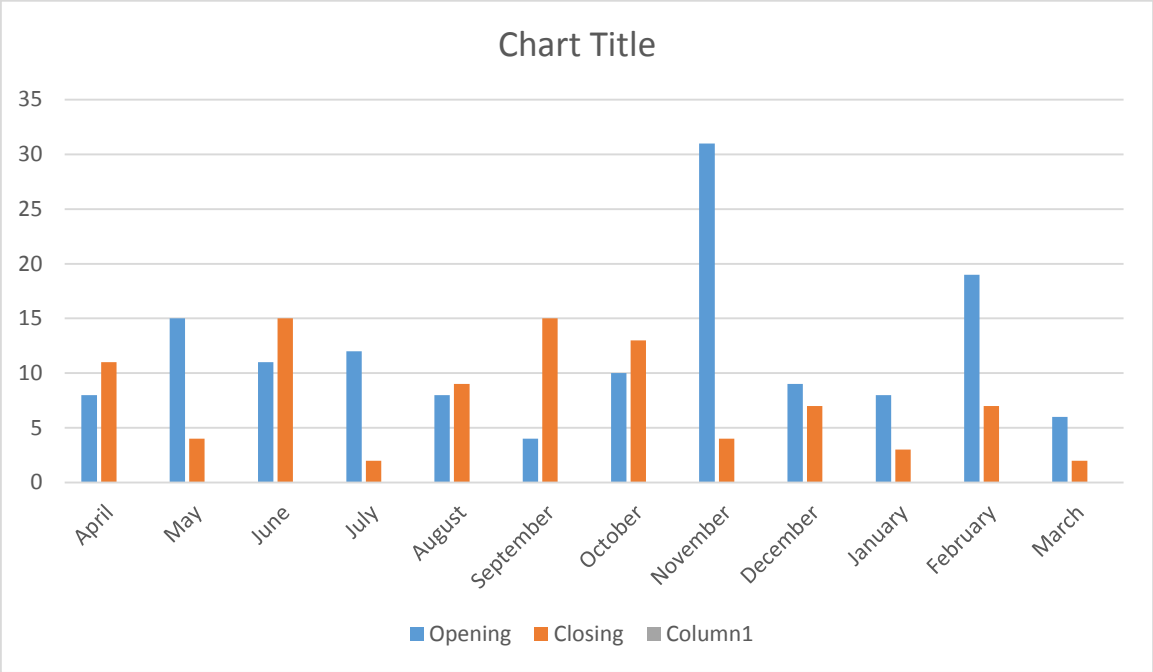
Correlated Statistics for CAMHS CLA for the year 01.04.18 – 31.03.19

Please be aware that the data below has been manually collated

Table 1 – cases opening and closing



	Opened	Closed
April	8	11
May	15	4
June	11	15
July	12	2
August	8	9
September	4	15
October	10	13
November	31	4
December	9	8
January	8	3
February	19	7
March	6	2
Totals	141	93

We currently have involvement with 187 Children in Care Cases. The break-down of this comprises:

- 170 allocated cases (across 6 City-employed staff).Some of the 170 allocated cases be nearing the end of an intervention and will be scheduled to close.
- 15 cases that have been allocated and are awaiting assessment with a confirmed date,
- Two awaiting allocation.

We provide a service to City CIC, living in the City.

We are continuing to develop practice around strengthening transitions pathways. These include where children are turning 18 and require interventions or services from Adult Mental Health Services (AMHS) or where we have been working with a child with needs that can no longer be met within the City and are therefore moving Out of Area.

Knowing when to end our involvement remains a challenge. We use the THRIVE model of care as the framework to provide our service. Nottingham's THRIVE model is underpinned by the THRIVE model of care (Wolpert et al 2016, CAMHS press, EBPU). Research by the CAMHS Research Outcome Consortium, designed to map need and provision for all young people in need of support for mental health and well-being or mental illness, identified 5 groups of young people within services. These are described in the model as:

1. Thriving
2. Getting Advice
3. Getting Help
4. Getting More Help
5. Getting Risk Support

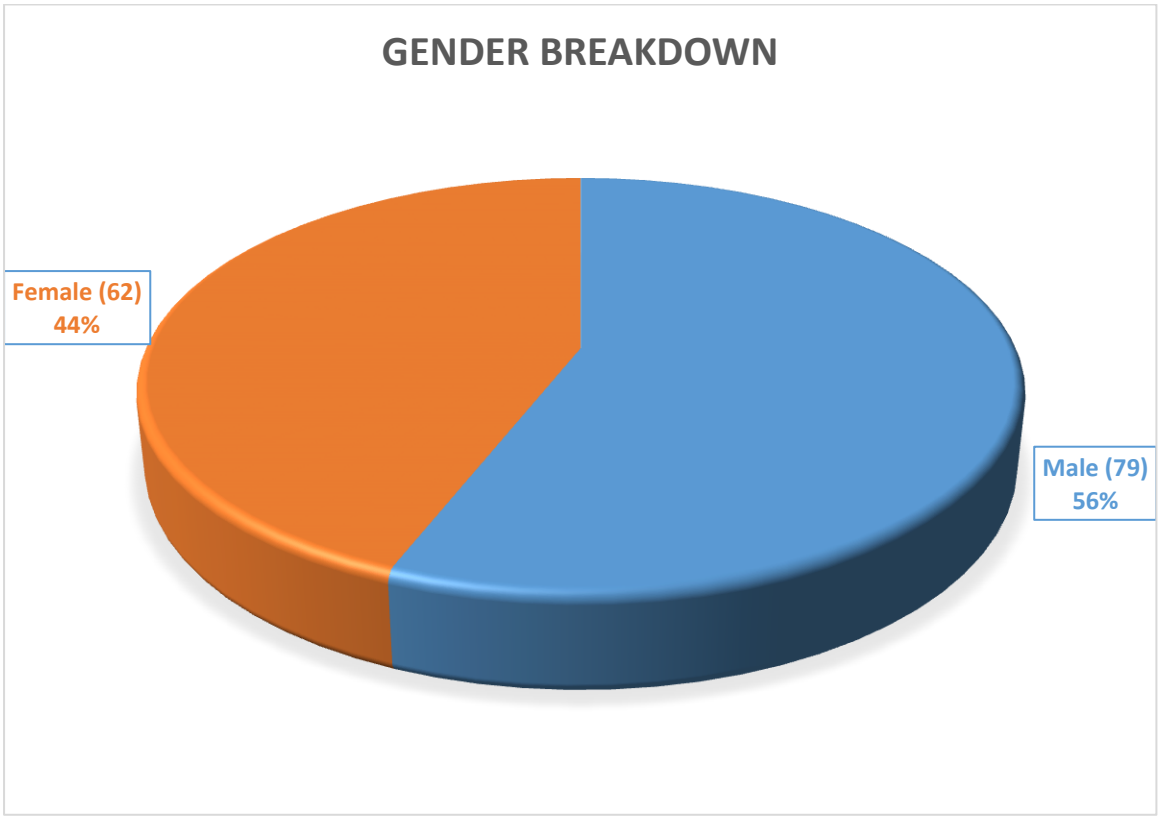
Many difficulties in young people referred to CAMHS CLA are potentially life-long issues stemming from early trauma and adverse life experiences. However, if early assessment and intervention (which includes direct, systemic and indirect multi-agency interventions under supervision of specialists) can be provided, there is good research evidence to suggest that their life trajectory can be shifted in a more positive direction (

Given current resource limitations, CAMHS CLA ultimately has to limit the duration of its involvement and care-planning ensures that the professional network have a clear understanding of desired and expected outcomes (using the THRIVE model), and are empowered to manage some of the difficulties themselves, reducing dependency.

We acknowledge that looked after children, young people and their networks may need to use this service for additional support at different times and timely access back to the service is important (re-referral)

We use a formulation approach to strengthen assessment, planning, intervention and review.

