Croydon Council

For General Release

REPORT TO:	**Corporate Parenting Panel** **3 July 2013**
AGENDA ITEM:	**8**
SUBJECT:	**Review of Child and Adolescent Mental Health Service for Looked after Children**
LEAD OFFICER:	**Paul Greenhalgh**
CABINET MEMBER:	**Councillor Tim Pollard,** **Cabinet Member for Children, Families and Learning**
WARDS:	**ALL**
CORPORATE PRIORITY/POLICY CONTEXT:	
FINANCIAL IMPACT: None	
FORWARD PLAN KEY DECISION REFERENCE NO.:	

1. RECOMMENDATIONS

1.1 The report be noted

2. EXECUTIVE SUMMARY

In May 2012 the Safeguarding and Looked after Children Inspection expressed concern about the timeliness and access by LAC to specialist Child and Adolescent Mental Health Service (CAHMS) services. Croydon CAHMS Partnership Commissioning Group (PCG) requested a review of LAC CAHMS to identify strengths, weaknesses and gaps and to make recommendations for improvement to the PCG. This Corporate Parenting Panel requested that the report from this review should also come to a meeting of the Panel for discussion once it had been received by the PCG and that the report authors should attend the Panel to speak to the report.

This review report is based on analysis from Children's Social Care provided by Paul Chadwick and from LAC CAHMS provided by Dr Sue Goode, and includes the public health analysis of LAC CAHMS undertaken by Kate Naish, Public

Health strategic Lead – Young People.

The analysis includes a survey of young people, social workers, foster carers and clinical practitioners and an analysis of anonymised case studies. These three analytical strands were expected to overlap with each other considerably as to findings and recommendations.

The findings and recommendations were reported to the PCG Meeting of 4th June 2013 and the recommendations included in this report were accepted and endorsed with agreement that the Clinical Commissioning Group should progress work to design an offer of health services to looked after children that clearly articulates what looked after children will receive to achieve their best health outcomes.

3. REVIEW REPORT OF CROYDON'S LAC CAHMS

3.1 Context of this review

In May 2012 the Safeguarding and Looked after Children Inspection expressed concern about the timeliness and access by LAC to specialist CAHMS services. Croydon CAHMS PCG requested a review of LAC CAHMS to identify strengths, weaknesses and gaps. The review would be based on analysis from Children's Social Care and from LAC CAHMS contextualized by the public health analysis of LAC CAHMS undertaken by Kate Naish, Public Health strategic Lead – Young People. These three analytical strands were expected to overlap with each other considerably as to findings and recommendations so as to inform the discussion and decisions of the CAHMS PCG.

Improving the emotional health and well-being of children and young people in Croydon and improving the outcomes of looked after children and young people are key priorities for the Children and Families Partnership. As a consequence specific actions have been identified and included in the Croydon Children and Young People's Plan1 to ensure improvement in the emotional health and well-being of Croydon's looked after children and young people.

Currently, responsibility for improving the emotional health and well-being of children and young people lies with the Children and Families Partnership: Be Healthy Sub-Group, supported by the CAHMS PCG and TAHMS sub-group. Responsibility for improving the emotional health and well-being of looked after children is additionally supported by action developed and agreed by the LAC Strategic Partnership. Representation from public health, commissioning, the local authority, SLAM, and the voluntary sector sit on all associated strategy groups.

Additionally, the theme of this year's Joint Strategy Needs Assessment (JSNA) is around mental health. Three deep-dives are currently being undertaken, of which one is focusing on the emotional health and well-being of children and young people aged 0-18 years of age in Croydon. It is expected that the findings and recommendations will inform local commissioning intentions for 2013-14 and support the development of the updated Children's and Young People's Emotional Health and Well-Being Strategy in Croydon.

3.2 Public Health Analysis

Epidemiology

Looked after children and young people have a five-fold increased risk of mental disorders, a six- to seven-fold increased risk of conduct disorder and a four- to five-fold increased risk of attempting suicide in adulthood. Care leavers continue to share many of the same health risks and problems as looked after children. Timely and effective health assessments are crucial to the speedy identification of problems and referral to support services. The use of screening tools such as the Strengths and Difficulties Questionnaire can help to prioritise referrals to child and adolescent mental health services (CAHMS).

