In summary:

- The numbers of young people currently seen and supported by CAMHS in Scotland represent a small proportion of young people who need mental health support.

- Despite the investment in CAMHS workforce, there continues to be high pressure on accessing services; the majority of funding seems focused on acute rather than preventative services.

- SAMH wants to see a wholesale review of CAMHS, and its extension up to age 25

- Mental Health education in schools should be a priority, to develop life skills around resilience, to promote wellbeing and improve early intervention. Better teacher training in mental health is required.

- The previous Mental Health Strategy was more focused on outputs than outcomes, with poor reporting of progress and no published evaluation to date.

In preparing our submission, we have consulted children and young people who have experience of CAMHS, through a survey and focus group; and discussed these challenges with sector colleagues. We have drawn on our experience of being involved in the last Mental Health Strategy for Scotland 2012-15, and on the evidence which led to our Ask Once, Get Help Fast Manifesto. We hope that the Committee will speak to young people directly when exploring these important issues.

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

Some recent studies\(^1\) suggest higher levels of poor mental health than 1 in 10 young people experiencing poor mental health. Rates of poor mental health amongst children in areas of deprivation are significantly higher than these statistics suggest\(^2\); the interaction between poverty, austerity and poor mental health cannot be separated. The increased awareness of mental wellbeing and (relative) reduction in stigma may also have alerted young people to ask for help.

CAMHS waiting times are measured for tier 3 and tier 4 specialist CAMHS services, with Health Boards tasked to ensure referral to treatment within 18 weeks for 90% of

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children and young people. Only 8 of the 14 Health Boards are reported as achieving this target, which was due for delivery by December 2015³.

Resources appear to be focused on specialist services rather than on prevention and early intervention. Many young people are unable to receive support at the early stages of their illness, leading to them joining waiting lists for more specialist treatment due to a dearth of appropriate support, or if their unsupported condition deteriorates.

There has been a 30% increase in the CAMHS workforce from 764.6 WTE (883 headcount) in 2009 to 993.5 WTE (1154 headcount) as at 31 March 2016⁴. In that time period, however, there has been a significant increase in the waiting list for assessment, as well as the numbers of young people being admitted for CAMHS treatment (4,436 children started treatment in the quarter leading to March 2016; compared with 2,600 in the quarter leading to June 2012)⁵.

Of the 993 WTE CAMHS workforce, there are 80.6 WTE medical staff (i.e. psychiatrists), a drop of 4.3% in 2015; this figure has remained relatively static in recent years. The small proportion of medical staff overall may contribute to long waiting times for assessments; and SAMH heard of short assessments which may not capture the full picture of a young person’s mental health.

“I waited a year for my CAMHS assessment, and it lasted 20 minutes. It was the school nurse who told me a few weeks later that I wasn’t being referred, they never sent me a letter. I asked why not and apparently it was because I wasn’t suicidal. But they never asked if I was suicidal.” (Female, SAMH focus group)

With over 16,000 children rejected for treatment over a three year period⁶, the needs of too many young people are not being met. Demand outstrips supply, and we believe it will continue to do so until there is a radical shift towards prevention and supporting people at the earliest opportunity in social as well as medical settings.

While ISD Scotland reports the waiting times for treatment to begin, there is no subsequent measurement of the wait between first and second appointments for treatment; nor follow up if support is provided for young people who are deemed not to need CAMHS treatment, or whether they re-enter the system at a later date; and there is no record of the waiting time for support for tiers one and two.

Referral routes to CAMHS differ by health boards – there is no consistent ‘Ask Once, Get Help Fast’ approach. Nor is there equity of provision for all children in Scotland; some health boards still only provide CAMHS services to children aged 16, rather than 18, which will also affect numbers on waiting lists, and the outcomes for those young people attempting to access support.

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Speaking to children and young people who have been assessed for CAMHS, many apparently struggled to be taken seriously about their mental health; this problem also perseveres for young people treated in adult settings due to lack of CAMHS capacity. Reductions in school nurses and counselling services could also mean there are ‘risk-averse’ referrals due to lack of capacity, training or awareness amongst existing tier 1 services. SAMH therefore recommends a wholesale review of CAMHS tier 1-4 provision.

