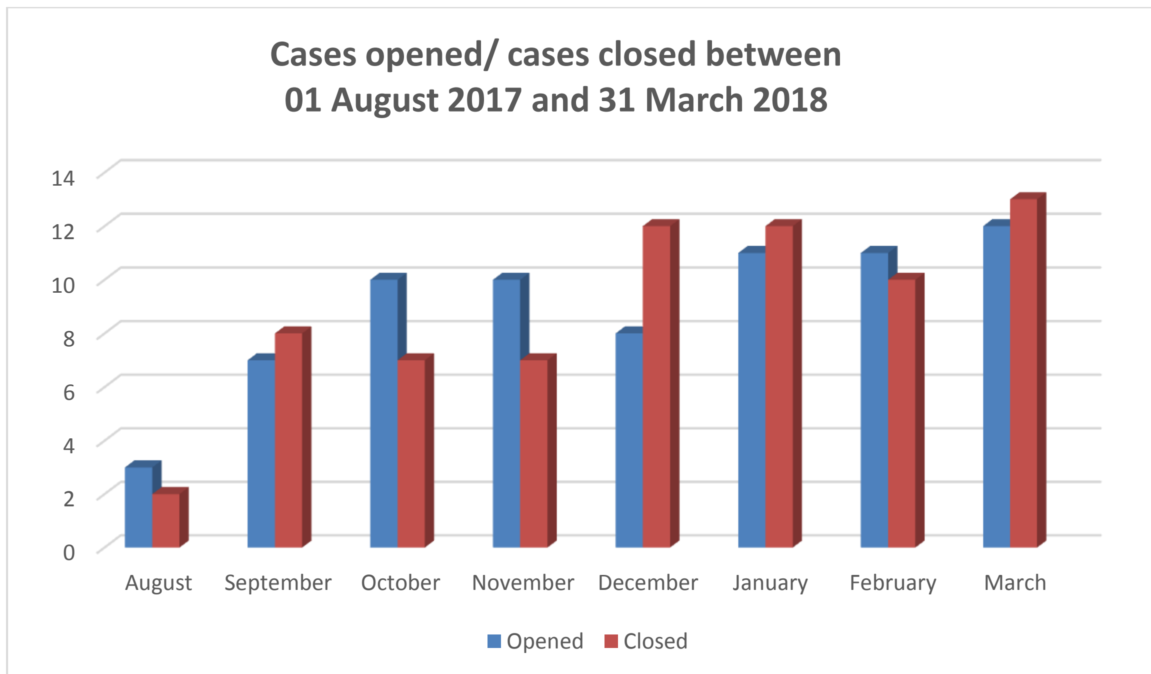
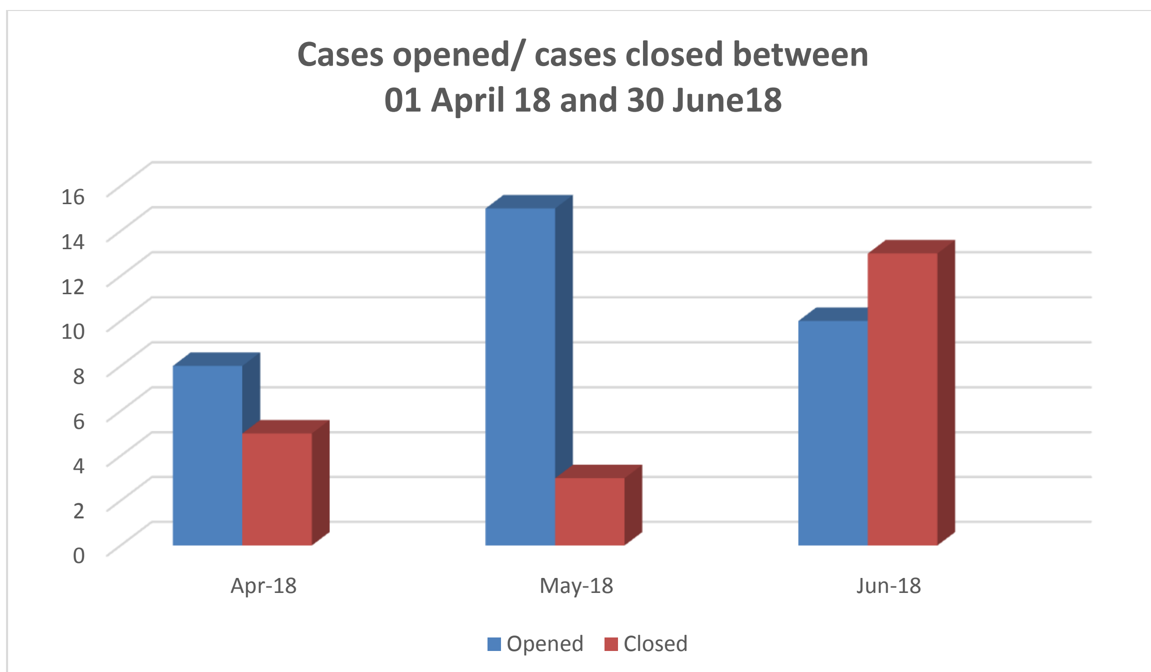
<u>**Nottingham City CAMHS Children Looked After Team**</u>

