Agenda Item 5
Report CT&F/02/10 Appendix 1

Essex CAMHS Progress Review, 9 November 2009: Focus group

Facilitated by Roz Rospopa, CAMHS Regional Development Worker, NCSS in EDC
Attendees: Jenni McRae, Tina Russell, Carmen Tyler, Mariette Bezvidenhout, Suzie Stephens, Anne Possami, Jubada Adams-Kassen, Grace, Sandie Dunne, Samson Jebutu, Kai Vindu Singh Gill, Peter Everett, Juliet Butler, Sharon Walle, Ann Creitzman, Cathy Constable, Lucie Taylor, Catherine Hitchins, Sian Brand, Susie Alexander, Adi Steiner, David Mash, Lonica Vanclay, Barbara Cooley and Pia Sievers-Greene (notes)

A pack of documents was available to all attendees.
These are notes of the open discussion, they are points raised not validated.

What is good about CAMHS in Essex?

- Primary school quick access to Tier 2. Working really well and seems across primary and secondary schools.
- Healthy Schools introduced well, good awareness raising work.
- Development of Learning Mentors in CAMHS, a good development welcomed by young people. However, only have this in West Essex – possible option for further development.
- Structured meetings with School team in Saffron Walden secondary school has been welcomed by the school team.
- Healthy Schools as part of SW Essex PCT multi-agency team for LAC – trying to join services together brings – other pocket of good practice.
- Services at the Junction- advocacy into schools. Survey in schools 50% of young people said they could not speak to their teacher – a valued service.
- Access to referral paper work via CAF. Also direct referral routes.
- Good relationships between children's centers and targeted provision.
- Partnership between community paediatrics and CAMHS is good.
- Outreach, out of hours service & self harm provide 7 day service from specialist CAMHS.
- A&E, & paediatrics value joint assessment opportunities. Crisis assessment teams are now across county inequalities are beginning to level out.
- Service for LAC has been inconsistent but now improved. From 12 to 70 workers in past 2 years.
- The interface between CAMHS and children's homes support to staff. Doing pedagogy in children's homes.
- Involvement of children and young people - PCT started youth health trainers – young people want flexible, nice services, consistent

What are the opportunities for development/ barriers?
- Essex is like a small country, lots of inequalities. Analysis process is there a pattern re rural areas/ infrastructure and attendance to appointments. Currently case loads are based on risk – some professional do home visits – there is flexibility. Increased clarity of what is available but still needed to navigate the system.

- Definition of exactly what is CAMH and who it includes in Essex, clarity of responsibilities.
- Transition still difficult – still lots of 18 and 19 year olds that do not meet adult MH service thresholds.
- Babies and U5s – bits of pieces across North Essex, still a gap.
- Navigating a complex system, need increased clarity on pathways.
- Work with LAC – 16+ really difficult area challenges in social care and health but access crisis quite a lot. Would be really good to have much more defined pathways across county. Even if it was different but consistent.
- Particular difficulty if placed out of county and changing addresses and therefore differences in service.
- LAC subject to CPP – you can only refer to services if you are aware of them . Some good links to child protection team e.g. West Essex.
- Increased flexibility of services, issues of capacity but still need more choice of appointment location.
- Mechanisms for information sharing need clarifying. Schools have information from ‘level descriptors’ which is relevant to assessments in CAMH, sense that this needs to be valued within the context of the assessment process. Educational information is contextual, not specialist MH but still felt this needs to be valued in the process.
- CAMHS staff do not go to do many school assessments- issues of communication as to where need and capacity decisions are made and communicated.
- Inequalities resulting from differences in Healthy Schools funds, smaller schools in rural areas can provide less e.g. learning mentors