City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Interim Assistant Director (Children's Social Care Improvement) to the meeting of the Corporate Parenting Panel to be held on 15th April 2019

Subject: **T**

EMOTIONAL AND MENTAL WELLBEING OF LOOKED AFTER CHILDREN

Summary statement:

Progress report on the CAMHS (Child & Adolescent Mental Health Service) Psychological Assessment and Therapy Team for Looked After and Adopted Children, including information on the allocation of the available finance

Anne Chester-Walsh
Interim Assistant Director (Children's Social Care Improvement)

Report Contact:
Dr Jennie Robb, Clinical Psychologist & Clinical Lead for CAMHS LAAC
Phone: (01274) 723241
E-mail: Jennifer.robb@bdct.nhs.uk

Portfolio:

Children & Families

Overview & Scrutiny Area:

Children's Services

1. Summary

Progress report on the CAMHS (Child & Adolescent Mental Health Service) Psychological Assessment and Therapy Team for Looked After and Adopted Children, including information on the allocation of the available finance.

2. Background

2.1 Introduction

The Psychological Assessment and Therapy team for Looked After and Adopted Children was established in November 2016 following recommendations outlined in the Future in Mind document and in line with NICE guidance (National Institute for Health & Care Excellence). The Specialist Team consists of dedicated, highly trained therapists who work with looked after, adopted and Special Guardianship Order children within the NHS Trust Boundaries of Bradford, Airedale, Craven, and Wharfedale. There has been a reduction in provision since July 2018, when the Local Authority Therapeutic Social Workers were redeployed from the team. The current functional clinical capacity is 4.6 WTE (Whole Time Equivalent).

2.2 Service Development and Clinical Capacity

In May 2016, health funding was agreed for £186,000 per year for 5 years in addition to the existing provision of 2.6 WTE Psychological Therapists, and three Local Authority Therapeutic Social Workers. These funds were used to create four new additional WTE posts. All Psychological Therapist posts are currently filled, and the effective clinical capacity is at 4.6 WTE (26% of that originally proposed).

The Team began operating at the beginning of November 2016. Service reviews were undertaken after six months of operation and one year. This review incorporates a comparison of the first two years of operation.

2.3 Document Overview

This document provides information about the second year of operation of the Service. Details are provided about the evolution of the team, the service model and the clinical work undertaken from 1st November 2017 to 31st October 2018. A comparison of the first and second years of service delivery is provided. Clinical work is divided into Direct Clinical Work and Indirect Clinical Work; where possible client demographics are provided along with baseline and outcome data for Direct Clinical Work. Indirect Clinical Work includes the Consultation Clinic for professionals and carers, and Consultation to Children's Homes.

2.4 Direct Clinical Work

1) Referrals and Waiting Time

Referrals for Direct Work can be made from Social Workers, School and LAC (Looked After Children) Nurses, and Paediatricians. The LAAC (Looked After and Adopted Children) Team received 118 referrals for direct work in

Year 2 compared with 126 referrals for the previous year. Referral outcomes are shown in Table 1.

Table 1. Referral Outcome for the LAAC Team

	1st November 2016 - 31st October 2017	1st November 2017 - 31st October 2018
Total Number of Referrals for Direct Work	**126**	**118**
Number of Referrals Accepted and Offered Initial Consultation	108	95
Referrals Not Accepted or signposted	18 (14%)	23 (19%)

All referrals for Direct Work (assessment or therapy) are now offered an initial consultation to support the carers and professional system and make recommendations in terms of future service involvement. Following the consultation, children are either added to the waiting list for assessment, offered a follow-up consultation or signposted elsewhere/discharged.

The average waiting time for consultation from referral between 1st November 2017 and 31st October 2018 was 49 days (see Table 2). This compares with 25 days for the previous year. The average wait from consultation to assessment for Year 2 was 171 days, compared with 113 days for the previous year. The increase in waiting times is due to higher demand for the Service and staffing issues which are discussed in more detail later in the review.

