

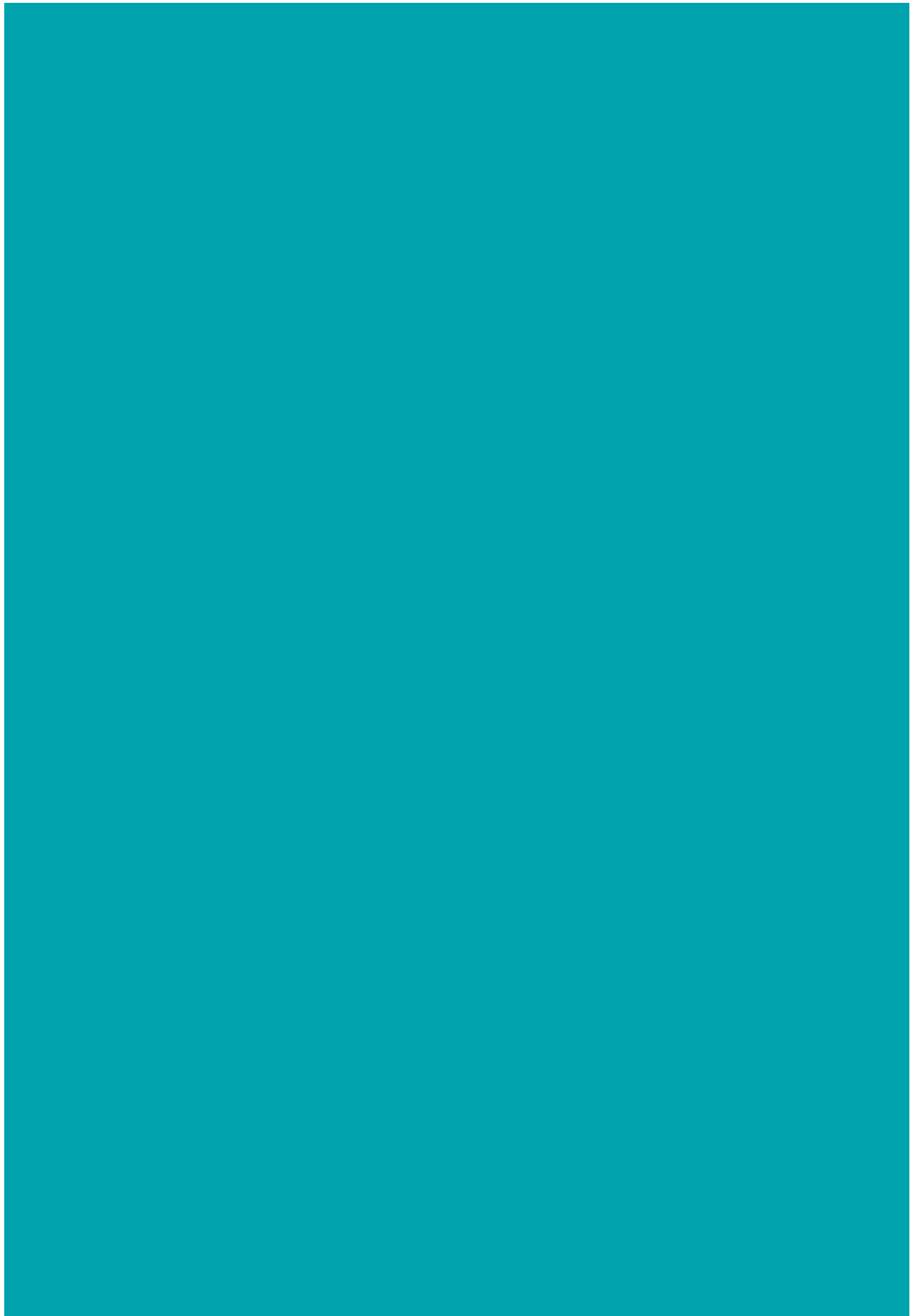


Audit of rejected referrals to Child and Adolescent Mental Health Services in Scotland

**Experiences of Barnardo's Scotland
staff working in children's services**

By Nicki Wray, June 2018

**Believe in
children**
 **Barnardo's
Scotland**



Executive Summary

This report looks at the experience of Barnardo's Scotland services working with children and young people who have been unable to access specialist CAMHS following a referral. Drawing on evidence gathered from around 40 practitioners working across 10 Barnardo's services in Scotland, the report provides a practitioner perspective of some of the difficulties within the current system.

Our services highlighted five key reasons why a referral to CAMHS may be rejected:

- 1 Lack of stability**
Children and young people who do not present as stable or who are not in a stable placement are likely to be rejected by CAMHS for treatment
- 2 Lack of engagement**
Children and young people who do not engage with CAMHS or fail to attend appointments can be rejected for treatment
- 3 Symptoms not severe enough**
Referrals are often rejected because young people are not presenting with severe enough clinical problems; behavioural and emotional problems tend to be outwith the remit of CAMHS
- 4 Lack of clarity around referral criteria**
A lack of clarity around the criteria and thresholds for those referring into CAMHS results in inappropriate referrals and rejections for young people
- 5 Service already being provided by another organisation**
Young people can be rejected for treatment with CAMHS because they are already receiving a service or support of some kind from another organisation, in this case Barnardo's Scotland

Given the findings of this report, Barnardo's Scotland is calling for some fundamental changes to the support available for children and young people's mental health. The current system is failing many of our most vulnerable young people and prevents the extremely dedicated staff within CAMHS from being able to help those most in need.