<u>**Team Overview**</u>

<u>**2017 - 2018**</u>

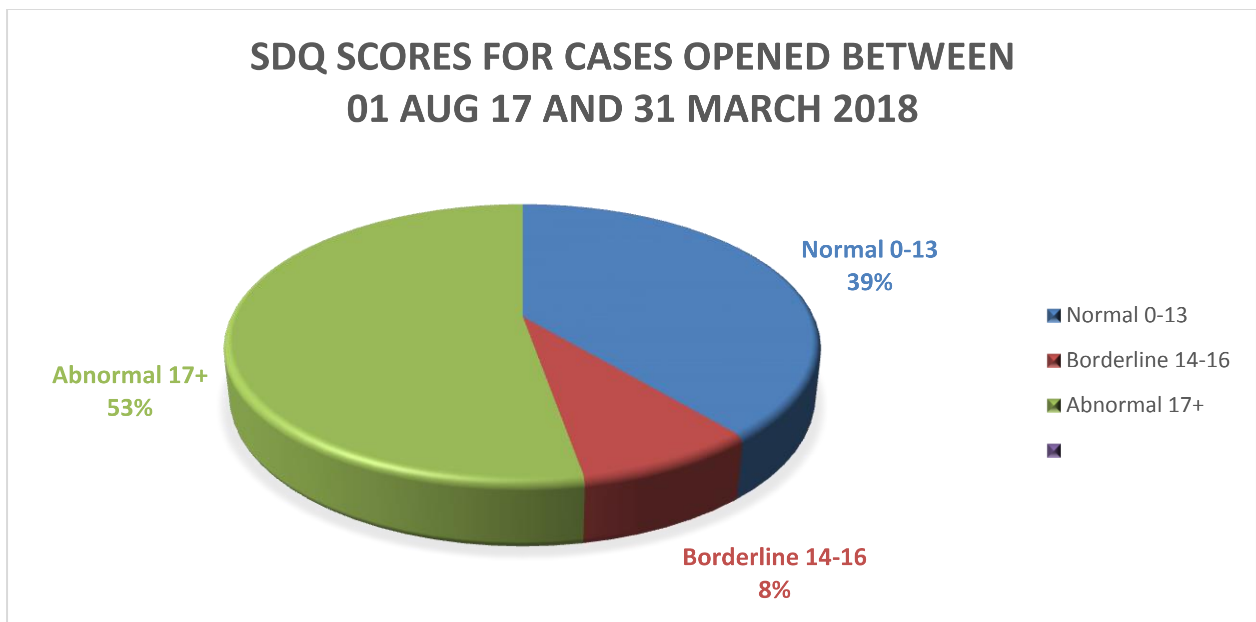
Table 1

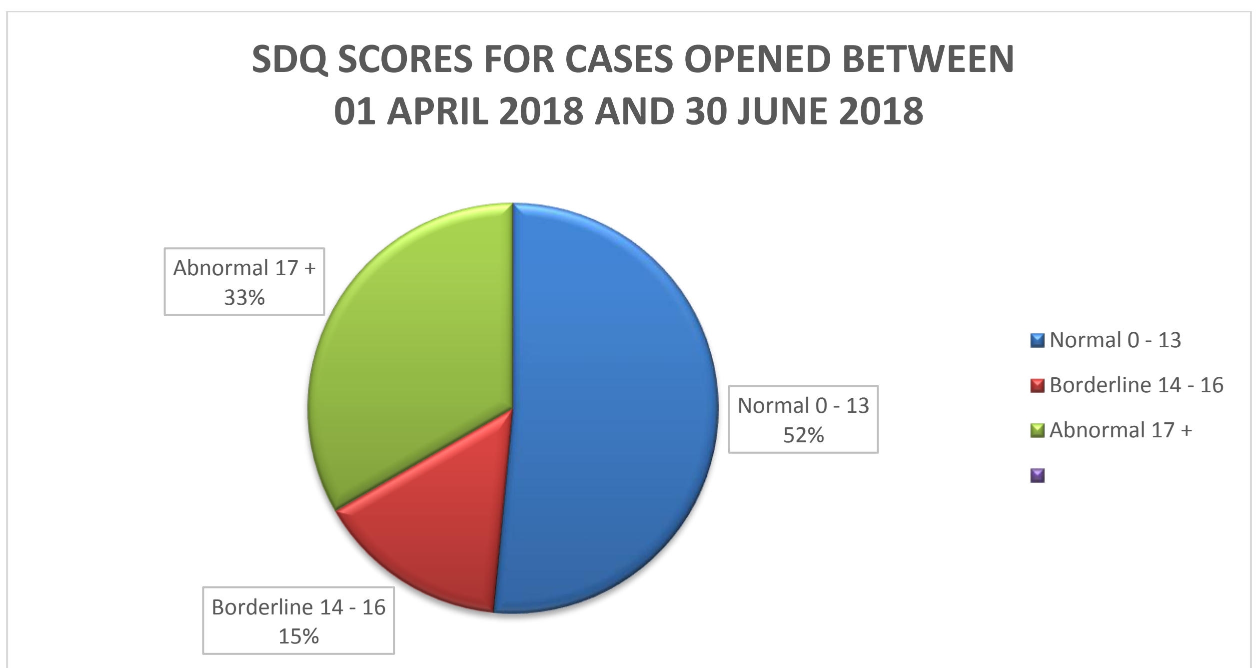




A revised operating model is being tested before final sign off. This has provided improved focus on formulation, goal setting and planning within casework . There is also closer collaboration with Health colleagues, through fortnightly multiagency complex case discussions, proposed multiagency post-choice planning meetings and regular joint working to determine the best CAMHS interventions for children and young people. The team are currently working with 164 open cases, which is a slight increase in the number of cases open to the team in March 2018 (159). The team currently has a vacancy and recruitment is underway to fill this on a temporary basis to further test further information.

Table 2



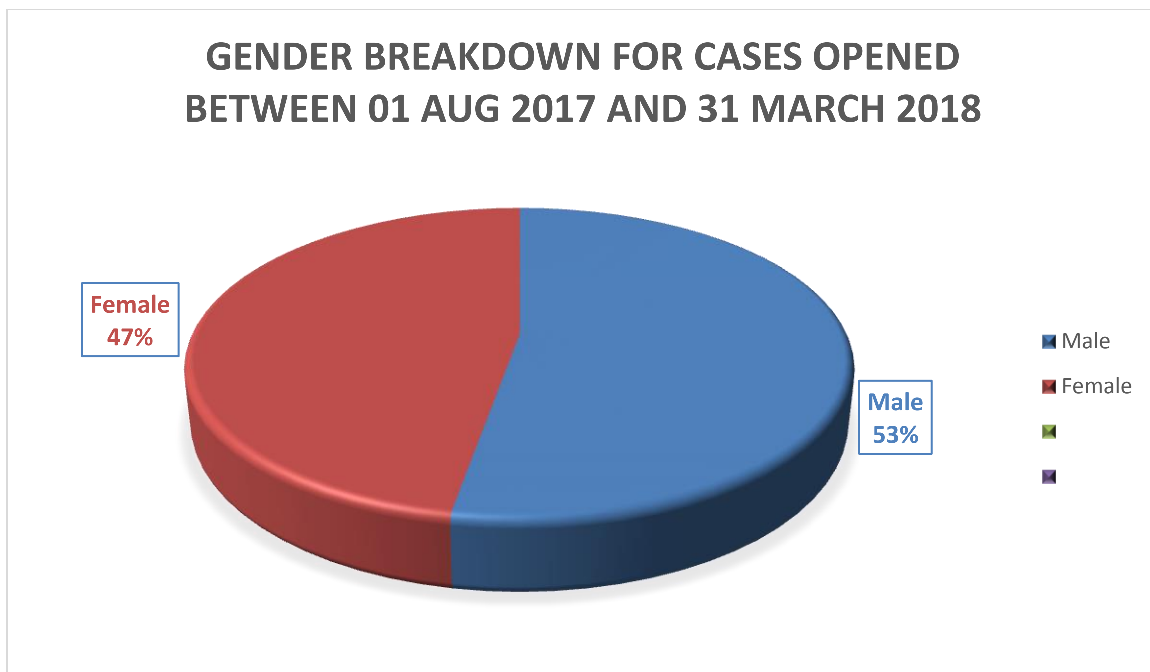


The referral guidance generally advises for those children and young people with a high (abnormal) SDQ (Strengths and Difficulties Questionnaire) score, who would benefit from an initial consultation. Whilst recognising the value of the SDQ as an aid to indicate difficulty, this cannot be used in isolation when making an assessment. Therefore the team will accept referrals where there are other concerning factors beyond the SDQ score (this, again, reflects the complexity and the bio-psycho-social nature of the difficulties that looked after children and young persons present with, and the subjective nature of SDQs scores). This may account for the increase in the number of children and young people referred with 'normal' SDQ scores.

We liaise with CIC Teams to ensure that as far as possible children, young people with abnormal SDQs who are not in receipt of a service are identified, and referral is encouraged. The mechanism for this is a review by CAMHS CLA of recent SDQ scores, which have been completed by CIC social workers, in the preceding month.

We are keen to target this team's resources towards children and young people with complex emotional, behavioural and mental health difficulties. This group can be placed out of area to support their need but this involves engaging the support of the relevant CAMHS service via the Clinical Commissioning Group, which can create further delay in accessing services. Residential homes provision is being developed to address this and the CAMHS CLA team is fully engaged in this.