Table 2. Average waiting times to access input from the LAAC Team

	1st November 2016-31st October 2017	1st November 2017-31st October 2018
Average Waiting Time for Consultation (Days)	25	49
Average Waiting Time for Assessment from Consultation (Days)	113	171
Average Whole Time Equivalent (Clinical)	5.9	5.9

2) Assessment and Therapy

In total, 122 cases were open and seen by the LAAC Team between the 1st November 2017 and 31st October 2018. This compared with a total of 121 cases open in Year 1.

The total clinical contact for the year was 1561 sessions, comprising assessment (288), therapy (922) and client systemic work (351). Clinical capacity ranged from 4.6 to 7.3 WTE and this averages out at 5.9. Productivity was stable from Year 1 to Year 2 (Table 3.).

Table 3. Productivity for Direct Clinical Work

	1st November 2016-31st October 2018	1st November 2017-31st October 2018
Whole Time Equivalent	Ranged from 4.4-7.3	Ranged from 4.6-7.3
Average WTE for the year	5.9	5.9
Number of sessions that took place	1490	1561
Productivity	252	265
Number of open direct work cases	121	122
Number of cases per WTE	21	21

Assessment

During Year 2, 288 assessment sessions were completed by the LAAC team (Table 4). All data are displayed in Table 4 with a comparison with the previous year.

Therapy

During Year 2, 922 sessions were offered evidence-based therapy. In line with the NICE guidelines for working with Looked After Young People and those with Attachment difficulties (NG26, PH28), the therapies delivered were dominated by Therapeutic Parenting/parenting group (211), Dyadic Developmental Psychotherapy/Relational and DDP Informed Therapy (407) and Art Therapy (174).

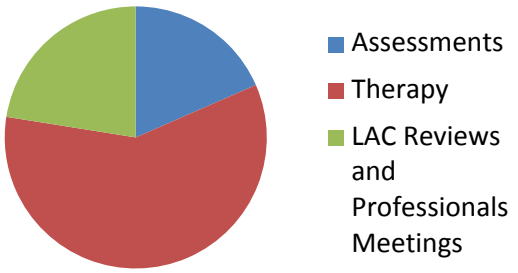
Client Systemic Work

There were 351 occasions when staff attended professionals' meetings and statutory LAC reviews, as well as Team Around the Child Meetings. This accounted for 22% of clinicians' direct work time over the course of the year.

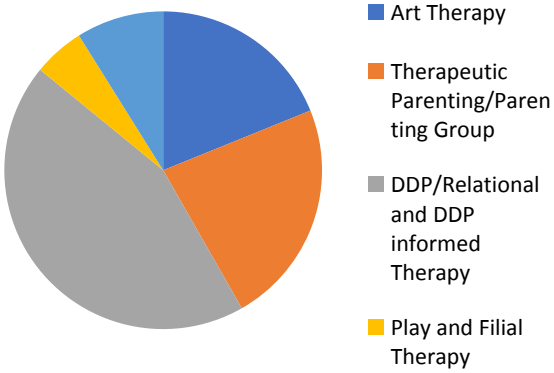
Table 4. Categories of Direct Clinical Work

	Year 1	Year 2
	No.	No.
Assessments	**241 (16%)**	**288 (18%)**
Assessments for Therapy	80	105
Cognitive Assessments	13	38
MIM (Marschak Interaction Method) Assessments	3	4
Story Stem Assessments	2	1
Other assessments, including home and school observations and liaison	143	140
Therapeutic Work	**820 (55%)**	**922 (59%)**
Art Therapy	123	174
DDP	74	145
Family Therapy	31	42
Filial Therapy	19	3
Relational and DDP Informed Therapy	163	262
Other	122	40

Play Therapy	123	45
Therapeutic Parenting	156	207
Therapeutic Parenting Group		4
Theraplay	9	0
Client Systemic Work Incl. TAC, EHCP, ongoing systemic support to school, LAC Reviews, Professionals Meeting	**429 (29%)**	**351 (22%)**
Total Sessions	**1490**	**1561**



Graph 1. Pie Chart displaying the distribution of different sessions completed by the LAAC team from the 1st November 2017 to the 31st October 2018



Graph 2. Pie Chart displaying the number of different therapy sessions completed by the LAAC team from the 1st November 2017 to the 31st October 2018

3) *Client Demographics*

Client demographics are recorded below for both Year 1 and Year 2 for all direct work cases. These include age, ethnicity, gender and care status. It should be noted that 81 cases that were open in Year 2 had been open the previous year.