Access to specialist CAMHS must be improved for those children and young people who really need it. But for this to happen, pressure on the service must be relieved further upstream.

A national conversation about the funding structures for the kinds of issues not best suited to CAMHS is needed. Until there is parity of esteem as far as funding is concerned, the NHS and particularly specialist CAMHS will continue to bear the brunt of referrals for children and young people's mental health. The third sector is currently picking up the pieces but with unstable and uncertain funding this is not a long term solution.

Better referral pathways for young people experiencing distress and difficulties with their mental health are essential; these pathways should be accompanied by appropriate funding streams and support services. The current system creates a bottleneck for specialist CAMHS and sets up young people for more and more rejection at a critical time when they are most in need of support.

Recommendations

Recommendations 1 and 2 are necessary within the current CAMHS system. Recommendation 3 is for a new model of provision but should be implemented in conjunction with recommendations 1 and 2 to ensure that CAMHS are able to complement this new model.

- 1** Clearly understood, consistent referral criteria AND assessment processes for referrals to CAMHS should be established nationally.
- 2** Clarification is needed as a matter of urgency for all professionals and families about what the role, scope and remit of specialist CAMHS is.
- 3** Consideration should be given to the development of an alternative service to CAMHS for children experiencing distress. This service should be rooted in children's experiences and environment and take a trauma-informed approach.



Introduction

In March 2017 Barnardo's Scotland called for a review of the number of children and young people who are not accepted for treatment by Child and Adolescent Mental Health Services (CAMHS)¹. This was as a result of an internal review of the case files of almost 3,000 children and young people within our own services, which found that 50% of those we were supporting at that time had a diagnosis of mental ill health or were presenting with a mental health issue. At the time of the review, three quarters of those presenting with mental health issues were not receiving a service from CAMHS. However the reasons for this were not clear.

We therefore very much welcomed the commitment within the Scottish Government's Mental Health Strategy to commission an audit of CAMHS rejected referrals, and to act upon its findings².

While we know that not all children and young people with mental health difficulties will need a specialist CAMH service, they do have a right to appropriate support.

The view of Barnardo's Scotland is that children's mental health and wellbeing is not an issue for Health alone to deal with. If the right services, and joined-up referral pathways, are in place for these children, then the dedicated staff within specialist CAMHS will have more capacity to work with those children who really need them.

In this report we have highlighted some of the key reasons raised by our staff for referrals to CAMHS being rejected. However, we want to make it very clear from the outset that our intention is not to criticise CAMHS. Rather, it is to encourage better ways of working in order to achieve improved outcomes for our children and young people, and we acknowledge that the third sector has a central role to play in these improvements.

The evidence we have provided in this report is designed to complement other material being gathered for the Audit, including the quantitative work of the Information Services Division (ISD) and the work the Scottish Association for Mental Health (SAMH) are undertaking with children, young people and their families.

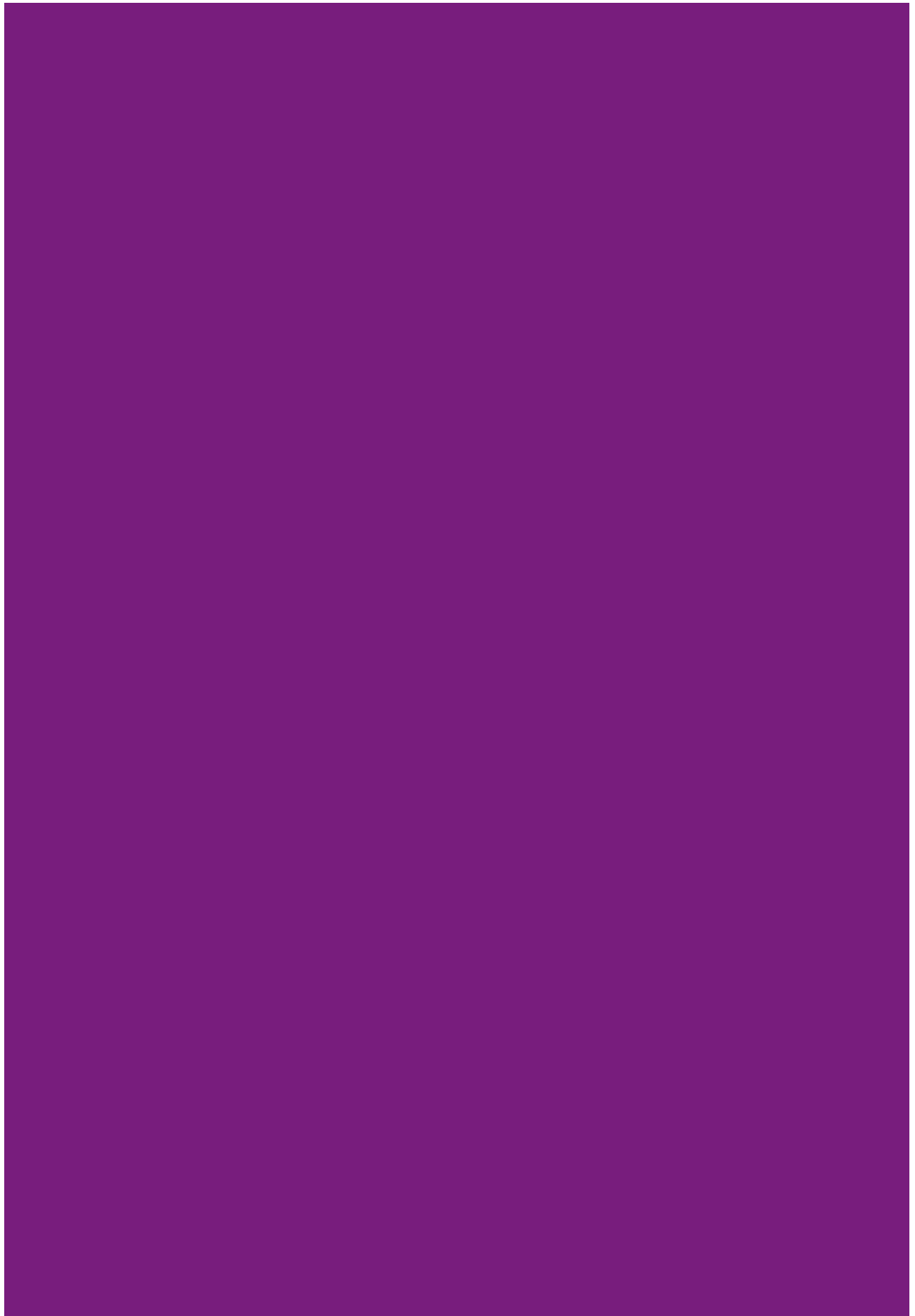
Throughout our engagement with our services we heard many examples of CAMHS providing an excellent service for children and young people who are accepted for treatment, and we highlight some of these later in this report. However, the key purpose of this report is to look at access to CAMHS rather than the service provided³.



