

Walk with Phoenix

Beyond the target: children still waiting, gaps in care and lives lost

Evidence and requests for change for the First Minister of Scotland

Submitted by Lisa Birkett, Phoenix's mum
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A mother's request

Phoenix Birkett was 17 when he died following an incident at the Tay Road Bridge on 8 April 2026. I founded Walk with Phoenix to seek safer bridges, earlier recognition of distress and better support for neurodivergent young people. I ask the Scottish Government to judge success through children's access to effective care, safety and experience, alongside waiting-time performance.

What the evidence establishes

Meeting the national CAMHS treatment-start target does not establish that children's needs are being met. Published evidence documents gaps in referral pathways, community support, neurodevelopmental assessment and specialist inpatient provision. The campaign asks for these gaps to be measured, independently examined and addressed.

The latest published CAMHS national result exceeds the formal threshold. This report therefore does not claim that the defined national target was missed. It challenges the use of that result as assurance about the whole system, and asks ministers to demonstrate improvement beyond the headline. Deliberate statistical manipulation has not been established.

Evidence	Why it matters
22 deaths at ages 15-19 registered as probable suicides in 2024 [2]	A continuing loss of young lives; not evidence of a recent national increase.
42,530 children waiting for neurodevelopmental assessment in March 2025 [5]	Substantial assessment demand outside the separate CAMHS headline.
Documented referral and care gaps [7-9]	Independent monitoring and professional research support action.

Decisions requested: a named ministerial lead; independent assurance of referral and waiting-list practices; published outcomes for children outside treatment; coordinated crisis and neurodevelopmental support; and a review of bridge safeguards. A written response and an accountable delivery plan are requested on page 5.

1. Death statistics and recent cases

The latest NRS annual release covers 2024. It reports 704 probable-suicide deaths across all ages, down from the revised 790 in 2023. “Probable suicide” includes specified deaths of undetermined intent; it is not a finding of intent in every case [1].

Age group	2022	2023	2024
10-14	4	3	1
15-19	14	26	22
20-24	55	53	40

Source: Samaritans' Scotland 2024 briefing, Table 1, reproducing official data [2]. In 2024, the 15-19 group comprised 18 males and four females. Ages 10-14 include non-teenagers; ages 20-24 are young adults. Neither band is an exact teenage total. Counts fell between 2023 and 2024; these data do not demonstrate an increase in the past year.

The recent period of interest is 21 October 2025-20 October 2026. A complete published annual total for that period has not been established. NRS schedules its 2025 release for 3 November 2026, with revised age thresholds and historical series. Current figures require rechecking when that release appears [1].

Illustrative recent cases - not an additional suicide count

Person / date	Evidence status
Phoenix Birkett, 17 8 April 2026 incident	Public reporting confirms age, bridge disappearance and 10 May recovery [10]. Lisa describes ADHD, sensory difficulties and an impulsive crisis; these are attributed family accounts, not proof of planned intent.
Daniel Kerr, 19 8 March 2026	SPS confirms his death at Polmont [11]. No final cause determination is established by that register; do not treat it alone as a confirmed suicide.
Ronan Brown, 19 5 June 2026	Mental health difficulties and an ongoing COPFS investigation are reported [12]. His mother disputes suicide [13]. Do not include him in a suicide total.
Lexi, 17 August 2026	ITV Border reports suicide and her sister's account [14]. Exact day, diagnosis and a final independent determination are not established here.

These non-exhaustive examples illustrate different circumstances requiring careful investigation. They do not show a service caused any death, nor a national trend. Requests for aggregate recent death and linked healthcare data were sent to NRS and PHS on 21 October 2026; responses are awaited.

2. What the CAMHS headline measures

April-June 2026 [3]	Reported result
Started treatment within 18 weeks	90.9% (national standard: at least 90%)
Treatment starts	4,006
Referrals received	8,822
Waiting at quarter end	4,379

Boards supply aggregate data to PHS. The percentage concerns those starting treatment in the quarter, not all children seeking help. The figures above concern different cohorts; subtraction does not measure rejection. Orkney's June submission was missing. PHS also warns against direct comparison with its developing patient-level dataset [3].

