APPENDIX 1

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CAMHS Psychological Assessment and Therapy Team for Looked After and Adopted Children

Annual Service Review (November 2017-October 2018)

Document completed: 31st January 2019

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Summary and Recommendations

Service Capacity

- The original proposal requested **18 WTE (Whole Time Equivalent)** posts; 12 WTE Psychological Therapists (Health funded) and 6 WTE Therapeutic Social Workers (CSC funded)

- From the funding agreed, a team was created comprised of 5.6 WTE Psychological Therapists, 1.7 WTE Therapeutic Social Workers and 1 WTE Assistant Psychologist. A total of **8.3 WTE** posts

- In February 2018, CSC decided take all their funded posts back to local authority governance and out of the LAAC team. Capacity was thus reduced to **6.6 WTE** posts

- By the end of this period of review, the functional clinical capacity of the team was **4.6 WTE**

Service Model

- A model was developed with three main elements to the work:

    - A consultation clinic – offering four sessions per week, with no threshold and equal access to all
    - Consultation on a monthly basis to all Local Authority Children's Homes teams
    - Direct work – assessment and therapy

- The consultation clinic was a new way of working that has been found to be effective in a number of ways. Attendance has been high, and feedback from professionals and carers who have attended has been extremely positive

- The consultation clinic has been effective in managing 51% of cases referred to the team in this way, averting the need for more intensive assessment and therapy

- Direct work has taken place through assessment and therapy but the demand for this is extremely high. Work often needs to be long-term (in excess of 12 months) and intensive, often requiring two members of the multi-disciplinary team to co-work a case

Demand, Waiting Times and Waiting List Initiatives

- For the first year of operating, consultation appointments could generally be offered within **a month** of referral

- In year two, the average wait for consultation appointments was 9 weeks

- Waiting times for direct work were on average **9 weeks** within the first 12 months of operating, but rose to **exceed 12 months** in year two

- To manage the significant wait in for assessment and therapy, two waiting list interventions were devised – a therapeutic parenting group and an assessment clinic

- The success of these strategies has led to them being incorporated into the service offer

Outcome Measures

- Psychometric measures taken at initial assessment indicate that the population of young people referred for direct assessment and therapy have very high levels of mental health needs. SDQs indicate elevated (clinical) levels for 81% of those cases referred

- The direct work of the team has been shown to be effective. The percentage of cases following intervention with total difficulties scores at a clinical level was 76% (81% at baseline). However, the average score was still elevated beyond 'normal' levels.

- On the ACC, baseline clinical levels were at 88% and post-intervention clinical levels were at 70%. Similarly, the scores on the ACA were 87% at baseline and 69% post-intervention.

- Outcomes measured using the carer questionnaire showed that carers overall scores improved after intervention from 84 to 88.

Recommendations

- The team requires greater capacity to meet the demand of the looked after, adopted and SGO population of Bradford District. Analysis of need and capacity concluded that 15 additional WTE posts, with a combination of Psychologists, Creative Therapists, Occupational Therapists, Community Psychiatric Nurses, Therapeutic

Social Workers and Assistant Psychologist, with Bands ranging from 5-8a are required.

Contents

A. Introduction

A proposal for a 'New Health and Emotional Well-being Team for Young People Looked After and Adopted' was completed by the CAMHS Psychological Therapies Lead, Ben Lloyd, in April 2016. This was devised based on the recommendations outlined in the 'Future in Mind' (DoH, 2015) document with a focus on care for the most vulnerable in terms of mental health needs, and in order to improve access to the most effective, specialist support when it is needed. NICE guidelines for Looked After Children and Young People (2010, PH28) also recommended 'dedicated services to promote the mental health and emotional wellbeing of children and young people in care' and a focus of the Bradford Safeguarding Children's Board Looked After Strategy (2014-2016) was to improve access to emotional and behavioural support for Looked After Children. Additional NICE guidance for Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care (2015, NG26) was further used to structure the service in terms of consultation, assessment and therapeutic intervention.