1 http://www.barnardos.org.uk/what_we_do/corporate_strategy/scotland/scotland_news.htm?ref=123542

2 <http://www.gov.scot/Resource/0051/00516047.pdf>

3 Throughout this report when we refer to CAMHS we are talking about specialist CAMHS, i.e. tier 3 and above as this is the stage at which the referrals we discuss are being rejected.



Who we spoke to

The views in this report were gathered between January and March 2018 through meeting with Barnardo's Scotland staff teams and individuals, this included 1:1 meetings as well as focus groups, workshops and the gathering of case studies. Approximately 40 staff from 10 different services across Scotland contributed their experiences. The geographical spread of these services spanned nine different Local Authority areas.

Barnardo's Scotland practitioners have a range of knowledge, skills, expertise and qualifications and come from a range of backgrounds. These include social work, psychology, therapeutic work, trauma and bereavement, child development, community learning and development, education and many more.

The Barnardo's Scotland services covered within this report work on a huge range of issues including attainment, family support, child sexual exploitation, drug and alcohol misuse, fostering and adoption, children leaving care and independent advocacy.

Despite the diversity in the type of service being provided to children and young people, the messages we received about services' experiences of working with young people who had been referred to CAMHS were very similar and there were some very clear themes which emerged, particularly around reasons for rejection.

We have therefore chosen not to identify individual services or Local Authorities within this report; rather we have drawn overarching conclusions which we believe are relevant at a national level.



Who does Barnardo's Scotland support?

Our services support thousands of children, young people and their families across Scotland every year. We provide support for a range of reasons and our work includes child sexual abuse and exploitation, domestic abuse, children in and leaving care, family support, disability, drug and alcohol misuse, and educational attainment. Mental health and wellbeing is an issue that cuts across and spans all of these services in some way.

Our services will receive referrals directly from CAMHS that have not reached the threshold for a service from CAMHS themselves. Referred children and young people may be displaying low self-esteem and confidence, have general wellbeing issues, attachment problems, issues related to trauma and bereavement and other concerns that can lead to self-harm. This group of children and young people can lack support and reassurance, and what often helps is someone to listen and enable them to develop strategies that will support them going forward.

Our services will also make referrals directly into specialist CAMHS for children and young people who staff members feel need specialist mental health support; these referrals are often rejected for not meeting the criteria or thresholds.

While it is undeniable that these children and young people need support, it is equally clear that CAMHS does not have the remit or capacity to work with them. The main concern for us is what happens next for these children and young people when they are not accepted for treatment with CAMHS; what alternative supports are available; and how their needs are being addressed.



Reasons for rejection cited by our services

Our services highlighted five key reasons why a referral to CAMHS may be rejected.

1. **Lack of stability;**
2. **Lack of engagement;**
3. **Symptoms not severe enough;**
4. **Lack of clarity around referral criteria;**
5. **Service already being provided by another organisation;**

1. Lack of stability

Key message

Children and young people who do not present as stable or who are not in a stable placement are likely to be rejected by CAMHS for treatment

Consistent feedback was received from our staff around lack of stability, lack of stable placement and a chaotic home life being cited by CAMHS when a referral was rejected. Barnardo's services are frequently called upon to 'stabilise' a child or young person within the home environment before making a re-referral to CAMHS, this can include placement stability as well as the individual stability of the child.

But a chaotic background and instability are commonplace for the children and families we work with and often go hand in hand with problems relating to mental health. These aren't issues which can be easily separated. The children and young people in our services have often experienced trauma and will not be presenting as stable.

