2. Referrals

Participants identified several ways to improve communication and clarity around referrals:

- **Establish structured referrer–specialist interfaces:** to improve mutual understanding of systems, reduce silo working, and enable discussion of pathways and rejected referrals. These forums would help safeguard vulnerable children and enhance referral quality by clarifying the information required for effective triage
- **Kind, clear letters:** Rejection or redirection letters should be supportive, easy to understand, and include more than a list of websites or QR codes. Services should routinely monitor the tone and content of these letters.
- **Consistent information sharing:** CAMHS letters should be shared (with consent) with young people/families, GPs and schools to avoid confusion and ensure all professionals have the same information.
- **Proactive follow-up:** Consider piloting brief phone calls for redirected referrals to validate families' experiences, explain decisions, and help identify appropriate next steps.
- **CAMHS-facilitated onward referral:** Where a child has been assessed, CAMHS could, where appropriate, refer directly to community or third-sector services rather than returning responsibility to GPs or families. This would reduce delays, prevent families feeling abandoned, and provide better data on utilisation of community services.
- **Three-way conversations:** Options for joint conversations between CAMHS, the referrer, and the young person could support continuity and mutual understanding, in line with positive experiences from paediatric services in Lothian.
- **Navigator roles:** Families with additional barriers – language, low literacy, parental mental health issues – may benefit from a navigator to help them opt in, prepare for appointments, manage transport or access issues, and understand their options. Some third-sector organisations already provide this informally.
- **Improved query mechanisms:** A non-urgent CAMHS email address for queries about rejected referrals or young people already under review would improve efficiency and reduce reliance on duty lines

3. Responsive Preventative Services (Addressing the "Missing Middle")

Participants strongly supported the development of preventative mental health services that bridge the gap between school counselling and CAMHS. These services would support children with moderate needs and reduce crisis escalation.

Key components could include:

- evidence-based psychological therapies (CBT, mindfulness-based approaches)
- family support and family therapy
- trauma-informed stabilisation work
- play therapy, especially in primary schools

For ND pathways, existing networking and duty systems could be expanded or co-located with broader supports.

Community Support Hubs

One proposal was the creation of **Multi-Agency Community Support Hubs**, initially piloted in Deep End areas and located within or near schools. These hubs would:

- be jointly funded by Health and Social Care Partnerships and Education.
- Provide initial psychological therapeutic support.
- Offer low-threshold access for GPs and schools (with most primary care referrals expected to be to these hubs, but allowing for escalation to CAMHS where needed).
- Streamline navigation through co-location of services
- Make early intervention more accessible for families

Critically these hubs should have an ethos of "working with" rather than "doing to" families and could draw on the significant third sector experience in this area. These hubs could also connect families to financial inclusion, housing, and other social support, recognising the role of wider determinants in emotional wellbeing.

Primary Care Mental Health Capacity

Participants highlighted successful examples of mental health nurses embedded in Deep End general practices, offering support to young people aged 12+, liaising with schools, and helping reduce CAMHS referrals. Although national plans for increasing mental health workers in primary care have paused, reinstating such initiatives was seen as beneficial, with the design of these services involving both primary and secondary care representatives.

Trauma-Responsive Practice

The group emphasised a shift from being merely "trauma-informed" to "trauma-responsive," ensuring timely access to stabilisation and therapeutic support after

trauma. Not all families may be ready for therapy immediately, but there should be a clear pathway for re-accessing support when they are.

School Non-Attendance as a Trigger for Support

Non-attendance should be recognised as a significant warning sign, akin to a failure-to-thrive indicator in younger children, or "missingness" research in healthcare. Multi-agency support for emotionally based non-school attendance (EBSA/EBSNA) should be available, with escalation to CAMHS where appropriate. For some children, alternative provision beyond mainstream schooling may be required and should be timely and supportive.

4. Relationships (with Families and Between Professionals)

Empowering Families

Peer support for parents was seen as an underused but powerful resource. CAMHS clinicians noted that advice often "lands differently" when it comes from another parent. Current provision is patchy; expanding secure, sustainable peer-support networks – whether through statutory or third-sector organisations – could provide families with valuable reassurance and community.

Family therapy and family support workers were widely recognised as effective but insufficiently available. Protecting and expanding these roles, particularly in primary schools, would help families at earlier stages.