In 2003, the Office of National Statistics published data comparing the prevalence of mental disorders in children looked after by a local authority in comparison with a representative sample of children living in private households. About two-thirds of children living in residential care (68%) were assessed as having a mental health disorder as were about four in ten of those placed with foster carers (39%) or with their birth parents (42%).

In Croydon there were 845 looked after children as of 31st March 2011; of these there were 130 children and young people in different forms of residential care. Based on mental health prevalence estimates amongst looked after children this would equate to a total of 88 children in residential care and around 275 children and young people looked after in other settings who may experience some type of mental health disorder, a total of 363.

3.3 Local Data

Children's Social Care

	31st March 2009	31st March 2010	31st March 2011	31st March 2012
4. CIN and CIN CPP	Number	Number	Number	Number
Children In Need	3700	4545	4616	4011
of those, Children in Need with CPP	290	346	331	288

Source: CIN Census

As of March 2012 there were 4011 identified children in need to Croydon Children's Social Care Team, of those 288 had in place a child protection plan. Overall numbers of children in need are reducing in Croydon.

	31st March 2009			31st March 2010			31st March 2011			31st March 2012		
1. LAC Age Group & Gender	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Under 1:	9	10	**19**	10	13	**23**	9	6	**15**	6	10	**16**
1 - 4:	28	31	**59**	38	35	**73**	42	29	**71**	49	29	**78**
5 - 9:	43	25	**68**	40	42	**82**	33	32	**65**	45	37	**82**
10 - 15:	318	94	**412**	234	76	**310**	184	85	**269**	166	81	**247**
16 and Over	413	100	**513**	421	99	**520**	345	80	**425**	258	62	**320**
Total	**811**	**260**	1071	**743**	**265**	1008	**613**	**232**	845	**524**	**219**	743

Source: SSDA903 *Note: 2009 figure is a manual calculation based on SSDA903 download files. DFE publication rounded up to nearest five so total figure was published as 1075, not 1071.

The number of looked after children in Croydon has reduced dramatically over recent years, with the 743 looked after children in Croydon, with an approximate ratio of 2.4 males to 1.0 girls. The majority of looked after children are ages 16 and over, with significant numbers also in the 10-15 year old age group.

	31st March 2009	31st March 2010	31st March 2011	31st March 2012
2. LAC Ethnic Group	Number	Number	Number	Number
White	447	340	190	202
Mixed	87	88	79	82
Asian or Asian British	253	297	340	244
Black or Black British	247	245	223	205
Other Ethnic Groups	37	38	13	10
Total	1071	1008	845	743

Source: SSDA903

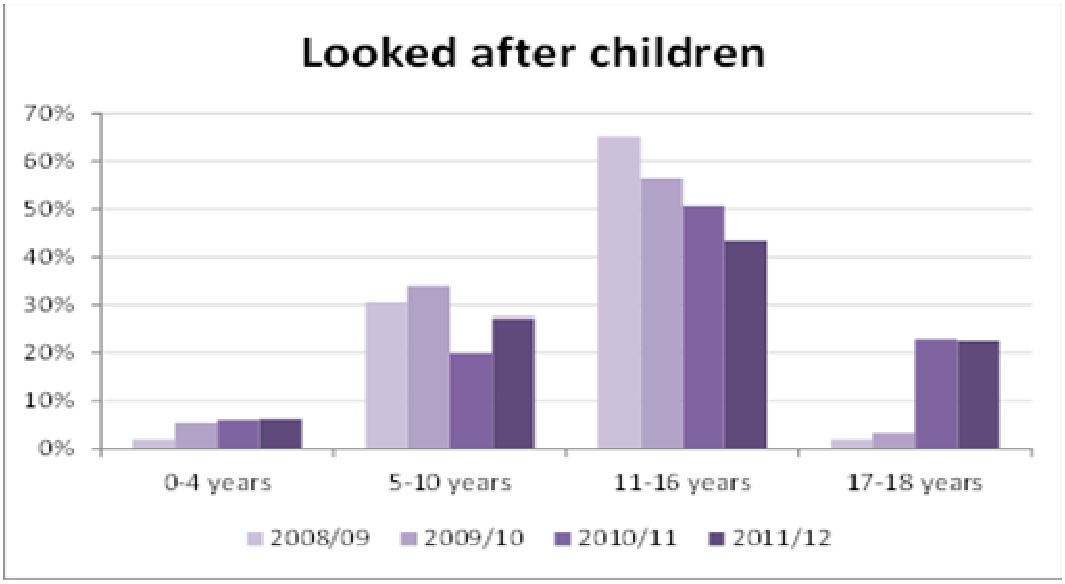
33% of Croydon's looked after population are from Asian or Asian British ethnic groups. Closely followed by Black or Black British (28%) and white (27%) ethnic groups.