This is a particular issue for looked after children who move around a lot and will likely have multiple placements. We know that placement stability is a key protective factor for young people's mental health, so placement instability is likely to exacerbate mental health problems which then make it less likely they will be able to access specialist support. Unstable placements can also lead to out of area placements for

a child or young person which then means going back to the bottom of a different CAMHS waiting list if it is a different health board area.

"We were working with a 13 year old girl who was very distressed after a rejection from her foster family. Social Work made the referral to CAMHS who set up the meeting.

"CAMHS wouldn't take it any further as they required her to have more stability before they would help."

Barnardo's Scotland Project Worker

Misuse of drugs and alcohol is a common reason for rejection due to instability. But our services know from working intensively with young people with issues around substance misuse, that drugs and alcohol are a coping mechanism often used to mask underlying trauma. These referrals are rejected because the drug and alcohol misuse could be causing the mental health problem rather than being a result of it.

Too often our young people will be self-medicating as a coping mechanism and they won't be able to stop doing that without specialist support, but this specialist support isn't available until they have stopped self-medicating. This is a vicious cycle and doesn't result in the young person getting the help they need. Children who have experienced ACEs and trauma are more vulnerable to developing risky behaviours and mental health problems in later life, yet these circumstances and the environments they find themselves in are often the reason they are unable to access specialist help.

Case study – Danny

Danny received a criminal justice forensic psychological assessment which included a requirement for a mental health assessment. However his GP would not refer him for assessment because he had previously referred Danny to CAMHS five times and these referrals had been rejected because Danny uses cannabis.

Danny admits that he is using cannabis to self-medicate as it helps him to feel calmer, but CAMHS have said that his mental health symptoms could be down to his cannabis use so they cannot assess him.

Barnardo's staff working with Danny have highlighted to CAMHS that he was displaying these behaviours and symptoms of mental health issues before he started to use cannabis (at aged 11), but this has not resulted in an accepted referral.

Barnardo's staff eventually got Danny a mental health referral through the local Community Alcohol and Drugs service.

This is a difficult issue to negotiate and whilst we can see the rationale behind these criteria, more flexibility is required in how these referrals are dealt with and the expertise and professional opinion of third sector organisations taken into consideration.

These young people require a service which can take into account everything going on in their life, how this may be affecting their mental health and wellbeing and what support needs to be put in place to help them. This is not the way services are currently configured, and as such life experiences and environmental factors are seen as unrelated to mental health rather than inextricably linked.

Professionals need the time and space to be able to see beyond the presenting symptoms to the underlying issues. If stability is required for access to one particular model of support, there must be an alternative model of support available for those who are not at that level of stability, either personally or within their placement.

2. Lack of engagement

Key message

Children and young people who do not engage with CAMHS or fail to attend appointments can be rejected for treatment.

'Did not attend' or DNAs are officially recorded as children and young people who did not attend their first contact appointment for CAMHS. The most recent ISD statistics show a DNA rate of 11.8% nationally⁴. The experience of our frontline staff is that young people will often be removed from the CAMHS waiting list for missing a certain number of appointments, although this number can vary depending on the local area.

Although not technically a rejected referral, for the children, young people and families we work with, this is very much a rejection. Support has been offered which provides families with hope, and then taken away because of the expectation that families will engage in the way statutory services want them to, rather than designing services around children and families based on their need.

⁴ <https://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2018-03-06/2018-03-06-CAMHS-Report.pdf>

The experience of our services is that DNAs can be linked to practical issues such as the opt-in letters CAMHS use to communicate with young people and their families about appointments. Parents are often the gateway for young people accessing CAMHS, and low levels of literacy in some families can mean that letters go unread. A chaotic home life and mistrust of statutory services can also be reasons for appointments being missed, and parents may not actively engage or support a young person to attend in case family issues are raised in sessions which they do not want being shared.

The opt-in process unfortunately puts the onus on parents and young people to be responsible for accessing their own support. This model may work for adult services, where adults have more agency and control over their decisions; but children are much less able to do this. Our staff told us that letters are a very adult way to communicate, while text or email are more suited to young people and may stop parents acting as barriers or gatekeepers to support.

Evidence has shown that relationships are absolutely crucial for young people when accessing services, particularly for their mental health. For example the Right Here pilot from the Mental Health Foundation found that relationships with peers and youth workers made the biggest difference to many of the young people involved:

“Relationships grow from repeated exposure, trust, constancy and reciprocity. It can sometimes be transformational simply to find in another person someone who remains a point of constancy when other areas of your life are in flux. Finding someone who is interested in you as a person, rather than a patient or client, can be revelatory for young people who have had difficult lives.”⁵



Case study – Jack

Jack attended CAMHS for an initial appointment alongside a Barnardo's worker. Jack's parents took him to CAMHS due to concerns regarding his violent behaviour towards his mother within the family home. During the initial appointment Jack was asked to sit outside while the CAMHS worker spoke with his mother who became emotional during their conversation. Jack overheard this and subsequently decided he did not like CAMHS or the CAMHS worker because he felt the worker had not been nice to his mother.

CAMHS felt the family did not require support from their service and subsequently the family were advised by CAMHS to attend Barnardo's for support. Two years later a re-referral was made to CAMHS by Barnardo's when Jack attempted suicide within the family home. Immediately following this the family had contact with social work and police, at this time they received the initial “opt-in” letter from CAMHS. The family then subsequently misplaced their letter over the Christmas period. A Barnardo's worker contacted CAMHS in the New Year and found that Jack had been discharged from the service as the family did not “opt-in” within the set timescale.

