Evidence to the Scottish Parliament Health and Sport Committee, providing information about CAMHS services – Response from Social Work Scotland.

1. What are the key factors that result in long waits for CAMHS services?

The Child and Adolescent Mental Health Service (CAMHS) is the main service in Scotland targeted at understanding and supporting children and young people, experiencing mental health difficulties. CAMHS services are generally categorised by four tiers, which demonstrates the level of specialist intervention the child or young person needs.

Members of Social Work Scotland have indicated significant waiting times across CAMHS services, in particular for children and young people who are experiencing emotional distress or requiring additional support for learning disability; ADD.

One key factor appears to be the volume of referrals. However, this is exacerbated by the fact that some children may be referred inappropriately. CAMHS services do not routinely provide specialist support to all children and young people who are experiencing emotional distress. This emotional distress could stem from children and young people whose care arrangements are unstable or who experience distress alongside other difficulties, such as substance misuse. It appears that some children and young people may be nonetheless, routinely referred for support in these circumstances. This is due to both a lack of clarity and understanding around the criteria for CAMHS services, and the lack of alternative support options for young people experiencing emotional distress.

A lack of awareness of alternative parenting support services, may also be a factor in inappropriate referrals, particularly from GPs.

CAMHS should produce clearer referral criteria, to ensure that unnecessary referrals do not happen, as these can slow the system down and contribute to the long waiting times.

Consideration of other models of support is needed, to address distress and mental wellbeing issues impacting on children and young people. Investment in these is also important if pressure on CAHMS services is to be addressed and improved outcomes for children and young people are to be achieved.

Local authorities and the NHS need to work together to achieve clear pathways for CAMHS services. A joint approach would support earlier interventions, and make sure the right services get to the right child at the right time.

According to Kindred Scotland[1], the prevalence of children being assessed and diagnosed with ASD and ADHD[2] is on the increase which creates evident pressure on CAMHS services. Children with suspected ASD/ADHD tend to go through **extensive assessment** by CAMHS services with a view to receive a conclusive diagnosis. This can also lead to long waiting times.

There is evidence of a **lack of appropriate personnel in mental health services** to meet the level of support and treatment needed. This is supported by a 2014 study by the Royal College of Psychiatrists[3]. Lack of staff in these areas contribute to the waiting times, as it takes longer to assess support available to children and young people. A review of the skill mix of teams would be helpful; to ensure that the right multi-disciplinary mix of staff are in place, including social work input.

2. What would you identify as the main reason(s) for the CAMHS waiting time target not being met?

Broadly the Social Work Scotland members found the main reasons to be;

Too many referrals – as previously discussed CAMHS do not routinely support and provide service to children and young people who are experiencing emotional distress; however, this is not clear to everyone in the health and social care sector who are making these referrals.

The increased prevalence of children being diagnosed with ASD and ADHD is creating increased demand.

A range of factors appear to be leading to more children and young people experiencing distress and mental health issues, for example online bullying.

The level of staff does not meet the level of need for mental health services to provide timely support.

3. Are there any other issues in CAMHS that you would identify as being a priority for improvement?

The lack of appropriate support of those children and young people experiencing emotional distress is an area for improvement. Social workers are finding it increasingly challenging to provide support to children and young people who are expressing self-harm behaviours or challenging behaviour.

[1] http://www.kindred-scotland.org/home
[2] The National Autistic Society. (2016). Autism Facts and Statistics. Available: http://www.autism.org.uk/about/what-is/myths-facts-stats.aspx.
[3] http://www.rcpsych.ac.uk/systempages/gsearch.aspx?cx=005217297982068972824%3aqhx0tmhjcsy&cof=FORID%3a9&q=lack+of+mentla+health+staff+2014

There is also a lack of flexibility in the model of CAMHS provision which, with some exceptions, remains essentially clinic based. This can hinder their ability to engage and offer support to some of the most vulnerable children and young people, in particular those whose family and own circumstances may be chaotic and for whom an outreach model is required.

As already highlighted in order to promote early intervention and to meet the needs of all young people experiencing emotional distress, further consideration requires to be given to reviewing the scope and service delivery models of CAHMS or refocusing and investing in alternative supports.

Some children with ASD and ADHD will require additional support in school and at home from CAHMS services; however, at the moment this support is limited. It is central to the idea of early intervention and prevention: a child or young person receiving the correct professional support at the right time could prevent additional challenges later in childhood. For example the lack of support could spiral into the child being removed from school due to challenging behaviour. This challenging behaviour can then continue at home, and in extreme cases this could result in a family breakdown. This could then result in risks escalating and the child becoming involved in the formal care sector. This could be reduced if more children were supported earlier.

There is inconsistency in the availability of some types of CAMHS service across the country for example CAMHS Learning Disability teams and services targeted at looked after young people and their carers.

For children and young people with the highest levels of need there is a significant lack of resource. Children and young people who are experiencing significant mental health difficulties and require tier 4 inpatient specialist services; can be left seriously unwell in their community due to lack of suitable inpatient care in Scotland. In some instances young people are still admitted inappropriately to adult wards, due to limited facilities in Scotland or sent to specialist facilities in England. A vast majority of valuable resources are used up in this way. Placing a young person so far from home and family supports is often detrimental to recovery and transition back in to the community. Inpatient care is a key priority for improvement.

There is also inconsistent practice in terms of CAMHS support to 'looked after' children and young people who are place out with their home authority including those in secure accommodation. Our member's experience is that whilst there are examples of good practice in the co-ordination and planning of such support between the home and host areas, this is not universal and children and young people at times experience a lack of coherent support.

