# CAMHS Derbyshire Mental Health Services NHS Trust

**Alison Reynolds - Service Manager, Specialist Child and Adolescent Mental Health Services - Mental Health Practitioner team, Young Persons Specialist Service**

**Kim Thompson – Primary Mental Health Worker**

1. **Please can you give us some information about your service and your specific roles?**

2. We work for Derbyshire Health Care NHS Foundation Trust.

3. The Trust works across Derby and South Derbyshire.

4. There are complicated commissioning procedures for CAMHS services - especially for the City.

5. The service is split into Tiers 2 and 3 and there is a 16-18 year old service.

6. The 16-18 year old service is now offering a trial Tier 3+ service for a year. This service will be a step down from a child being admitted to hospital because of their mental illness.

7. There is no local service for admitting children to hospital with a mental health need – Thorneywood in Nottingham is the nearest service.

8. The number of admittances to hospital are increasing as children's needs across the Trust are increasing.

9. Services offered at Tier 2 aim to prevent children from needing a higher input of more specialist services at Tier 3.

10. Tier 2 has to equip the carers of CLA with the skills to stop CLA's mental health from deteriorating.

11. This is done by 1 full time member of staff who works with all 5 Children's Homes across the City for training and consultation.

12. **How quick is your response?**

13. We have to respond within 4 weeks

14. When a referral is received it is reviewed weekly then an appropriate appointment is made.

15. **What are your contacts per week?**

16. Each clinician sees a minimum of 3 children per day for direct work in a Tier 3 service. In the Primary Mental Health Work team direct work and indirect is 50:50, contacts are distributed between direct appointments and consultation and training.

17. **Is that figure restricted by staffing levels?**

18. We have to meet a performance target in relation to contact figures. If a Child self harms a clinician can be out dealing with the child for a day which impacts on these figures.

19. CAMHS is not a statutory service.

20. CLA cannot be forced to attend appointments. The nature of CLA means that attendance rates can be low. Engagement is a key factor with this vulnerable group.

21. **What would you like to see change?**

22. Our clinicians are from an ever decreasing number of team members but demand is increasing. Our service has been capped so there is no capacity to grow and we have to consult, do direct work with children and train staff.

23. **What work is taking place at Tier 2?**

24. We are currently trying to set up a group to help disseminate information about mental health to carers. This will include 2 Champions from each care home plus the field social workers. The aim is to teach them about mental health issues so that they in turn can teach their colleagues.

25. It must be understood that CLA are often not ready for formal weekly therapy. There are insufficient resources to place children in a care home that is tailored to their individual needs.

26. We cannot provide additional support for CLA other than the therapeutic services we currently offer. But we are willing to review the model currently being used and improve provision.

27. The behaviour of parents is mirrored in their children and we need to intervene early in families to stop children's mental health being damaged.

28. Training key staff to understand the issues and problems that CLA

present is vital. Staff need to be aware of early indicators that a child's mental health is deteriorating.

29. As a rule of thumb the greater the trauma a child has suffered the more subtle the intervention from carers and professionals needs to be.

30. **Does your work with training staff reduce the time you have to work directly with CLA?**

31. No. By training staff up we are making the best use of our time.

32. **If a child is seen by you, do you work with the other professionals involved in that child's care?**

33. Yes, we work with their social worker/key worker and other professionals to improve a child's situation.

34. **Do you do outreach work with children?**

35. Yes.

36. There is a stigma about CAMHS amongst CLA. This can affect engagement levels of this group. The words mental and health in the title don't always help

37. **Do CAMHS in other areas do mental health assessments of CLA when they are taken into care?**

38. Not that we know of routinely, we all use the strengths and difficulties questionnaire but this is not the most robust tool. We would have concerns about offering every child a mental health assessment – not every CLA has a mental health need and that is rightly so. We expect the SDQ to identify early indicators that are then referred to the Single Point of Entry Team consisting of CAMHS, Psychology and Leopold St. These practitioners will make decisions as to the most appropriate service to direct the youngsters to.

39. Changing the Strengths and Difficulties Questionnaire format would help to flag up problems.

40. **Would it be wise to have any kind of assessment regarding a child's mental health after they were taken into care?**

41. We would expect a health assessment to be done and we need to train all staff to spot the signs of potential mental health problems as early as possible.

42. Clinical Psychology and CAMHS are based in separate locations in Derby. This is fairly unusual and isn't ideal.

43. Referrals to CAMHS aren't always done using the specific CAMHS referral form, and previously referrals were made to multiple providers in an attempt to get the child seen.

44. To help streamline services for children who do have a mental health need we are now meeting monthly with Clinical Psychology and 42 Leopold Street to look at a child with a mental health need to determine who would be best placed to work with a child.

45. **The December quarterly performance figures for CAMHS - can you provide more detail regarding the figures?**

46. The figures need to be read with caution as the child may not have a mental health record and therefore will not be included in the figures. Consultations, training and support, indirect work, is not included in the performance data and this makes up 50% of the teams provision.

47. Performance is monitored on a weekly basis and please rest assured that we are working to the demands of the service level agreement.

48. A lot of CLA do not need intensive intervention from a therapeutic service. They need a drip feeding of help from sources closer to them eg their care workers.

49. Funding for other sources that offer low level intervention – like safe speak and SHB – is being reduced. This will mean that children's needs will escalate and there will be increasing numbers of referrals to the more specialist services like CAMHS.

50. Services at a 'grass root' level are essential to prevent mental health needs down the line.

51. **Are you confident that GP Consortia will commission services from CAMHS following the demise of PCTs?**

52. We don't know the impact of the changes to PCTs yet. We would look forward to working with GP Consortia and would favour an opportunity to discuss our work with them. We are understandably anxious as a service about the proposals.

53. **Is there a self harm protocol and has training been given on this?**

54. Yes and training to all relevant partners has been delivered.

55. CAMHS will assess a child on a children's ward within 12 hours of a child being admitted to hospital through self harm. There will then be follow up appointments relating to the incident.

56. The quality of inpatient provision for children who self harm is not always of good quality, effective in terms of outcomes or value for money. We need provision locally that can be governed locally. Parents/carers have to travel long distances in some cases to see their children in these units.

57. Self harm is a huge issue for the team.

58. **Can you describe the structure of your team?**

59. 1 Service Manager covering Tier 3, PMHW and County CAMHS LDis team; 6.4 clinical staff from social care, nursing and AHP professional backgrounds. Targeted provision is made to TaMHS, Pupil Referral Units and Children Looked After.

60. **You mentioned previously that the referral forms to CAMHS aren't always used does this cause you significant problems?**

61. It isn't essential that this form is used but they are designed specifically to help with referrals and saves time as it avoids the need for unnecessary phone calls.

62. **Are there weak links in communications with colleagues in other areas?**

63. Yes, we have poor communication from the Clinical Psychology Team generally but not in relation to CLA.

64. CAMHS and Psychology working from separate bases and with different systems is nonsense. It could be easily fixed and would be wonderful to work more closely with this team.