⁵ <https://www.mentalhealth.org.uk/projects/right-here/why-focusing-relationships-vital-improving-young-people%E2%80%99s-mental-health-and-wellbeing>

Despite some excellent practice in certain areas, the experience of our practitioners is that CAMHS are not set up with the capacity to do outreach or sustain meaningful relationships with young people. Young people will often be rejected for non-response or non-engagement with no follow up. Our staff told us that CAMHS workers change quite frequently which makes it difficult for them to build relationships with a young person. Our services will support young people to maintain attachment to their CAMHS worker, often reinforcing the work CAMHS are doing, building resilience and coping strategies.

“Young people are often written off by CAMHS because of their behaviour and their mood swings. Sometimes we are the only people keeping these young people in contact with CAMHS, we are relentless.”

Barnardo's Scotland Children's Services Manager

Young people and their families very often need support from third sector organisations to engage with and work with CAMHS. Without this additional support, relationships can break down. The medical model of current provision means that assessment processes can often be clinical and ‘tick boxy’ and CAMHS staff on their own can struggle to engage with vulnerable young people in a meaningful way.

These young people who don't attend or engage still require a service. More flexibility is needed to allow young people to engage in a meaningful way; this may mean they, and their families, need support to engage with CAMHS in the first place.

Almost all the services we spoke to highlighted concerns about the children and young people who are not engaged with Barnardo's or another third sector support agency, and where the additional support they may need to engage with CAMHS would come from.

3. Presenting symptoms not seen as severe enough

Key message

Referrals are often rejected because young people are not presenting with severe enough clinical problems; behavioural and emotional problems tend to be outwith the remit of CAMHS.

Our services told us there are no set referral criteria for acceptance to CAMHS, and the thresholds for acceptance vary across the country. However, the general criteria for specialist CAMHS specifies the need for ‘severe or enduring problems’. The experience of our staff is that this can be subjective and interpreted differently by different staff, different services, and different health boards.

Acceptance is often based on the presenting symptoms of that young person rather than what has happened to them or their experience. Trauma often doesn't manifest itself in the ‘right way’ for an acceptance to CAMHS and our staff have experienced children being rejected because their symptoms are seen as a behavioural issue, not a clinical one.

“There was an indication that CAMHS would not accept past experiences and environment as causality of a mental health issue.”

Barnardo's Scotland Project Worker

Research around trauma and Adverse Childhood Experiences (ACEs) continues to emerge and gain traction in Scotland. We now know that early trauma and adversity can have a very real impact on a child in later life: it is estimated that 1 in 3 adult mental health conditions relate directly to adverse childhood experiences.⁶ We know that children's behaviour is a form of communication which is often masking deeper underlying issues.

⁶ https://youngminds.org.uk/media/1241/report_-_beyond_adversity.pdf

Provision of mental health support for children and young people must keep pace with this knowledge and reflect the complexities of children's lives rather than continuing with a model based on diagnosis or disorder.

“We were working with twin boys in foster care who were referred to CAMHS by Social Work. CAMHS agreed to work with one boy as they felt it would be too difficult for both boys to be in therapy at once. The boy who acted out more was seen first and his quieter sibling was not seen.

“Therapy was really good for the first boy for two years, but his brother has deteriorated, his behaviour has escalated and he's just not being seen.

“CAMHS are saying he's not distressed just behaving badly.”

Barnardo's Scotland Project Worker

Children with 'emotional problems' or 'behavioural problems' are the most likely to be rejected – these issues are often seen by specialist CAMHS as sitting outwith their remit and more appropriately dealt with at home or school. Recent research by the University of Stirling showed that the odds of being rejected by CAMHS are significantly higher if a child or young person is referred by a teacher or has emotional or behavioural difficulties.⁷

Our extensive work in schools shows that teachers often struggle to know how to support children and young people who are experiencing mental health problems. If a teacher is really worried about a pupil, often CAMHS is the only place they have to turn because of its statutory nature.

Case study – Sarah

We were working with Sarah who was in primary three and a non-attender at school. She would frequently feign illness and was presenting as extremely anxious. We had three meetings with CAMHS who would not accept a referral for Sarah because she wasn't outwardly expressing any symptoms. CAMHS received three different referrals from Barnardo's, the GP and the school but the referral wasn't accepted.

Our staff were led to understand that CAMHS saw non-attendance as an issue with parenting or with behaviour and not the remit of CAMHS.

It may well be that specialist CAMHS is not the right place for these children, but teachers and other professionals must have alternative supports or referral pathways to turn to otherwise we are creating an untenable situation in schools where teachers are increasingly struggling to stem the tide of mental health difficulties for children and young people.

We also frequently hear that unless a young person is suicidal they are unlikely to get accepted for support through CAMHS. The need for early intervention and prevention is clear, and this includes an important role for schools, but the current system is set up to only kick in at the point of crisis.

⁷ <http://dspace.stir.ac.uk/handle/1893/25107#.WstOKxUrLIV>

4. Lack of clarity around who can refer and why

Key message

A lack of clarity around the criteria and thresholds for those referring into CAMHS results in inappropriate referrals and rejections for young people

This was a recurring theme from our services and the extent of the problem around clarity varied between different local authority areas. This was also highlighted in the NSPCC report ‘The Right to Recover’⁸. Some of our services reported clear and recognised pathways and others cited a complete lack of knowledge or clarity around when and why they should be referring to CAMHS and where alternative provision was available.

