Occupational therapists are one of the five core professions in mental health services and have been working within multi-disciplinary teams in Child and Adolescent Mental Health Services (CAMHS) in Britain for many years (Lougher 2001).

The key role of occupational therapy in CAMHS is well recognised (NHS Advisory Service 1995, Finch 2000, Bamford 2000) and it is essential that children, young people and families are given access to an appropriate mix of different professionals that includes occupational therapy.

Occupational therapy is founded on the concept that occupation/activity is essential to human existence, and to health and wellbeing. Occupation has the potential to restore, maintain and improve physical and mental health and prevent ill health.

Occupational therapists use a social rather than a medical model and work as part of multi-disciplinary teams and with parents and carers. Many service users tell us that it is occupational therapy, which has made the difference to their recovery as it focuses on their everyday lives and how their strengths and difficulties affect their performance at home, in education, leisure, work/play. Also, as it is the service user’s own goals and interests which direct therapy, ensuring that the pace and outcomes are what the service user wants.

The College of Occupational Therapists (COT) wishes to draw the Committee’s attention to the fact that many CAMHS teams in Scotland do not employ occupational therapists. Of those who do, our members report capacity and therefore the ability to deliver best practice in prevention, early intervention and ongoing treatment, is compromised.

This is further compromised for those CAMHS who do employ occupational therapists by difficulties in succession planning. For example, when an experienced occupational therapist leaves a service it can be difficult to replace them with someone suitably experienced. Lack of numbers means lack of student placements etc.

**An example of intervention from an occupational therapist in CAMHS**

An occupational therapist describes her work with a teenager who has a four year history of psychogenic vomiting and social anxieties. The extent of his difficulties compromised his mobility to such an extent that he used a wheelchair. He had been in the CAMHS system for three years with little shift in his condition, and indeed a worsening of his mobility.

Her approach as an occupational therapist was different from other therapists he had seen and she could deal with both his physical and emotional difficulties and carry out therapy in his home and local community, as opposed to the clinic. Client-centred assessments were administered and he set graded goals in collaboration with the occupational therapist.
Her therapy approach included adapting the environment, using a Cognitive Behavioural approach to reduce panic symptoms, and using relaxation and functional activity in the home and community setting.

After five months of occupational therapy, the client made huge progress. She says:

“He is now independently completing toilet, bath and shower transfers; he no longer spends the day in pyjamas on the sofa under a duvet; he attends physiotherapy and is walking using a rollator; he is more active daily including gardening and going shopping with his family and he attends horse riding sessions on a weekly basis.

There are many more goals that the client would like to achieve including outdoor mobility, further decreasing his daily panic symptoms, decreasing the vomiting, decreasing social anxiety to be able to build appropriate friendships with peers.

Hopefully with continued graded occupational therapy intervention he will achieve these aims.”

**Early identification of children and adolescents potentially at risk of developing mental health problems**

Occupational therapists in community paediatric services for children routinely identify and treat children who are at risk of developing mental ill health for example children with Developmental Co-ordination Disorder (DCD) which affects 5-6% of the school-aged population.

Children with DCD have an inability to participate fully in life, leading to social isolation, and, are therefore, vulnerable to being unemployed, breaking the law, being an alcohol or drug mis-user and/or having emotional difficulties in childhood (Mandich A, Polatajko H, 2003).

The recognition of the social, academic and emotional consequences of DCD has resulted in a significant increase in referral for children with presumptive DCD to mainstream Paediatric Occupational Therapy services. For example, in Greater Renfrewshire and Inverclyde the demand for assessment of young children presenting with DCD-type symptoms has resulted in referrals to the DCD Service increasing by 42% over a 5 year period.

Treatment and intervention is most effective at an early age to prevent mental health problems which are mainly associated with social isolation and low self esteem, but although work around waiting times for AHP may have led to improvements in waiting times in some occupational therapy services, there is still a significant shortfall in resources to meet demand leading to long waiting lists and continued distress for clients.
In areas where there are no or insufficient occupational therapists in CAMHS referrals are routinely made to Community Paediatric Occupational Therapy who also do not have the resources to meet demand. For example, a high percentage of children with ADHD will have co-existing conditions such as DCD, Tourette’s, dyslexia or specific language disorder and need to see an occupational therapist but in Renfrewshire, where there are no occupational therapists within the CAMHS team children are referred to the community paediatric occupational therapy service as part of a differential diagnostic process. As this service is already overstretched, these children are put on a waiting list. This is not an ideal care pathway.