The early intervention model offered by "family wellbeing workers" in some Deep End practices was noted as particularly promising.

Professional Relationships

The roundtable highlighted how independently the three sectors often operate, and how valuable it was simply to hear each other's perspectives. Participants suggested forming ongoing interface groups to facilitate understanding and explore and agree on mutual decisions moving forward

Stronger information-sharing arrangements are also needed. Simple steps – like routine CAMHS letters after each review, use of secure email addresses within schools and practices, and local advice lines – could improve communication. Job-shadowing opportunities were also proposed to build understanding across services.

Schools and general practice noted the effectiveness of regular multi-agency meetings for under-5s, facilitated by health visitors, and expressed interest in exploring similar structures for school-age children where feasible.

5. Reflection and Supervision

Participants strongly supported the introduction of reflective supervision for teachers and GPs, using established models drawn from psychology and mental health disciplines. Such supervision could reduce burnout, support emotional resilience, and validate the experiences of frontline professionals.

Education and primary care are the two universal services for children and young people, and both face similar challenges in Deep End contexts. For the GPs present, the Deep End group provided a valuable mechanism for solidarity, advocacy, and the development of practical, frontline solutions. This collective voice has proven effective in supporting clinicians and influencing policy. Emergency medicine has recently adopted a similar model.

Following this discussion, participants suggested exploring the potential for a comparable initiative within education – such as a “Teachers at the Deep End” group – to strengthen collaboration and advocacy for schools serving high-deprivation communities.

Appendix 1: Attendees

Lorna Kelly, National Strategic Lead for Primary care, Health and Social Care Scotland (chair)
Harriet Rushworth, GP partner Clydebank, member Scottish Assembly of parents and carers.
Nora Murray-Cavanagh, GP partner Wester Hailes medical practice, Edinburgh
Karen Nicolson, Sessional GP Dundee, Clinical lecturer St Andrews University
Lisa Fitzharris, Depute Headteacher, Port Glasgow High School
Nikki MacLellan, Depute Headteacher, St Andrews High School, Glasgow
Claire Dancer, Depute Headteacher, Wester Hailes High School, Edinburgh
Lisa McGroarty, Depute Headteacher, Newark Primary School, Port Glasgow
Laura Davidson, Headteacher, Wallacewell Primary School, Glasgow
Irene Cronin, Highly Specialist family and systemic psychotherapist, NHS GGC
Clare Roberts, Consultant Clinical Psychologist, NHSGGC
Barbara Adzajlic, Health Improvement Lead (Children & Young People's Mental Health)
Ruchika Gajwani, Senior Research Fellow in Clinical Psychology, University of Glasgow
Georgia de Courcy Wheeler, Team leader CAMHS and ND Improvement, Mental Health Directorate, Scottish Government
Stephen McLeod, Professional Adviser, Mental Health Directorate, Scottish Government
Carey Lunan, Chair, Scottish Deep End Project
David Blane, Academic co-lead, Scottish Deep End Project
Marianne McCallum, Academic co-lead, Scottish Deep End project

Apologies

Sharron McMillin, Headteacher, Our Lady of the Rosary Primary School, Glasgow
Lisa McGroarty, Depute Headteacher, Newark Primary School, Port Glasgow
Charlotta Gorski, Child and Adolescent Therapist, NHS Orkney
Jane Killin CAMHS Clinical and Operational Manager, NHS Lanarkshire

Members of original planning discussion

Clare Roberts, Consultant Clinical Psychologist, NHSGGC
Lauren O'Hagan, Headteacher Newark Primary, Port Glasgow
Lisa McGroarty, Depute Headteacher, Newark Primary, Port Glasgow
Lisa Fitzharris, Depute Headteacher, Port Glasgow High School
David Blane, Academic co-lead, Scottish Deep End Project
Marianne McCallum, Academic co-lead, Scottish Deep End project

Appendix 2: Post it note responses at the start to two key questions

What do you most want others here today to understand about what it's like in your role/job?

