The Targeted Citywide CAMHS Offer 2018/19

Our vison and mission is:

- "Our vision is to provide children and young people with flexible support around emotional well-being, **so no child or young person has to face emotional distress alone**."
- Our mission is that-We strive to offer an honest, open, creative and respectful service to support positive change; so that all children and young people will have the skills to cope with life's challenges, to feel happy with themselves, and will be empowered to be proud of who they are to achieve a brighter future." *(Targeted CAMHS, SHARP and CYP Group Teens 4 change)*

Our Aims:

- We aim to be a responsive and innovative CAMHService that offers children, young people and families a high quality emotional and mental health service as quickly as possible.
- We aim to continue to develop a service where **meaningful** participation and co-production is built into all we do, and our children, young people, parents and carers help us to shape our services to be responsive to their needs.

This document is an overview of our current prioritises and performance in the following six focus areas:

- Prevention and early intervention
- Single Point of Access
- Choice and Partnership Approach (CAPA)
- Evidenced based interventions for vulnerable groups
- Participation work and our 'Young Minds Amplified' project
- Our performance:
    - How we know we make a difference (performance)
    - Monitored weekly wait-times (performance)

Prevention and Early Intervention:

- **Universal Services CAMHS Practitioner** who works directly with schools and universal services to offer support and training to staff in schools/other services, to help them to gain confidence in working with mental health needs, and prevents services referring to CAMHS when this is not required.
- We have a number of ways that they **link to our local schools to offer support**:
    - An initiative called **Time4Me,** where young people can access direct monthly support in their secondary school from a consistent and present CAMHS professional.
    - A pilot project for primary schools called, **'Amazing Me': Early Intervention to promote Emotional Wellbeing in primary schools.**
    - **Next Steps:** A joint partnership venture with NSPCC Childline developing ways we can help CYP to achieve their **next steps and goals** following their support from CAMHS.
    - **Monthly Self-Harm Clinics**

A Single Point of Access:

- The City's CAMHS SPA model is quite unique nationally, sitting alongside our City's MASH. Our SPA model has clear protocols to ensure that referrals are processed quickly and effectively and that the CYP can be navigated to the right support for them depending on their presentation and needs.
- Our model offers many strengths and benefits by ensuring that CYP who have emotional health needs that would ordinarily be rejected by the more traditional NHS CAMHS clinical model services.
- As we manage all the referrals for the city, we can ensure that our children and young people can get access to emotional health support in different ways as early as possible. This model has ensured that **over the last 4 years 95% of cases remain at a Targeted CAMHS or universal level,** only escalating to specialist community CAMHS when absolutely essential. **(See link below on page 5, link 'Copy of Referrals to Community CAMHS).**
- Over the last 6 months a specialist clinician from our NHS provider of specialist community CAMHS, has been co-located with our SPA, with the aim to improve access into specialist community CAMHS when this is required.
- Our SPA has representation from all services on our behavioural emotional mental health pathway and works closely with our social care colleagues daily.
- A multiagency **Access Working Group** led by Targeted CAMHS, with all partners of the pathway, GP's and education representation. The group is working to increase and strengthen how CYP/families can self-refer to us, and get access to help quickly, including guided self-help as a first line of treatment, or whilst they are waiting for their CAMHS appointment and access to other forms of support such as **Exam Stress Less** etc. **(See action plan appendix 1)**
- **Self-harm joint-protocol** ensures we respond jointly, alongside our social care colleagues, within 48 hours when there are serious concerns about a child/young people's self-harm or suicidal behaviours. A thorough a joint assessment is completed at home and self-harm risk assessments and safety plans are implemented jointly with the young person and their family.
- **Self-harm follow up's: SOL to provide**

Choice and Partnership Approach (CAPA):

CAPA is a service transformation model that combines collaborative and participatory practice with families to enhance effectiveness, leadership, skills modelling and demand and capacity management.

CAPA brings together:

•The active involvement of children, young people and families, demand and capacity ideas/'Lean Thinking', and a new approach to clinical skills and job planning.

As a service, we can then:

•Do the right things (have a clear working goal with the child/young person and their family).

•With the right people (use therapists with the appropriate clinical skills).

•At the right time (without any external or internal waits).

CAPA improves services to families by focusing on engagement, therapeutic alliance, choice, strengths, goals and care planning, and by improving, access by ensuring timely appointments that are fully booked i.e. no waiting lists. By ensuring children and young people are seen by a clinician with the right skills, uses outcome measures.

As a service who have implemented, and been using CAPA for several years, we are able to demonstrate what we are doing and to whom. We can provide data weekly on own capacity and activity. (© CAMHS Network 2017)

Specific and Targeted Evidenced Based Interventions for Vulnerable Groups:

- **CBT (cognitive behavioural therapy) Specialist** working with CYP with more complex and enduring mental health needs, such long-standing depression and more enduring anxiety disorders
- **Evidenced based therapeutic models**: **50% of our workforce are trained** in specific evidenced based therapies the offer includes:
    - **Interpersonal Psychotherapy for adolescents (IPT-A)** is a treatment for young people with depression, which looks at the relationships around the young person.
    - **Systemic Family Practice (SFP)** enables family members, couples and others who care about each other to express and explore difficult thoughts and emotions safely
    - **Enhanced Evidence Based Practice (EEBP)** trains CAMHs practitioners to deliver CBT-based interventions, to enable CYP and families to learn specific techniques.
    - **Pilot of Time Limited Adolescent Psychodynamic Psychotherapy (TAPP)** to support adolescents who require more in depth assessment and therapy for more complex or trauma history presentations such as attachment disorders and emotional dysregulation. **(For case studies, see appendix 2)**

- **Animal assisted therapy:** We have a trained and qualified **therapy dog named Freud** led by his animal assisted qualified practitioner, working with CYP who need more support to feel comfortable to develop therapeutic relationships, or who have additional needs making accessing talking therapy more difficult. **(See individual report appendix 3)**
- Part time **Domestic abuse CAMHS practitioner**- offering bespoke support and consultation to professionals, for CYP who have mental health struggles/trauma symptoms having experienced domestic abuse

- Part time **Syrian/Asylum seeker CAMHS practitioner**- funded by the Home Office developing ways to link to vulnerable groups in the community to ensure they get access to the right emotional health support/assessments (currently under review)

Participation:

- **'Teens 4 Change'** who come together to support each other, do lots of amazing projects and who consult with us to co-design our services to fit their needs. **(See individual report appendix 4)**
- **We are an Amplified Trailblazer with Young Minds!** Who are supporting us to embed our parent/carers participation strategy/action plan and parent/carer support group by November 2018- to then showcase via Young Minds-best practice to other areas around the country **(Please see report appendix 5)**
- **Our Participation events so far:**
  - Splendour Festival
  - Ruby Wax at the Play House
  - Expo parenting teens event

- **Parent/carer Psychoeducation Workshops:**
  Targeted CAMHS are developing and offering 5 x 45 minute workshops on:
  - Anxiety
  - Depression
  - Attachment
  - Self-harm Awareness
  - Transgender Child
  - Workshops will be 45mins, followed by a 15min Q&A.

  The dates are:
  - 24th Jan – sessions running throughout the day
  - 19th Feb – sessions running throughout the day
  - 22/01, 29/01, 05/02, 12/02 and 18/02 – sessions between 18:00-19:00

- **MH2K:** working jointly with this project, has captured the voices of **647 young people** about mental health who have told us that they want us to work on 5 key main priorities. We want to truly hear and understand their recommendations and how we can shape our services to meet ***their*** needs; we are therefore working hard to begin to implement their recommendations. Starting with the co-design of a poster detailing support available to them from the pathway- to be on the back of all toilet doors in schools so CYP can access the support they want when they need it. **(See appendix 6)**
- Our **CAMHS Newsletter** with the aim of helping us to better communicate and tackle the miss-conceptions of CAMHS, to promote mental health and wellbeing using an anti-stigmatising approach. With articles from CYP and professionals on all different topics related to mental health, (2 editions per year, spring/summer and autumn/winter) **Please see link CAMHS Newsletter Issue 4 May 2018.pdf**

How we know we make a difference: What CYP/Families tell us (our performance):

We have implemented Routine Outcome Measures (ROMS) so we obtain regular views from children, young people and families about how their therapeutic intervention is going, what they like, dislike, and if the support being offered is helping them or not.

