

The Scottish Parliament’s Health and Sport Committee

Written evidence on Child and Adolescent Mental Health Services and the Mental Health Strategy from the Royal College of Psychiatrists in Scotland

The College is pleased to respond to this important consultation. We would like to preface our responses to specific questions 1-5 with a diagram representing the CAMH System, which is broader than NHS CAMHS.

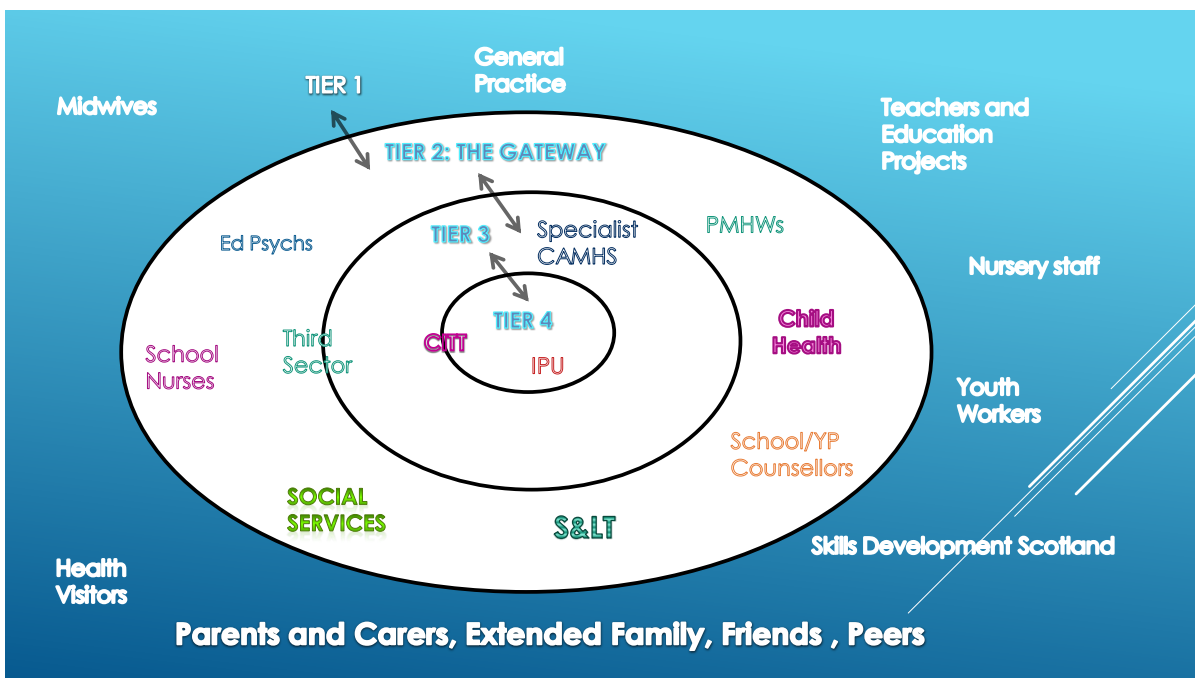


Figure 1: The CAMH System

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

On receiving a referral, most CAMH Services prioritise those in need of an emergency response (immediate) or urgent response (within a few days). Systems need to be well-enough resourced and flexible enough to respond in a timely matter and also deal with more routine (non-urgent) cases.

The structure of teams in addition to their size may not allow this flexibility and those deemed non-urgent may have to wait longer. Whilst workforce numbers have increased, they have not kept pace with referral numbers (see Q2).

There continue to be workforce challenges with psychiatrists in particular facing serious recruitment issues. In practice, this means that children and young people with the most complex presentations or the most serious mental illnesses may not get an ideal service. The enhancement of skills is critical to the delivery of evidence based treatment, and NES (NHS Education Scotland) has developed appropriate training, particularly for professionals with a psychology background. However, patients may have to wait some time for the right treatment after a period of assessment.

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

Increased awareness of mental health problems in children and young people has led (appropriately) to a hugely increased referral rate to CAMHS. The investment in the workforce, whilst considerable, has not matched demand. In addition, there appears to have been a real increase in the prevalence of mental health problems. For example, there has been a considerable rise in the numbers of young people presenting with self-harm and overdose.

The CAMHS System includes agencies other than Health who have appeared to be less well able to respond to the need for early intervention. Local authority cuts have impacted on the capacity of Social Work and Education to respond to children in need. Referral on to specialist services should be reserved for those with the most severe and enduring problems, but in the absence of multiagency CAMHS at Tier 1 and 2, a lot of children and young people are being referred to Tier 3 services.

Within NHS structures, the HEAT target has led to a reorganisation of workforce to meet demand and this is often at the expense of Primary Mental Health work and other work at Tier 2 level, for example, a Psychology led drop in clinic for young people which includes prevention and early intervention. Children and young people should have access to the right support at the right time as part of a stepped response.

Non-recurring funding can support better training and systems within the CAMHS system but does not address the need for sustained increased staffing within CAMHS.

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

The needs of children with Neurodevelopmental disorders (e.g Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Tourette's syndrome) should be met more consistently across the country. There is a need for post-diagnostic services within the wider CAMH System.

