

Child and adolescent mental health services Evidence to the Scottish Parliament Health and Sport Committee

The mental health and wellbeing of Scotland's children and young people is of increasing concern to social work.

There are real areas of good practice and areas where the services work well, but there are also some concerns about provision now and provision into the future that we would also like to highlight to the committee.

The main points that we want to make to the committee are as follows:

1. It is important to think about mental health provision for children and young people out with formal CAMHS services. We cannot solve issues with waiting times for CAMHS, by looking only at CAMHS. We need a much more holistic and systemic approach in respect of mental health and look at early intervention such as counselling in schools and programmes which all children can access which look at increasing resilience in children and young people.
2. We must bear in mind that often the best way to deal with mental ill health is through a social model and not always through a medical model. A more person centred approach is required so that mental health is rooted in social models and a public health model.
3. We need to think about services fitting to the needs of our children and young people and not trying to make children and young people fit into the services we have already established. This is particularly key for young people in secure care and those who are in the care system.
4. Our services need to have an eye to the future – how do we plan for the influx of unaccompanied asylum seeking minors and the very specific needs they may have.
5. Children and their mental health issues do not exist in isolation. Children live within communities and with families or carers. It is important that any service is able to support children and young people in their context so that the impact of the support can be maximised.

What factors are currently constraining meeting the target time of 18 weeks for all children and young people being seen at tier 3?

Demand for CAMHS services remains high and waiting times are long. Most recent published figures for the quarter ending June 2016 indicates that 77.6% of children were seen within 18 weeks, down on the previous quarter (84.4%) but slightly better than the same quarter the previous year (76.7%). Demand for the service continues with 4,642 children and young people accessing treatment which is an increase to the previous quarter (4,496)¹.

Children and young people not turning up to appointments is an issue, but only slightly more so than across the NHS outpatients services as a whole, where the figure is around 10%². There are still some issues with a slight increase in non-attendance at first appointments (13.1% compared to 12.1% in previous quarter) according to current published figures. Whilst this will be for a variety of reasons, and perhaps explained through both the nature of the conditions and the group involved, it will inevitably impact on demand and consequently waiting times. DNAs are an issue for CAMHS across

¹<https://isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2016-09-06/2016-09-06-CAMHS-Summary.pdf>

² <http://www.isdscotland.org/search/?q=did%20not%20attend>

Scotland (but also UK with mean at 10%). All children's outpatient services experience DNAs and the reasons for it are complex.

The nature of demand is changing. There is a rise in concern about children experiencing anxiety in recently published Childline figures³. Previous media reports indicate that anxiety is the fastest growing illness in young people under 21 and that by the time a child is accessing treatment, the level of illness has increased resulting in overwhelmed services⁴. Whilst many parents of children and young people with emotional or behavioral problems will seek help, teenagers and young adults seldom seek support from formal sources and are more likely to go online or speak to friends, which could lead to delays in referrals and those coming through presenting as acute⁵.

We need to get support to children and young people sooner and also consider different approaches to encouraging children and young people to come forward and seek the help they might need at a time where support can prevent any illness developing and escalating, although there are differences across Health Board areas

There is an issue about whether the referrals made are appropriate and this impacts on the numbers of cases being presented that are not taken forward and then there is a knock on effect on delays. This is potentially as much to do with availability of resources at tier 2 as it is about an understanding of service provision at tier 3. Referral Guidance agreed by boards in 2012 supporting the CAMHS Referral To Treatment targets (RTT). However, some Health Boards use the Choice and Partnership Approach (CAPA) and the CAPA criteria is very accessible, child and family focused and outcome focussed.

There is a varied landscape across Scotland with respect to performance of CAMHS both across and within health boards. In their report on the findings of joint inspections 2014 – 2016, the Care Inspectorate noted that there continued to be clear gaps for some children and young people who were waiting for significant periods for intervention following assessment⁶.