Please refer to CAMHS data for more specific performance data **Copy of Q2 - 2018-19 - Targeted CAMHS Quarterly Report Final.xls** **and** **Copy of Referrals to Community CAMHS from Targeted October 2018.xlsx** Below is a 'snap shot' of how we know we are making a difference:

In 2017/2018:

- **1857 referrals** were received and processed by the CAMHS Single Point of Access of them **918 assessments** were carried out with CYP and their families.
- **94%** of young people offered feedback on their assessment experience with Targeted CAMHS said **they would recommend us to a friend.**

In Quarter 2: (2018-19)

- **78% of CYP** told us that they saw a clear **clinical reduction** in their depression and anxiety after their CAMHS intervention (reported by the clinical measure called RCADS).
- **81% had an improvement** in a clinical outcome measure (for the closed cases).
- **100% of families were offered the opportunity to feedback** on their satisfaction with the service using the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ) from this **78% of families chose to offer feedback** and from that feedback the average scores were:
  - **Parents/Carers scored: 23 out max satisfaction of 24**
  - **CYP scored: 22 out of max satisfaction of 24**
  -

Specific comments around their experience included:

- "Young Persons key worker was very understanding of our anxieties and was quick to arrange our appointments."
- "The care was really good because the person who saw me understood me and helped me achieve my goals and to manage my anxiety."
- "My therapist listened to everything I had to say and supported me through tasks that be easily achieved."
- "I felt listened to and the resources I was given helped me."
- "I really liked working with Freud (Therapy Dog) as it meant I did not feel awkward in sessions."

- "My worker was nice, cool and knew what she was on about; genuinely care for me as well. Didn't take any of my constant swearing too personally."
- "There was nothing that I didn't like; I loved every bit of it. Also I did like the people who helped me, they were both really kind".
- "My daughter has been able to open up more to myself and her Dad. If she is worried about anything that is worrying her i.e. school, friends."
- 'They always listen to me and take me seriously on everything'.
- 'Everything we did together was great; I really enjoyed it and feel much better.'
- 'Everyone listened, not only to my child but also to me and came up with some good strategies.'

Wait Times (our performance):

In 2017, we introduced an assessment team, with its existing staff, to better manage caseloads and wait times. Since the development of this team, the recruitment to the vacant posts, and with better strategies and innovation within the service, the current waits have reduced in line with our commissioned targets. We produce weekly stats to ensure that we closely monitor waits and raise any pressures in the service internally and with our commissioners. Please refer to our most up to date weekly data sheet. **(See appendix 7)**

Self-harm Awareness and Resource project (SHARP) Offer 2018/19:

- SHARP have trained **3600 professionals** since October 2015 and delivered **398 training sessions.**
- **SHARP training has been delivered to varied front-line professionals in our city including Social Workers and Family Support Workers, Health Workers, Clinical Practitioners (including CAMHS), Education and many of colleagues from the City Voluntary Sector.**
- **6000 front-line professionals have been trained** since SHARP was formed just over 5 years ago.
- Our training sessions are varied with a focus on self-harm and those impacted by self-harm and includes:
    - **Under the Skin (Self-harm Awareness)**
    - **Suicide Everybody's Business**
    - **Breaking the Silence (Males and Suicide)**
    - **Teenage Girls who Self-harm**
    - **Safe From Harm (Safety planning and risk assessment)**
    - **Transgender – Get Used to It**
    - **One Bad Choice (Substance misuse and the impact on Mental Health)**
    - **A to Z of Your Head**
    - **If Toys Could Talk (Identifying harmful behaviours in primary children)**
    - **Exam Stress-LESS (workshop for young people)**

- SHARP offer monthly self-harm clinics to **18 City secondary schools** and also 1 to Nottingham College and 1 to Children Looked After – approximately **80% of YP seen over a 2.5 year period have received support from Universal Services and not required input from Targeted/Specialist MH Services, clearly evidencing that early and targeted interventions can reduce self-harm and suicidal behaviours.**
- SHARP have delivered assemblies to **650 CYP aged 11 – 16 years** – raising awareness around healthy coping strategies and also breaking down barriers to access to services - informing CYP about SHARP clinics and other support such as Kooth, Childline, CALM-App and Base 51.
- SHARP have delivered 5 **'Exam Stress-LESS' workshops** to CYP over the last few months and have another 5 schools booked in for the next academic year.
- SHARP produced a training package called **'If Toys Could Talk' as an action from a Serious Case Review in 2017** which focusses on helping professional to recognise and support young children where self-harm is a concern **22 City primary schools have been trained.**
- **Trans4Me has supported around 40 YP aged 13 – 19 years** who identify as transgender/non-binary – our group runs weekly ensuring this group of YP have a safe, accepting space where they can build confidence and social interaction, this support has helped reduce maladaptive behaviours such as self-harm/suicidality, improve self-esteem and mood, reduce anxiety and support these YP to access the correct health pathway.

- **25 training sessions** raising awareness around transgender/gender dysphoria have been delivered over the last 2 years.
- **SHARP4Parents** continues to offer support to parents/carers across the city through twilight awareness workshops.
- Currently developing training around **'harmful and risk behaviours'** (using a high risk CSE case study).
- Researching and developing recommendations on how we can **break down barriers for young males and BME groups accessing mental health services.**

Anna Masding
Nottingham City Council CAMHS Service Manager

Nottingham City Council

CAMHS
Child & Adolescent Mental Health Services

Appendix 1

Improving Access to BEMH Pathway – Action Plan

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
Early and easy access to any service on the pathway	Online Self-referral developed	New CYP and Family referral form active and self-referrals increased by 15% in 2018/19	If agreed with CityCare and website provider	Consultation with YP Website redesign time	March 2019	Jo Powell
	Diverse communities Access (including faith, BME, gender etc.)	3 drop-ins and awareness raising events	If through partnership working – could be linked with parent's participation events for CAMHS?	Staff time Information leaflets	March 2019	??
	Leaflets and posters (back of toilet doors	Leaflets produce and distributed to all CAMHS link schools and an additional 15 children's' centres and Youth Groups in Nottingham	Yes – with funding	Consultation with YP £££ Design time Links with schools, community groups and play and youth	January 2019	??

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
Better and more appropriate referrals into the service	Mini-assessments taking place on SPA	Criteria created for appropriate mini-assessments	Yes – once clear criteria and appropriate staffing on SPA	Base 51/Kooth input on SPA	October 2018	Jo Powell and Elayne Forster
	Review and Re-write referral forms for BEMH and GP services (Self-referral, Professionals and GP forms)	Forms have been re-written and reviewed by CYP, Parents and Professionals	Yes – as long as they can be amended on the BEMH website	Time Input from professionals, CYP and parents	January 2018	??
	Guided Self-Help offered as an intervention from SPA	Set self-directed workbooks for specific presentations used with 10 early intervention cases from SPA monthly	Follow up support - Timeframe for follow-up support (July/Aug)	Base 51/Kooth input on SPA Appropriate self-help resources for ages and presentations	October 2018	Tammy Gibson and Elizabeth Kelly
	Professionals consultation line	Consultation available 2 afternoons per week	Yes once universal services fully staffed	Universal services staff	October 2018 -1 afternoon per week January 2019 - 2 afternoons per	Tami Brown

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
					week	
	Upskill workforces (e.g. schools, youth groups)	Training sessions – MHFA-Y – 4 per year to universal services Recognising neurological disorders – BEHT – 4 per year Interventions to work with ASD – 2 per year Interventions to work with ADHD – 2 per year MeSource – 8 schools/youth groups per year What is BEMH Pathway - Awareness raising around pathway to community groups, play and youth, GP's, Social care. Resources section on the website for professionals	Yes with buy in from all partners on the pathway If website redesign is agreed	Staff time Training materials Advertising/ marketing Need to develop website to include stats – downloads	Start October 2018 March 2019	All services on pathway Jo Powell (all group members reviewing

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
				etc.		resources
CYP and Families able to access most appropriate 'treatment' without waiting for more than 6 weeks	Self-help section on website with links to crisis and support services (plus self-referral) in place)	Links to directed self-help for different ages in: • Anger • Worry and anxiety • Confidence and self-esteem • Bereavement and loss • Low mood • Panic • Post-Traumatic Stress • Social Anxiety? • Sleep difficulties • Managing stress • Managing your emotions Info section... • Self-harm • Feeling suicidal • Eating • Gender identity • Healthy Relationships • Bullying	If website redesign is agreed	Need to develop website to include stats – downloads etc.	March 2019	Jo Powell (all group members reviewing resources)

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
		Links section available for youth groups, and activities for accessing support – outburst, trans4me)				
	Parents section on website – including how to refer, how to write a referral, support for parents, things you can do with your children.	Increased referrals from parents – 10%	Yes with website redesign agreed	Parents resources Links to external sources agreed Web design time	March 2019	Jo Powell
	Better referrals (criteria)	Criteria sent out to all link schools, City GP, paediatricians, social care (GPPLT – GP Protected learning time meetings, Head Conference etc.) Examples of referrals (what info we need etc.) sent out to all current	Yes – may be challenging to access GPPLT and Heads Conferences Yes	Criteria (printed and on website) Time	December 2018 October 2018	Jo Powell Elayne Forster/ Sarah Fernandes

Goals	Specific	Measurable	Achievable	Resources	Timescale	Responsible
		referrers				
	CYP only assessed when needed	YP assessed within 3 weeks of referral No re-assessments in other pathway services	Stats – if above has be done!	Ability to share assessments Assessments meet all services needs	January 2019	Jo Powell
	Evidence based and alternative groups	3 different groups running: • CAT Project • Managing your emotions • Embodied or parents group	Yes with staffing	Manuals for EB groups	January 2019	Jo Powell

Appendix 2

Citywide Targeted CAMHS: Interventions and outcomes

Evidence Base Practice Interventions:

- **Cognitive Behavioural Therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave.** It is most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems. CBT is based on the concept that your thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a vicious cycle.