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

SAMH acknowledges the additional funding and staffing for CAMHS in recent years, and that there has been progress for some young people in accessing treatment; however, we believe that the lack of investment in prevention and early intervention to this point has impacted the provision of CAMHS support in the round. The support needed by young people before they become acutely unwell is not adequately provided.

“I saw my GP twice, who was very understanding, and my school were excellent. However, I did feel a bit "stranded"- my problem was recognised but there was limited resources to address it. By the time of my assessment, I believe my problem has deteriorated.” (Survey respondent)

Clear training in mental health and guidance on referrals is required for everyone working with children and young people. A consistent approach to referral is required across Scotland, and the measurement of access needs to improve. We know that many people assessed by CAMHS do not receive treatment, yet wait for a long time without support before this assessment, and if they do not receive a diagnosis or referral to treatment, they have no support at all. More support should be provided in tiers one and two, with greater emphasis on primary care and community support, including within schools. Recent reductions in educational psychologists is concerning and educational authorities must do more to ensure adequate staffing.

Social prescribing and community support for young people should be explored outwith the medical model of CAMHS; GPs, teachers (including named persons), school nurses and other tier 1 CAMHS professionals should be able to quickly direct young people to community supports. This requires knowledge of local support services and for those services to be resourced.

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

SAMH believes the time is right for a wholesale review of CAMHS, and a longer term, recovery-focused approach which builds on the work to date, and drills down into how this is helping young people to recover. As 50% of mental illness in adult life

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7 Scottish Parliament PQ S5W-00691
starts before the age of 15\textsuperscript{8}, we need to ensure children and young people get the help they need, when they need it. A rights-based approach should be adopted. As well as ensuring fast support for young people, the quality of the support they receive must improve – we hope the Health and Sport Committee will scrutinise the adequacy of staffing, the availability and range of community based services, and the interaction between health, social services, advocacy and education; and what happens to children and young people who are deemed not to need support from CAMHS, despite being referred for assessment. On a clinical basis, the Mental Welfare Commission’s young person monitoring report 2014/15\textsuperscript{9} highlighted a number of issues which require improvement – including not receiving information from all Boards on a quarterly basis about young person admissions to adult wards; the lack of educational links and age-appropriate activities for young people when in hospital; and the ongoing disparity of CAMHS provision to under-18s across Scotland.

Transition from children’s to adult services can often set back the recovery of young people; some of our focus group attendees reported not being referred to adult services after they had turned 18, yet they felt they still needed support. The Scottish Government’s Children and Young Person’s Act 2014 recognised that some young people require support beyond their 18th birthdays, and this principle should extend to mental health care and treatment for those vulnerable young people. SAMH recommends that access to CAMHS, for those young people who need this support, should be extended until the young person is 25, in order to cement their recovery.

Stigma from health and social care workers remains an issue according to the young people we heard from. In our focus group, one young person spoke about attending A&E whilst in crisis, having been waiting for a CAMHS assessment; but he was told to go home and wait for his assessment because ‘you’re still here’ (i.e. he hadn’t attempted or completed suicide).

64% of our survey respondents felt they were not consulted about their care.

“I was given a really unsupportive occupational therapist who I felt didn’t really take me seriously and it was only until I started self harming more severely that they begun to take me seriously.” (Survey respondent)

“My GP was really dismissive. He told me I just need to learn to calm down. I have anxiety!” (Female, SAMH focus group).

“I was self harming and went to see my CPN. She said, those marks on your arm, those are cat scratches, aren’t they?” (Male, SAMH focus group)

It should be said that other members of the focus group and survey praised their GPs as providing them with ‘top notch’ support.

“GP was the best help I received I think even more so than the CAMHS team. Very, very reassuring and sympathetic with me and made me feel like I was


doing the right thing, unlike the CAMHS team who made me leave my sessions feeling like I didn’t want to go back because I felt pressured to take blood tests and make diaries that I didn’t want to do or share.” (Survey respondent)

In our focus group, young people told us about the pressures to open up to strangers about their mental health, often in a short space of time for their assessment; and how they disengaged from a process when they felt unheard, leaving their health unsupported. There must be more time to ensure that young people are supported and treated with dignity and respect; a holistic assessment that takes all their needs into account and co-produces their recovery journey; and if CAMHS as is currently set up is not appropriate for them, they must receive support elsewhere.