4. Are there any particular factors or initiatives you can identify which has helped improve services either locally or in other parts of Scotland?

The introduction of self-directed support is a positive development for some children and young people, including those who have a disability or mental health difficulties; however, there are practice and policy challenges in applying this across health services.

Specialist services for eating disorders are reported on the whole to be very good. These inpatient facilities are very well staffed and the young people receive a huge amount of support. It would be helpful if all mental health conditions could be given equal weight in terms of support and services.

'Intensive Home Treatment Services' in the community are available in some areas, for example Lothian and Lanarkshire, have an Intensive Treatment Service. These services provide an alternative to inpatient admission to some young people with significant needs. This service is a very positive example of a successful approach, and demonstrates that children or young people receiving the right medication and behavioural support means the condition becomes manageable. This service is not available in many other areas, and should be considered.

The National Child Sexual Exploitation Action Plan update published earlier this year, identified that monies had been made available for CAMHS services to support children and young people affected by sexual exploitation. This is welcomed; however, it is not clear where the funds were fed through at a practice level in some areas, or whether this money was badged and used simply to address waiting times target.

5. What support is provided to children and young people while they are waiting for a stage three referral?

At stage 2 primary health care workers, psychologists, social workers and school support children and young people in the community and via primary care settings. Children and young people who have moved from stage one to stage two and showing signs of needing more specialised intervention and assessment are referred to stage three. The stage two specialists will continue to provide the child/young person will support until the stage three referral is assessed and treatment plan verified. This can lead to pressure on these services and potential risks if there is a significant delay in provision of stage 3 support.

It should, however, be recognised that with support professionals at stage 2 can be empowered to continue working with children without always seeking to refer to a higher level of intervention. If services at the preventative and early intervention part of the continuum are strengthened this would ensure children received help at an earlier stage, reduce referrals to specialist services thus enabling them to focus on the children that require that level of intervention.

6. Which parts of the previous Mental Health Strategy have been the most successful?

It is difficult to pin down the most successful aspects of the strategy, as there is yet to be a comprehensive reported evaluation on the delivery. The lack of a performance framework

did not allow for annual progress reports. The implementation of these reports would have allowed for plans to be made for remedial action for failing approaches[4].

7. Which parts of the previous Mental Health Strategy have been the least successful?

The Mental Health Strategy 2012-2015 Scotland set out 36 commitments, of which there has been some progress. However, it is important to note, that there have been significant short comings:

The strategy appears to have been inadequately resourced to meet all the aims and objectives

The commitment to reduce admissions of under 18s to adult wards was unsuccessful. In a Statistical Monitoring Report 2014/15, 207 admissions (involving 175 young people) were admitted to non-specialist wards – a mixture between paediatric and adult wards[5]. Children and young people being admitted to non-specialist wards can be detrimental to the care and support they receive. Nurses and healthcare workers are not trained in non-specialist wards to assist in mental health distress. This highlights the failing of the Mental Health Strategy commitment of reducing these admissions.

Waiting time for CAMHS have also not been realised in the Mental Health Strategy. One of the Mental Health Strategy commitments was to increase access to specialist CAMHS services; however, some local authorities are waiting up to a year to have access to assessment and treatment. The 18 week target is only being met eight boards in Scotland[6] (Ayrshire and Arran, Dumfries and Galloway, Greater Glasgow and Clyde, Highland, Lanarkshire, Orkney, Tayside and Western Isles). Service provision has to change in order to ensure that every local authority reaches the 18 week target.

8. What would you identify as the key priorities for the next mental health strategy?

The development of pathways to services that are based on GIFREC and the single child's plan. A clearer pathway is required for children and young people with mental health issues that is directly related to GIFREC and the SHANARRI indicators of wellbeing.

Further focus on early intervention, engagement with hard to reach children and young people and models of support for children and young people experiencing distress.

[4] https://www.samh.org.uk/media/462301/samh_ask_once_get_help_fast_manifesto_for_the_2016_scottish_parliament_election.pdf

[5] http://www.mwcscot.org.uk/media/240702/yp_monitoring_report_2014-15.pdf

[6] ISD Scotland. (2016). Child and Adolescent Mental Health Services (CAMHS) Waiting Times. Publications Report. 1 (1).

There is more support needed in residential secure units for young people and for young people placed away from their local areas. This should be a key priority for the future mental health strategy.

Clarity about the place for CAMHS services in the range of provision for children and young people diagnosed with ASD and ADHD.

A greater focus on early intervention and prevention.

Good practice guidance to Health Boards on support and planning for young people in out of authority placements. Often when children are placed out of the area they live in; the CAMHS service does not follow or it can be inconsistent, which is a major safeguarding issue. This has to improve in order to support children and young people in this area.

An evaluation of which services we are likely to need in the future is required, including services for unaccompanied asylum seeking children and victims of child abuse identified in the historical child abuse inquiry.

There is an underlying structural issue that agencies are having to manage funding efficiencies, in the current state of austerity. Therefore, the role of CAMHS and ongoing funding should be reviewed in the future Mental Health Strategy, linking directly to the whole pathway of care across local authorities and health.

Conclusion

Overall Social Work Scotland members note that currently CAMHS services do provide some very effective support to children and young people. However, a lack of clarity about their role, long delays in accessing services and the need to review this service in light of the increasing numbers of children and young people experiencing emotional distress and self-harm across the pathway is required. We need to have services that fit the needs of our children and young people and not expect them to 'fit' into what is currently on offer. The way ahead is for a mental health and wellbeing strategy that has a much more holistic approach.

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