Table 3



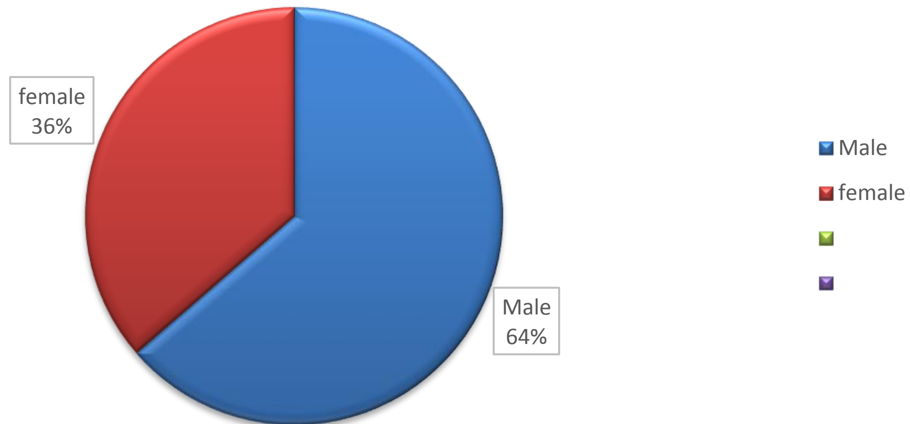
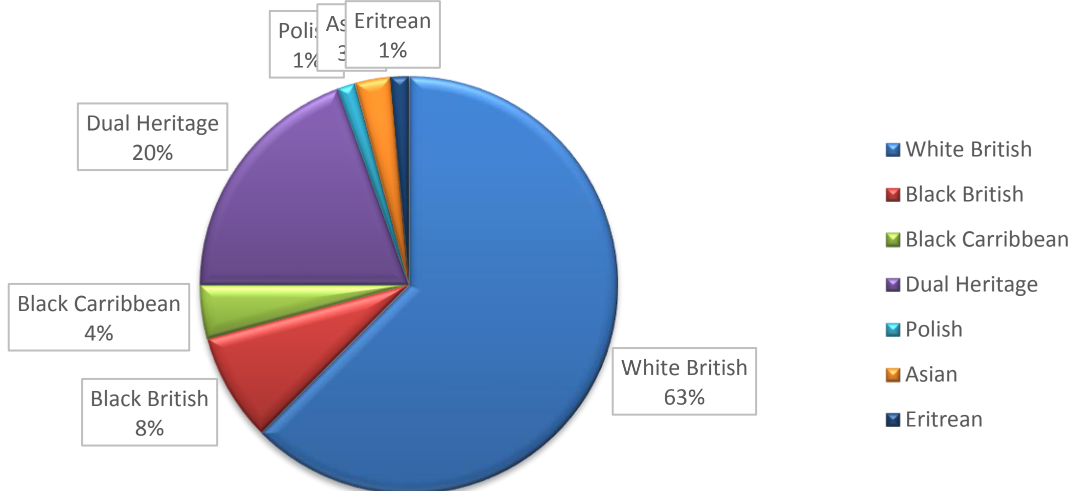
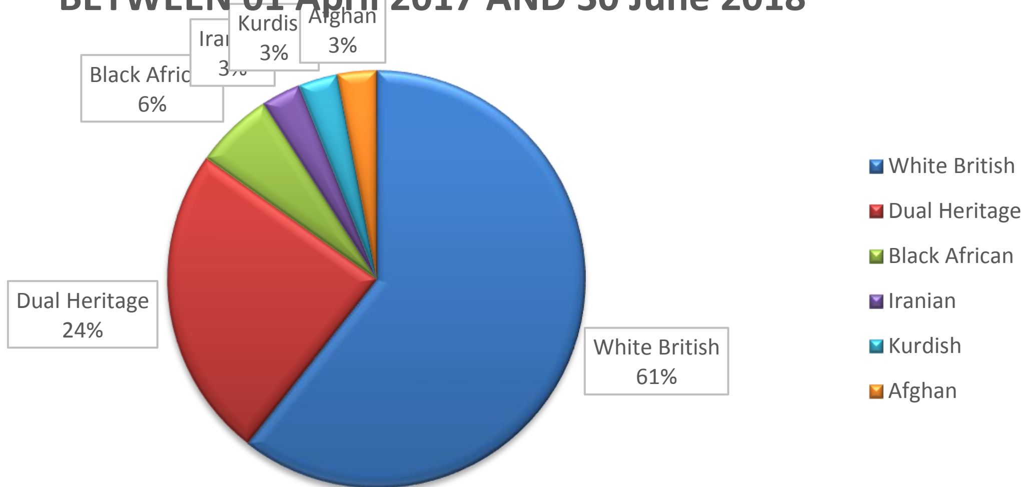


Table 3 shows the gender split across open cases and shows that we work with a slightly smaller group of females. This has remained consistent with previous figures from last year.