Age

It can be seen from table 5, below, that the majority of direct work cases across the two years were of school age, with a relatively even split between primary school age and high school age. Only 2% of referrals were for children under 5 years for both years, and approximately a fifth (23% in year 1 and 20% in year 2) were for children post-16.

Table 5. Age Distribution of Direct Work cases (Nov 2016-Oct2017 and Nov 2017-Oct 2018)

	Nov 2016-Oct 2017		**Nov 2017-Oct 2018**	
	Number of open cases	Percentage (%)	Number of open cases	Percentage (%)
Under 5 years	2	2	2	2
5-11 years	46	38	48	39

11-15 years	45	37	48	39
16-19 years	28	23	24	20
Total	121		122	

Ethnicity

The categories for ethnicity were restricted to those detailed in Table 6. The majority of direct work cases were White British (76% in Year 1 and 84% in Year 2). The remaining were distributed between White Other (2-3%), Mixed – White/Black (2-3%), Mixed – White/Asian (7 and 4%), Mixed Other (2-3%), Asian or Asian British (7 and 4%) and Black or Black British (1-2%).

Table 6. Ethnicity of Direct Work Cases (Nov 2016-Oct 2017 and Nov 2017-Oct 2018)

	Year 1		Year 2	
	Number	Percentage (%)	Number	Percentage (%)
White British	93	76	103	84
White Other	4	3	2	2
Mixed – white & Black	4	3	3	2.5
Mixed –white & Asian	8	7	5	4
Mixed Other	2	2	3	2.5
Asian or Asian British	8	7	5	4
Black or Black British	2	2	1	1
Total	121		122	

Gender

The number of male Direct Work Cases increased from 53% to 62% in Year 2.

Table 7. Gender of Direct Work Cases (Nov 2016-Oct 2017/Nov 2017-Oct 2018)

	Year 1		Year 2	
	Number	Percentage (%)	Number	Percentage (%)
Male	64	53	76	62
Female	55	45	44	36
Transition	2	2	2	2
Total	121		122	

Care Status

There was a notable shift in Care Status with fewer children on Special Guardianship Orders and more adopted children entering the Service.

Table 8. Care Status of Direct Work Cases (Nov 2016-Oct 2017/Nov 2017-Oct 2018)

	Year 1		Year 2	
	Number	Percentage (%)	Number	Percentage (%)
Looked After	67	56	64	52

Adopted	27	22	39	32
Special Guardianship Order	27	22	19	16
Total	121		122	

Out of Authority Placements

Due to the loss of the Therapeutic Social Workers in July 2018, a decision was made to only accept Bradford Looked After children into the Service. Non-Bradford Looked After children continued to have access to Core CAMHS where appropriate and those already open to therapists continued to receive a service.

4) Baseline and Outcome Data

Baseline data were collected for young people attending the service for assessment and/or therapy. This was comprised of the following:

- Strengths and Difficulties Questionnaire (Parent Form) (Goodman, 1997, 1999)
- Strengths and Difficulties Questionnaire (Young Person's Form) – if over 11 years (Goodman, 1999; Goodman, Meltzer, & Bailey, 1998)
- Assessment Checklist for Children (ACC) (Tarren-Sweeney, 2007) or Assessment Checklist for Adolescents (Tarren-Sweeney, 2013).
- Carer Questionnaire (Golding & Picken, 2004; Granger, 2008).