Table 2 – Gender



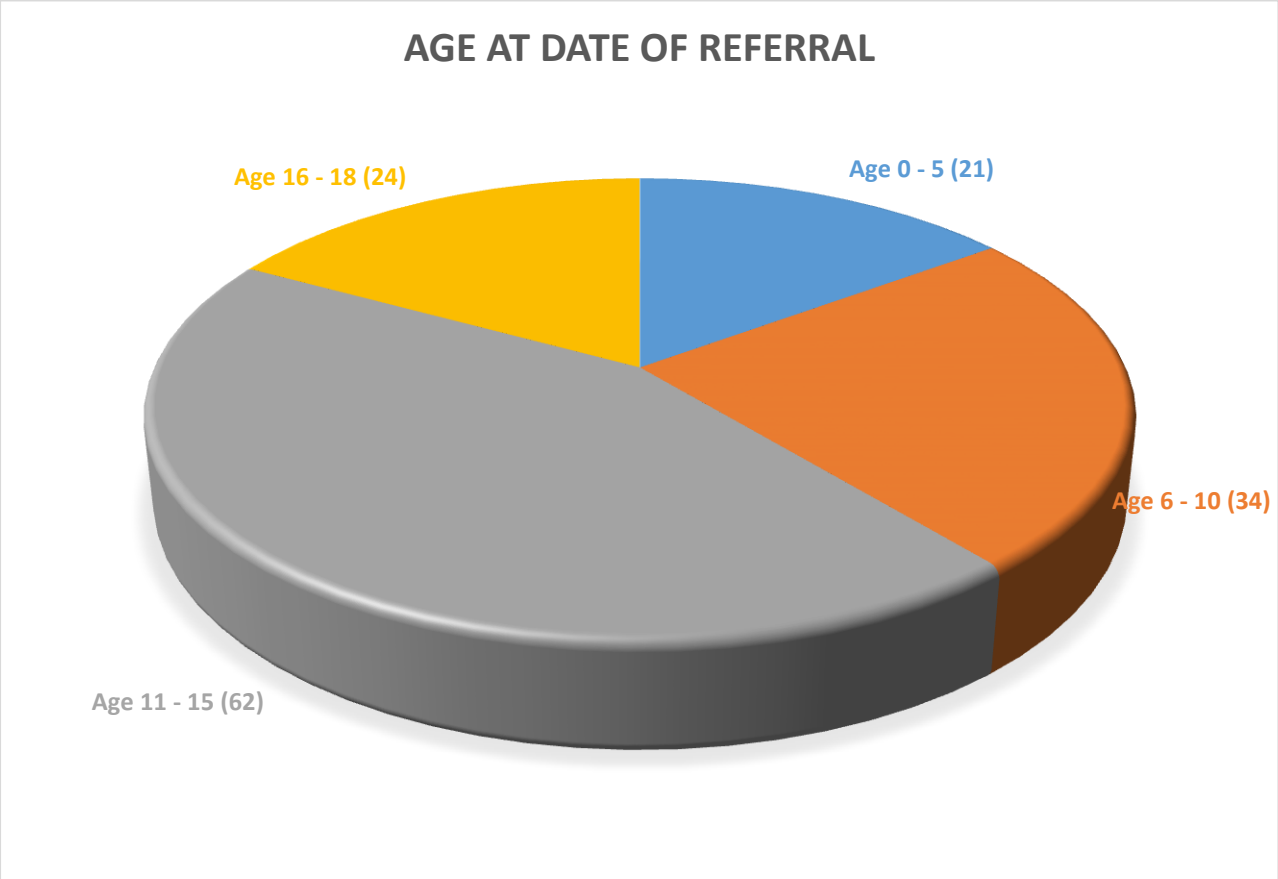
Consistent with previous years, the number of females we are working with remains smaller than the number of males. This, we understand, reflects the make-up of the CIC population as a whole.

Table 3 – Ethnicity

The team continues to work with a number of UASCs (Unaccompanied Asylum Seeking Children). This year, we have made links with NEST (Nottingham Education Sanctuary Team) which is an education provision attended by some of the children we work with. We have begun attending their Advisory Group; as a team we are hoping to think further in the coming months about our 'offer' in terms of better meeting the emotional well-being needs of UASCs referred to us, and collaborative planning and intervention with other agencies (eg. education provider) can be a clinically effective and economically efficient way forward to achieve this.

Ethnicity/ Country of origin	Percentage of referrals
White British	55%
Dual Heritage	21%
Polish	5%
Afghan	2%
Kurdish	2%
Black African	2%
Iranian	1%
Iraqi	1%
Black Caribbean	1%
Black British	1%
Romanian	1%
British Asian	1%
Asian	1%
Vietnamese	1%
Bangladeshi	1%
British Pakistani	1%
Asian Pakistani	1%

Table 4 - Age at point of referral



Age at referral	Number of referral
0 – 5	21 (15%)
6 – 10	34 (24%)
11 - 15	62 (44%)
16 - 18	24 (17%)

There has been an increase in the number of referrals in the 11-15 age band. W we have not identified a clear reason for this, although we are aware that a number of children with complex presentations have moved back into the City in this age range from placements elsewhere.