  Evidence for use with – Depression and anxiety disorder (all), PTSD, OCD

- **Interpersonal Psychotherapy for adolescents (IPT-A)** is a treatment for young people with depression, which looks at the relationships around the young person. IPT-A helps the young person to make sense of the difficulties they are experiencing and to understand how their relationships with other people contributed to how they feel.

  Evidence for use with – adolescent depression

- **Systemic Family Practice (SFP)** helps people in a close relationship help each other. It enables family members, couples and others who care about each other to express and explore difficult thoughts and emotions safely, to understand each other's experiences and views, and make useful changes in their relationships and their lives.

  Evidence for use with – Depression and self-harm – conduct disorder (12 plus) – eating disorders (Community CAMHS)

- **Enhanced Evidence Based Practice (EEBP)** trains CAMHs practitioners to deliver CBT-based interventions, to enable children, young people and families to learn specific techniques (for example, thought challenging and behavioural activation) with the aim of relieving distress and improving daily functioning.

  Evidence for use with – anxiety and depression

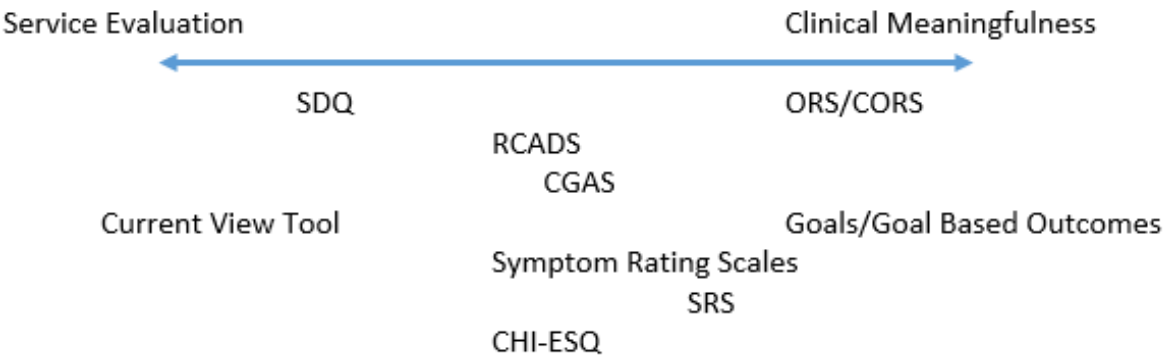
Non-IAPT Approaches with growing evidence based

- **Dyadic Developmental Psychotherapy (DDP)** is based on a theoretical understanding of attachment and intersubjective relationships; and the impact of developmental trauma. DDP uses the principles of PACE Playfulness, acceptance, curiosity and empathy, which is a way of thinking, feeling, communicating and behaving that supports connection with the child and helps them to feel safe.

  Growing evidence base for Attachment disorders or issues
- **Dialectical Behaviour Therapy (DBT)** is a type of talking treatment. It is based on cognitive behavioural therapy (CBT), but has been adapted to help people who experience emotions very intensely. DBT focusses on finding a good balance between acceptance and making positive changes.

  Growing evidence base for Emotional dysregulation – no evidence base for this in teenagers – based on Borderline Personality Disorder in adults where is has a strong evidence base to work with emotional instability.
- **Time-limited Adolescent Psychodynamic Psychotherapy (TAPP)** based on psychodynamic thinking and working relationally with transference and countertransference, this model aims to work with transitions and on a developmental focus for the young person – from 14-25 years of age. It can include confusion and pressure from the social world, anxieties around events in their social worlds e.g. exams/education, changes within family, difficulties in relationships (including self-destructive relationships, self-harming behaviour and suicidal ideation), anxieties and difficulties with separation, depression, where the earlier treatment was in a different modality, and TAPP is offered as a second treatment, when there is an external time-limit, when presentation is post-trauma, to support transition from CAMHS to Adult Mental Health.
  Within the City we are part of a group developing and evidencing this model - it has yielded positive results for depression, emotional dysregulation and attachment issues by focusing on the relational and developmental areas of these presentations

Outcome Measures



Acronyms

SDQ – Strengths and Difficulties Questionnaire

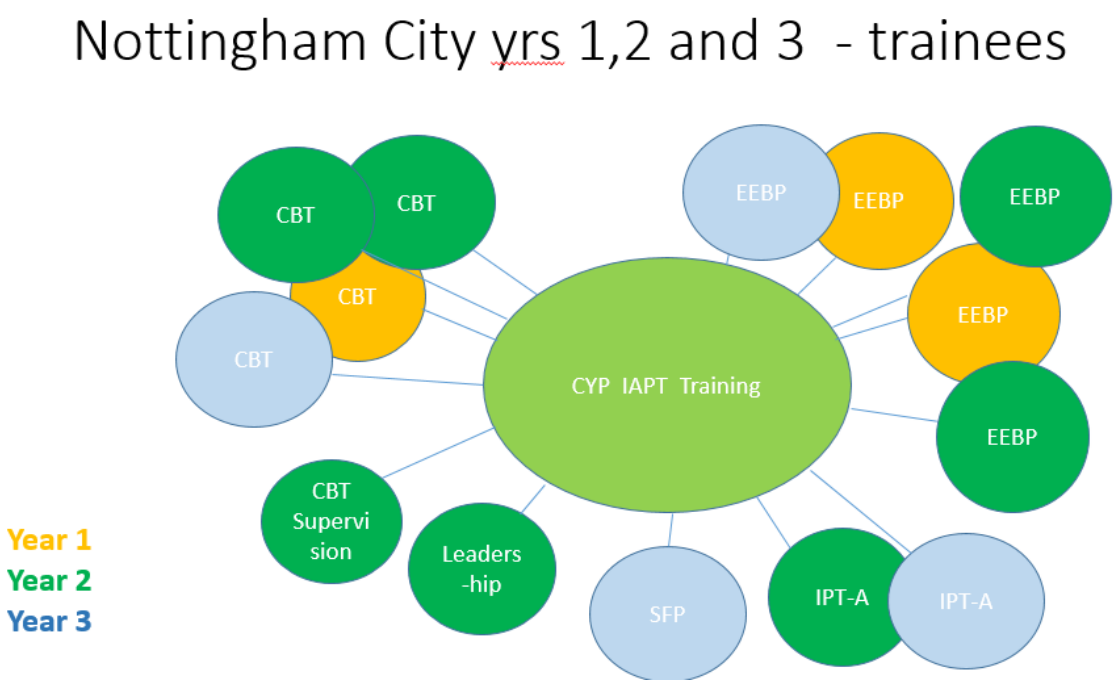
ORS/CORS – Outcome Ratings Scale – Child Outcome Ratings Scale

SRS – Sessional Rating Scale

RCADS - Revised Children's Anxiety and Depression Scale

CGAS – Children's Global Assessment Scale

CHI-ESQ – Commission for Health Improvement Experience of Service Questionnaire



IAPT Model: Systemic Family Practice

Referral

13-year-old female referred into CAMHS by GP to talk about low mood and self-harming.

Decision to allocate to Systemic Family Practice to explore the system around the young person and how it can help with some of the problems she was facing.

Individual work

Individual work around understanding anger, friendships and self-esteem.

Exploration of difficulties in relationship with Mum and how young person struggled with parental communication.

SFP

14 sessions: 11 with YP and Mum; 1 individual session; and 2 sessions with Mum and Dad.

Young person and Mum agreed and worked on goals of improving trust and communication, taking small steps to reach these goals.

Work with Dad and Mum together to support a more consistent environment and parenting style that both followed.

Discharge/ Ending

RCADS: Young Person: Start depression was 78 end score 45.

Parent: Start depression 76 end score 48.

Family Scores

	YP Feb 2018	YP August 2018	Mum Feb 2018	Mum August 2018
Strengths and adaptability	18	15	14	12
Overwhelmed by difficulties	24	10	12	10
Disrupted communication	24	19	13	9

IAPT Model:

CBT for social anxiety using The Cat Project;

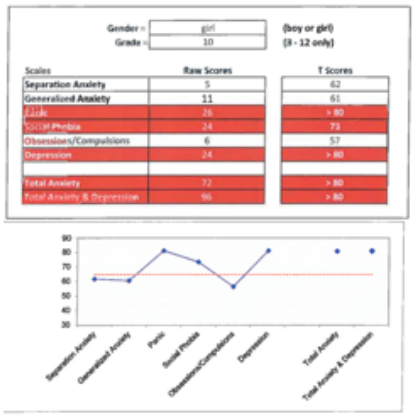
16-year-old Female of Polish descent.