In Bradford district in March 2018, there were 986 Looked After Children, approximately 500 Adopted Children and 500 Children on Special Guardianship Orders. The number of Looked After Children has been steadily increasing. The service was set up to respond to the high level of need in terms of mental health difficulties in this population. Ten percent of non-looked-after and non-adopted young people have a recognised mental health need. However, research indicates that this figure for children who are, or who have been, looked-after is between 45% - 72% (NICE, 2015). This cohort of young people typically do not respond well to behavioural approaches and usually require a more psycho-developmental approach to their clinical management, with close liaison with other professional services and a comprehensive understanding of processes at a systems, as well as an individual, level.

The proposal was to develop a specialist team of dedicated, highly trained therapists with a formalised governance structure and a sufficient whole-time equivalent to operate efficiently and respond to the high level of need within the NHS Trust Boundaries of Bradford, Airedale, Craven, and Wharfedale. **An appraisal of likely demand led to a request for 12 WTE Psychological Therapist posts and 6 WTE social worker posts.; a total of 18 WTE posts.** The actually provision and funding agreed is described below.

B. Service Development and Clinical Capacity

Funding was agreed for £186,000 per year for 5 years in addition to the existing provision of 2.6 WTE Psychological Therapists. These funds were used to create four new additional WTE posts. Alongside this, Children's Social Care agreed to the redeployment of 2.8 WTE Therapeutic Social Workers into the team from generic CAMHS. Psychological Therapists were recruited incrementally and by September 2017, all new posts were filled providing a Psychological Therapist WTE of 5.6, an Assistant Psychologist (1 WTE) and Therapeutic Social Workers WTE of 1.7; a total of 8.3 WTE posts (46% of that originally proposed). A further reduction in clinical capacity occurred in July 2018, when all Therapeutic Social Worker posts were redeployed back to Social Care bases. In addition, a full-time member of the team left for maternity leave in June 2018 and there was also a degree of staff turnover within the year, with posts vacant for a number of months. By October 2018, all Psychological Therapist posts were filled, and the effective clinical capacity was 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.

C. 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.

D. Direct Clinical Work

1) Referrals and Waiting Time

Referrals for Direct Work can be made from Social Workers, School and LAC Nurses, and Paediatricians. The LAAC 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

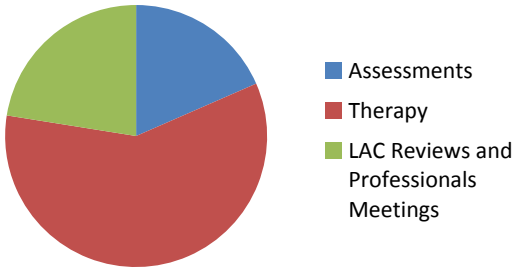
There were 351 occasions when staff attended professionals' meetings and statutory LAC reviews, as well as Team Around the Child Meetings. This accounted for 22% of clinicians' direct work time over the course of the year.

Table 4. Categories of Direct Clinical Work

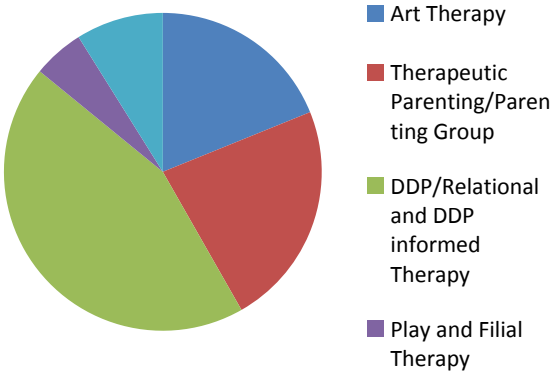
	Year 1	Year 2
	No.	No.
Assessments	**241 (16%)**	**288 (18%)**
Assessments for Therapy	80	105
Cognitive Assessments	13	38
MIM Assessments	3	4
Story Stem Assessments	2	1
Other assessments, including home and school observations and liaison	143	140
Therapeutic Work	**820 (55%)**	**922 (59%)**
Art Therapy	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**

Cancelled Appointments

In Year 2, 231 (13%) appointments for Direct Work were cancelled by clients or other professionals. In some cases, this led to a review of the therapeutic offer from weekly to fortnightly. However, there is still a significant number of appointments that were not attended and therefore impacted on the efficiency of the Service. The cancellation rate for Year 1 was 250 (14%). The cancellation rate for this population was stable across the two years.