SAMH reiterates calls from other organisations, such as See Me, Barnardo’s Scotland and the Scottish Youth Parliament10, for better mental health education. There must be capacity building in schools for a whole school approach, to help teachers to promote wellbeing and respond appropriately to young people who may need support in this environment; and outwith schools, with other adults who support and interact with young people. SAMH highlights the respectme model – policy support, training and resources to build the capacity of parents and other adults working with children and young people.

The overwhelming majority of individuals responding to our survey felt they had received no mental health education in school aside from minimal information about coping with exam stress. Due to such a lack of provision, most said that any form of mental health education would be helpful – even if it was very general or basic. Respondents felt there was a lack of knowledge about mental health issues amongst teachers, including guidance teachers; and a lack of communication between schools and health bodies.

“I haven’t received any mental health education in school. I think it should be taught as much as physical health issues. It may be helpful for young people to be taught the signs/symptoms and how to help others and themselves. As well as giving them advice on where to go for help, such as CAMHS but also a teacher or school counsellor”. (Survey response)

“My guidance teacher didn’t know what CAMHS was” (Focus group attendee)

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

Young people told us that third sector counselling in schools had been helpful, when it was offered; recent reductions in funding and cuts to services in many parts of Scotland have therefore left these young people unsupported; time will tell if this will translate into greater demand for specialist CAMHS support.

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

10 http://www.syp.org.uk/our_generation_s_epidemic 2016
We asked people responding to our survey what support they had received whilst waiting for an assessment. Fewer than 5 respondents (71 responded to this question) said that they received support, stating that their GPs and schools had provided support.

“We have received no support at all. No follow up communication, no updates, no suggested support or advice.” (Survey respondent)

Many comments in our survey stated that support once received was helpful but lack of continuity was a problem. Many also noted that there was a lack of range of support available and not having a say in the type of help provided; some young people spoke of being dismissed when they said that the support they were getting wasn’t appropriate to their needs.

Our survey responses also showed a great reliance on support from parents, who themselves might be struggling to help their child navigate a confusing and disjointed system.

“CAMHS idea of help is for my mum to hold me close when I'm knocking lumps out of her.” (Survey response)

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

General Points
SAMH welcomed the overarching seven themes for mental health and four Key Change Areas. SAMH has been an active participant in implementing the strategy, participating in several working groups, and co-leading the Employability (Commitment 29) group.

Commitment 4
One of the most successful aspects of the strategy was the refounding of See Me (Commitment 4). This followed a 2009 evaluation, which highlighted See Me’s ground-breaking work in tackling attitudes but recognised the need to refocus on behavioural change\(^\text{11}\). The development and management of the newly constituted See Me are excellent examples of partnership working between Government, the third sector and people with lived experience.

Commitment 5
Another success was the partial fulfilment of Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental health care in Scotland. The report was published in September 2015\(^\text{12}\). It identified good practice and made recommendations to embed a human rights approach in the next Mental Health

\(^{11}\) Scottish Government Evaluation of ‘see me’ - the National Scottish Campaign Against the Stigma and Discrimination Associated with Mental Ill-Health 2009

\(^{12}\) MWC and SHRC Human rights in mental health care in Scotland A report on progress towards meeting commitment 5 of the mental health strategy for Scotland 2015
Strategy. However, publishing a report does not in itself fulfil Commitment 5: we need to see a genuine shift in mental health care in Scotland. There have undoubtedly been other successes. We have limited our comments both for brevity and because, due to the lack of reports or scrutiny of the strategy, it is very hard to know which commitments have been fulfilled.

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

Commitments 11 and 13
Commitments 11 and 13 related to the 18-week waiting times target for CAMHS and psychological therapies respectively. Both targets were due by December 2014. However, the most recent statistics showed just five of the fourteen Health Boards have achieved the psychological therapies target and eight met the CAMHS target.