YP fear of sounding weird and being judged due to being from Poland and worrying about pronunciation of English language – created a barrier to making friends, participating in school and going out/asking for things in a shop in public.

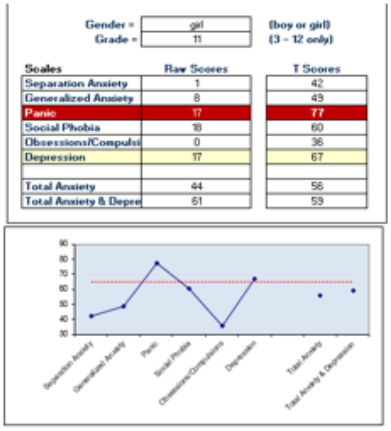
Protocol covered; psychoeducation around anxiety, psychoeducation of somatic symptoms of anxiety, raising awareness of negative thinking patterns and using coping self-talk, problem solving and experiments. Also included a parent session to include in the process.

ROMS;

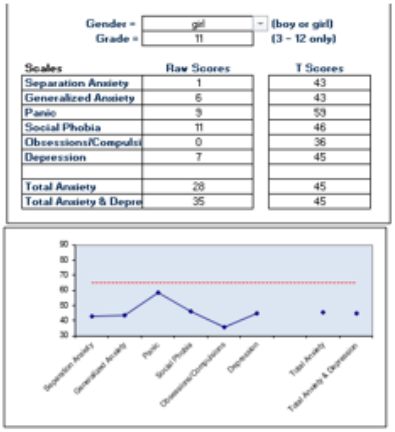
19/12/2017 – Beginning RCADS



28/08/18 – Review RCADS



01/10/18 – Closure RCADS



IAPT Model: Enhanced Evidence Based Practice

Case Study 1

10 year old, British Asian. Follows Sikh religion. High achieving student at school.

The referral was made by the GP advising that RS has anxiety that mum will die and therefore avoids school and extracurricular activities.

Onset: young person was on an ice-skating outing 1.5 years ago, mum was sat on the side watching where young person could see her for most of the time. However, as she finished and was coming off the ice, she could not see mum amongst the crowds and thought something had happened to her and got into a state of panic. Since then separating from mum has been really difficult. Mum advised, for example, when she drops young person and young person' sister to school, young person has to be the last one to give mum a hug and she will hug her really tight like it's the last time she will see her. On odd occasions where mum has picked young person up late from school due to traffic or something coming up at work, young person starts to panic and often crying uncontrollably. On days where mums out and is not home by the time she says she will be young person will be clock watching and will ringing her to check if she's ok and will be very anxious.

Young person advised that the panic and worry sets in roughly 15/20 minutes before she leaves mum and will start again 15/20 minutes before mum is due to pick her up.

<u>Symptoms:</u>

Thoughts - Something will happen to mum or dad (mainly mum), mum will have a car accident, mum will die.

Emotions – Sad, upset and angry.

Behaviour – Clings to mum, has emotional outbursts. Mum advised that she will not allow young person to stop going places without her because of her anxiety but it just makes drop offs really emotional and difficult.

Physiological symptoms – Crying and heart races, cannot think clearly.

Goal: young person not to worry when leaving mum.

Evidence Based Intervention: Worry management intervention, which covered looking at the thoughts, behaviour, feelings and physiological responses. We covered distractions, worry time, worry tree, problem solving, relaxation and breathing exercises, constructive positive self-talk and talking back to worries.

Treatment feedback: young person and mum felt the goal had been met and they advised that they found the treatment helpful.

Young person Raw Scores and T Scores:

Separation anxiety – 12 and 76
Generalized anxiety – 13 and >80
Social Phobia – 1 and 32
Depression – 3 and 49
Total anxiety – 31 and 59
Total anxiety and depression – 34 and 57

RCADS at the end:

young person Raw Scores and T Scores:
Separation anxiety – 4 and 49
Generalized anxiety – 5 and 53
Social Phobia – 0 and 29
Depression – 1 and 44
Total anxiety – 12 and 43
Total anxiety and depression – 13 and 43

Case Study 2

17 years of age, polish, female, Catholic. Lives at home with mum and dad, no siblings.

CAMHS received a referral from the GP advising that young person appears to be suffering with symptoms of anxiety and depression. Reporting that she 'has not felt like she is real' for quite a while, feels like she 'is watching everything from a TV', Like 'everything is happening around her without her'. Poor concentration. Decreased motivation getting out of bed. Has lost interest in things she used to do. Gets scared that everyone will abandon her. Feels empty and can go from feeling okay to feeling very low very quickly.

Young person reported feeling like this for the last two years approximately and feels as though it is getting worse and is more prominent.

Triggers – young person advised she does not know what the trigger is, however there has been difficulties at home with mum and dads relationship, with constant arguments. Both have said that they are only together because of her - for this, she holds a lot of guilt and blame.

She scaled mood at 4 during the day and at 5 in the evenings, drops to 1-2 at night when she is on her own in her room.

She is currently not eating in the day, only tends to have dinner.

Young person advised she gets roughly 3 to 4 hours sleep a night as she finds it hard to fall asleep, once she falls asleep she sleeps throughout the night.

Thoughts: what is the point, why do I even try, what have I done wrong, what is my future going to be like.

Feelings: feels numb, the sadness feels really heavy, lonely.

Behaviour: Stays in bed just lays there, stares at the wall, said she pity's herself. Only does the bare minimum just to get by.

Physiological symptoms - cannot move, very tearful and cries a lot. Occasionally she disassociates with reality - finds herself being in situations where she feels she is watching it on TV from the outside looking in.

Advised she has felt quite low for the last 2 years.

Young person advised she does have friends but does not see them very often.

Goals: to be able to deal with the overwhelming feelings and to feel happier in herself. To feel more motivated to do things and see friends more.

Evidenced-based intervention: We used Behavioural Activation, with looking at problem solving, pros and cons and separating thoughts, feelings, and behaviours as the low-level intervention.

We slowly increased activities and set little tasks to help improve her mood and identified things that contributed to her mood using the ACE log – reflecting on what gave a sense of achievement, closeness and enjoyment.

Treatment feedback - young person had noticed the shift in mood as the sessions went on and she engaged really well and was able to identify the benefits of socialising on her mood. She was open and honest when she had not managed to complete the homework and tasks set, which was useful to reflect on. When young person was completing the Relapse Prevention Plan she stated that by doing the pros and cons activity – comparing if she had done her task to not doing her task, emphasised the rational for Behaviour Activation even more for her, and stated she uses that tool quite regularly to push herself to do things when she lacks motivation.

Start PHQ-9: 14

End PHQ-9: 11

ORS start: 12.9

ORS end: 23.3

IAPT Model:
IPT-A (Interpersonal Psychotherapy for Depressed Adolescents.

Number of sessions:
13 (12 + 1 extra middle phase session)

Biographical data:
Sixteen-year-old male of Indian descent living with Mother and Brother. Father lives in India and little contact with him, however Mother and Father maintain a long distance relationship.

Presentation:
Escalation of depressive symptoms for 3 months including reduced appetite, struggling to sleep/sleeping too much, lack of energy, isolating himself from others, difficulties concentrating in school, often feeling sad, not finding anything fun/enjoyable, fleeting thoughts of self-harm/suicide.

Formulation:

The interplay of the client's depression symptoms, lack of social support and unresolved difficulties with his Father continued to maintain the client's depression.

Therapeutic work:
The aim of treatment using IPT-A was to decrease depressive symptoms and to improve interpersonal functioning. Three phases of therapeutic work completed including assessment/formulation, middle phase, and ending phase. Therapy aimed to provide a space for the client to process and express his past experiences with his Father, whilst considering what opportunities there were in his new role to improve his situation. Middle phase work focussed on helping the client develop his relationship with his Mother and adjust to the circumstances around his Father.

Family work:

Two sessions with Mother through therapy to help gain further understanding of the difficulties, provide psychoeducation around depression and help her to make stringer connections with her son. Mother was supported in accessing her own therapy due to her ongoing difficulties with her husband in India.

Outcome of treatment:

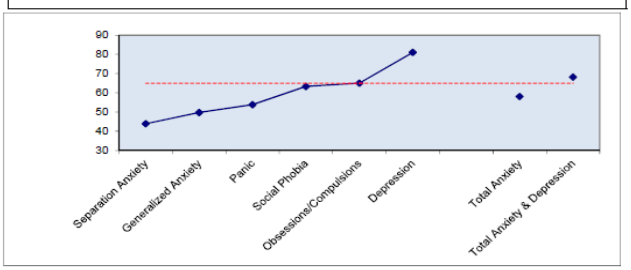
The client made significant symptomatic and interpersonal improvements by the end of treatment, making a full recovery. Communication had improved between YP and Mother and had begun to rely on her for emotional support. Client reported an increase in confidence and was optimistic around his future. The client was no longer experiencing thoughts of harm to self.