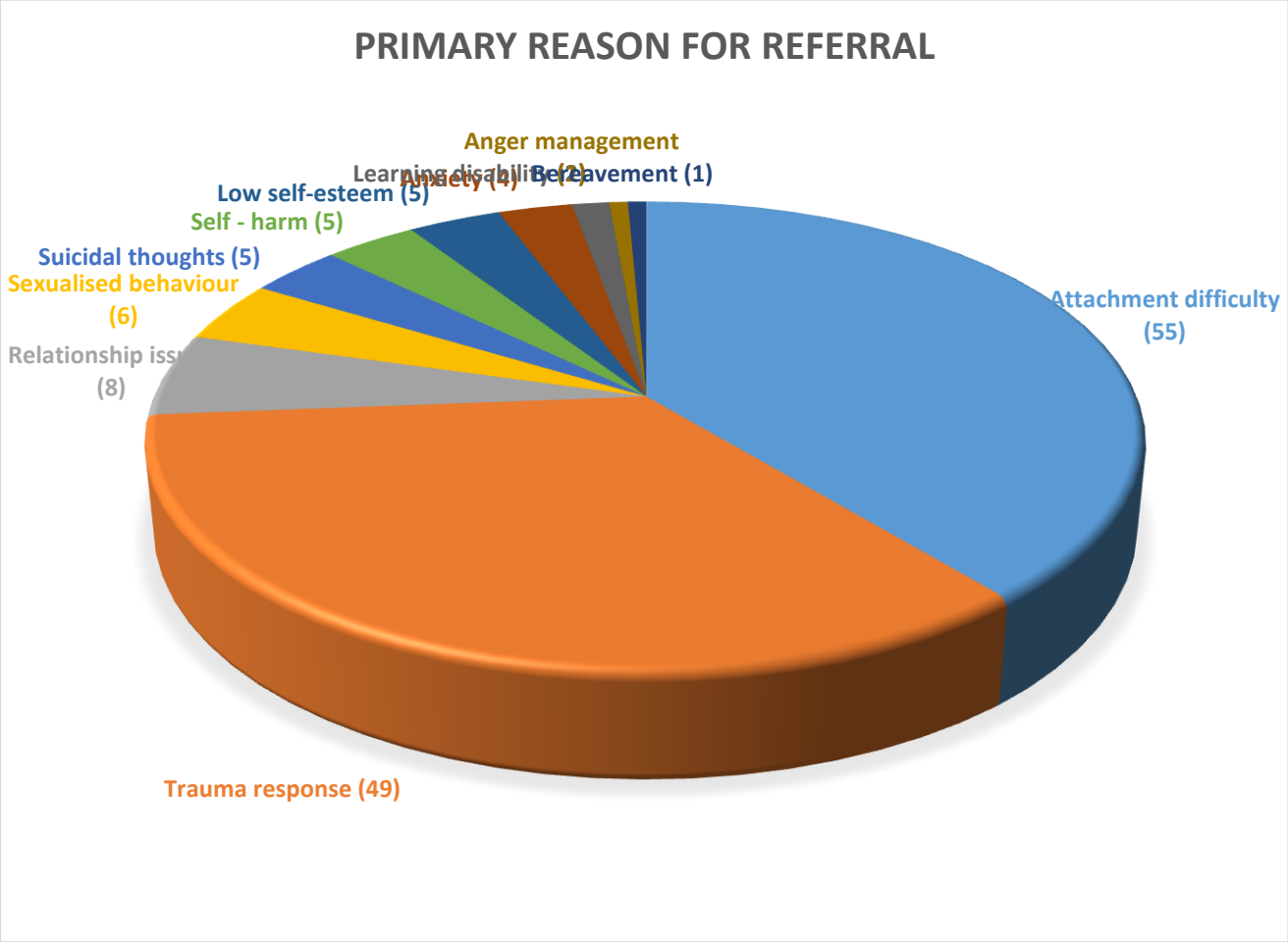
There have been slight decreases in the numbers of referrals made in the other age bands.