GPs

- GPs care, GPs are busy, GPs are well placed (family doctor).
- How hard it is to hold families when they fall through the gaps. We feel frustration over lack of services or access to them.
- We really care and can make a difference by being kind and connecting with young people.
- As a GP, end up carrying very high-risk patients and a feeling of being rejected on behalf of patients and families.
- Limited time to manage hugely complex scenarios. Limited resources. "Last resort" – lots of managing expectations. Seeing impacts on entire families. Major underfunding of all services.
- It's not just the index person who suffers – families, carers & those around about them too.
- "Inverse care law = Deep End GPs lack time and resource to adequately address needs. Family Wellbeing Workers (pilot) are able to provide proactive, outreach, holistic support, with a focus on young people, building trust/confidence."

Teachers

- "That we have to be here every day, that solutions in school are much cheaper than emergency equivalents in care, in emergency health settings - that we are trying our best."
- My role as a DHT: year group of 360 pupils; child protection co-ordinator for 1952 pupils; line manager for 9 staff; JST chair for learning community.
- "We are much more than just educators - our role doesn't stop at 3pm."

CAMHS

- "Tier 3 CAMHS was never designed to be for all MH problems in young people."
- "Please call us and talk through your referral dilemmas."
- "Please be aware of the need for consent of the young person to come to CAMHS"
- "I start from the position of the family as the child's main resource. I work with past, present, future - over generations. I work with child & their family, as well as system around the child. Sitting with families together in the room is exceptionally complex."
- Clinical Psychology, like a lot of professions, holds a lot of power - how do we re-address this?

Others

- "My role is about listening, working out the gaps and potential solutions, and bringing partners together to improve the system."
- "It's different especially to being frontline but we're feeling the pressure too."
- Know more about unwarranted variation across Scotland and good practice in local areas to be spread. Be clearer about national policy intent on C&YP mental health and neurodivergence.

What keeps you awake at night about Child and Adolescent Mental Health?

GPs

- Young people at high risk of suicide who are assessed and deemed "not high risk enough"
- All the future morbidity by not intervening now.
- We see the mental health challenges and want to make a difference. We see the parent's distress and the child's.
- Young people with unmet mental health needs who are not thriving and who don't get the therapy input the need.
- Preventable harm – families struggling and complex needs.
- How many children are facing adversity and trauma – particularly emotional neglect.
- The very tricky upstream issues that are often the cause of CYP's distress (and their families).

Teachers

- A young person taking their own life and we haven't even known they were struggling.
- How disappointed and upset and powerless families are. How I try to remain hopeful when you can't see down the road.
- The young people on waiting lists often leaves teachers feeling helpless.
- Inequalities of children with ND, poverty, etc. Lack of resource and gap between guidance/law and reality.

CAMHS

- Sometimes, the burden of caring for families and caring for staff who are struggling.
- Letting families down as I don't have enough time to do what I wanted to do/said I would do, e.g. phone school.
- C&YP waiting for something that won't help them. Detriment to C&YP on unseen waiting lists.

- In CAMHS/services, children's problems are often viewed individually rather than systemically. I worry this is harmful.

Others

- The ones that are "getting" away.
- CAMHS ND waiting times. Lack of resource. Suicide risk in young people "no support". Especially young men – substance use, prison, ADHD, poor academic attainment.
- All the things that need to be done but no time! Are we making any difference or progress?

Appendix 3: Responses to "What is your one key take-home from today?"

- "Proportionate universalism" – targeting of resources in proportion to needs. And the need to organise (e.g. "Deep End" teachers!) – for solidarity, support, and collective action.
- Look after yourself / self-care.
- ACEs learning – "one adult who cares" can make a difference.
- Supervision / support.
- We are better together, to make changes we need to work together.
- What would it take for our children and young people to thrive (and think about those missing).
- What would it take to make the school day more interesting (see the Hayward report).
- Collective action.
- Thriving not surviving… lean in with compassion.
- Power of collaboration between universal services – sharing of information – more active local collaborations – "missing middle" – enact GIRFEC principles. Local as much as national.
- Primary care and secondary care becoming aligned – need to be unapologetic about the impact of deprivation.
- Community focus.
- Health & Wellbeing first. Move from "informed" to "action"
- Getting it right for those in most need will help to get it right for others / increasing inflexibility of funding (less creativity) / red rules (absolutes) and blue rules (negotiable – space for innovation).
- Self-care / PR campaign around mental health and parenting supports.
- Hopeful… what would parents and CYP think of this discussion? Lots of hard work going on – but huge levels of need… "Parent MH services".
- What is still missing from the "middle"?

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