Psychometric measures

The Revised Children's Anxiety and Depression Scale (RCADS) was used pre and post treatment and the subscale Low Mood/Depression tracker used throughout therapy. Initial Depression RCADS score was 25Raw/80T, reducing to 3Raw/39T at the end of treatment. Although not problematic at assessment, we also saw a positive reduction in all other categories of the RCADS scores. Symptom tracker scores indicated a steady decrease over the course of therapy, Treatment goals were used and tracked throughout and were achieved to a good level.

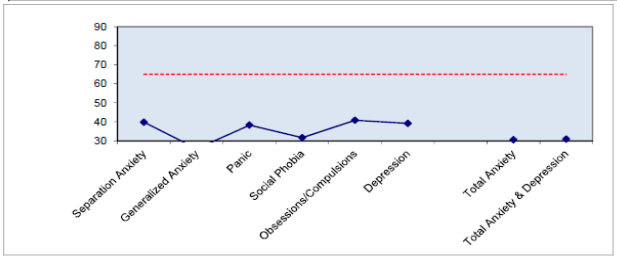
Gender =	boy	(boy or girl)
Grade =	10	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	1	44
Generalized Anxiety	7	50
Panic	5	54
Social Phobia	18	63
Obsessions/Compulsions	9	65
Depression	25	> 80
Total Anxiety	40	58
Total Anxiety & Depression	65	68



Gender =	boy	(boy or girl)
Grade =	10	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	0	40
Generalized Anxiety	0	26
Panic	0	38
Social Phobia	3	32
Obsessions/Compulsions	2	41
Depression	3	39
Total Anxiety	5	31
Total Anxiety & Depression	8	31



What is TAPP?

TAPP stands for 'Time Limited Adolescent Psychodynamic Psychotherapy'

Time Limited-TAPP is a brief therapy consisting of 2 parts:

x4 1 hour assessment sessions with a TAPP therapist. This may include time with parents/carers, but mostly time with the young person alone so they can get a sense of what TAPP is like and together to decide a treatment plan.

x16 1-1 therapy sessions, at an agreed time and venue, sessions last for 1 hour every week (though there may be a break in between e.g. if there are school holidays).

TAPP includes the offer of a review meeting 4-6 weeks after the end of treatment. This is an opportunity to meet again with the therapist, to take a slightly more distanced perspective and to think about the thoughts and feelings the young person has after completing the therapy.

Adolescent-The therapy is suitable for young people aged 14+ 

Psychodynamic- This type of therapy recognises the role of growth and development in particular stages of life. 

Teenagers can experience frustrations and barriers that arise during this stage of change, no longer in childhood but not yet entering adulthood, building independence and realising responsibilities, but still in need of understanding, support and direction.

Young people can experience strong emotional responses to friendships, home life, and expectations from education/exam pressure, emerging identity, physical changes, sexuality and uncertainty of how the future may be for them.

Psychotherapy-Through the therapists active listening and confidential discussion, the young person will feel supported to talk through their thoughts and feelings relating to all aspects of life at home, education and their social world.

Supervision

To ensure the therapist gives the right focus and understanding to the young person's needs, the therapist will meet weekly or fortnightly with other TAPP therapists in the service to discuss the sessions. We call this a seminar group. The supervision is confidential.

In addition, the therapist will have monthly group supervision with the TAPP therapists and Professor Stephen Briggs. Stephen offers training and supervision to services providing TAPP.

<u>TAPP Criteria and key points to consider</u>

- Age 14+
- Young Person has asked for support, actively wishes therapy.
- Is this the right time for the young person, are external factors going to be a barrier to sessions, e.g. moving out of area in 6 weeks, about to start exams, significant change about to take place
- Will the young person be able to travel to the appointments; are those around them supportive to get them to the session?
- Does the young person show evidence of taking responsibility for 'self', do they have the ability to be psychologically minded e.g. to be able to reflect on their own internal world, TAPP may not be appropriate for young people with intellectual disabilities
- Has the young person already received other support/psychological therapies, found this did not meet their needs therefore still wanting further help?

TAPP can be particularly helpful for young people who have:

- Confusion and pressure from the social world and therefore TAPP provides the structure, which may be lacking in their social context.
- Anxieties around events in their social worlds e.g. exams/education, changes within family
- Difficulties in relationships (including self-destructive relationships, self-harming behaviour and suicidal ideation)
- Anxieties and difficulties with separation
- Depression. Where the earlier treatment was in a different modality and TAPP is offered as a second treatment.
- When there is an external time-limit
- When presentation is post-trauma
- Transition from CAMHS to Adult Mental Health

Appendix 3

Animal-Assisted Therapy Pilot Initial Outcome Measures and Qualitative Feedback

(April-September 18)

Freud joined our CAMHS team in April 2018. Since his arrival, he has been working with a diverse caseload of young people experiencing difficulties ranging from coping with bereavement, life transitions and attachment difficulties, anxiety and Selective Mutism.

Freud is currently working with a caseload of around twelve young people (September 2018). We have used Animal-Assisted Therapy (AAT) in a number of different ways to work with the individual needs of the young person and their families. We have combined the approach with Interpersonal Psychotherapy, shaping and fading techniques with Selective Mutism and confidence and self-esteem building strategies using agility, dog handling and walking.

Freud is a regular member of our CAMHS young people's participation group Teens for Truth. He enjoys spending time with the group and they report he is a welcomed member. Some of the group members have formed close bonds with him and spend time fussing and playing with him when we meet. We have even been on a group dog walk where the group met for a walk around Wollaton Park.

Here are some case studies including the young people's qualitative feedback and outcome measures.

All photos are included with parental and young person consent for the purpose of this feedback. Photos are taken with all young people who wish to make a photo collection of their time with Freud. They are presented to the young person at the end of the work with a note from Freud.

Case 1

16-year-old male. Experienced significant loss. He had been working with CAMHS prior to being referred to AAT. It was felt he would engage well with AAT due to his love of animals.

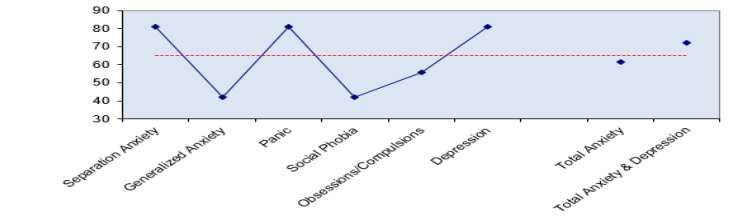
He was also struggling to manage his behaviour in school and so it was felt sessions outside would fit much better with the young person's needs.

The loss of his best friend was the most significant, complicated bereavement. We used AAT in combination with a grief focus Interpersonal Psychotherapy. We met at Burnstump Country Park for our sessions and utilised the time by walking, throwing Freud's ball, sitting to complete work and fussing Freud. The young person even taught Freud some tricks with his ball. The bond between them built up quickly and the YP soon started to work with Freud and look forward to his weekly sessions. It was clear each session the YP would arrive with a heightened level of anger and frustration and by the end of the session; he had calmed significantly and could start to access the work around the loss. He reported he noticed this and said he felt a weight was lifted in each session. His symptom tracker scores on the PHQ-9 went from initial scores of around 15-17 to a score of 2-3 suggesting no mood difficulties. His reports using the ORS and SRS rating scales suggested the work helped him to improve his family and social networks and feel more connected to those around him. He reports the work has allowed him to talk about the deceased to his family and close friends and this has helped him process the loss in a more manageable way. In order to work with the YP around ending, as he had bonded so well with Freud, we made a photo book of his time with Freud and he has been invited to our YP group where Freud is a regular member. We have also started to dog walk with the group, which gives the YP access to Freud and walking should he wish to. In our last session, he told me his dad had agreed for him to buy two guinea pigs. He was so excited to have his own pets and have the contact with an animal he had found with Freud. I felt this was his way of replacing the bond with Freud and his family had accommodated this, as they understood how much he had improved since our work together began.

Gender =	boy
Grade =	11

(boy or girl)
(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	11	> 80
Generalized Anxiety	4	42
Panic	13	> 80
Social Phobia	7	42
Obsessions/Compulsions	7	56
Depression	26	> 80
Total Anxiety	42	61
Total Anxiety & Depression	68	72

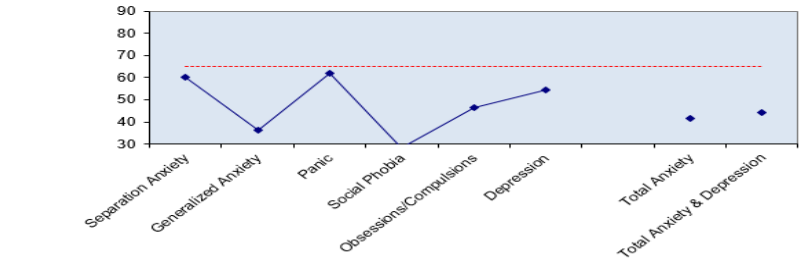


Case 1 Start RCADS

Gender =	boy
Grade =	11

(boy or girl)
(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	4	60
Generalized Anxiety	2	36
Panic	7	62
Social Phobia	1	28
Obsessions/Compulsions	4	46
Depression	9	54
Total Anxiety	18	41
Total Anxiety & Depression	27	44



Case 1 End RCADS

Case 2

15-year-old girl. Adopted at 18 months. Sibling adopted when she was 5 years old. Experiencing low mood and difficulties getting along with her sibling and maintaining meaningful friendships. YP suffers from long -term health condition and at times struggles to come to terms with the management of this.