After six months of intervention, the questionnaires were reissued, and the data collected and analysed. As the body of data accumulated, it was possible to look at the baseline scores for those entering the service. Data across Year 1 and Year 2 indicated that the population of children referred to the Service showed a high percentage of clinical levels of difficulties as measured by the SDQ (Strengths & Difficulties Questionnaire) and the ACC/ACA (81%, 88% and 87% respectively) (Tables 9, 10 and 11). A reduction in clinical difficulties was observed across the SDQ and the ACC/ACA following intervention. This is also recorded in tables 9-11.

Table 9. Pre and Post-Intervention scores on the SDQ

VH = Very High, H = High, SR = Slightly Raised

	Average score Pre-Therapy (n=42)	**Percentage at Clinical Levels Pre-intervention**	**Average score Post-Intervention (n=56)**	**Percentage at Clinical Levels Post-Intervention**
Conduct Difficulties	4.8 (H)	74	4.5 (H)	74
Emotional Difficulties	5.8 (H)	57	3.9 (SR)	45
Hyperactivity	7.3 (SR)	62	6.5 (SR)	69
Peer Relationships	4.9 (VH)	71	4.2 (H)	55
SDQ Total Score	22.9 (VH)	81	19 (H)	76
Pro-Social	5.3 (VH)	29	5.4 (VH)	29

Behaviour				
Impact Score	5.1 (VH)	90	5.1 (VH)	93

Post-intervention, the impact of therapeutic intervention appears to have been in reducing Emotional Difficulties, Peer Relationships Difficulties and overall difficulties scores. This shows positive outcomes but clinical levels of difficulties, although improved, remained elevated when compared to the general population. Also, the impact of difficulties on the child and family's life was not altered in terms of the Impact Score on the SDQ.

Table 10. Pre and Post-Intervention scores on the ACC

	Percentage at Clinical Levels Pre-Intervention	**Percentage at Clinical Levels Post-Intervention**
Sexual	18	13
Pseudomature	71	53
Non-Reciprocal	65	55
Indiscriminate	47	38
Insecure	76	63
Anxious-Distrustful	53	23
Abnormal Pain Response	12	10
Food Maintenance	47	20
Self-Injury Index	41	20
Pica Index	29	15
Suicidal Discourse	35	33
Total Clinical Score	88	70

There were fewer cases with overall scores at a clinical level after intervention (70% post-intervention compared to 88% pre-intervention). Furthermore, the number of young people presenting with Self-Injury that was at a clinical level halved from 41% to 20%. There were also significantly fewer clinical levels in terms of the attachment difficulties subscales (i.e. Pseudomature, Non-Reciprocal, Indiscriminate, Insecure and Anxious-Distrustful).

Table 11. Pre and Post-intervention scores on the ACA

	Percentage at Clinical Levels Pre-Intervention	**Percentage at Clinical Levels Post-Intervention**
Non-Reciprocal	53	58
Social Instability	67	52
Emotional Dysregulation	87	65
Trauma Symptoms	33	29
Maintenance behaviours	13	13
Sexual Behaviour	13	10
Suicidal Discourse	60	27
Total Clinical	87	69

Score		

As with the ACC, there were significant reductions in clinical scores post-intervention, with 69% at clinical levels overall, compared to 87% at assessment.

In terms of the Carer Questionnaire, a sample of 28 questionnaires were completed pre-therapy. A higher score represents a carer with a better perception of the relationship with the child. Therefore, the hope would be that the scores would increase following intervention. A small increase was observed post therapy (Table 12).

Table 12. Average scores on the Carer Questionnaire completed Pre-Intervention compared with Post-Intervention

	Pre-Therapy Scores (n=28)	**Post-Therapy Scores (n=55)**
Parent Skills and Understanding	28	30
Parent-Child Relationship	21	22
Child responsiveness to care	19	19
Placement Stability	8	8
Total	**84**	**88**

5) Additional CAMHS Work

The data presented above is purely for the work of the CAMHS LAAC Psychological Therapy Team. It does not encompass all work with Looked After and Adopted Children and Children on Special Guardianship Orders that is carried out in CAMHS. Child and Adolescent Psychoanalytical Psychotherapists, for example, have therapy cases comprised of roughly 33% Looked After and Adopted Children. All referrals of significant self-harm and parasuicide or otherwise of an urgent concern are responded to by the Urgent Team in the first instance and risk tends to be managed by this team, at least until a case can be picked up for therapeutic input by the LAAC team. Specific requests for Autism or ADHD assessment are processed by the neurodevelopmental teams in CAMHS.