We have also had several referrals made ‘late’ to the service where children have been very close to 18 years; this can present some additional difficulties in ensuring smooth transition to AMHS (Adult Mental Health Service). This can be related to the age at which children come into care.

We continue to escalate through colleagues in Health those cases that become ‘stuck’ in transition to AMHS. There is a very clear process in place for this, but anecdotally, while the process appears to be embedding within wider CAMHS services, it is not always effective within AMHS. This is being explored with the Trust.

We are aware that there still need to be stronger links with the Leaving Care Service and this is another area for development over the next few months.

Table 5 – Primary reason for referral



Reason		
Attachment	55	(39%)
Trauma Response	49	(35%)
Relationship Issues	8	(6%)
Sexualised behaviour	6	(4%)
Suicidal thoughts	5	(4%)
Self - harm	5	(4%)
Low self-esteem	5	(4%)
Anxiety	4	(2%)
Learning disability	2	(1%)
Anger management	1	(Less than 1%)
Bereavement	1	(Less than 1%)

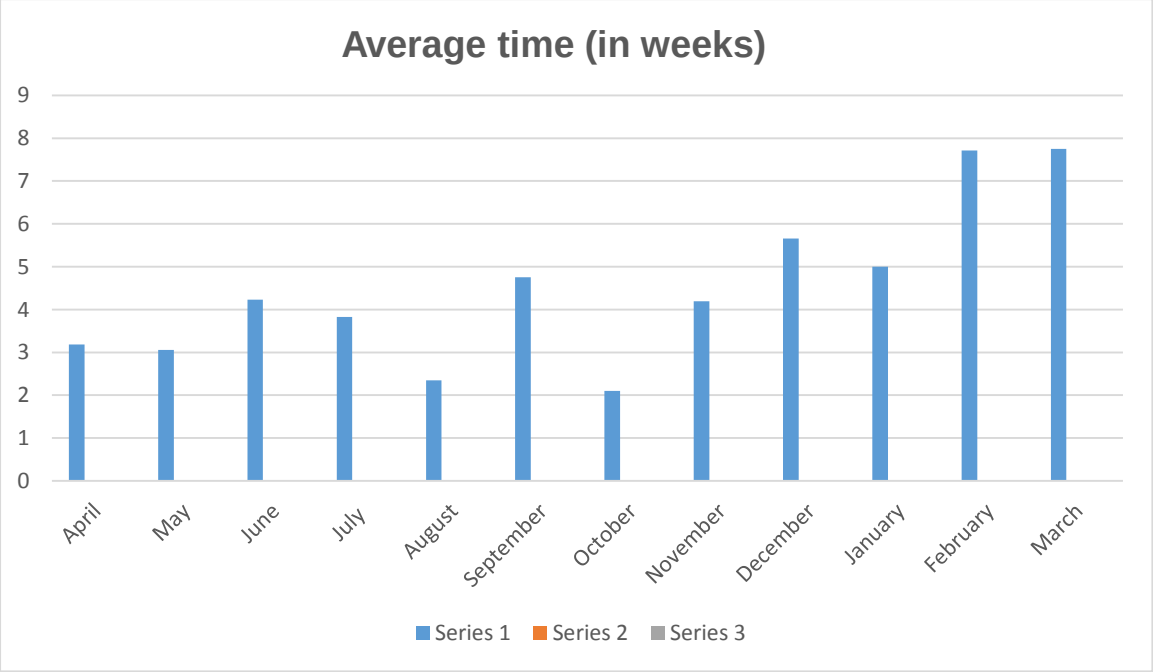
Consistent with previous years, the biggest reasons for referral remain ‘trauma’ and ‘attachment difficulty’. The categories given will never fully represent the range of issues we work with as often the underlying difficulties will only become clear after assessment. ‘Attachment difficulty’ and ‘trauma’ may also be used as a broad descriptor for other issues, for example, challenging behaviour, anger, low self-esteem, depression, personality difficulty, bereavement, anxiety etc.

Table 7 – Waiting time in weeks between referral and initial Choice Consultation.