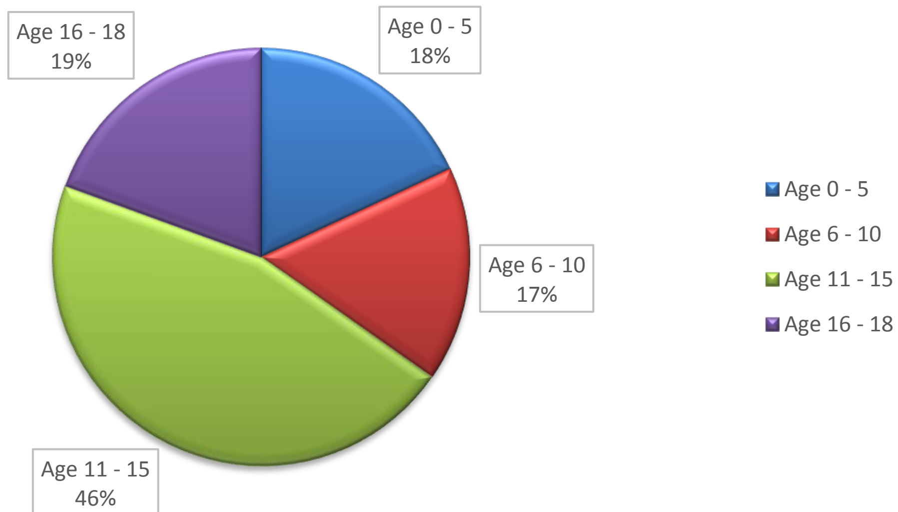
Table 4

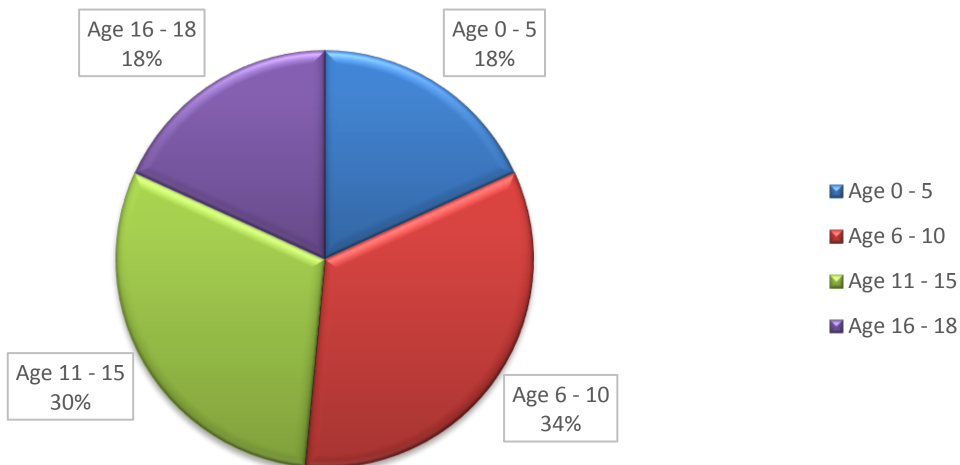




As in previous years, the team continues to work with a small number of UASCs (Unaccompanied Asylum Seeking Children). These figures remain similar to those previously collated. The team continues to work closely with the Refugee Forum and the Asylum Seeker and Refugee CAMHS Practitioner.