A recent pilot study to evaluate whether the needs of children with ADHD would be better met through community paediatricians rather than CAMHS highlighted that joint funded services were an effective way forward. It also demonstrated the key role for occupational therapists where their assessments contributed to the diagnosis given by the doctor (Price 2008).

**Obstacles to identifying children and adolescents with mental health problems**

The Delivering for Mental Health target to have mental health link workers for every school is excellent as this would allow training and consultation to guidance teachers, school nursing staff etc. There however seems to be insufficient CAMHS staff to do this effectively. This could be provided by occupational therapists as they are skilled in working across agencies and in early identification and intervention based in the individual’s own environment but many services do not have the occupational therapy capacity to do this.

Activity based programmes can assist engagement with hard to reach groups e.g. looked after and accommodated children, homeless families and young people. It is essential that occupational therapy is available in CAMHS teams to support creativity and flexibility in their ability to engage families and young people.

**Action being taken to facilitate early intervention and what else can be done**

The creative approaches occupational therapists use with hard to reach groups enables early engagement with young people who do not engage with talking therapies e.g. activity based groupwork, projects using music, film, drama etc vocational courses (such as introduction and tasters in voluntary work).

Occupational therapists should be employed in every CAMHS team to support early intervention with creative and occupationally/activity based approaches.

**How to improve access to services and ongoing support**
Address the shortage of occupational therapists within CAMHS teams to enable children and young people to access the services they need from occupational therapists…

Example: For young people with eating disorders occupational therapy enhances self perception and self worth (American Psychiatric Association 2006) and, as Natenshon (2003) says, is crucial to successful treatment outcomes.

Services need to be provided across agencies and occupational therapists are experienced in working across health, social care and education and with carers …

Example: In one area an occupational therapist has been working with social services colleagues to help looked after children with their social, developmental, and occupational needs. This has also involved liaising with education services, and providing training and support for foster carers. (Hardy 2004)

What problems there are around transition from CAMHS to adult mental health services and how a smoother transition may be achieved.

Occupational therapists should be available in CAMHS teams to support young people with the transition to adulthood and are key to providing graded steps into leisure activities, voluntary work, training, work and education.

Many young people lack the confidence and skills to move into mainstream services and benefit from occupational therapy intervention to do so. For example, in Edinburgh, occupational therapists lead a number of projects introducing young people to mainstream services e.g.

- ACE- Supported bridging course for young people with mental health problems run in partnership with Further Education College.
- WAVE- Course introducing young people to voluntary work through group work and taster sessions
- Music project- Socially anxious young people meet up with the occupational therapist and a musician to write and practice music with the aim of performing in a concert for invited guests.
- Duke of Edinburgh Award Scheme - many young people with mental health problems have had poor experience of school, often struggling to sit exams and have tangible success. Credit toward this award can be very helpful in acknowledging achievement and building confidence and motivation to move forward.
• Work with Careers Scotland and other vocational organisations supporting them to find the appropriate options for the young person

NOTES

The British Association of Occupational Therapists (BAOT) is the professional body and trade union for occupational therapists, their support workers and students in the UK, representing approximately 29,000 members. Around 3,000 members are working or studying in Scotland.

The College of Occupational Therapists (COT) is a registered charity and subsidiary of BAOT. COT contributes to policy consultations throughout the UK and sets professional and educational standards for occupational therapists. COT also provides leadership, guidance and information relating to research and development, education, practice and lifelong learning.

Occupational therapists work in a range of settings including the NHS, local authority social services and housing departments, schools, primary care services, vocational and employment rehabilitation services and in the voluntary and private sector.

Occupational therapists are Allied Health Professionals and are regulated by the Health Professions Council. They work with individuals of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

Elizabeth MacDonald
Policy Officer-Scotland
College of Occupational Therapists
January 2009