Some of our services said that they would directly refer to CAMHS but others said this was not the case in their area and they had to go through Social Work to get a referral or encourage parents or teachers to self-refer through their GP. Some staff noted that third sector organisations aren’t taken as seriously as Social Work, so getting a referral through them rather than it coming directly from Barnardo’s was seen as having a better likelihood of success for a young person.

In some areas our staff know what CAMHS will and won’t accept so they advise parents, teachers, GPs etc. In other areas staff told us they do not know what the criteria is, what the referral pathways are or whether or not their referral will be accepted. There is a danger with this level of inconsistency that professionals start to ‘ascribe symptoms’ to young people based on what they think the referral criteria is, just to try and get them some support.

“We don’t know what the criteria is, we’re just told it hasn’t been met.”

Barnardo’s Scotland Project Worker

Inappropriate referrals were raised consistently by our services and in our experience are often raised by CAMHS as a problem. Some of our staff noted experience of being told by CAMHS they had submitted an inappropriate referral for a young person, but they didn’t know what deemed the referral inappropriate. They suggested that clarity and consistency around this decision making process would be welcome in order to make the whole process more efficient and prevent children, young people and families being given false hope.

Other staff highlighted examples of families we are working with who have been seen for the first triage appointment by CAMHS but then re-directed to other services such as third sector counselling services, school counselling, or parents directed to complete parenting work rather than accepted for treatment by CAMHS themselves. This suggests that CAMHS may not have been the right place for the initial referral but also highlights a lack of an alternative service to triage those kinds of referrals. Inappropriate referrals are detrimental to both young people who don’t need specialist help, and those who do need it because they have to wait longer to get help.

Overall our staff cited referral processes as difficult for professionals to navigate, and even more complex and difficult for children, young people and their carers. A more consistent feedback loop about why decisions are made and clearer criteria for specialist CAMHS may help in reducing the number of inappropriate referrals.

⁸ <https://www.nspcc.org.uk/globalassets/documents/research-reports/right-to-recover-sexual-abuse-west-scotland.pdf>

5. Service already being provided by another organisation

Key message

Young people can be rejected for treatment with CAMHS because they are already receiving a service or support of some kind from another organisation, in this case Barnardo's Scotland

Most of our services will be working with children and young people who are on the CAMHS waiting list, for various reasons. But we will very often see referrals rejected by CAMHS specifically because the young person is already working with Barnardo's, so it is assumed their needs are being met. This is something that was raised by almost all of the services we spoke to.

Some of our services will have therapeutically trained staff within them such as play or art therapists or psychologists. However this is very much dependent on what that service has been commissioned or set up to do. Many of our services will not have that kind of expertise so there cannot be an expectation that they, or other third sector providers, will be able to provide specialist mental health provision.

Many of our services told us of the pressure of this expectation when there are no specialist therapists or mental health professionals within our service or project. This is often compounded by Social Work and CAMHS closing cases if we still have an open case with that young person. This is undoubtedly due to the pressure CAMHS is under, but these are not decisions made in the best interests of the child or young person, or that put their needs first.

Depending on the nature of the service, Barnardo's may not be able to provide the appropriate mental health support a young person needs. For example, some of our services may only be able to offer group work, but often what that young person needs is 1:1 support. Our services sometimes find that there is a lack of understanding about the type of support and service Barnardo's can provide in their area; our staff will try their best to accommodate a young person within existing services, or signpost elsewhere in terms of mental health support, but if they can't that is just another rejection for that young person when they desperately need support.

Our services supporting foster carers also told us that where Barnardo's are providing support to carers, CAMHS will often not accept children for 1:1 direct support. Rather they provide consultation to carers alongside the support we are providing. In some areas this consultation offer does act as a gateway to direct support for the young person but not in all cases. We set out below why this consultation is very welcome, but it shouldn't be at the expense of direct work if that is what is required.



Case study – Jessica

We were working with Jessica who had been removed from her family home due to neglect and abuse and put into the care of her dad who had mental health problems himself. Jessica had been through lots of moves, different houses and different schools, Jessica's mum had several different partners and Jessica had experienced a very high number of Adverse Childhood Experiences (ACEs). Her dad's mental health problems were becoming a real issue and impacting on Jessica.

A referral went in to CAMHS which was rejected because Barnardo's was already working with Jessica, the service we were providing was a family support service, not a mental health service and the service did not have therapeutically trained staff.

We re-referred in partnership with the school and eventually got Jessica play therapy through CAMHS. However this re-referral was only accepted after a lot of work and refusal to give up by Jessica's Barnardo's support worker.

Sometimes a Barnardo's or other third sector service may be the best place for a young person to receive support, but the correct referral pathways and systems are not currently in place to allow this to happen. The third sector should not be picking up rejected referrals to CAMHS on an ad-hoc basis as this then becomes a postcode lottery for young people. Services for young people requiring mental health support should be based on their need and they should be able to get access to the right support at the right time without being bounced between whatever service might be available in their area, at that time.

Positive practice

We also received evidence from our staff around areas of good practice in terms of mental health support for children and young people, where joint and flexible working has benefited young people and where an understanding of alternative support has resulted in positive outcomes.