Table 5

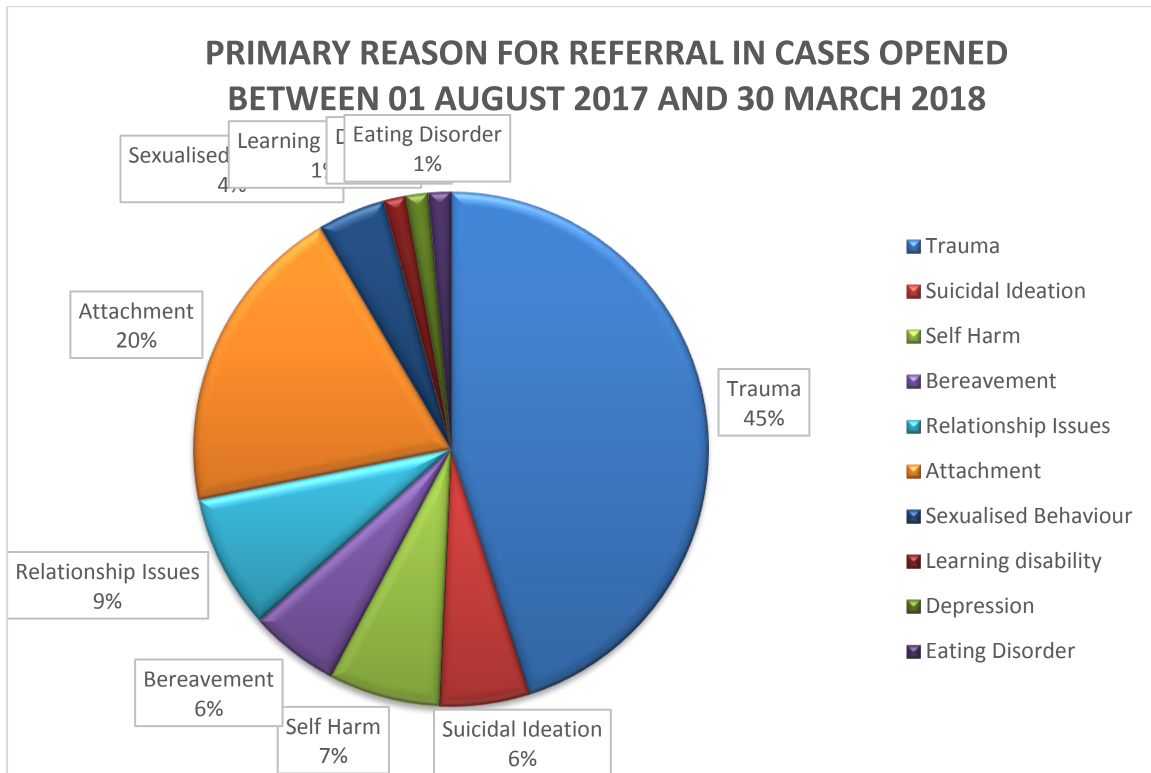


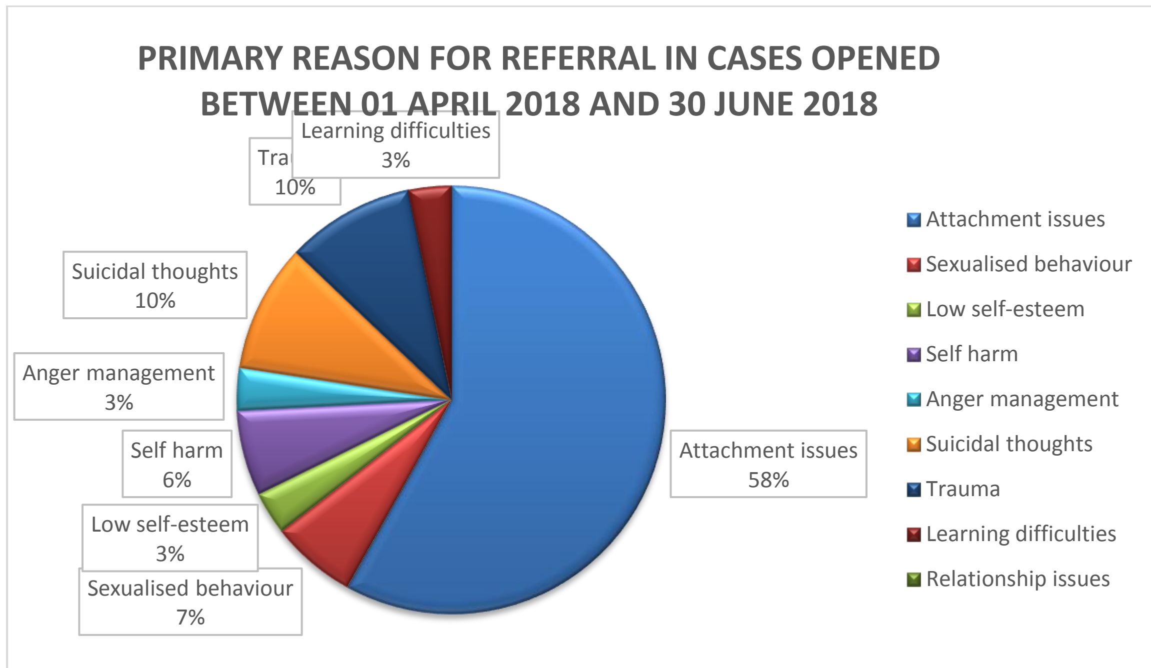


We have seen an increase in the number of referrals for children in the 6-10 yrs age range. We welcome this change, as the research evidence suggests that early CAMHS intervention is linked with better outcome. Therefore, the earlier we can intervene, the more likely it is for the young person to shift towards a positive trajectory and reach optimum functioning in different areas of their of their lives by the time they reach adulthood (and contribute to society rather than poor functioning and costing the public sector). This could reflect a number of factors, including an awareness of the need to refer children as early as possible for support or that we are often asked to provide consultation to networks where the plan for children is adoption and networks are seeking advice and support.

With regard to the 16 – 18 age group, we have recognised that we need to play a bigger part in the Pathway Planning process, one of the elements of which is *emotional and behavioural development.* This is an issue, which we will continue to work on over the next year. Our Health partners have introduced a more robust transitions pathway and this is now being included in our work with young people who are over 17 years within their CAMHS plan.

