About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

About this Response

The response was jointly led on behalf of the Society by:
Dr Ruth Stocks CPsychol, Division of Clinical Psychology and Division of Forensic Psychology

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<th>Introduction</th>
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<td>CAMHS</td>
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We do not know precisely how many children and young people (CYP) experience mental health difficulties, in part because the last national survey was undertaken more than 10 years ago. Some current estimates suggest that one in three CYP will experience mental health difficulties before the age of 16 (Costello et al., 2003), or even more if we consider young people up to the age of 25, those in the social care system, and those in the criminal justice system (Burns et al., 2004; Skowyra, & Cocozza, 2006). However, evidence suggests that around 50 per cent of lifelong mental health problems develop before the age of 14 years, with 75 per cent developing before the age of 25 years (Kessler et al. 2007; Murphy & Fonagy, 2012). We also know that only 25-40 percent of CYP with mental health difficulties receive input from a mental health professional early enough, if at all (Green et al., 2005; Children's Society, 2008). There seem to be various reasons for this, including: lack of resources, lack of psychological health promotion, primary prevention and early intervention, lack of recognition of mental health problems, and, stigma (Law et al., 2015). A survey conducted by the Scottish Youth Parliament also revealed that a fifth of young people did not know where to go for advice and support,
and respondents consistently highlighted poor access to treatment and treatment which did not meet their needs. Additionally, a lack of confidentiality, not being taken seriously, a fear of being judged and embarrassment at discussing personal problems were also cited as barriers to getting help.

The introduction of targets for CAMHS, has led to a huge increase in capacity to deliver evidence-based psychological therapies and waiting times have undoubtedly shrunk. However, only 8 out of 13 Health Boards have been able to meet the targets. It is hoped that a Scottish Government funded project run by Health Improvement Scotland to help those areas having difficulties will be successful in improving the success rate.

Attention should also be paid to incorporating the following criteria in psychological services for children, young people and families (Faulconbridge et al., 2015):

- services configured around ease of access and reaching out
- services that embrace diversity and work to avoid marginalization
- services that get children and young people involved in making better services
- services that are integrated, co-operative and collaborative with other services and settings
- services that use evidence-based practice
- services that have effective care pathways
- services that use outcome measures and feedback tools
- services that are flexible over transitions (between parts of the systems as well as into adult mental health).
- services that are effectively resourced

It is also important that services are delivered by an appropriately trained workforce to offer assessments and interventions for CYP with increasing levels of complexity.

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<th>What are the key factors that result in long waits for CAMHS services?</th>
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| **1.** Limited resources.  
  Currently, only 4.6% of the NHS Scotland budget is spent on CAMHS and this is not enough to meet the demand.  

Increasing demand.  
There are a number of reasons for this:  
- An increase in general awareness and recognition of mental health problems.  
- An increase in the prevalence of mental health problems, linked to factors such as social inequality, economic deprivation, etc.  
- A lack of awareness of where to approach or where to direct children and young people with mental health problems and their families, other than CAMHS. |
- The success of campaigns to reduce stigma, encouraging people to seek and accept help.
- Efforts made by services to make themselves more visible and to reach out to those who need them, leading to more people accessing services. However, in the long term
- Financial cuts across sectors leading to a reduction in services from other agencies which support children and young people (e.g. education, social work, third sector) resulting in greater reliance on statutory health services. Where the cuts affect services providing interventions which prevent or contain mental health problems, there is a knock-on effect of children and young people developing more complex problems and requiring more intensive support.
- When resources are scarce, there is a tendency for provision to be skewed towards those children and young people who have already developed more serious difficulties, shifting resources away from services designed to promote psychological wellbeing and reduce harm (Law et al., 2015).
- Specialist services restricting their entry criteria or limiting the range of services provided, leaving generic CAMHS services to deal with those who are not accepted for specialist input.
- Adult services changing their age criteria, so that the upper age limit for CAMHS is extended.

| What would you identify as the main reason(s) for the CAMHS waiting time target not being met? |
| 2. | Insufficient resources within CAMHS to meet the demand. |
|  | Insufficient numbers of staff with appropriate training to deal with complex difficulties. |
|  | Insufficient resourcing of other services which support children and young people, often including the voluntary sector. |
|  | A lack of services that offer early intervention to CYP and families, focusing on psychological wellbeing rather than mental health difficulties. |

| Are there any other issues in CAMHS that you would identify as being a priority for improvement? |
| 3. | CYP leaving the public care system. |
|  | CYP in contact with the criminal justice system. |
|  | Inpatient services for CYP. |
|  | Services for CYP with learning difficulties and autistic spectrum disorders. |
|  | Addressing the psychological needs of CYP with physical health problems. |
• CYP who need to access mental health services in their school or education setting.
• CYP with co-occurring difficulties - these CYP often fall between the gaps in services designed to meet single presenting problems, such as conduct disorder, or attention deficit difficulties (see e.g. Hunt and Craig, 2015).
• National provision of multidisciplinary Tier 4 outreach services.
• Effective IT systems to collect data and monitor progress.
• Better use of technology to reach and deliver services to CYP.