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 collect 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 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 Behaviour	5.3 (VH)	29	5.4 (VH)	29
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 Score	87	69

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.

E. 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

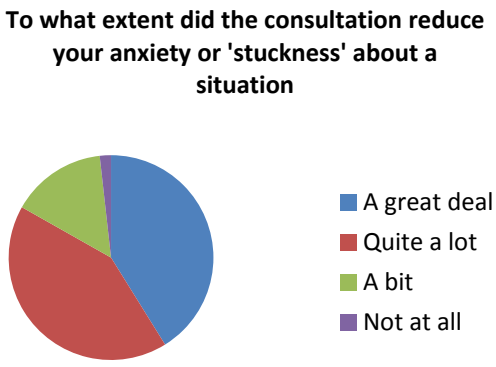
Consultees were asked to complete a feedback form at the end of each consultation (See Appendix 2). The form consists of four rating scales, ranging from 'a great deal' to 'not at all' answering the questions: 'Did the consultation give you the opportunity to discuss what you wanted?'; 'To what extent 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?'

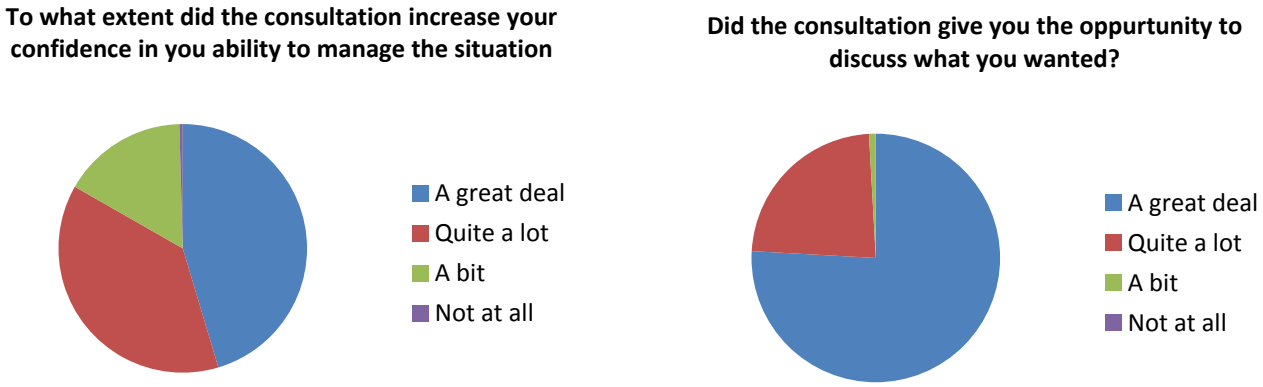
Over the whole year, 228 (75%) feedback forms were collected from a total of 304 attendees. The previous year, 218 (73%) feedback forms were collected from a total of 297 attendees. Of the 228, all (100%) felt that they had the opportunity to discuss what they wanted either **a great deal** or **quite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





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

Overall, the feedback from the consultation clinic has remained positive and thus supportive 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 (i.e. Owlthorpe, The Hollies, Rowan House, Skye View) and also to Far Shay Farm, a supported accommodation for Care Leavers. Group Supervision for this work takes place monthly with Ben Lloyd (Lead Psychological Therapist in CAMHS). The team of consultants to the Local Authority Children's Homes is comprised of LAAC team members, Sarah Butcher, Jennie Robb, Deborah Lloyd and Tom Matthews, as well as Child and Adolescent Psychoanalytical Psychotherapists, Jo Higgins and Barnaby Rhodes.

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 Mussarat Hussain, LAC Social Worker, and Sally Chance, 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 Dr Jennie Robb, Clinical Lead, and Lindsey Calpin, 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, Caroline McCormick undertook the Team Manager role from November 2017 and remains in this role. In addition, Jennie Robb, has contributed to the Innovation Project, Be Positive Pathways, through advice, liaison and support to recruitment. As part of the Be Positive Pathways Project, Jennie Robb will continue to offer two hours a week clinical supervision to the Clinical Psychologists in these teams. Caroline McCormick will be responsible for the NHS management role for the BPP health professionals from April 2019. Ben Lloyd 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.

F. 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 and the work of Kim Golding, Sarah Neish and Dan Hughes, 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 14. 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 Understanding	29	33
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.

