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

Collating views for the purpose of this response across Falkirk Council’s Children’s Services has highlighted a range of factors that we consider to be key factors resulting in long waits for CAMHS services. These views are based on individual worker/collective team/child/family experiences.

- Children perceived to be in ‘crisis’ or not considered to be ‘settled’ enough to receive a service
- Reluctance to label young people with a diagnosis appears to be a barrier to appropriate treatment
- Volume of referrals
- Referrals from multiple sources are possible within the current system
- Inappropriate referrals are possible due to referral criteria not being clear
- Capacity issues which lead to long waiting times and children not receiving timely help that can significantly increase good outcomes
- Referral screening processes take a long time

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

Increasing demand due to a range of factors i.e. risk of sexual exploitation, substance misuse, increasing prevalence of online bullying.

Staffing levels do not seem to be at the right level.

Lack of clear criteria which results in inappropriate or excessive referrals.

With a focus on prevention, early intervention (as outlined in the new duties within the Children and Young People Act), the service may require significant adaptation to contribute to improved outcomes for children and young people.

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

Limited support from CAMHS for children and young people who are experiencing
significant emotional distress.

Flexibility to meet children outwith the clinical setting is required. Consideration needs to be given to the sometimes chaotic home environments that children, young people and their families live in, these can be contributing factors to their issues. Timing of appointments, venue and feasibility of travel etc. all require to be taken into consideration.

An understanding of the importance of relationship building and consistency of worker is required when working with children and young people. Withdrawing the service after a few attempts to have the child attend an appointment is not appropriate. This response can be viewed as a rejection and will make any possibility of re-engagement at a later stage more difficult.

The most vulnerable young people i.e. in secure settings or care settings are not provided with support due to where they are resident.

Attendance of CAMHS personnel at multi-disciplinary meetings should improve to contribute to the assessment and child’s plan.

The name of the service may in itself be a barrier to young people accessing it; it potentially creates an additional sense of stigma which we would like to reduce around mental ill health.

Mental health services should work in collaboration with other professionals and not in isolation.

If young people move to a different area, resources ought to follow them to provide them with consistency and contribute most effectively to improved outcomes.

Consistency in approach i.e. dealing with self-harm.

Offering consultation to workers is very helpful but could be more effective if strategies and potential diagnosis could be part of discussion.

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

- Looked after children psychologist; this is a joint approach by Falkirk Council and
NHS Forth Valley. Young people are seen promptly, with many being able to access the service on more than one occasion; it is very flexible and responsive. The looked after children’s psychologist has delivered significant benefits for looked after children and those who care for them.

- Primary Mental Health Service (Tier 2). One named person as point of contact and effective relationships established with education, social work and CAMHS which led to improved joined up planning for children and less unnecessary escalation (conversely it allowed prompt escalation when necessary). It proved impossible to sustain this approach due to staff being re-directed to reduce CAMHS waiting times.
- Psychology of Positive Parenting initiative.
- Infant mental health work – very successful pilot with Barnardos in Forth Valley.
- Befriending project for pregnant women.
- Five to Thrive – training the whole staff group to promote attachment based work at every opportunity.
- Braes High School Falkirk – Listening Service: staff report has had a significantly positive impact for young people.
- Access to consultation and an openness to work with others.
- Links to schools and added value to young people via an informal approach.
- Home visiting with social work colleagues.
- Family Nurse Partnership.

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

Given the criteria for a stage 3 referral it is likely that other professionals are involved with the child and typically a Child’s Plan will be in place. The Team Around the Child require to be aware of their own role in supporting young people but they can feel unsure of what to do and their reliance on specialist support increases. Pastoral/guidance teachers/social workers will offer support where they can but often feel unskilled or have restricted time.

Not all children require to be referred to stage 3. A focus on prevention and early intervention via earlier stages would contribute to a reduction in referrals. Joint training, access to consultation and recommended strategies would all assist in this area.

6. Which parts of the previous Mental Health Strategy have been the most successful?
There are 36 commitments within the Mental Health Strategy for Scotland 2012-2015 and there will be many which have been successful, either fully or partially. It has not been possible to locate an overall evaluation of the success of the commitments and we are unaware of annual performance reporting to chart progress.

7. Which parts of the previous Mental Health Strategy have been the least successful?

The waiting time target is not being met for Falkirk’s children and young people. It is our view that significant and more stretching changes to service delivery are required to change this position.

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

Make the strategy accessible. Consider the format of TAMFS as people felt it was a very accessible policy document and very clear. The headings, ‘Promotion, Prevention and Care’ are still relevant today. Key priorities could include:

- Building resilience within families to cope with life’s ups and downs
- Taking control back/ Self-Management
- Stress Control – rather than social prescribing or along with social prescribing.

Early Years
- Attachment – parents/carers are the most influential people in a child’s life
- Commitment to infant mental health work (perinatal mental health services
- Psychology of positive parenting – continue the emphasis on this

Adolescents:
- Teenage brain development for young people and for parents
- Exam Stress
- Coping with online bullying
- Mental Health first aid for young people

Good quality accessible services
- Pre-birth to adulthood
- Transition stages and how to manage these well
- Confident, capable, skilled staff from universal to specialist services.

Early Identification of Need
- Named Persons confident to respond to identified needs early on.
- Good assessment - Integrated Child’s Plan – As per Children and Young People (Scotland) Act 2014
• All staff know mental health is their job not only CAMHS

The strategy needs to ensure we can demonstrate we are moving towards early intervention and prevention as legislated in the Children and Young People (Scotland) Act 2015.

The next strategy (for children and young people) must embed GIRFEC at its heart. It must link all relevant national policy to ensure people see promotion, prevention and care as every one’s job, not only a CAMHS task.

**Conclusion**

Responding to this call for written evidence has required set questions to be answered within a specific format. We would like to add that whilst collating views and feedback there have been many comments made about effective intervention and examples of joint working with our colleagues in CAMHS which have led to improved outcomes for children and young people.