Commitment 36
Commitment 36 required arrangements to coordinate, monitor and performance manage progress on the strategy. This did not happen. While six Implementation and Monitoring groups were established, there has been no regular programme of reporting and no consistent publication of the implementation and monitoring group meeting minutes. Indeed, a recent response to a PQ about progress on the strategy confirmed that there were no plans to publish a final report and stated that updates could be found on a Scottish Government webpage. But at the time of writing, there were no updates whatsoever for 14 of the 36 commitments. Indeed, as part of our role chairing the Commitment 29 group, SAMH and our colleagues delivered a report to the Scottish Government making recommendations on improving employability for people with mental health problems. This report has never been published.

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

It is essential that an outcomes approach is adopted in the forthcoming 10 year Scottish mental health strategy. We need:
- A clear overall vision to transform Scotland’s mental health
- Supplementary rolling 3 or 4 year delivery plans
- Targets for each commitment, reported on annually
- A Steering Group, chaired by the Minister and including the key delivery partners, meeting at least three times a year

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13 ISD, Psychological Therapies Waiting Times in Scotland, June 2016
14 ISD, CAMHS Waiting Times in Scotland, June 2016
15 See Scottish Government Mental Health Strategy (web page):
Mental Health Delivery Team (Commitments 1, 14, 24, 26, 27, and 28 - 36);
Psychological Therapies(Commitment 13);
Child and Adolescent Mental Health Services(Commitments 7-12);
Primary Care and Common Mental Health Problems(Commitments 6, 15-22);
Rights, recovery, Families and Carers, Peer to Peer and Employability (Commitments 2-5 and 29);
Community, Inpatient and Crisis Services (Commitments 23 and 25)
16 Question S5W-01497: Monica Lennon, Central Scotland, Scottish Labour, Date Lodged: 14/07/2016
17 Specifically, commitments 6, 7, 8, 9, 12, 14, 24, 26, 30, 31, 32, 33, 35 and 36.
- An Advisory Group, including people with lived experience, families and carers and the third sector, meeting at least biannually

Earlier this year SAMH launched our Ask Once Get Help Fast manifesto, informed by over 700 people.\(^{18}\) We propose the overall vision: “Everyone who needs mental health support will be routed to an appropriate recovery-focused source of help at the first time of asking, within a clear timescale”.

We propose four key areas of focus:

**Access to Support**
We want a new mental health support service within GP surgeries, providing community based supports that build on current care and treatment models. This is much-needed, since one in three GP consultations relate to mental health, rising to one in two in deprived areas.\(^{19}\)

We want an independent inquiry into the failure of Health Boards to meet waiting time targets for psychological therapies. Health Boards should then be supported towards an interim 12 week target, giving mental health treatments parity with treatment for other illnesses. It is notable that in England, 61% of people are seen within 28 days.\(^{20}\)

**Employment**
Mental ill health accounts for the highest cohort of people who are unable to work due to sickness; yet it has the poorest outcomes through the DWP’s contracted Work Programme.\(^{21}\) SAMH recommends redesigning employability support to include Individual Placement and Support principles. IPS has eight times the success rate of placing and retaining individuals with mental health problems in work.\(^{22}\)

**Supporting people in crisis**
SAMH recommends a Scottish Crisis Care Agreement to strengthen joint working between NHS, social care, emergency services and police, creating clear pathways for people in crisis or distress. We must end the revolving door between A&Es, GPS, Police Scotland and other statutory services.

**Children and Young People**
We want a review of CAMHS, extending support to people up to the age of 25 and to a much wider cohort. In education, a whole school approach is required, with mental health education a stronger part of the curriculum, and training and support for all professionals working with children and young people with self-harming behaviours and eating disorders.

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\(^{18}\) SAMH *Ask Once Get Help Fast* 2016

\(^{19}\) RCGP Scotland Policy Paper on Mental Health 2012


\(^{21}\) Mind, *We’ve Got Work To Do*, 2014, p29

\(^{22}\) 40% of SAMH IPS participants achieve employment within 6-12 months of joining