	31st March 2009	31st March 2010	31st March 2011	31st March 2012
3. LAC SDQ	Number	Number	Number	Number
No. of LAC who Took SDQ	310	315	281	220
Average SDQ Score (0-40)	11.5	8.1	11.1	8.6

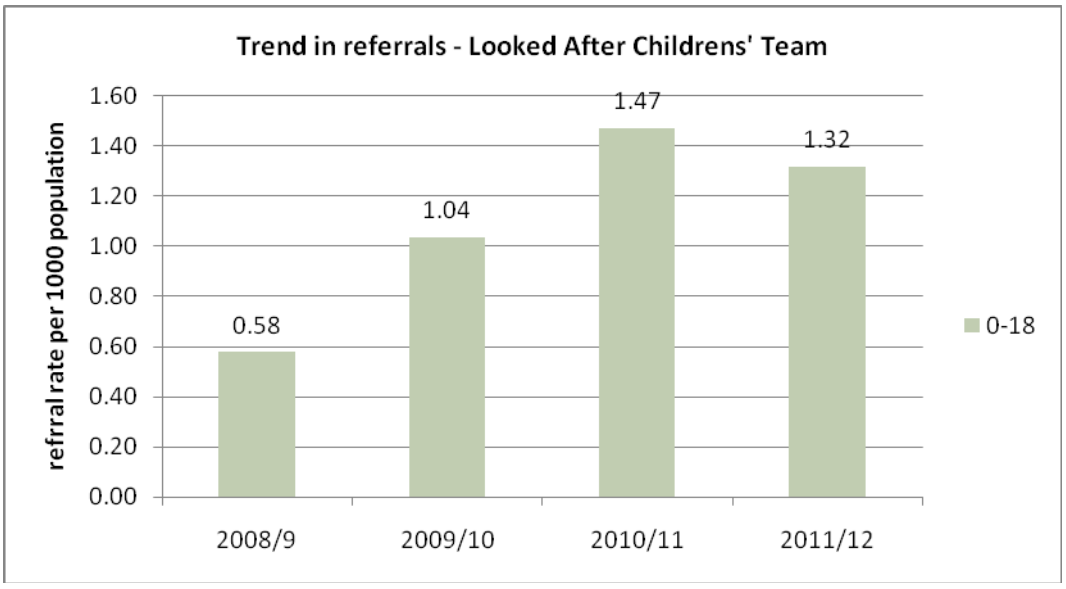
Source: SSDA903

In 2010, Croydon had the lowest SDQ score amongst it's looked after children in the country with a score of 8.1 and the second lowest in 2011, just behind Newham with a score of 11.1. 75% of eligible children undertook a strengths and difficulties questionnaire in 2011, which was an increase of 2% from 2010. National trend data as of March 2012 will be released at the end of the year.

