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

Awaiting specialist skills around Psychologist assessments relating to neurodevelopmental disorders, physical health conditions and learning / intellectual disability, ASD with co morbidity. The Consultant Psychiatrist is also only locum with twice a month visits.

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

Our waiting times are always met.

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

CAMHs referrals are increasing in numbers with many of the cases having reached a level of complexity without difficulties being addressed. Early detection, prevention and intervention remain a challenge within lower tiers. Numbers of referrals to WI CAMHs far outweigh other island boards (ISD data April 15-June16) but at an average with other national boards.

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

Many…… Inclusion Policy within schools prioritising additional support needs; Mental health and Wellbeing Agenda a priority for schools through Curriculum for Excellence; Early Years initiatives; Parenting Psychology (Triple P) being delivered by wider CAMHs at Tier 1; Integrated care pathways being developed that are condition specific; NES training in psychological therapies for key staff; Standards developed for CAMHs; GIRFEC processes for shared understanding and risk management.

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

Our services have CAMHs Tiers 2&3 under one umbrella. There is no distinction or separation within our team for Tiers 2 and 3 but we do differentiate for skill set best placed to meet needs at whatever tier .i.e Nurses more likely to carry Tier 3 cases.

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

   a) **Commitment 7 and 8 Early Years** aspects of the strategy and through the exemplary work of the Early Years Collaborative has given impetus to innovative local initiatives that have improved service delivery at all tiers. Particularly useful was the approach in bringing about an integrated and seamless shared understanding of roles and responsibilities for infant Attachment and Early years’ needs. We have made some progress in the realms of Conduct disorders although this work is ongoing.

   b) **Commitment 9** We are responding better to the needs of **Looked After Children** particularly around the issues of physical health needs being met
and a better understanding and focus given to the emotional difficulties stemming from disorganised attachment. We have set up triage clinics facilitating early referral for mental health assessment. There has been education delivered around attachment across Education, Social care and Health care services in relation to the challenges of this vulnerable group. GIRFEC principles are applied improving liaison and consultation.

c) **Commitment 11: Access to Specialist Child and Adolescent Mental Health Services** within specified waiting time has been extremely useful in providing a time frame expectation giving urgency and agency to referrals and providing equity across the service.

d) **Commitment 12: CAMHs admissions to Adult beds** has had little impact as we generally do not use adult beds unless 16+ and out of education. Policies and protocols are in draft for ensuring non-mental health wards are prepared for CAMHs admissions as we await specialist beds or to accommodate the acute phase of the condition until with the support of CAMHs Young People can be safely transferred back to their family and their community living.

e) **Commitment 13: Access to Psychological therapies** within specified waiting times has facilitated a much needed and appreciated approach to workforce training. Working to psychological models and programmes continues to a have positive impact on length of case contacts which in turn affects waiting times for accessing CAMHs. CAMHs staff do not work within the ‘choice and partnership’ model as small and rudimentary hence treatments are usually delivered by the assessing clinician unless specific therapy required to be delivered by other staff who hold the required skill set. The impact on staff receiving this training has been a fundamental force in raising standards and staff empowerment.

f) **Commitment 14: Reporting on ethnicity of service users** is still not as effective as 100%. Greater emphasis needs to be prioritised. This omission in administration does not evidence equality is not being applied as allocation of case and the waiting times remit ensures all referrals are equally addressed.

g) **Commitment 15: Social prescribing and Self Help** are core to CAMHs work as many of the issues arising for Young People sit within relationships, navigating adolescent phase of development and general health. ‘Cool to Talk’ website has been a most valuable resource for Young People and accredited as a ‘good practice initiative’ by the Education and Children’s Services Inspectorate.

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

**Commitment 10: CAMHs Learning Disability** has had minimal representation since the Learning Disability speciality locally has no or limited service. However it is clear that nationally this commitment is developing and progressing well and whoever takes up the role for CAMHs will be required to make catch-up with national objectives. When we are able to employ into this position it is envisaged that the NHs
Western Isles will give the national group initiatives for CAMHs LD their full commitment.

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

- Consolidation with previous commitments particularly around training and systems for working. All of which need to be embedded. Ie Looked After Triage
- Primary care better supported for referral for psychological interventions with stronger links to Educational Psychology dept, School nursing systems and Named persons at school.
- Homeless group particularly involved in drug and alcohol issues and unwilling to address those. Motivational Model will require programmed work.
- Early intervention for lower level needs require greater focus and support. Educational Psychology alongside Principle teachers for Learning Support struggle with school demands in regard to emotional and behavioural difficulties expressed both in the classroom and by concerned parents. The stepped staged intervention process within schools for ‘Additional supports’ has on many occasion had children and young people stuck at a stage of intervention with ‘more of the same’ emotional/behavioural interventions being applied by exhausted teachers and learning support assistants. There are many situations where school setting does not recognise the gravity of the child’s difficulties complicating the diagnostic process for CAMHs. At other times it is noticed that interventions applied focus on managing disruptive behaviour in the classroom but does not deal with overall difficulties in other settings. In many situations conditions and difficulties which are not being detected within primary schools and difficulties accelerate complexities into adolescence.

Improving the early detection of emotional, behavioural and developmental disorders, and initiating early prevention and intervention strategies require to be better supported. Paediatrics need to consider their role in diagnosing neuro-developmental disorders particularly around learning disabilities, Foetal Alcohol Syndrome, ASD.

Public Health – School nurses are a valuable resource and could be considered the matrix between services. Some of this work is currently being undertaken but is minimal. School nurses taking a proactive role in supporting Named Persons (Head Teacher) in recognising and addressing low level needs, assisting teachers with family issues and giving guidance re developmental disorders would be of great value across lower level tiers.