As noted above, in some areas CAMHS provides a consultation service for parents and carers which in our experience can be particularly helpful in supporting them to manage and understand how the child or young person's experiences and environment may be impacting on their behaviour. Looked after children in particular will have experienced multiple adversities and traumatic experiences in their lives and will often need intense support from their carers, CAMHS support in this context is therefore very welcome.

Our services tell us that where they have been able to access direct work from CAMHS for our young people who are looked after, they have some really positive examples of therapy working well. They have seen individual CAMHS workers holding and protecting young people, they have seen the same worker provide continuity and stability for a young person, and they have seen CAMHS workers in schools who look systemically at everything that is going on in that young person's life in order to offer the right support in the right environment.

There are other examples of good practice in relation to looked after children in some local authority areas. For example Falkirk Council have a Looked After Children Psychologist who sees children who cannot get access to CAMHS. This service is child-centred, flexible and much more easily accessible for children and young people. A recent Care Inspectorate Report of Falkirk Council noted of the service:

“The highly personalised flexible approach has demonstrated considerable successes in overcoming barriers to accessing and sustaining engagement with vulnerable young people.”⁹

Feedback from professionals using this service has indicated it is taking pressure off CAMHS and without it waiting lists would be even longer.

⁹ <http://www.careinspectorate.com/images/documents/3257/Falkirk%20services%20for%20children%20and%20young%20people%20on%20inspection%20report%20June%202016.pdf>

“Removal of this service would place a greater strain and demand on an already pressured CAMH service who cannot offer the same speedy service and response offered by LAC Psychology”

Practitioner, Falkirk

Examples were also given of where young people referred from CAMHS to a Barnardo's service was the right decision, and had positive outcomes. In these instances there appeared to be a good relationship between CAMHS and the third sector and an understanding of what it was Barnardo's could offer.

Case study – Ellie

A request for assistance was received for Ellie from CAMHS to a Barnardo's service. She had been experiencing behavioural difficulties at home and school. Her mum was struggling to manage Ellie's aggressive behaviour within the house and Ellie was struggling to maintain friendships at school. The family had been subjected to emotional abuse in the past from Ellie's father.

CAMHS had assessed Ellie's difficulties and felt this wasn't linked to a mental health issue and that the family would benefit from family support.

Focus of the support provided by Barnardo's:

- Five to Thrive (attachment) support was provided focusing on supporting Ellie's mum to introduce and maintain consistent boundaries in the house and understand the effects that Ellie's early childhood experiences may now be having on her behaviour.
- 1:1 support for Ellie focused on emotional literacy and managing her feelings.
- Ellie consistently attended the secondary school peer group run by Barnardo's and said that she has enjoyed it. She has said she plans to keep in contact with her friends from the group.
- The worker linked Ellie in with the school-home link worker for support to complete her homework within school as this was causing arguments and upset within the house.

Where are we now?

Ellie has now settled in well to her first year at secondary school. The school report that she is managing well within the school environment. Ellie has made some new friends who appear to be a positive group of peers. Ellie's mum has said that she feels that there has been an improvement in Ellie's behaviour although at times requires support to maintain consistency when supporting Ellie.

The way forward

Recommendations

Recommendations 1 and 2 are necessary within the current CAMHS system. Recommendation 3 is for a new model of provision but should be implemented in conjunction with recommendations 1 and 2 to ensure that CAMHS are able to complement this new model.

- 1** Clearly understood, consistent referral criteria AND assessment processes for referrals to CAMHS should be established nationally.
- 2** Clarification is needed as a matter of urgency for all professionals and families about what the role, scope and remit of specialist CAMHS is.
- 3** Consideration should be given to the development of an alternative service to CAMHS for children experiencing distress. This service should be rooted in children's experiences and environment and take a trauma-informed approach.

The system for supporting children and young people with their mental health requires significant change and re-design. The current system is failing many of our most vulnerable young people and prevents the extremely dedicated staff within CAMHS from being able to help those most in need. Increasingly CAMHS are being put under a huge amount of political pressure to provide the solution to the 'crisis' in children and young people's mental health.

The current CAMHS structure exists within a medical model of mental ill health, and its primary function is the diagnosis of mental illness. The system pathologises and individualises children and young people's problems through a medical lens rather than taking an ecological approach to their mental health and wellbeing. A lack of alternative provision for children and young people needing support for their mental health means that this service becomes the default and many young people are pushed through a process which is not appropriate for their needs. This in turn results in those children who really require specialist help not being able to access it when they need it.

CAMHS is a crucial service for children and young people in need of very specialist support, and has an important role to play in the provision of therapy. But it is not the most appropriate place for many of the children and young people in our services. Many of the issues we see in our services are related to poor attachment, poor emotional literacy, inability to self-regulate, emotional and developmental problems. A child's environment and life experiences are contributory factors to these kinds of issues but the focus of specialist services is on the individual child and what needs to be 'fixed'. Dr Elizabeth Gregory argues that:

"Children and the adults around them are steeped in a model that views 'symptoms' as signs of a disorder or illness, rather than 'signals' that all is not right in the child's world."¹⁰

¹⁰ <https://weneedtotalkaboutchildrensmentalhealth.wordpress.com/2017/10/30/the-adverse-childhood-experiences-evidence-base-a-wake-up-call-to-radically-redesign-childrens-mental-health-services/>

Through her work in Wales Dr Gregory proposes ten steps towards action which we recommend are considered in a Scottish context, these can be found in Appendix 1 of this report, alongside an example of an existing alternative model of provision in Appendix 2.