There are specific issues for children and young people in the care system in particular in secure care (although some secure settings have dedicated CAMHS and Forensic CAMHS provision) and in foster care. Often provision for these young people is not easy to access and their issues may escalate before they are given the support they need. In foster care the provision available to a child or young person in the location they were living may differ in the area they are moved to. For example, a young person may receive tier 2 support in one area and then be moved into a foster placement in another where there is no tier 2 support.

How are these factors being addressed and over what timescale?

Where areas have been more successful in addressing the need for child and adolescent mental health supports, this is likely to have been at least in part due to closer working between health boards and their partners, most notably local authorities. This promotes a greater understanding of services roles and opportunities for more collaborative practice to address gaps in service provision.

In recent years more has been done by way of improved training addressing issues such as suicide prevention which has been extended beyond clinicians to partners in local authorities and 3rd sector. Whilst it cannot be expected that services within tier 1 and 2 could or should address gaps in tier 3 provision, there is much which can be done to support children at an early stage via staff in schools and other relevant services.

³ <https://www.nspcc.org.uk/fighting-for-childhood/news-opinion/anxiety-rising-concern-young-people-contacting-childline/>

⁴ www.bbc.co.uk – 28th May 2016 *Mental health support denied to children*

⁵ <https://www.rethink.org/media-centre/2016/06/missed-opportunities>

⁶ <http://www.careinspectorate.com/index.php/news/3362-joint-inspections-of-services-for-children-and-young-people-2014-16>

The continued rise in demand however would indicate that services need to expand and that requires investment not only in specialist CAHMS provision, but also to extend the knowledge of practitioners within services such as schools and nurseries. Knowing that young people in particular are more likely to seek help from friends or online, we need to review the online presence of support and whether more needs to be done where the internet is the first line of response.

For those Boards who are meeting the target what were the principal factors that had to be met?

Greater Glasgow and Clyde Health Board (GGCHB) use the Choice and Partnership Approach (CAPA) which offers a 'choice' appointment earlier in the process to distinguish who is appropriate for CAMHS. Tier 3 and Tier 4 CAMHS work together to ensure that the right support is in place dependent on the presenting problems.

The experience in NHSGGC with the adoption of CAPA is that 90% of children referred are seen; 75% of all children referred receive treatment. For those where the decision is not to provide treatment it is usually where another agency is better placed to help and this is agreed with the family i.e. Tier 2 support being provided by the education service.

Influencing factors in GGCHB are:

(i) CAMHS Service Specification (ii) Workforce plan to deliver (i) and (iii) efficacious implementation of CAPA (iv) robust monitoring and evaluation of productivity and outcomes i.e. good data and (v) good partnership working across the Tiers with Education (critical) and SW and voluntary sector.

What support is provided to children and young people while they are waiting for a stage 3 referral?

Where the child has a supportive family, it is likely that much of the support is provided through universal service provision to both the child and family. Additional supports often come via services such as home school link workers which are attached to schools but which can undertake outreach work. Depending on the area in which the child lives and the presenting issue, there may be access to counselling services, parenting approaches, self-help materials and accessing support through universal services such as GP's, Health Visitors and Educationalists. (Provided often by 3rd sector partners and Local Authorities).

For looked after children, mental health issues can be further complicated by family discord and parental issues such as depression, addiction, violence in the home, domestic abuse and other issues sometimes linked to poverty. In these circumstances it is more likely to be the social work service and the specialist looked after nursing provision (alongside any counselling support) which is attempting to support the child pending access to CAMHS.

There have also been some services developed such as Functional Family Therapy, which whilst not specifically targeting child mental health seeks to address family dysfunction which can impact on the child's health in the long term and reduce potential need for Tier 3 CAMHS in future, particularly if FFT is offered early to the family e.g. primary school age. However FFT for under 11 years is not widespread across Scotland, although it is being piloted in some areas.

In the most extreme of cases, such as where the child's behaviour is likely to result in a breakdown of their living arrangements unless support is provided, local authorities have had to purchase access to specialist mental health provision utilising other budgets. This has been an issue both in relation to delays in accessing CAMHS services and also in addressing circumstances (particularly in the looked after children population).

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