We used AAT in combination with Interpersonal Psychotherapy focusing on strategies to help her maintain relationships that are more meaningful to her. We used Freud as a way for her to connect and be more relaxed in sessions. We met in school and walked to the school field to complete work. The young person enjoyed Freud being there throughout the session, threw his ball and fussed him whilst we completed work. We held a family session in order to work with Freud with both young person and sibling. They both enjoyed this and worked well together. They both led Freud around the agility course and timed each other. They even had a go at the weaves themselves. They raced Freud to his ball and raced one another back. They started to recall things they used to do together when they were a little younger and the young person suggested they should spend more time together as a result. Mum commented they never like spending time together and this had been beneficial. We have agreed a further session with her sibling and mum at the young person's request that again was a pleasant surprise to mum. The young person felt Freud had really helped her work with her brother and she commented she enjoyed seeing how enthusiastic her brother was about spending time with Freud. I felt this bought them together as they had a common interest to start recognising the positives in one another.

Initially her low mood symptom tracker was high scoring up to 22. By session, nine this has decreased to 7 suggesting a large reduction in low mood symptoms. She initially reported struggling with relationships on her ORS. However, she reports feeling more confident and supported within her relationships. The improvement is indicated on her ORS, SRS graph. Initial sessions scored around 20 on ORS compared to 32 by session ten. We have two further sessions remaining. RCADS will be added to this report once our work is complete. She has agreed to join the participation group and sees this as a way of maintaining the relationship she has built with Freud but also to remain involved with CAMHS.

Case 3

14-year-old girl referred through Sharp Clinic for self-harm and low mood. She reported past trauma of witnessing DV, anger outbursts and relationship difficulties in school and with her sibling. She also reported difficulties maintaining peer relationships.

The young person had four sessions of AAT following work with Sharp. Self-harm had stopped and continued to no longer be an issue for her during our work. She reported Freud helped her by making her laugh and feeling safe around him to talk. She felt the sessions gave her time to think and reflect on what was going well for her. We had initially planned to complete a longer piece of work however, the young person felt she had improved so much over the course of the work, she no longer required further sessions. As the young person did not want a photo of herself with Freud, she opted for a picture of Freud with a message to her to remember her sessions. She reports talking more openly with her mum and spending more time with her and her brother. She feels she is focusing more in school and has made positive choices since recognising the need to change in order to feel better and to feel more connected with those around her.

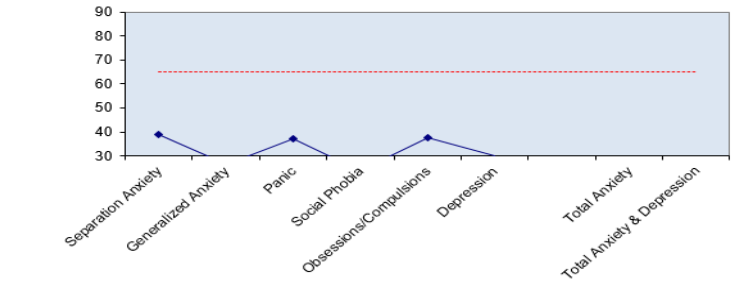
Start RCADS

RCADS Child/Young Person	Raw Score	T Score
Separation Anxiety	3	53
Generalised Anxiety	11	61
Panic	13	79
Social Phobia	8	41
Obsessions / Compulsions	6	57
Depression	20	80
Total Anxiety	41	59
Total Anxiety & Depression	61	66

End RCADS

Gender =	girl	(boy or girl)
Grade =	8	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	0	39
Generalized Anxiety	0	27
Panic	0	37
Social Phobia	0	24
Obsessions/Compulsions	1	38
Depression	0	30
Total Anxiety	1	27
Total Anxiety & Depression	1	26



Case 4

13-year-old girl. Struggling to manage the changes in her relationships that occurred at the same time as at the loss of her grandmother suddenly. Young person was finding it hard to maintain her relationships at home and in school as a result to finding processing changes in her family relationships hard to manage. We used IPT-A and AAT together due to the young person having a passion for animals. She took to Freud straight away and fussed him during our sessions. Her feedback on Freud said she really liked him being around, as she felt comforted by him and found him funny. The young person has made lots of progress using the combination of AAT sessions using IPT-A and family sessions to help both young person and family talk about the loss but also the changes in the family that followed. This has helped her to feel more settled within her family relationships, communicate her own needs and has helped her to feel more able to navigate her friendships in school due to feeling more settled overall.

We would meet at school and walk to a nearby park. The young person likes sitting on the skate park when no one was around and throwing Freud's ball in to the skate bowl so he would chase it and bring it back to her. She reports it was a distraction from what she was talking about as sometimes she found it difficult to talk about her family difficulties, but felt Freud helped make this feel lighter and allowed her to talk more freely.

Her verbal reports regarding the improvements to her relationships and mood are really positive. She feels her sleep and appetite has improved and she is spending more time with her family. Her RCADS show a positive change in her symptoms of anxiety and depression.

I have agreed one further maintenance session with the young person in order to check on progress now she is back in school and to complete her ending photographs for her to keep. She is currently actively encouraging parents to purchase a dog like Freud.

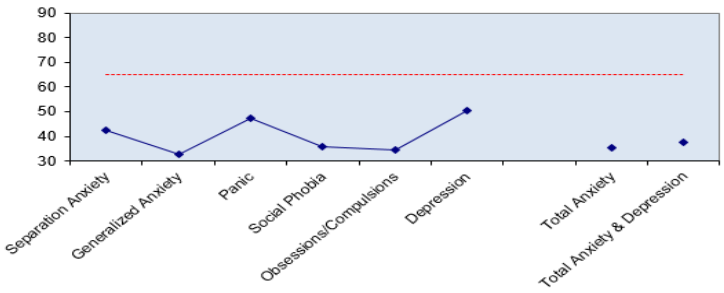
Case 4 Start RCADS

RCADS Child/Young Person	Raw Score	T Score
Separation Anxiety	5	57
Generalised Anxiety	11	61
Panic	8	58
Social Phobia	20	64
Obsessions / Compulsions	4	47
Depression	18	76
Total Anxiety	48	60
Total Anxiety & Depression	66	65

Case 4 End RCADS

Gender =	girl	(boy or girl)
Grade =	7	(3 - 12 only)

Scales	Raw Scores	T Scores
Separation Anxiety	1	43
Generalized Anxiety	2	33
Panic	4	47
Social Phobia	6	36
Obsessions/Compulsions	0	35
Depression	8	50
Total Anxiety	13	35
Total Anxiety & Depression	21	38



Appendix 4

Teens for Truth support and participation group update 2018

The group helped design the mental health passport, thinking about what would be engaging for young people. This has been implemented and used by practitioners with young people and their families. They also provided feedback on other ways of getting the young person's voice and journey such as use of computer based downloadable versions, which are available to download as a resource on the website. They also talked about apps and how they may be useful but expensive.

They also had input into if an exercise group would be useful for CAMHS to run to improve mental health/wellbeing. A practitioner who was interested in designing and implementing an exercise and fitness group to help children and young people with emotional wellbeing. The group provided feedback on how useful they thought this project would be for some young people. They also advised on how some young people would find this setting difficult and ways this could be managed.

Discussions re the CHI form

The group feedback on the CHI form. They felt the CHI form could be made more user friendly and more appropriate for CAMHS as a whole. They have provided alternative questions for the CHI form and voted on which questions they found useful and how this could be scored out of 10 rather than the current format.

Discussions re the website and what could be improved

The young people attempted to complete a self-referral using the BEMH website to see how user friendly the website was. They provided feedback on this and are very keen to become involved in the new design, as they felt strongly about this being accessible to all young people and families and less confusing.

Publicity material for CAMHS

They were asked to think of how to break down the barriers both from a point of view of young people not knowing about CAMHS but also stigma around mental health. They came up with some really useful ideas around having straightforward, easy to read leaflets discussing the difficulties we can help support and having straightforward ways of contacting CAMHS. They also provide ideas such as restroom posters and small cards similar to Kooth cards. The leaflets have been created with teens for Truth input around wording and being straightforward and restroom leaflets have also been taken forward.

Next Steps Project

They provided feedback on the idea itself, how this could work and during evaluation provided feedback on how to engage young people in the take up of the service.