2.5 Indirect Clinical Work

1) Consultation Clinic

The consultation clinic can be accessed by any professional or carer working with a looked after child, an adopted child, or a child on a Special Guardianship Order (SGO). The team offer four consultation slots per week, across Fieldhead and Hillbrook. These take place over an hour and a half and are usually offered by two members of the CAMHS-LAAC team. Consultations offer an opportunity to think in depth about a child's difficulties or presentation, reflect on a child's experiences and early development, and draw on psychological expertise. They can also be utilised to think about the

network of care around a child and to consider plans for the child with regard to home and school placements and psychological therapy needs.

Clinicians provide a written summary on the consultation for all attendees and all attendees are asked to complete a feedback form at the end of every consultation.

Table 13. shows a comparison of the consultations that took place in Year 1 and Year 2.

Table 13. Consultation Clinic Data

	1st Nov 2016 – 31st Oct 2017	**1st Nov 2017 – 31st Oct 2018**
No. of consultations attended	**130**	**133**
No. of consultations cancelled	27 (17% of the total booked)	40 (23% of the total booked)
No. of cases discussed in Consultation Clinic	121	127
No. of cases attended for a second consultation	9	13
Total number of professionals and carers who attended	297	304
No. of consultations that led to Direct Clinical Work	59 (49%)	64 (48%)
No. of cases that were held at a consultation level	62 (51%)	69 (52%)

There was consistency overall with roughly 130 consultations taking place and a similar number of cases discussed. Cancellations increased, and it is hypothesised that this may be due to the increased wait for consultations which reached 136 days (see Table 14.) during periods of minimal clinical capacity. The consultation model is designed to be responsive and timely, to meet the needs of a professional network at a time of crisis or when it is at its most challenged. A wait of more than four weeks is inadequate in terms of meeting this need as the difficulty may have led to placement breakdown or further developments by the time support is offered. That said, there continued to be approximately 50% of cases held at the consultation level. This is a highly effective service at responding to cases where assessment and therapy may not be indicated but psychological knowledge, reflection and formulation can be of benefit.

Table 14. Average wait for consultation

	Year 1	Year 2
Average wait (days)	25	49

Evaluation and Feedback

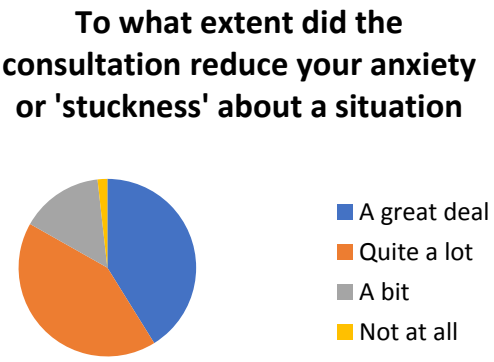
Consultees were asked to complete a feedback form at the end of each consultation (See Appendix 2). The form consists of four rating scales, ranging from 'a great deal' to 'not at all' answering the questions: 'Did the consultation give you the opportunity to discuss what you wanted?'; 'To what extent did the consultation reduce your anxiety or 'stuckness' about a situation?'; 'To what extent did the consultation increase your confidence in your ability to manage the situation?'; and 'How satisfied were you with the consultation?'

Over the whole year, 228 (75%) feedback forms were collected from a total of 304 attendees. The previous year, 218 (73%) feedback forms were collected from a total of 297 attendees. Of the 228, all (100%) felt that they had the opportunity to discuss what they wanted either a great deal or quite a lot. This was a slight increase from the previous year (96%).