Waiting have times have increased in 2019 because we experienced a sharp rise in referrals at the end of 2018 and because there have been staff vacancies for which we have only recently been able to begin the recruitment process. We believe that the increase in referrals at the end of 2018 was as a result of two actions taken by the CIS Leadership Team. The Director sought assurance from the CiC Service that all abnormal SDQ scores had resulted in a referral to the CAMHS CLA team and a series of restorative audits were completed by the Head of Service (Children's Duty and Targeted Services) and Acting Head of Service (Children in Care). To address capacity issues, interviews are taking place for 2 specialist social worker vacancies on 02.09.19.

In the interim, we have responded to this by changing the process for screening referrals to ensure these are prioritised more effectively and offering additional assessments on a duty basis to ensure urgent referrals aren't having to wait for long periods.

We have also been continuing to focus on thinking 'THRIVE' in supervision and through formulation with practitioners and making sure involvement with cases ends in a timely manner.



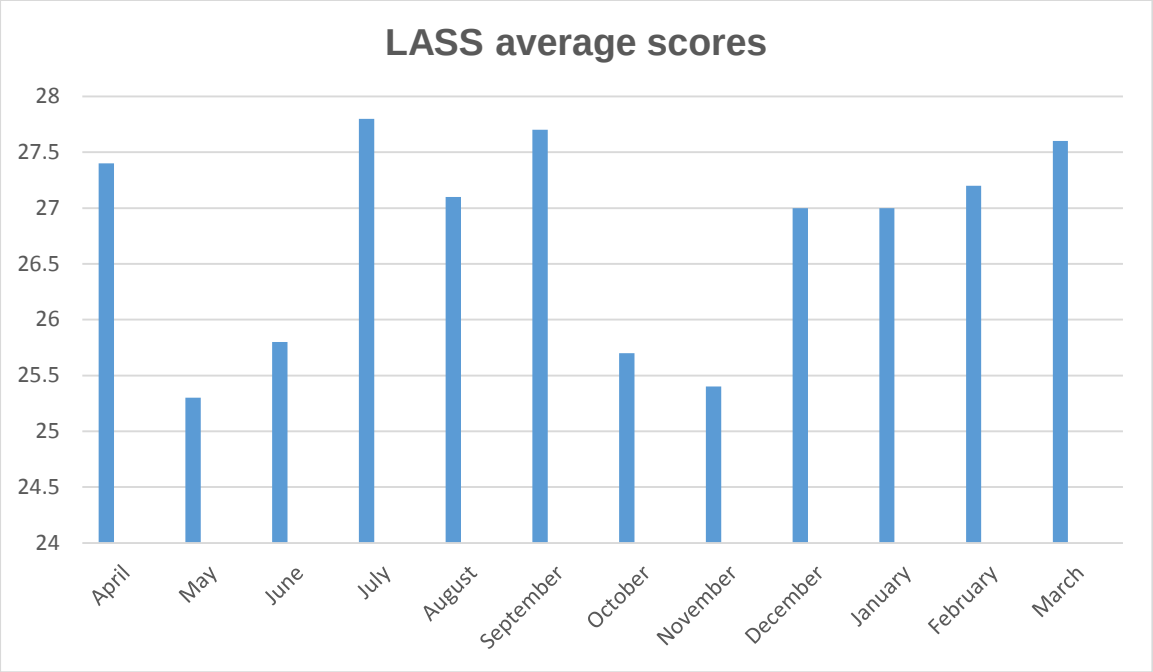
Month	Time (in weeks)
April 2018	3.18
May	3.06
June	4.23
July	3.83

August	2.35
September	4.75
October	2.1
November	4.19
December	5.66
January	5
February	7.71
March 2019	7.75

Table 8 – Supervision feedback

We use the Leeds Alliance in Supervision Scale (LASS) with supervisees in supervision where supervisees are asked to scale their experience of each supervision session across three domains: approach; relationship and meeting my needs. Scaling is out of 10 with 10 being 'this supervision session was focussed', 'my supervisor and I understood each other in this session' and 'this supervision session was helpful to me'. The scores for each domain add up to a total possible score of 30.

As can be seen from the scores below, for 8 months out of 12, the score has been on or above 27, and the lowest scores have been above 25.



Month	Average score for the month
April	27.4
May	25.3
June	25.8
July	27.8
August	27.1
September	27.7
October	25.7
November	25.4
December	27
January	27
February	27.2
March	27.6