CAMHS Citywide Team Day on Participation

They attended a CAMHS team day, which went really well. This highlighted the importance to the young people and to participation as a whole for CAMHS and the young people. They were able to reach practitioners in terms of them thinking about referring young people to the group and ways they could help support young people who may be anxious about meeting new people and practitioners. They were also able to share with practitioners what they get themselves from attending the group in terms friendship, improved self-esteem and confidence.

They discussed what would be useful around parent participation

They discussed what they felt would be useful around parent participation and how CAMHS could involve parents more. The practitioners who are leading on parent participation took on board this and the feedback used to help support this project.

They discussed what they would want in a CAMHS practitioner

They discussed what they feel are the important qualities and competencies in a CAMHS practitioner. This has helped to shape the person specification for the role.

Key Themes

Participation means everyone being involved. The group are keen to expand as they find the group very useful for their own needs in terms of confidence building and self-esteem. They feel by supporting staff to encourage participation, our group will also be able to evolve and develop further, which would be more meaningful to CAMHS and to the young people.

Overall, their feedback has been listened to and they have felt a sense of worth as practitioners, managers have got back to them about updates etc.

Martina Hayhoe and Heather Kelly

CAMHS Practitioners and Teens for Truth group leads

October 2018.

Appendix 5

Participation Summary Report (October 2018)

In order to deliver best practice, Targeted CAMHS have enrolled to be a Young Minds Trailblazer; part of 'Amplified, a NHS England funded programme to develop the participation of children, young people and their families at every level of the mental health system.

A whole organisation participation plan focussing children and young people was previously developed by the service. The Trailblazer action plan is currently being developed to embed the participation and co-production with parents and carers within the service with the support from Young Minds.

The overview shows our current participation and the ideas to be developed. Since July 2018 the service have gained the views on participation from the community, children young people, service users, parents/carers and families.

In order to gain views parents and carers we launched a **'Your Voice'** campaign and the community were invited to give their views of the service, on what participation looked like to them. In addition, we sought the community's views and attended the Splendour festival at Wollaton Park.

Here we gained the views of 120 + members of the community, on mental health, CAMHS, participation and event feedback. The main themes from their voices were:

- *"Young people parents/carers wanted to get involved.*
- *Parents sometimes need support too.*
- *CAMHS needed to have more presence in the community and in schools.*
- *Young people and families wanted a say in the service they received.*
- *More transparency.*
- *Putting a human face to CAMHS made the service seem more transparent and accessible.*
- *Talking about mental health was good"*

The feedback enabled the service to develop many ideas of further innovation, particularly The Open Door pre Choice Assessment session, which is held now held monthly. This is to break down the barriers about what to expect from their assessment process and coming into a CAMH service and helping the community to see 'a face to CAMHS'.

The Parents in Mind Group has also been developed to embed participation from parents and carers into the service. This is a group for parents run by parents that offers peer support and a focus group to look at helping shape the CAMHS service with co-production. It is also a forum for discussions and to develop ideas including a community garden idea. The group are also aiding the development of a questionnaire to gain parent/carer feedback and involvement once their child has completed their time with CAMHS. Young Minds are also supporting this work and are offering free participation training to our workforce and young people and parent/carers group. This will also be an opportunity to look at the Trailblazer action plan and develop it further with co-production from our service user groups.

The importance of having a presence in schools and the community has come from service users, the community, parents and MH2K. The community/schools events are listed in the overview. Parents in Mind and the Teens 4 Truth group have also developed the leaflets for these events.

There has been one focussed Team Day around participation where young peoples from MH2k, Teens 4 truth and Trans 4 Me gave the team feedback on their views on the importance of participation for young people, they also gave ideas on how to improve the service and how to gain further participation from young people and their families. The action plan is constantly being developed by the ideas of the CAMHS community to improve the service and embed participation.

<u>"Your Voice" Splendour Report</u>

Through the community stand at the festival, Targeted CAMHS gained the views of our young people, parents, carers and community.

We talked and engaged with over 120 people, children, young people, parents, carers, families and professionals.

<u>Below are some examples of the feedback:</u>

"Participation is really important; to ask the views of parents and carers and young people helps with transparency" social worker and parent.

"We need to work together, we know our kids and you know how to help" parent.

"Love this stall, great idea, making CAMHS more human, a face, more approachable" YP with Parent.

"*Well done CAMHS, I would love to get involved in a parent support group, it is hard when you're a lone parent"* parent.

"What a good idea to come into the community to ask our views" YP.

"Knowing what's happening, what to expect from the services" Family.

<u>Main themes from the engagement of our community:</u>

5 main themes were highlighted:

- Both parents/carers and young people would like the choice to participate, get involved with shaping their care; particularly decision making and support groups; working together.
- CAMHS presence has been received well in the community and more presence is needed to help break down barriers and reduce stigma (a human face)
- It is essential CAMHS have more presence in schools/ more awareness/assemblies/teacher awareness
- More transparency about the service that is offered
- Easier access

This feedback helped with informing and developing our further service development in line with embedding meaningful participation, including:

- The Open Door Drop in Sessions (pre choice assessment: session explaining what to expect/transparency etc.)
- Facilitation of a parents support and focus participation group
- Presence/stands at community events
- Stands at school parent's evenings

From this work, Targeted CAMHS have now:

- Developed a parent/carer support and participation group
- Have planned more events in the community including a series of workshops in the community and stalls at different events prompting a face for CAMHS and tackling stigma, such as having a stall at the up and coming Ruby Wax event at the Play House in October 2018.

Appendix 6

MH:2K Nottingham & Nottinghamshire - Big Showcase

10th May 2018

About MH:2K

About MH:2K

- **MH:2K is a pioneering youth-led model for engaging young people in conversations about mental health in their local area.**
- MH:2K helps decision-makers and researchers to gain deeper understanding of mental health issues in their area and new insights about effective solutions for prevention, support and services.
- MH:2K is delivered by **Involve**, a leading charity working in the field of participation, and social enterprise **Leaders Unlocked**.
- In 2016-2017, we piloted MH:2K in Oldham. In 2017-2018, we are running it in Birmingham, Central Lancashire, North Tyneside, and Nottingham and Nottinghamshire. The project also now has a National Advisory Panel.
- MH:2K in Nottingham & Nottinghamshire is supported by the Wellcome Trust People Award, Nottingham City Council, Nottinghamshire County Council, and Clinical Commissioning Groups.

How it works

- **Recruitment:** of a core team of young people as 'Citizen Researchers'
- **Design Days:** to explore key national and local information and determine which mental health issues are most significant for their area.
- **Roadshow:** The Citizen Researchers co-design and co-deliver workshops to engage at least 500 other young people in the topics identified.
- **Results Day:** The Citizen Researchers help analyse and extract key findings. They work with local decision-makers on recommendations for change.
- **Big Showcase:** The Citizen Researchers present their findings and recommendations to key stakeholders and discuss next steps.
- **Local Advisory Panel** of key local decision-makers and stakeholders informs the project throughout.

What we did in Nottingham & Nottinghamshire

- We recruited **29** motivated young adults with diverse backgrounds and life experiences to become the MH:2K Citizen Researchers.
- The group selected 5 key priorities to address through the pilot:
  - Stigma and Public Awareness;
  - Treatment and Therapies;
  - Education and Prevention;
  - Cultures, Genders and Minorities;
  - Family, Friends and Carers
- The team designed and delivered their Roadshow events to schools, colleges and community groups across Nottingham & Nottinghamshire.
- The Roadshow reached **647 young people**. There **were 30 events at 15 different organisations.**

Our Local Advisory Panel

- **Elizabeth Allcock**, Service Improvement Facilitator for Quality, Governance and Patient Experience, Nottinghamshire Healthcare NHS Foundation Trust
- **Kate Allen, Consultant in Public Health**, Children's Integrated Commissioning Hub and Public Health Nottinghamshire
- **Pav Ayoub,** Senior Practitioner, Countywide Team, Nottinghamshire Youth Service
- **Pom Bhogal**, Youth Service Manager, Children, Families and Cultural Services, Nottinghamshire County Council
- **Hayley Bipin**, Commissioning Officer (Children), Nottingham City CCG
- **Jane Caro**, Citywide Targeted CAMHS Manager, Early Help Services
- **Brodie Colton,** Young person representative
- **Helene Denness,** Consultant in Public Health, Nottingham City Council
- **Lucy Hawkin**, Schools Health Hub Coordinator & Young Minds Local Delivery Lead
- **Lucy Peel**, Programme Lead, Children and Young People's Mental Health and Wellbeing (Nottinghamshire and Nottingham City)
- **Nichola Reed**, Public Health and Commissioning Manager

Findings and recommendations

Stigma and public awareness

Stigma and public awareness:
Key findings

- **There is a general lack of awareness of mental health** among young people, parents, professionals, and within the education system.
- **There is not enough training for schools, the workplace and professionals** in the correct use of language and terminology around mental health.
- This leads to young people **being left unsupported, their problems escalating, and an inaccurate picture** of how mental health is really affecting them.
- **There is an urgent need for greater promotion of the services** available to young people and how to access them.
- **Within some cultures, religions and ethnic groups,** there is a lack of understanding that mental health affects everybody, including young males.