Separate neurodevelopmental pathways are excluded. This does not mean all children with ADHD or autism are excluded: coexisting mental health needs can meet CAMHS criteria [3]. The Scottish Government acknowledged in a February 2026 FOI release that it did not then hold national neurodevelopmental wait-length data [6].

Counting rules that require transparent assurance

The clock begins when CAMHS receives a referral and ends when qualifying treatment begins. Treatment can include a planned intervention or coordinated treatment plan; recovery and completion are not required. Clinical judgement applies. Triage alone must not stop the clock, nor an ordinary assessment without treatment [4].

Specified patient unavailability may pause the clock. Guidance requires capacity to report unadjusted waits and prohibits adjustments after breach. Pathways can end without treatment following discharge, refusal or non-attendance, subject to the relevant rules. These endings must not be confused with successful treatment starts [4].

The unmeasured or separately measured journey

A family can struggle before referral, be redirected, remain waiting, or face gaps after an initial intervention. The headline cannot by itself establish whether that child receives appropriate continuing care. Rejected, redirected and accepted referrals are recorded separately [15]. A national result does not establish uniform access across every board.

SPICE's March 2025 total of 42,530 children waiting for neurodevelopmental assessment lacked a Grampian figure. It is a historical assessment count, not today's waiting list or a count of children without any support. It cannot be added to CAMHS lists as a unique-child total [5].

Required assurance: reconcile treatment starts, list removals and pathway transfers; publish adjusted and calendar waits; and track whether redirected children actually receive help. This is a request to test recording practice, not a conclusion that the rules were broken.

3. Evidence of gaps in care

Referral research: risks beyond the headline

A peer-reviewed study published on 7 October 2026 examined one Scottish service's referrals during January-June 2019 and 2022. Of 560 referrals mentioning suicidality, 97 were classified as rejected. Eight referrals involving passive suicidal thoughts had no further action such as signposting or redirection recorded after rejection [7].

Among 478 referrals available for that analysis, 43.6% contained no evidence of risk assessment and 67.7% no evidence of safety planning. Missing documentation does not prove no assessment or plan existed. Most rejected referrals were judged appropriate under national policy; some related to children already in CAMHS or living elsewhere. These findings identify specific pathway and documentation concerns, not a national 2026 rejection rate [7].

Frontline professionals: a gap between services

The Scottish Deep End Project's December 2025 report records a roundtable involving GPs, teachers and CAMHS representatives. Participants described children whose difficulties exceed low-intensity provision but fall below specialist thresholds. They identified limited alternative services, capacity pressures and families left without a workable route to help. These are qualitative professional observations, not population prevalence estimates [8].

Independent monitoring: specialist provision remains incomplete

The Mental Welfare Commission recorded 71 admissions involving 57 under-18s to non-specialist wards in 2024-25, primarily adult mental health wards. It identified continuing gaps in specialist provision. It also recognised fewer admissions than a decade earlier, so its findings should not be presented as evidence that every measure is worsening [9].

What these sources support

There is documented evidence that some children experience gaps in support despite a national access target being met. The sources justify independent scrutiny of referral, crisis and inpatient pathways and stronger accountability for children outside specialist treatment. They do not prove every rejection was wrong, that all CAMHS care is ineffective, or that waiting-time rules caused an individual death.

What remains to be established

Current board-level rejection outcomes, removals without treatment, subsequent service access, continuity, clinical improvement and safety outcomes are needed. These should be tested through linked cohorts and case-record audits, with disclosure controls, rather than assuming that a single access percentage answers the whole question.

4. Decisions requested from the First Minister

Walk with Phoenix requests a point-by-point response. The timings below are campaign requests, not statutory deadlines or existing government commitments.