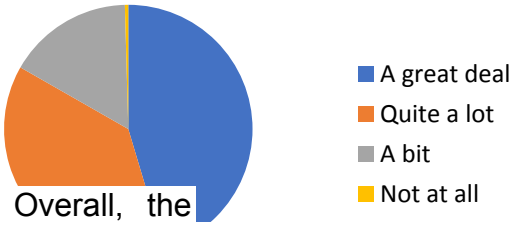
One hundred and eighty eight out of 228 (83%) felt that the consultation reduced their anxiety or 'stuckness' about a situation a great deal or quite a lot. Fifteen percent of individuals felt that the consultation had helped reduced their anxiety of 'stuckness' about a situation a bit and 2% no change. Compared to the previous year, 86% reported a great deal or quite a lot, so there was a small decrease, and small increase in the number of attendees reporting a bit (12% in Year 1), and those that felt that the consultation did not reduce their anxiety or 'stuckness' about a situation remained the same (2%).

In year 2 the same number of people (83%) who attended the consultation increased their confidence in their ability to manage the situation a great deal or quite a lot. Sixteen and one per cent felt that it increased their confidence in their ability to manage the situation a bit and not at all, respectively.

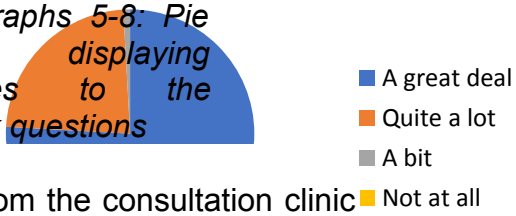
All attendees, as with the first year, were satisfied with the consultation either a great deal (76%), quite a lot (23%), or a bit (1%).



To what extent did the consultation increase your confidence in you ability to manage the situation



Did the consultation give you the oppurtunity to discuss what you wanted?



Graphs 5-8: Pie charts displaying responses to the feedback questions

Overall, the feedback from the consultation clinic has remained positive and thus upportive of the consultation model. The waiting time has doubled between year 1 and year 2, and it is hypothesised that this has had an impact on attendance.

2) *Children's Home Staff Consultation*

Consultations were offered monthly to all eight mainstream Local Authority Children's Homes in Bradford District until the development of the Be Positive Pathway in 2018, which recruited psychologists and other health professionals to three specialist homes. Since that time, Children's Home consultation has been offered to those not receiving a service from BPP (B Positive Pathways) (i.e. Owlthorpe, The Hollies, Rowan House, Sky View) and also to Far Shay Farm, a supported accommodation for Care Leavers. Group Supervision for this work takes place monthly with the Lead Psychological Therapist in CAMHS. The team of consultants to the Local Authority Children's Homes is comprised of LAAC team members as well as Child and Adolescent Psychoanalytical Psychotherapists.

3) *Consultation to LAC Social Work Teams*

Prior to the redeployment of the Therapeutic Social Workers, consultation to LAC Social Workers took place monthly at Sir Henry Mitchell House. These 30-minute consultation slots offered an opportunity for the screening of cases that might need a direct referral into the LAAC Team. They were also an opportunity to offer support and advice at a general level. The consultations were organised and co-ordinated by the LAC Social Worker, Therapeutic Social Worker and Family Therapist. When a more in-depth consultation was required to think psychologically about a child's presentation or issues within the system around the child, social workers were encouraged to book into the CAMHS-LAAC Consultation Clinic (described above).

This service is no longer available through the CAMHS-LAAC team but it is understood that Therapeutic Social Workers will offer a similar approach described as Therapeutic Thinking Time in their new roles. The interface between this Service and the CAMHS-LAAC team remains in development.

4) *Service Development and Across Agency Support*

Liaison across Bradford Children's Social Care and CAMHS has been maintained since the early stages of development through the Clinical Lead, and the Team Manager, attending Through Care Strategy Meetings, the Corporate Parenting Panel, DDP implementation groups, meetings with the Adoption Service Manager

and SGO Team, and regular meetings with the Residential Service Manager. Due to sickness, another worker undertook the Team Manager role from November 2017 and remains in this role. In addition, Clinical Lead, has contributed to the Innovation Project, B Positive Pathways, through advice, liaison and support to recruitment. As part of the B Positive Pathways Project, Clinical Lead will continue to offer two hours a week clinical supervision to the Clinical Psychologists in these teams. The Team Manager will be responsible for the NHS management role for the BPP health professionals from April 2019. The Lead Psychological Therapist in CAMHS has attended the pre-Joint Review Panel (JRP) meeting fortnightly and will continue to do so in order to aid decision making about jointly funded placements for young people.

