BACKGROUND

1. The Children and Young People’s Health Support Group is an expert Ministerial Advisory Group established to provide advice on children and young peoples health in Scotland. The Support Group and its predecessor, the Child Health Support Group, have consistently highlighted the importance of mental health and well being and the delivery of appropriate services to children and young people in Scotland. The Support Group has been involved in producing a number of reports which have resulted in the development of policy in this area including:

- Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland
- Delivering for Mental Health: Children and Young People Mental Health Services Conference 28 February 2007
- Child Health Support Group, Inpatient Working Group - Psychiatric Inpatient Services for Children and Young People in Scotland -A Way Forward
- The Mental Health of Children and Young People; A Framework for Promotion, Prevention and Care (FPPC).

2. The Scottish Government continues to accept the importance of this area of activity and has highlighted specific actions in Better Health Better Care, the Best Possible Start Section and continued endorsement of the direction of travel set out in The Mental Health of Children and Young People; A Framework for Promotion, Prevention and Care.

3. There have been a number of other publications including the Mental Health Delivery Plan which set out a number of key actions and targets in relation to CAMHS. The development of a target for improving access to CAMHS has recently been included in the performance management process for NHS Scotland and the information being produced on the implementation of this target will be a significant factor in improving CAMHS in the next few years.

4. The Support Group has established a working group, the CAMHS National Advisory Group to continue to address specific issues around development of the CAMHS workforce and improving access to services.

5. This submission provides a summary of the key issues in relation to epidemiology, key areas for development, potential changes to improve services that should be taken forward over the next few years sets out how we will know that investment will make a difference to children and young people.

EPIDEMIOLOGY

6. At any one time 10% of Scotland’s 1,250,000 children and young people are likely to be experiencing a clinically significant mental health problem. 45% of Scotland’s 14,000 Looked After Children are likely to be so affected.
7. QIS report (May 08) reports there are 4,539 children and young people with a diagnosis of ADHD. The report also indicates the likelihood of a further 7000 children and young people with the more severe form of ADHD who have not yet been identified and offered treatment.

8. Disruptive behaviour disorders occur in almost 5% of 5 – 10 year olds in the UK. It is likely that there are about 18,240 children in Scotland with these problems, two thirds of them boys.

9. The most recent published rate of clinically significant depression amongst 11 to 16 year olds in the UK (1.4%) suggests that there would be 5430 young people (3530 girls, 1900 boys) so affected in Scotland. 50% are likely to remain depressed for more than one year.

10. The needs assessment study of adolescent onset psychosis in Central Scotland found that among this population, the majority had persisting serious or pervasive impairment of functioning. The study noted that for 80% of these young people their first experience of in-patient care was in an adult acute ward.

KEY AREAS OF DEVELOPMENT

11. The Support Group has also identified a number of areas that should be addressed over the next few years if we want to meet the needs of children and young people in Scotland. These include:

The Development of Early Years Mental Health Services

- **Evidence**
  - Disruptive behaviour disorders which begin in childhood tend to persist.
  - Untreated, they are associated with significant costs to all public services throughout childhood and into adult life.
  - Appropriate intervention, in the form of structured parenting programmes, can introduce improvements at the pre-school stage which appear to persist.

- **Link to existing aims**
  - Mental Health Delivery Plan Commitment 4 – “we will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers”.
  - Better Health, Better Care section 6 – The Best Possible Start -“support effective parenting in the earliest stages of a child’s life”.

The Development of an Integrated CAMHS Presence in Schools

- **Evidence**
  - SIGN Guideline 52 indicates the importance of early recognition and appropriate intervention in relation to ADHD which is likely to reduce core symptoms and improves educational and social functioning.
  - The NICE Guideline on Depression in Children and Young People highlights the importance of recognition, of the assessment of the risk of self harm and of early,
MH69

Child and Adolescent Mental Health Services Inquiry
Child and Adolescent Mental Health Services in Scotland – Children and Young People’s Health Support Group

active treatment of depression in young people. These measures are likely to be associated with improved mood, social and educational functioning.

- **Links to existing aims**
  - Mental Health Delivery Plan Commitment 10 – “a named mental health link person is available to every school, fulfilling the functions outlined in the Framework”
  - Delivering a Healthy Future – “there is an annual increase in primary mental health work until 2015 by which time it should account for 25% of NHS specialist CAMHS activity in every NHS Board area”.