Stigma and public awareness:
Our recommendations

1. **Provide compulsory education on mental health from a young age**, and deliver training for teachers and parents in how to support young people. Even using the terms in more positive way can help to reduce stigma and normalise conversations.
2. **Harness social media as a positive tool to promote an accurate and well-informed portrayal** of mental health. E.g. Kooth are currently piloting this service using Instagram.
3. **Use proven methods, like posters on the back of toilet doors and anonymous helplines,** to direct young people to the best place for help, without the fear of exposure in public. Get young people involved in developing these promotional materials.
4. **Target religious groups and cultural spaces** to bridge the gap in knowledge and awareness through the community.
5. **Carry out youth-led campaigns and projects like MH2K** to build positive momentum. Use peer-to-peer support groups, youth-led workshops and assemblies.

Treatment and therapies

Treatment and therapies:
Key findings

- Young people face barriers when trying to access services due to **long waiting times, assessment periods, insufficient duration of treatment and the transition** from child to adult provision.
- Some professionals **aren't trained well enough in how to communicate with young people** and how to support them.
- **Access to services is restricted,** with unrealistic hours, opening times which don't correlate with school times, and locations which may be too far to travel to if unaccompanied.
- Some young people feel that **the type of treatment they are given is not suited** to them or the professional they are seen by isn't someone they feel comfortable with, and they are not offered an alternative.
- **The transition from child services to post-18 services** is not smooth or reliable enough. The waiting time and consistency of care isn't followed through meaning some young people are falling through the system.

Treatment and therapies:
Our recommendations

1. **Offer 24/7 helpline support and drop-in sessions** which are open at suitable times that don't clash with school/college hours.
2. **Use staff members from teams across mental health services** to ensure better coverage when some areas are facing high demand. Ensure that flexible staffing is being used effectively.
3. Put an end to only offering limited weeks of treatment and make it a **continuous assessment which reduces the pressure and stress** on the young person to 'feel better' within just 6 weeks for some issues.
4. I**nclude young people when training professionals**, and allow them to help educate teachers/counsellors about how to communicate with young people, making it more powerful.
5. **Use spaces where young people feel comfortable**, like community centres and youth centres, rather than clinical/hospitalised spaces which can be daunting and off-putting.

Education and prevention

Education and prevention:
Key findings

- **There is not enough privacy when seeking help in schools**, e.g. announcements to see the school counsellor are made publicly in front of other students, and you have to leave during lessons. This results in students shying away from seeking help in the first place.
- Many teachers that deal with students on a daily basis **do not know how to spot the signs or what to do** – only pastoral staff seem to know what to do.
- **It's hard to seek help in schools** as staff members don't explain the process properly or the circumstances in which parents have to get involved. Looking at leaflets and posters can make your problems more public.
- **There is too much focus on exams and academic achievement**, which is very stressful and counterproductive, making young people more anxious with no opportunity for a break or relaxation.

Education and prevention:
Our recommendations

1. **Make it possible to arrange appointments in a confidential way**, e.g. creating an online appointment system and booking with an arranged location to make it feel less daunting and make the first step easier.
2. **Provide a basic training day for all members of staff on mental health** and how to advise young people, create more informal situations with staff, so students feel more comfortable approaching and talking to them.
3. **Improve the accessibility of services**, and how information is distributed, keeping things clear and simple. Use private processes e.g. emailing mental health information to all students rather than leaflets on a public notice board.
4. **Set up peer support groups across year groups**. Set up older students to work with younger students who may not as comfortable with a teacher or adult.
5. **Reduce exam pressure and increase extracurricular activities.** Make person-specific revision plans, instead of setting unachievable goals which can be overwhelming. Educate parents on how much pressure is appropriate. Support session like yoga, mindfulness, opportunities for talking about self-care and ways we look after ourselves in times of stress.

Cultures, genders and minorities

Cultures, minorities and genders: Key findings

There **isn't enough mental health education for religious groups and ethnic minorities** through religious buildings, community centres, and faith schools. Some young people are having to live a 'double life' between western values and their own background.
Support systems are put into place **without full consideration of how young people actually feel about accessing the facilities**. Often, they're not advertised well enough therefore young people don't know enough about them.
Teachers are not trained on the subject of LGBTQ+ or knowledgeable enough about how to deal with homophobic bullying and discrimination.
Young males and some ethnic minorities are particularly affected by **addictions to drugs, alcohol, gambling, social media, gaming, and pornography** which are having a detrimental effect on young people's lives.
There is still a **huge problem with the stigma of mental health for young males**. They are constantly told to 'man up' and 'real men don't cry' which leads to them not expressing their feelings or seeking help.

Cultures, minorities and genders: Our recommendations

1. **School counsellors to be accessible to all students** during school hours, through online services and drop-ins. There should be safe spaces that students feel comfortable in, and counselling must be private and confidential.
2. **Work with the voluntary sector to provide earlier intervention.** Services need to be actively promoted within voluntary sector settings, religious centres, community centres and faith schools. Councils and services need to use their voluntary sector links more effectively.
3. **Use accessible means like street stalls to defeat ideas of masculinity from an early age** and raise awareness of topics like identity and equality. Prioritising work with males.
4. **Bullying should be taken more seriously at schools, particularly homophobic/ transphobic bullying.** Teachers need specific LGBTQ+ training in order to understand their students.
5. **Run PSHE/Citizenship** lessons to address the consequences of drug use, addictions, coping mechanisms and spotting the signs of MH**.**
6. Run specialist education programmes that **address masculinity and mental health in football clubs/sports clubs/air cadets/drama clubs etc**

Family, friends and carers

Family, friends and carers:
Key findings

- **Young people face feelings of isolation** due to racism, homophobia, or the pressure of figuring out identity. “Being isolated is probably one of the worst things you can feel, if you let out your feelings, you worry that you will push friends, family and carers away.”
- **Young people are afraid of being seen as different**, as they are under so much peer pressure. There is pressure to fit in, look good, and do things they don’t want to do. Many think they are abnormal, whilst everyone else around them is ok.
- **Many young people feel they cannot communicate** with their friends and family about . They feel that no one can relate to their problems.
- **Parents did not have this much exposure to mental health** when they were growing up. This results in huge gaps in their relationships with their children, who might be silently suffering.
- **Within the school environment, people are afraid of being judged by others**, and feel like there is nowhere they can go. This is largely due to the services offered in schools which are lacking in anonymity, not giving the young people the confidence to seek help.

Family, friends and carers:
Our recommendations

1. **Offer young people more choice of professionals to see and speak to**, in terms of age/gender/culture etc. This way they are more likely to open up and feel comfortable.
2. **Create an online booking system for school counsellors.** This way friends/ other students won’t know that you’re going to see the nurse/counsellor, therefore reducing the fear, anxiety and pressure of coming forward.
3. **Invite parents to compulsory talks throughout the school years**, not just in sixth form – providing information to reduce family pressures and make the whole family more at ease with talking about mental health.
4. **Run PHSE in schools to engage friendship groups** – include self-confidence, self-esteem, and self-belief workshops as well as providing the basis facts on mental health services.
5. **Consider innovative ways to engage parents. Y**oung people feel their parents wouldn’t be able to support them with their mental health due to the lack of understanding and knowledge, so an MH2K-style engagement project could piloted to engage/educate parents and carers directly.

Nottingham City Council

CAMHS
Child & Adolescent Mental Health Services

Appendix 7

Today's Date:	**Monday 29 October 2018**	Weeks Away:	Date of:	Surplus/Deficit Wait Time:
Next available Choice:		3.14	20 November 2018	**2.86**
Next available Choice if all waiting were booked into next available slots:		4.14	27 November 2018	**1.86**
Next Available Joint BEH/CAMHS Choice:		5.00	03 December 2018	**1.00**
Next Available Joint BEH/CAMHS Choice if all were booked in:		5.00	03 December 2018	**1.00**
Next Available Joint Community/Targeted CAMHS assessment:		3.00	19 November 2018	**3.00**
Next Available Joint Community/Targeted CAMHS assessment if all were booked in:		6.43	13 December 2018	**-0.43**
Next available Consultation:		1.29	07 November 2018	**4.71**
Next available Consultation if all were booked in:		12.29	23 January 2019	**-6.29**
Next Available Partnership:		6.43	13 December 2018	**1.57**
		Number:		
No. awaiting Choice in CAPA tray:		12		
No. awaiting Consultation in CAPA tray:		16		
No. awaiting Joint BEH/CAMHS choice in CAPA tray:		0		
No. awaiting Joint community CAMHS/CAMHS assessment in CAPA tray:		7		
No. awaiting Partnership:				