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

   a. Lack of clarity for referring clinicians and poorly-defined boundaries for specialist CAMHS services, which leads to unnecessary or inappropriate referrals.
   b. Lack of clear boundaries for CAMHS professionals themselves which may lead to unnecessary or inappropriate interventions.
   c. Lack or inadequate adherence to referral criteria, where these exist.
   d. Reduction or cuts in alternatives to CAMHS referrals, eg local authority supports etc.
   e. Complexity of individual assessments which may require multi disciplinary input initially and involvement over a long period of time: eg SIGN guidelines which stipulate 6-monthly review appointments for ever, even for stable ADHD patients.
   f. “New” diagnostic categories which have emerged as CAMHS issues: primarily Autistic Spectrum Disorders and ADHD. As consciousness has risen, so have referrals for assessment, which are time-consuming and complex.
   g. A relative lack of tier 2 provision and effective sign posting to other agencies; partner agencies (education/Social work) have reduced resource and therefore in particular have reduced services for children with Neurodevelopment disorders.
   h. Increased parent/patient expectations: a growing trend of requests for second opinions (and sometimes third opinions).
   i. Societal medicalisation of some parenting problems; fragmentation of families; poverty and deprivation.

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

   a. Staffing capacity consequent upon difficulties in professional recruitment and retention.
   b. Peaks and troughs in referrals have an impact on waits for assessments within 18 weeks. For example the average referrals per month in 2015/16 was 56 per month; in March 16 we received 70 referrals, which will have an impact in August when those “extra” referrals reach 18 weeks.
   c. The current capacity of the service is insufficient to deal with peaks of demand or sickness absence/maternity leave: the additional 21% staffing headroom for inpatient wards is not applied to community teams.
   d. Recruitment and retention: inability to recruit to CAMHS consultant psychiatrist post, with reliance on changing locums of variable quality.
   e. Lengthy delay in recruiting senior psychologist for the service: general shortage of specialist CAMHS skills and training programmes, succession planning across all professions.
   f. Services must work efficiently and effectively: managerial supervision of staff, capacity, new: followup ratios and caseloads is not always as it should be.
g. Poor levels of integration with Local Authority Children’s Services.

3. **Are there any other issues in CAMHS that you would identify as being a priority for improvement?**
   
   a. Early Intervention work to prevent/avoid future problems and referrals to CAMHS.
   
   b. Tier 2 psychological/family intervention services would allow for more child centred input for those experiencing mild to moderate mental health problems. They could be assessed and offered brief psychological interventions, which **might** prevent referral into specialist tier 3 CAMHS and support other services to provide appropriate input.
   
   c. Expansion and commitment to the Community Mental Health Workers in primary and secondary education would also reduce the requirement for tier 3 specialist services.
   
   d. Administration support, the generation of correspondence and reports presents a significant challenge to CAMHS services; efficient infrastructure and appropriate consultation facilities would improve efficiency of service delivery.

4. **Are there any particular factors/initiatives you can identify which have helped improve services either locally or in other parts of Scotland?**
   
   a. Generally increased emphasis and funding of psychological therapies across services.
   
   b. Psychology of parenting developments.
   
   c. AMBIT: well evidenced now; team training re high risk/ hard to reach young people
   
   d. Enhanced and consistent age ranges for CAMHS referrals: we now accept up to age 18, which is helpful in working with other services around the country

5. **What support is provided to children and young people while they are waiting for a stage 3 referral?**
   
   a. At present none specific: they may be “held” by parents, schools or others unless there is an emergency or urgency about her referral.
   
   b. We should not go down the path of offering or developing supports for people waiting to be seen: the focus must be on improving response times and capacity. There is already too much focus on “managing waiting lists” when the absolute priority must be to reduce them.

6. **Which parts of the previous mental health strategy have been the most successful?**
   
   a. Focus on psychological therapies.
   
   b. Focus on risk assessment and safety.
   
   c. Increased funding for CAMHS services: a 40% increase in funding and staffing in NHS Borders for CAMHS allowed the service to increase its age range to 18 AND
reduce maximum waiting times to less than 18 weeks (with most seen within 6-8 weeks).

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

   a. Lack of clarity re whether additional investments in all areas have been effective.
   b. Occasional problems still pertain on occasion when inpatient care is required: boundary disputes between Health Boards and capacity/occupancy issues can still mean that a YPU bed is not available when required.

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

   a. Unsurprisingly, continued focus on, and ring-fenced investment in CAMHS services.
   b. Further development of Early Intervention and LAC work.
   c. Review of capacity and functioning of Tier 4 inpatient services: are they fit for purpose?
   d. Consideration of formal integration of NHS and Local Authority Children’s and CAMHS services: hosted by Health.
   e. A programme of specific training for staff who would like to move into CAMHS work, to make it attractive and well-supported.
   f. Expansion of training numbers for psychiatrists who seek to specialise in CAMHS work.
   g. Development of rapid-response accessible Tier 2 interventions which would hopefully reduce referrals to Tier 3 in a cost-effective way.
   h. Development of (and centrally-funded) low-intensity high-volume web-based psychological intervention and parenting programmes (cf Living Life to the Full) for Children and Yong People and their parents.
   i. Regional Tier 4 Forensic CAMHS services.
   j. Consideration of societal expectations and how best to manage them.