**Orientate CAMHS Towards Vulnerable Children and Young People**

- **Evidence**
  - The evidence is growing as to the kinds of measures necessary to improve the mental health of children and young people who are looked after. Such interventions are often complex and more intensive than most community interventions and require particular attention to service design and delivery.
  - Vulnerable children and young people benefit from services which are designed with their particular needs in mind: a good example is the availability of skills in working with children and young people with a learning disability.

- **Links to existing aims**
  - Mental Health Delivery Plan Commitment 10 – “basic mental health training should be offered to all those working with, or caring for, looked after and accommodated children and young people”.
  - Looked After Children and Young People: We Can and Must Do Better, Action 15: “Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments……”

**Improve Intensive Community Services**

- **Evidence**
  - There is a world-wide trend to develop services - typically intensive and based in the community – to target adolescent onset psychosis; many of these services appear to be associated with improved short term outcomes, with the impact on longer-term outcomes yet to become clear.

- **Links to existing aims**
  - Mental Health Delivery Plan Commitment 11: “reduce the number of admissions of children and young people to adult beds by 50% by 2009”
  - Mental Health (Care and Treatment)(Scotland) Act 2003 – treatment should be provided in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care

**Demand and Capacity**

- Demand for CAMH Services currently outstrips capacity to a very significant level
Child and Adolescent Mental Health Services Inquiry
Child and Adolescent Mental Health Services in Scotland – Children and Young
People’s Health Support Group

- Services provided across Scotland are not equitable
  - Models of good practice in many places, but sporadic and little consistency
  - Variability in staffing levels in different NHS Board areas.
  - Variability in levels of investment in different NHS Board areas.
- Waiting times for some CAMH Services can be lengthy and some are increasing
  - However data is not collected routinely by ISD or reported on a formal basis.
  - Time spent managing waiting lists further reduces clinical capacity.
  - Information gathered from visits to Boards confirms that there are significant waiting lists and times in some parts of the country.
- Accessing inpatient beds continues to be a significant problem as evidenced by the Mental Welfare Commission

WHAT CHANGE CAN WE MAKE THAT WILL IMPROVE SERVICES?

12. To address the issues highlighted in this submission and the considerable body of evidence that has been produced and is continually being updated we have suggested that the following areas should be the main focus over the next 12 months.

- Developing the CAMHS Workforce
- Development of a strong framework to drive redesign

Developing the CAMHS Workforce

13. We should aim to meet a Community CAMHS workforce target of 20 Whole Time Equivalents (WTE) per 100,000/population for serving the age group 0 – 16 years (if 17 – 18’s are included this will require additional resource).

14. The case for 20 WTE is based on a more detailed argument of the kind (accepted by DoH in 2004) which is set out in the Building and Sustaining Specialist CAMHS report (http://www.rcpsych.ac.uk/files/pdfversion/CR137.pdf). The figures published in that report formed part of the case presented to SEHD in summer 2005 before the (then) Minister agreed to sign off the FPPC.

15. Raphael Kelvin made a finely detailed argument (paper available) taking best current epidemiological evidence and evidence about which treatments are best deployed, and by whom, to describe what CAMHS workforce is needed. He has also done some early work on the implication of providing services for the 17 – 18 year age group.

Table 1. Community CAMHS Staff: Comparison with England

<table>
<thead>
<tr>
<th></th>
<th>Year of data</th>
<th>Age range</th>
<th>WTE Community CAMHS specialists per 100k population</th>
<th>Target 0 – 16</th>
<th>Target number</th>
<th>Current Numbers</th>
<th>No. of add staff required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>2006</td>
<td>0 – 16³</td>
<td>10.6²</td>
<td>20</td>
<td>1025</td>
<td>535</td>
<td>480 (+90%)</td>
</tr>
</tbody>
</table>
Child and Adolescent Mental Health Services Inquiry
Child and Adolescent Mental Health Services in Scotland – Children and Young
People’s Health Support Group

<table>
<thead>
<tr>
<th>Scotland excluding NHS GGC</th>
<th>0 – 16</th>
<th>8.2</th>
<th>20</th>
<th>780</th>
<th>320</th>
<th>460 (+143%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2006/7</td>
<td>0 - 17</td>
<td>12.15</td>
<td>20</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes
1 The age range dealt with by CAMHS varies across Scotland
2 Although low, this figure is boosted by inclusion of some tier 4 staff.
3 English workforce figures are from the 2006/7 atlas, published at [http://www.childhealthmapping.org.uk/reports/CH_CAMHS_MS_Atlas_200607.pdf](http://www.childhealthmapping.org.uk/reports/CH_CAMHS_MS_Atlas_200607.pdf), pp 32

16. This figures provide in Table 2 provide a summary of the numbers of staff required if Scotland is to meet the target of 20 WTE staff to provide a fully comprehensive service by a community CAMHS workforce. This based on the illustrative skill mix discussed in the 2005 Strategic Review of CAMHS Workforce.