Requested action	Responsibility / evidence of delivery
1. Name an accountable lead	Within 14 days: identify the responsible minister and senior official; offer a meeting with Lisa and relevant service leaders within 30 days.
2. Commission independent assurance	Within 30 days: set out an independent review proposal covering referral decisions, removals without treatment, clock stops, pauses and transfers. Publish scope, reviewer independence and completion date.
3. Publish the whole access pathway	Report board-level accepted, rejected and redirected referrals; actual support received after redirection; unadjusted and adjusted waits; treatment continuity and outcomes. State data gaps and a timetable to address them.
4. Close gaps for neurodivergent young people	Publish consistent assessment and support measures alongside CAMHS figures, including interim support, coexisting mental health needs and routes for young people outside specialist thresholds.
5. Strengthen crisis pathways	Require named responsibility for safe onward referral, documented assessment and safety planning, follow-up after missed contact, and effective transitions at ages 16-18. Agree delivery standards with services and families.
6. Review bridge safeguards	Convene relevant bridge authorities, emergency services, prevention experts and families to assess physical safeguards, recognition of distress, intervention protocols and evidence preservation. Publish decisions, owners and delivery dates.
7. Make family participation meaningful	Provide a clear route to submit evidence, receive answers and understand review scope and exclusions. Explain which independent process addresses matters outside a Child Death Review.

The assurance families need

“Please do not rely on the CAMHS headline alone when reassuring families. Show what happens to children outside treatment, how risks are addressed and what independent evidence demonstrates that their needs are being met.”

Phoenix's individual case requires its own investigation. This report asks for wider change without pre-empting findings or attributing liability. A coordinated response should explain which body will examine each concern rather than leave families to navigate gaps between organisations.

5. Sources and evidence status

Public sources checked by 21 October 2026. Links are clickable. Dates and populations are retained to prevent historical findings being represented as current national rates.

- [1] NRS, Probable Suicides 2024, published 16 September 2025; methodology and forthcoming-release notice. [Source](#)
- [2] Samaritans, Suicides in Scotland 2024, Table 1, page 2. Secondary reproduction of official age/sex counts; direct NRS workbook extraction not verified here. [Source](#)
- [3] PHS, CAMHS waiting times, quarter ending June 2026, published 1 September 2026. [Source](#)
- [4] PHS, LDP standard definitions and scenarios, v1.4, 12 March 2024, sections 2.7-2.9. Read alongside current pathway exclusions. [Source](#)
- [5] SPICe, Neurodevelopmental Pathways and Waiting Times in Scotland, 24 June 2025; March 2025 board returns. [Source](#)
- [6] Scottish Government, CAMHS waiting-times FOI release, 16 February 2026, FOI/202500496846. [Source](#)
- [7] Moore et al., Frontiers in Psychiatry, 7 October 2026. DOI 10.3389/fpsy.2026.1863579; Results and Tables 2-3. Historical single-service evaluation. [Source](#)
- [8] Scottish Deep End Project, Report 45, December 2025, executive summary pp. 2-5. Professional roundtable evidence. [Source](#)
- [9] Mental Welfare Commission, Children and young people monitoring report 2024-25, December 2025, summary p. 4 and conclusion pp. 27-28. [Source](#)
- [10] The Courier, Phoenix Birkett, 26 May 2026. Family crisis/neurodivergence account additionally supplied by Lisa. [Source](#)
- [11] Scottish Prison Service, Death in custody register, Daniel Kerr entry. [Source](#)
- [12] The Courier, Ronan Brown investigation update, 9 October 2026; quotes COPFS. [Source](#)
- [13] The Courier, Ronan Brown family account, 12 June 2026; mother disputes suicide. [Source](#)
- [14] ITV Border, Lexi family account, 5 October 2026. Media-reported suicide, not a verified final determination here. [Source](#)
- [15] PHS open data, CAMHS referrals dictionary; accepted, rejected and redirected categories. [Source](#)

No current national rise in teenage suicide, deliberate statistical manipulation or causal link to individual deaths is established. Sources describe different years and populations; their totals are not combined. The report is an advocacy evidence assessment, not a clinical audit.