G. 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 with Julie Hudson and Kim Golding. Consideration will be given to the next developmental stage in terms of Level 2 for these team members.

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

Jennie Robb and Sarah Butcher attended Sensory Integration training in February 2018.

H. Conclusions

This review demonstrates that whilst referrals 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 waiting longest for assessment. This had successful outcomes in terms of carer understanding and child responsiveness to care. A decision was 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.

I. Recommendations

Additional funding should be requested from health and social care commissioners in order to expand the current service to encapsulate the offer below:

- 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

- To continue to offer therapeutic parenting groups to the most vulnerable carers

- 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

- 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

- 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 Be Positive Pathways. This is a regular request from Through Care Social Workers.

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

- 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.

- 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.

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

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

8a Psychological Therapists are needed to offer clinical supervision to lower banded clinicians. It is not possible for the Clinical Lead to offer this to all Band 7s. Furthermore, the 8a posts would allow

for recruitment of more experienced practitioners and enable better retention of Clinical Psychologists in particular. They could each take a lead on an aspect of the service, e.g. FASD assessments, group work

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

Band 7 Psychological Therapists have the level of training, skill and experience to offer assessment and therapy to these complex cases. They will be trained in evidence-based therapy and supervised by 8a psychological therapists. They will have the capacity to work with up to 10 individual cases weekly, offer two consultation slots a week and jointly input to one assessment clinic.

1 WTE Band 7/6 Occupational Therapist

A Band 7/6 Occupational Therapist will have experience in child and adolescent mental health and additional training in sensory integration and sensory development in children with developmental trauma. The OTs would also have a role in joint FASD assessment clinics with Community Paediatricians. The Band 7/6 will offer clinical supervision to the Band 5 OT.

4 WTE Band 6 – keyworkers

- **2 therapeutic SW**
- **2 CPNs interested in therapy/psychology**

Band 6 keyworker roles are needed to contain the system of professionals and carers in relation to these complex cases. This will involve contributing to aspects of the assessment clinics, joining Psychological Therapists to offer consultation and to add to the DBT and therapeutic parenting groups. They will not be offering complex therapy but will be in a supportive role and work alongside therapists in offering interventions. The CPNs, in particular, will also support urgent assessments of young people who deliberately self-harm. The CPNs in particular will also support urgent assessments of young people who deliberately self-harm with a clear pathway for therapeutic intervention, reducing repeated A + E admissions, police and primary care involvement.

The last two years of service delivery has highlighted a clear role for keyworkers at this level.

1 WTE Band 5 Occupational Therapist

Band 5 Occupational Therapist will carry out sensory assessments under the guidance of the Band 7/6 OT, contributing to holistic assessments of young people with sensory needs as well as assessments for FASD.

1 WTE Band 5 Assistant Psychologist

The current Assistant Psychologist collates and analyses all data collected in relation to demographics, assessments, therapy, consultation and clinician client contact. She co-ordinates referral meetings and consultation appointments. She has begun to write a research paper looking at the psychological factors that influence placement stability and carer wellbeing. In addition, she offers behavioural approaches supporting young people and completes cognitive assessments, under the supervision of qualified Clinical Psychologists. She has not been able to complete the research due to clinical demands and the level of data input her role requires. With additional clinicians, this demand will grow further. It is important to add a further Assistant Psychologist who can process data, contribute to cognitive assessments and continue to add to the evidence-base for this population.

1 WTE Band 3 Administrator

An administrator attached to the team would crucially reduce the amount of administration carried out by clinical staff, freeing them up to complete more of the essential clinical work. Groups and consultations generate a significant amount of administration as does information collating, record keeping and report writing.

J. References

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K. Appendices

Bradford District Care NHS
NHS Foundation Trust

BRADFORD CAMHS-LAAC REFERRAL

Please complete all sections of the referral form in as much detail as possible. The referral form will not be accepted unless sufficient information is received. If you wish to discuss this referral, please contact a member of the CAMHS-LAAC team on 01274 723241.