Children and young people with Learning Disability continue to receive a variable service across Scotland and have higher rates of psychiatric disorder than the general population

The role of nurses in Community CAMHS has not been valued historically. The development of community psychiatric nurse services is essential to the care of unwell young people in the community (Community Tier 4).

Within systems where performance is only measured in relation to patient attendance, there is a need to re-establish models of work which facilitate specialist mental health practitioners having time to support partners in the multiagency system to deliver direct services - for example, consultation to Health Visitors - which supports work with infants and pre-school children.

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

(a) in relation to outpatient services, some areas have successfully adopted a patient flow model (eg CAPA) which has resulted in more efficient practice

(b) The use of Early Care Planning Meetings in inpatient services has resulted in shorter stays and increased capacity

(c) Training community staff in specific therapeutic modalities and ensuring that these are delivered as reflected in appropriate implementation strategies. Examples include the use of Family Based Treatment for Eating Disorders, and Dialectic Behaviour Therapy Programmes for the treatment of emotional dysregulation often associated with chronic self-harming behaviour.

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

The availability of Tier 1 and Tier 2 services varies across the country.

6. Which parts of the previous mental health strategy have been the most successful?

There has been some progress against most of the commitments in the 2012-15 strategy, but few areas where action has translated into noticeable impact, either in services or for the people that use them. The two areas where there has been demonstrable change would appear to be CAMHS and psychological therapies. There has been investment in both areas but, as mentioned in response to previous questions, increased capacity has uncovered the unmet need, fuelling an increase in demand that has resulted in targets not being met. There has been growth in the availability of telephone or online therapies and of social prescribing, but this is patchy across the country.

In regard to CAMHS, we have welcomed the improved access to Tier 4 services including specialist Inpatient services. Variable development of community

intensive intervention teams as an alternative to admission have resulted in shorter inpatient stays and increased capacity in inpatient provision as a result.

7. Which parts of the previous mental health strategy have been the least successful?

The strategy did not seem to set a direction for mental health services in Scotland. It was made up of a series of discrete pieces of work that have progressed to a greater or lesser extent, mostly with little discernible impact across the mental health community. Much of the work seems to have reached a point where a report or a paper has been produced, but there is then no follow-up action which changes anything within the system. Services are struggling with significant issues created by ongoing requirements for efficiency savings and the impact of health and social care integration on budgets. New resources are being made available for mental health services and these are very welcome, but there is a danger that core services increasingly struggle while new initiatives attract investment and attention. In most areas there is a sense that resources are removed from mental health and other community services to prop up significant overspends in the acute sector, created by the pressure on health and social care systems to deal with access and delayed discharge targets. The strategy has done little to address the real issues mental health services face in achieving parity of esteem for those people with severe and enduring mental illness within the health and social care system.

Improved access for hard to reach young people has still not been achieved, with CAMH services for Looked After and Accommodated young people needing further development. Young people in secure care and in prison remain 'hard-to-reach'.

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

The next strategy needs to depart in tone and style from the previous two mental health strategies for Scotland. It needs to set ambitious aims and seek transformational change in the way we think about the mental health of the population of Scotland. We need a vision that sets a new direction for mental health in Scotland, not another list of laudable aims that are not too stretching to achieve. There needs to be much greater focus on mental health improvement for all. We need to develop thinking about what we mean by mentally healthy communities and how we can achieve them through a process that engages the public and those with lived experience of mental health problems. We need to consider how we plan our communities with a view to improving mental health. We need to think about what support employers can offer workforces in improving mental health.

Welfare services need to be designed in a way that respects the needs of those with mental health difficulties and focuses on enabling them to maximise their potential. We need to plan health and social care services in a way that encourages parity between physical and mental health and reduces the gap in life expectancy between those with mental health problems and the rest of the population. Where mental health problems arise, we need services that facilitate early intervention, focus on self-management where possible, and offer a diverse range of approaches in local communities, centred around the needs and wishes of the person involved.

Specifically for Children and Adolescents

(a) Health promotion and prevention in children and adolescents will be enhanced by the development of infant mental health services which offer a stepped and tiered response to early difficulties. This should include early intervention. Specialist CAMH services for children and families in the most adverse situations should also be developed.

(b) Working in partnership with Education to ensure that young people are aware of how to maintain good mental health and develop good strategies in the context of supporting structures to ensure that problems are identified and treated early. Education about relationships and parenting should be a key component of this.

(c) Development of Primary Mental Health Work in CAMHS. The Government's previous aim was to have 25% of the workforce in primary mental health by 2015. This was seriously eroded by the waiting times initiative which sought to address the increased referrals. The need for a stepped and tiered service with the right input at the right time will be supported by the (re-)development of Primary Mental Health.

(d) Developing services for hard to reach and disenfranchised young people; for example, those in the Looked After system, those with Learning Disability or those with a need for a more specialised Forensic mental health service.

This submission was prepared by Dr Alastair Cook, Chair of the RCPsych in Scotland and Dr Anne McFadyen; Chair, Child and Adolescent Faculty, RCPsych in Scotland

August 23rd 2016