The problem with the system as it stands is that CAMHS is not designed, and does not have the capacity or remit, to work with children in a holistic way; a child or young person is unlikely to get support without any presenting symptoms. However, we know that if left unaddressed these issues will worsen and lead to crisis, at which point CAMHS will need to step in. A clear shift to early intervention and prevention is needed and this will require investment in services for those children and young people who don't meet the thresholds for CAMHS.

A national conversation about the funding structures for the kinds of issues not best suited to CAMHS is needed. Until there is parity of esteem as far as funding is concerned, the NHS and particularly specialist CAMHS will continue to bear the brunt of referrals for children and young people's mental health.

The third sector is currently picking up the pieces but with unstable and uncertain funding this is not a long term solution.

Better referral pathways for young people experiencing distress and difficulties with their mental health are essential; these pathways should be accompanied by appropriate funding streams and support services. The current system creates a bottleneck for specialist CAMHS and sets up young people for more and more rejection at a critical time when they are most in need of support.

Specialist CAMHS has an important role to play for those children and young people who really need it, and who crucially are in a place to, and are able to benefit from it. This requires a level of stability and support which many of the children and young people our services work with do not have.

We must move away from the expectation that CAMHS will be able to 'fix' or 'cure' the problem. Whilst this remains the norm and services are designed and configured with this expectation in mind, children and young people will continue to be let down.



Acknowledgements

We would like to thank the Barnardo's Scotland service staff who took the time to share their experiences of supporting children and young people with mental health difficulties. Case studies have been anonymised.



Appendix 1

- 1** In addition to a Specialist CAMHS Service that is orientated to a 'within child' understanding of distress; develop a Multiple ACE's Service (MAS) equally resourced with experienced clinicians trained to work and think in this way.
- 2** Resource the Multiple Ace's Service by a) redirecting the significant resource within SCAMHS that goes into rejecting inappropriate referrals and attempting to fit complex children into a clinic based models and b) consolidating the many trauma informed services that have been developed by the voluntary sector and social care but are currently inequitable; funded on a short term basis and often invisible in the 'mental health' landscape and c) reinvesting funding that goes into emergency and 'therapeutic' placements when their families or foster care placements break down.
- 3** Have as the priority for this Multiple Ace's Service (MAS) the training of child care professionals; and the development of trauma informed schools and child care environments.
- 4** Have accessible consultation at the core of service delivery so that all child care professionals have quick access to expert support.
- 5** Redefine 'symptoms' as 'signals' that all is not well in a child's wider environment – let this become the common language of our child care systems.
- 6** Organise support for parents/carers and front line staff around adverse experiences that impact on children rather than 'symptoms' children display.
- 7** Give a clear message to referrers and families that individual therapy from the Specialist CAMHS service is only offered when a child is in a position to be able to benefit from it; and supported by psychologically insightful adults who understand their role in the process. Make this the exclusion criteria – not whether they meet the criteria for a disorder.
- 8** Allow SCAMHS to focus on delivering evidence based, clinic based psychological therapies and interventions to children and families in a position to work in that way.
- 9** At point of referral give professionals and families a viable option – is the child and family in a position to engage in regular therapy and all that it demands?
- 10** Link closely with Public Health to deliver the message far and wide that childhood experiences¹¹ impact on their mental and physical health throughout their life time. If we act now we can change the future.

¹¹ <https://weneedtotalkaboutchildrensmentalhealth.wordpress.com/2017/10/30/the-adverse-childhood-experiences-evidence-base-a-wake-up-call-to-radically-redesign-childrens-mental-health-services/>

Appendix 2

Good practice – Single Point of Access (SPA)

In other parts of the UK Barnardo's works collaboratively and in partnership with CAMHS to jointly deliver services for children and young people who require support for their mental health. Through these models of working we are seeing an increase in engagement and improvement in access to services for children needing support. Children are getting the right help, quicker.

The service is often referred to as a Single Point of Access (SPA) but can look different depending on the commissioning model. Crucially the SPA itself is not the standalone solution, there are jointly commissioned services which sit behind the SPA where children and young people are directed after the initial assessment. Where we are involved, we work in partnership with CAMHS to jointly assess referrals which would usually have gone straight to CAMHS. Referrals are never rejected, unless the referrer hasn't put enough information on the form, and the children and young people referred will have their referral passed on to the most appropriate service for them, based on their need.

The Barnardo's services which sit behind SPA still have high quality mental health provision, such as mentors, therapists and counsellors. The interventions can include play therapy, cognitive behavioural therapy (CBT), drama, art, music or wider work with the whole family. Therapy may not be right for every child or young person, we try and meet their needs at the lowest level of intervention, assessing very clearly what it is they require. This may only be 3 sessions with us, or it could be 4 months of counselling. Or it could be work to address the home environment and the external factors which may be at the root of the problem.

In England our involvement in this work is seen as Tier 2 work and any referrals that are dealt with by Health are seen as Tier 3. This model acknowledges that not every child or young person experiencing mental health difficulties will need a medical intervention, and it puts in place assessment, pathways and crucially services to support that child or young person based on need.



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