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

4.
• Early intervention and services that sit within whole system approaches are likely to be the most effective in supporting the psychological wellbeing of children and young people and preventing mental health problems (see e.g. Law et al., 2015). The highly regarded, national ‘Psychology of Parenting Project’ delivered primarily by health visitors is one such example. There are also various projects delivered in schools with joint working between health and education services which appear to be successful. For example, the programme Groups for Health which promotes young people’s attachment to social groups has been found helpful in improving psychological outcomes (Haslam et al., 2016).
• NES training initiatives to increase capacity in mental health services to deliver evidence-based psychological therapies for children, young people and families.

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

5.
This seems to vary across the country.

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

6.
The previous mental health strategy did much to improve mental health care in Scotland. In particular, the introduction of a waiting time target for psychological therapies was remarkably successful in raising awareness of the importance of this approach in addressing mental health problems. Anyone who suffers from a mental health problem and who would be likely to benefit from a psychological therapy, is now much more likely to receive an evidence-
based psychological therapy, delivered by someone who is properly trained and supervised, within 18 weeks of being identified as suitable for the intervention. To support the target, NHS Education for Scotland (NES) published ‘The Matrix: A Guide to Delivering Evidence Based Psychological Therapies’ (Second edition, 2015) and this has proved to be an excellent resource for local services, helping to ensure quality in the provision of psychological therapies. NES has also delivered extensive training for staff working in mental health care from a range of professional backgrounds and this has brought about a substantial increase in capacity to deliver and supervise evidence-based psychological therapies across mental health services.

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<th><strong>Which parts of the previous mental health strategy have been the least successful?</strong></th>
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<td>• There remain significant inequities in service provision between care groups and between different areas of the country. For example, there are low rates of referral to mental health services for older people and proportionately tiny numbers of psychologists employed to work in services for older people, compared to the numbers working with other adults or with CYP. Similarly, people with a diagnosis of learning disability often have limited access to psychological therapy services appropriate to their needs.</td>
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<td>• There are also gaps in the provision of psychological therapies for some populations, such as those in mental health hospitals and prisoners. Inpatient units vary across the country - some have dedicated input for psychological assessment and intervention, some have access to in-reach and some have no access to psychological support. In prisons, despite very high rates of mental health problems, services are woefully inadequate and the vast majority of prisoners in Scotland have no access to evidence-based psychological therapies.</td>
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<td>• The focus on targets may have led to specialist services narrowing the focus of their work leaving more and more people to be managed by generic services.</td>
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<td>• The focus on Tier 3 HEAT targets has had the unintended consequence of leading to the retraction of Tier 2 mental health input for CYP, which has then had a detrimental impact on Tier 3.</td>
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| **What would you identify as the key priorities for the next mental health strategy?** |
• We need a whole population, human rights approach to mental health, taking it away from the confines of one Government department and recognising that a strategy for good mental health goes hand in hand with reducing inequalities in health, wealth and education, addressing social and economic deprivation and building communities.

• A public health psychology model to match that of public health medicine would be welcome.

• Access to specialist psychological expertise should be available at the highest levels, to ensure a focus on psychological issues in all aspects of healthcare and related government strategy.

• Ensuring equity of provision across Scotland – particularly in relation to LD services, older people’s services, inpatient services and prisons.

• Prevention and early intervention through the early identification of problems, e.g. traumatic brain injury in prisoners, high risk families in perinatal care, trauma and neglect in young children, the psychological needs of people with long term conditions, etc. This will require investment in mental health awareness training for teachers, the police, social workers and primary and acute health care workers.

References


Haslam, C., Cruwys, T., Haslam, S.A. et al. (2016) Groups 4 Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. Journal of Affective Disorders, 194, 188-

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young people with neurodevelopmental difficulties and their families. The Child and Family Clinical Psychology Review, 3, 141-152.