Table 6

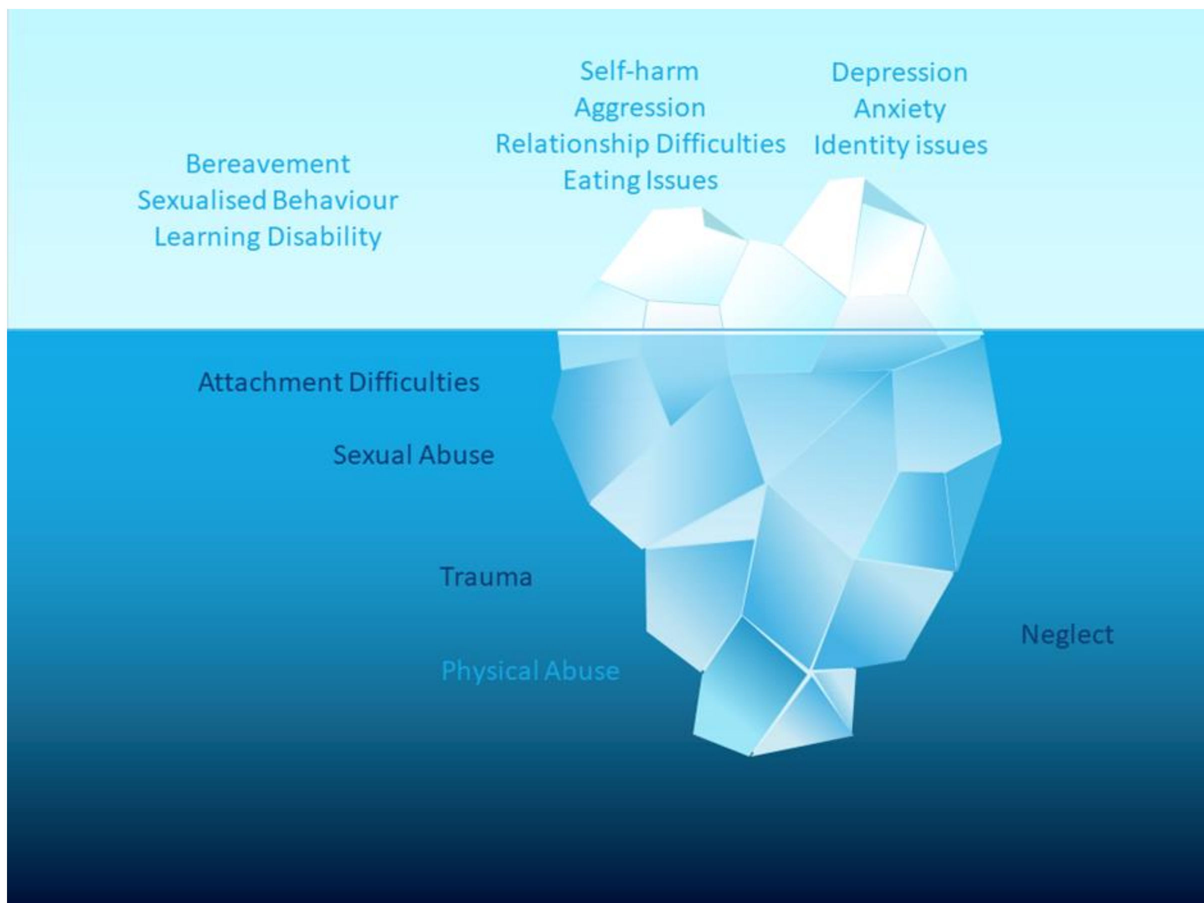




There has been a change in the reason for referral from 'Trauma' being the primary reason to 'attachment'. The young person's social worker, referring into the team, provides the reason for referral. The categories provided on the referral form and those indicated by the referring social worker, do not always represent the difficulties presented by the child / young person, as CAMHS clinicians would view them. Whilst some referrers may indicate trauma as a presenting issue, this does not provide a descriptor of what is potentially manifesting. Reasons for referral such as

neglect and sexual abuse also provide little clinical insight into what is presenting, instead offering a perspective on potential causal factors. The diagram below represents the relationship between observable and historical issues considered at referral.

Broad descriptors such as behavioural difficulties may represent issues such as anger, aggression and self-harm but alone offer little insight into the type of behaviour, which is presenting. Similarly, emotional difficulties could represent trauma reactions, anxiety, depression and suicidal ideation. The openness of these categories offer little clinical value and impede the consistency within which presenting issues communicated in referral forms.



Self-harm continues to be a significant issue in terms of managing risk within the team and we have now developed a CAMHS CLA self-harm pathway, which is in use across the team. This aims to provide a more consistent and robust follow-up to self-harm incidents with regard to risk assessment and safety planning. We have developed close links with SHARP, who have delivered a programme of training throughout the year to increase knowledge and confidence across the team, and SHARP also offer monthly consultations to the team (3 each month).

We contribute to the emerging Directorate Trauma Informed Practice and provide training in relation to the impact of developmental trauma in a range of settings. Feedback has generally been very positive and anecdotally practitioners have said

that it has a positive impact on practice. This work will be further development with support from the Learning and Development Team during this performance year.

Table 7

Average time from referral received to first appointment offered (in weeks):

August 17	4
September 17	3
October 17	2.5
November 17	3
December 17	4
January 18	4
February 18	4
March 18	3.5

April 2018	3
May 2018	3 .5
June 2018	3.5

The team aims to offer a Choice appointment within 2-4 weeks of referral. This table shows that we are consistently meeting this target, despite having a reduced staff team currently. The wait time to an extent is determined by network availability, particularly the availability of CIC social workers. We will always try to prioritise referrals for initial choice (i.e. where there are particular risk issues).