2.6 Waiting List Initiatives and Service Planning

With the increasing demand on the service and the reduction in capacity, two waiting list initiatives were developed in Autumn 2018 – A Therapeutic Parenting Group and A Family Assessment Clinic.

1) Therapeutic Parenting Group

The Therapeutic Parenting Group ran for eight sessions (2½ hours long) in Autumn 2018, with an additional review session in January 2019 and individual follow-ups with carers. Three members of the team facilitated this group and it was comprised of psychoeducation based on attachment and PACE, also a support element with a focus on carers own mental wellbeing, trouble shooting of particular challenges and the needs of children with developmental trauma in schools. The group was attended by carers of six families who had 11 children between them. Before and after measures were used to assess the effectiveness of the group and average scores are reported in Tables 15 and 16. The overall SDQ score reduced slightly for all children with the exception of one and the average score overall also reduced. There was little difference noted on the ACC/ACA. The greatest change was captured by the Carer Questionnaire, all carers showed an increase in their total score after the group, indicating greater skills and understanding and that their children were more responsive to their care.

Table 15. Average Total SDQ and ACC/ACA scores pre and post-therapeutic parenting group

	Pre-group Intervention	Post-group Intervention
SDQ Average Total Score	21	17
ACC Average Total Score	39	39
ACA Average Total Score	50	48

Table 16. Average Scores on the Carer Questionnaire pre and post-therapeutic parenting group

	Pre-Group Intervention	Post-Group Intervention
Parent Skills and	29	33

Understanding		
Parent-Child Relationship	26	26
Child responsiveness to care	22	24
Placement Stability	10	10
Total	95	102

Of the families involved in the Therapeutic Parenting Group, one went on to longer-term therapy, two were offered short-term interventions (1-3 sessions) and the rest were discharged or signposted elsewhere. The success of this pilot group led to a later decision that this would be incorporated into our core offer as a team.

2) Family Assessment Clinic

Those families at the top of the waiting list who were identified as not appropriate for the parenting group and requiring assessment were accepted into the family assessment clinic. The offer was of three assessment appointments over three months with a review and further assessment or intervention appointments offered as appropriate. This initial three appointments were a combination of observations, carer appointments and creative family appointments. This was an efficient use of time with targeted assessment appointments involving 2-3 clinicians. A formulation meeting with clinicians only followed the first three appointments and a plan for intervention or discharge was made at this stage.

Following this new approach to assessment with three targeted assessment appointments over a period of three months, a decision was made that this efficient assessment process could become an appropriate addition to streamlining the service, screening and signposting and informing the process of planning for intervention.

2.7 Training and Supervision of the Team

All new clinicians undertook a period of induction where they observed and shadowed existing clinicians. Supervision is structured according to the professional requirements and needs of each clinician, and meetings with each team member and the Clinical Lead and Team Manager take place every 4-6 weeks. Supervision by an accredited Dyadic Developmental Psychotherapist had previously been recognised as a significant gap in supervision provision. This was commissioned on a monthly basis from September 2017 and two therapists in the team are currently working toward accreditation in this therapy.

In September and October 2018, all clinicians in the team who had not completed the Dyadic Developmental Psychotherapy training, attended Level 1 of the course in Bromsgrove. Consideration will be given to the next developmental stage in terms of Level 2 for these team members.

The Play Therapist, completed training in the Story Stem Assessment Profile in January 2018 and her accreditation has been held up due to maternity leave.

Clinical Lead and one of the LAAC Team Members have attended Sensory Integration training in February 2018.