Please note that CAMHS-LAAC is not an emergency response service. If you have immediate concerns regarding a young person's safety, please contact the Core-CAMHS Duty line (Monday – Friday, 9am – 5pm) on the following contact numbers:

Bradford CAMHS – 01274 723241

Keighley CAMHS – 01535 661531

If you wish to raise an immediate concern outside of these hours, you may contact First Response on 01274 221181 or alternatively support the young person to attend their local A&E Department

Date of referral: Click here to enter a date.

Section 1	**Child / Young Person's Details**
Young person's name First name:Click here to enter text. Surname:Click here to enter text. Preferred name (if applicable):Click here to enter	Date of birth: Click here to enter a date. Gender:Click here to enter text. NHS number:Click here to enter text. Ethnicity:Click here to enter text.
What is the young person's current care status? ☐ Kinship placement / Arrangement order ☐Special Guardianship Order ☐Adoption Order ☐Care Order ☐Other, please specify: Click here to enter text.	
Current address: Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Postcode:Click here to enter text.	Who does the young person live with? ☐Relative(s) / SGO carers ☐Foster carer(s) ☐Adoptive parent(s) ☐Children's home staff ☐Shared care, provide details Click here to enter text.
Telephone no:Click here to enter text.	Mobile no: Click here to enter text.
Language: Click here to enter text.	Interpreter required? ☐Yes ☐No
GP address: Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Postcode: Click here to enter text.	GP Name: Click here to enter text. GP Tel no: Click here to enter text. GP Fax no: Click here to enter text.

Section 2	Referrer Details
Name: Click here to enter text.	Job title: Click here to enter text.
Address: Click here to enter text.	Telephone no: Click here to enter text.
Click here to enter text.	Mobile no: Click here to enter text.
Click here to enter text.	Fax no: Click here to enter text.
Click here to enter text.	Email address:
Postcode: Click here to enter text.	Click here to enter text.

Section 3	Social Worker Details (if different from referrer)
NB: Without details of a Social worker for Looked After Children we cannot accept the referral	
Name: Click here to enter text.	Job title: Click here to enter text.
Address: Click here to enter text.	Telephone no: Click here to enter text.
Click here to enter text.	Mobile no: Click here to enter text.
Click here to enter text.	Fax no: Click here to enter text.
Click here to enter text.	Email address:
Postcode: Click here to enter text.	Click here to enter text.

Section 4	Parent / Carer Details
Name of Primary Carer(s): Click here to enter text.	Relationship to young person: Click here to enter text.
Telephone no: Click here to enter text.	Mobile no: Click here to enter text.
Email address: Click here to enter text.	
Language: Click here to enter text.	Interpreter required? ☐Yes ☐No

Section 5	Care History Details
Please provide details about the circumstances under which the young person came into care. Please include whether the young person continues to have contact with their birth family and if there are any ongoing risk concerns Click here to enter text.	

Section 6	Involvement of Other Professionals / Previous Therapeutic Input
Please provide details of any other professionals currently involved e.g. Paediatrician, SENCO, Educational Psychologist, Private Therapist, Third Sector Organisations etc. Please provide names, job titles and contact details. Click here to enter text.	
Please provide details of any previous therapeutic involvement, including assessments, therapeutic parenting groups, 1:1 work etc. Click here to enter text.	

Section 7	Consent to referral

Has the referrer discussed this referral with the young person?	☐Yes	☐No
Has the young person provided consent for this referral?	☐Yes	☐No
Has the parent / carer provided consent for this referral?	☐Yes	☐ No
Comments (if any): Click here to enter text.		

Section 8	**Reason for referral**
Please describe in as much detail as possible the reason(s) for referral to CAMHS e.g. what are the primary concerns for this young person? Include details regarding duration and impact of difficulties Click here to enter text.	
Are there concerns regarding risk to the young person or others? If so, how are these currently being managed? Click here to enter text.	
What are the protective factors? E.g. friendships, relationship with carer, school etc Click here to enter text.	
What do you, the young person and/or carer(s) hope form this CAMHS referral? E.g. therapeutic support for carer / young person, assessments etc The referrers hopes: Click here to enter text. The young person's hopes: Click here to enter text. The carer's hopes: Click here to enter text.	

Section 9	**Other relevant information**
Please provide any further information which you feel is relevant to this referral, which is not otherwise supplied in the sections above Click here to enter text.	

Please send this form via secure email to CAMHSLAACreferrals@bdct.nhs.uk