Table 8

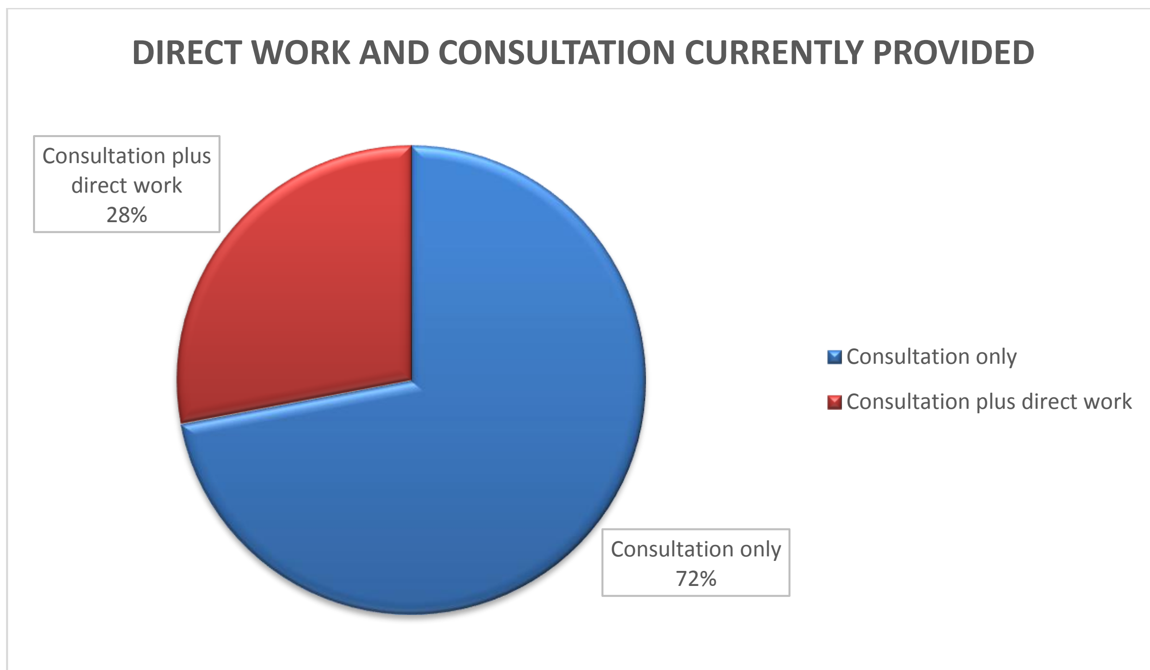
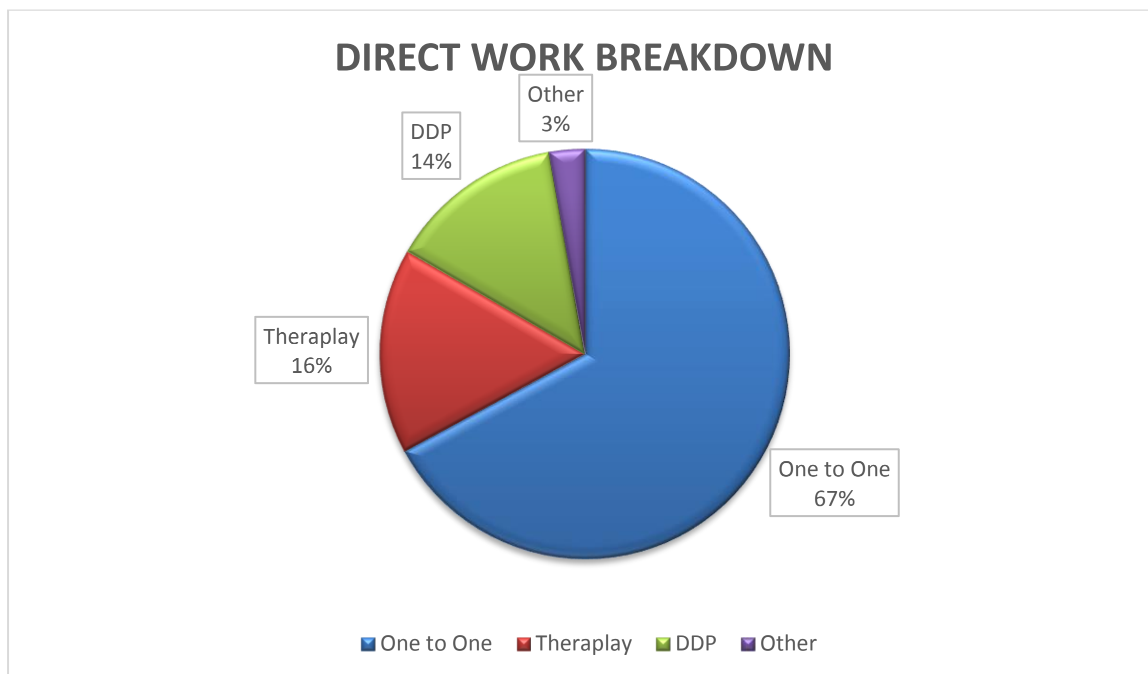


Table 9



Tables 8 and 9 show the balance between direct work and consultation and how the team delivers direct work. With regard to Table 8, this shows that the team primarily work through a consultation model, based around supporting professional networks and offering a reflective space to think about a child or young person's history and understanding their behaviours in context.

Table 9 shows different evidence based approaches used in direct work.

Matthew Jenkins
CAMHS CLA Team Manager
August 2018