2.8 Additional funding is requested from Health & Social Care Commissioners in order to expand the current services to encapsulate the offer as set out below;

1. To continue to offer quality, specialist, psychological assessments of looked after and adopted children with mental health and relational difficulties due to developmental trauma and loss, but without a significant wait and with the ability to fulfil recommendations for a range of evidence-based therapy in a timely way

2. To continue to offer therapeutic parenting groups to the most vulnerable carers

3. To continue to offer the consultation service, and to extend this, doubling the number of slots available and reducing the wait to less than 4 weeks, to meet current demand

4. To additionally offer Dialectical Behaviour Therapy (DBT) groups to adolescents and care leavers with emotional regulation difficulties and risk of self-harm and sexual exploitation

5. To offer urgent consultation appointments to carers and professionals where the placement is at immediate risk of breakdown and co-ordinate this with the work of placement support and B Positive Pathways. This is a regular request from Through Care Social Workers.

6. To offer longer term therapy where this is indicated (both clinically and through NICE guidance) as well as short term options

7. To develop the Service to extend to joint assessment clinics with Community Paediatricians where Foetal Alcohol Spectrum Disorder is indicated, and follow-up diagnosis with support to families and their children.

8. To additionally offer sensory integration and sensory developmental assessments where indicated. There are frequent requests from social workers and schools for these assessments and they should form part of a comprehensive assessment of children who are neurodevelopmentally compromised through in utero exposure to drugs and alcohol.

9. In order to offer such a service the following is required in addition to the current provision:

    - 3 WTE Band 8a Psychological Therapists (including. at least 1 Clinical Psychologist and 1 Creative Therapist)

    - 4 WTE Band 7 Psychological Therapists (including. at least 1 Clinical Psychologist and 1 Creative Therapist)

    - 1 WTE Band 7/6 Occupational Therapist

- 4 WTE Band 6 – keyworkers
  - 2 therapeutic Social Workers
  - 2 CPNs interested in therapy/psychology

- 1 WTE Band 5 Occupational Therapist

- 1 WTE Band 5 Assistant Psychologist

- 1 WTE Band 3 Administrator

CONCLUSIONS

This review demonstrates that whilst referral rates remained consistent across the two years, the service became saturated with longer-term complex cases and a reduction in capacity. This meant that waiting times for consultation lengthened from 4 to 9 weeks, and the wait for assessment and therapy exceeded 12 months.

Productivity was consistent when analysed according to Whole Time Equivalents, with an average of 21 cases per WTE. One hundred and twenty-two cases were open during the second year of operation and 133 consultations were attended.

Feedback from consultations continued to be very positive, although cancellation rates increased, perhaps due to the longer wait.

Baseline and outcome measures highlighted that the children referred to the service had a very high level of mental health difficulties and distress. This was reduced following intervention and carers perception of their relationship with the child improved.

The Therapeutic Parenting group was developed to support some of those who had waited longest for assessment. This had successful outcomes in terms of carer understanding and child responsiveness to care. A decision was made to include this group in our core offer.

The Family Assessment Clinic allowed us to pilot a focused multi-disciplinary three-session assessment with formulation and planning for intervention. This was identified as a streamlined, efficient and containing approach to cases referred and will influence assessment models in the future.

Despite the success of the service in terms of outcomes and service user experiences, the lack of capacity remains a stark reality that prevents the service from meeting the mental health needs in a timely way for some of the most vulnerable children and families. Recommendations follow, and these have been shared with commissioners in the form of a business plan to develop the service further.

3. OTHER CONSIDERATIONS

N/A

4. FINANCIAL & RESOURCE APPRAISAL

N/A

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

N/A

6. LEGAL APPRAISAL

N/A

7. OTHER IMPLICATIONS

N/A

8. NOT FOR PUBLICATION DOCUMENTS

N/A

9. OPTIONS

See Recommendations below.

10. RECOMMENDATIONS

10.1 That the Interim Strategic Director of Children's Services be recommended to request additional funding from Health & Social Care Commissioners in order to expand the current services to encapsulate the offer as set out in 2.8.

11. APPENDICES

N/A

12. BACKGROUND DOCUMENTS

N/A