Table 2. Suggested profile of the community based CAMHS Workforce

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Wte/100,000</th>
<th>Wte nationally @20/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; adolescent psychiatrist</td>
<td>2</td>
<td>104</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>5.33</td>
<td>273</td>
</tr>
<tr>
<td>CAMHS nurse</td>
<td>5.33</td>
<td>273</td>
</tr>
<tr>
<td>Social worker</td>
<td>2</td>
<td>103</td>
</tr>
<tr>
<td>Psychological therapist</td>
<td>2.66</td>
<td>136</td>
</tr>
<tr>
<td>Allied health professional 1</td>
<td>1.33</td>
<td>68</td>
</tr>
<tr>
<td>Other</td>
<td>1.33</td>
<td>68</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>1025</td>
</tr>
</tbody>
</table>

17. Tier 4 and inpatient services should be considered as part of a separate discussion and are not included in the figures above.

Current workforce plans position

18. Some Boards have recently or are in the next few months planning to agree increases to CAMHS however the financial packages to support these increases are not all reflected in Boards financial plans for 2009/2010 and beyond.

19. The CAMHS workforce will need to be grown over the next 5 years. Once there is a commitment to CAMHS supported by Board commitments it will be possible to engage with NES and others to put in place the necessary trainee numbers and educational programmes to train the workforce we require.

Consequences of not increasing CAMHS workforce

- As well as FPPC, there are key parts of GIRFEC, We Can and Must Do Better, ASL legislation which are based on expectations of CAMHS which can only be met by increasing resources.
- The QIS ADHD audit published in May 2008 reports that the levels of under-recognition in ADHD alone are substantial. If the children who are not currently receiving services are to receive proper care and treatment, resources available to CAMH Services will have to increase.
Child and Adolescent Mental Health Services Inquiry
Child and Adolescent Mental Health Services in Scotland – Children and Young People’s Health Support Group

- A similar case can be made in relation to:
  - young people with depression;
  - the unnecessarily late intervention for children with disruptive behaviour disorders and
  - the relative unavailability of out of hours CAMH Services.

- waiting times are likely to increase
- many CAMH Services publish referral criteria designed to make best use of limited resources. The Scottish Needs Assessment CAMH report identified that these can lead to exclusion of vulnerable children and young people and can orientate services away from early intervention.

Put in Place a Strong Framework to Drive Redesign

20. There is a conceptual model for re-design already established with clinical services and the National CAMHS Advisory group has already begun work on:

- creating a balanced score card for CAMHS
- identifying high impact changes and putting in place mechanisms to share good practice
- involving clinicians and local managers in leading the re-design process
- re-design using LEAN principles to enhance integration across children’s services

HOW WILL YOU KNOW INVESTMENT WILL MAKE A DIFFERENCE TO CHILDREN AND YOUNG PEOPLE

- The number of children and young people served by CAMHS will be greater
- There will be a number of strategic service developments
  - The development of early years mental health services
    - Establishing Incredible Years (or equivalently robustly evidenced) programme in each NHS Board area
  - The development of an integrated CAMHS presence in schools
    - In primary schools, identifying and facilitating appropriate intervention for children whose mental health is at risk because of recognised neuro-developmental disorders (including ASD and ADHD)
    - In secondary schools, identifying young people with depressive disorders and ensuring early, active management
  - Orientating CAMHS towards vulnerable children and young people
    - Ensuring that mental health provision is readily accessible for looked after and accommodated children in each NHS Board area
    - Ensure that mental health services are accessible and fit for purpose for children and young people with a learning disability
  - Improve intensive community services
    - Ensuring that, where treatment for severe mental health problems can be provided safely and effectively in the community, appropriate services are developed.
There will be measurable indicators in relation to these developments
Boards can expect a year on year improvement in these areas, in line with their investment.

Children and Young People’s Health Support Group Submission to the Health and Sport Committee Review of Child and Adolescent Mental Health Services.

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