3.4 SLAM CAHMS



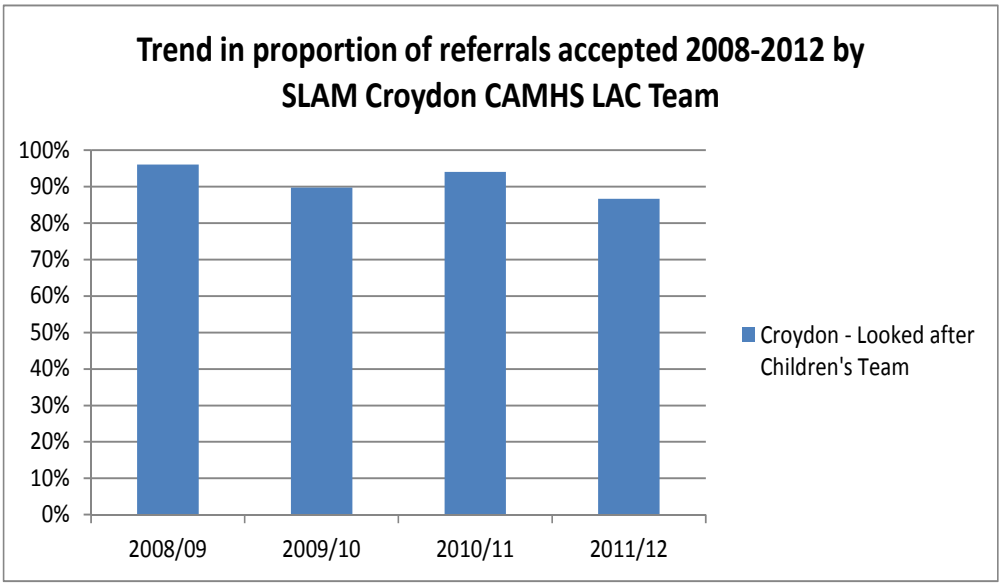
Over the last four years, SLAM CAHMS services have seen significant increases in the percentage of 17-18 year old looked after children seen by its services. Increases have also been seen amongst the 0-4 year old age group. Consistent reductions in the 11-16 year age group have been seen over the last four years, with a slight increase in the 5-10 year old age group from 2010-11 levels.



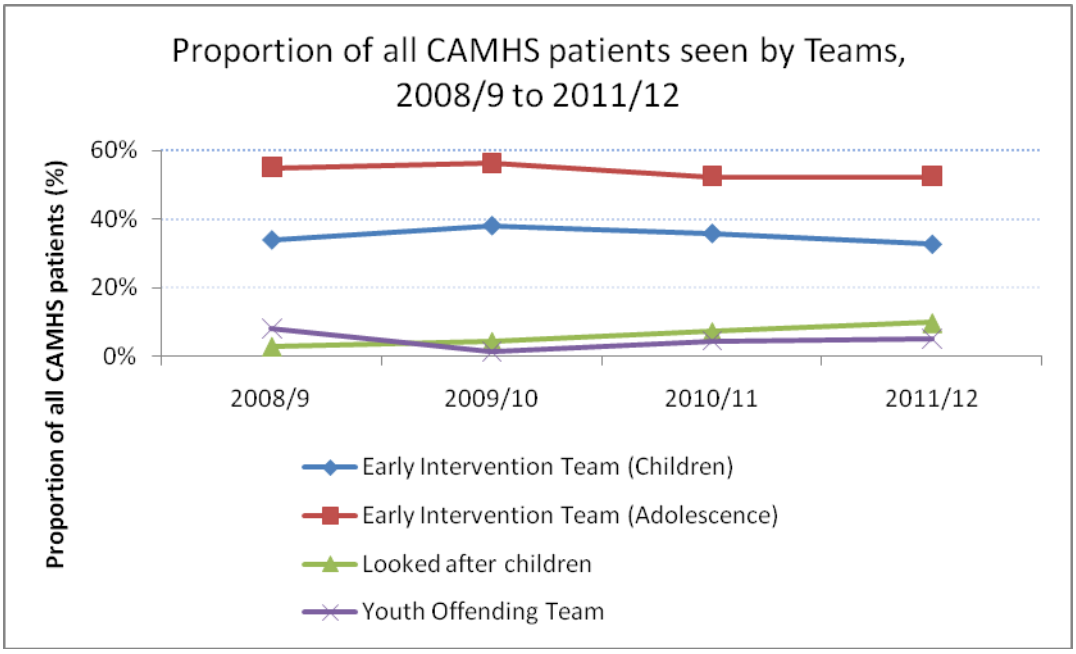
Rates of referral for LAC to SLAM CAHMS Services increased by 153% between 2008/9 and 2010/11, with a small reduction (10%) being seen in 2011-12.This contrasts significantly with similar provision for young offenders where rates of referral have reduced steadily over the same four-year period by 56%.

SLAM CAMHS LAC Team	2008/09	2009/10	2010/11	2011/12
No of referrals received	51	98	134	143
No of referrals accepted	49	88	126	124
No of patients seen	74	661	620	268
No of new patients seen	N/A	247	305	120
Proportion of appointments attended	87%	76%	75%	77%
Proportion of appointments DNAd	10%	14%	16%	16%

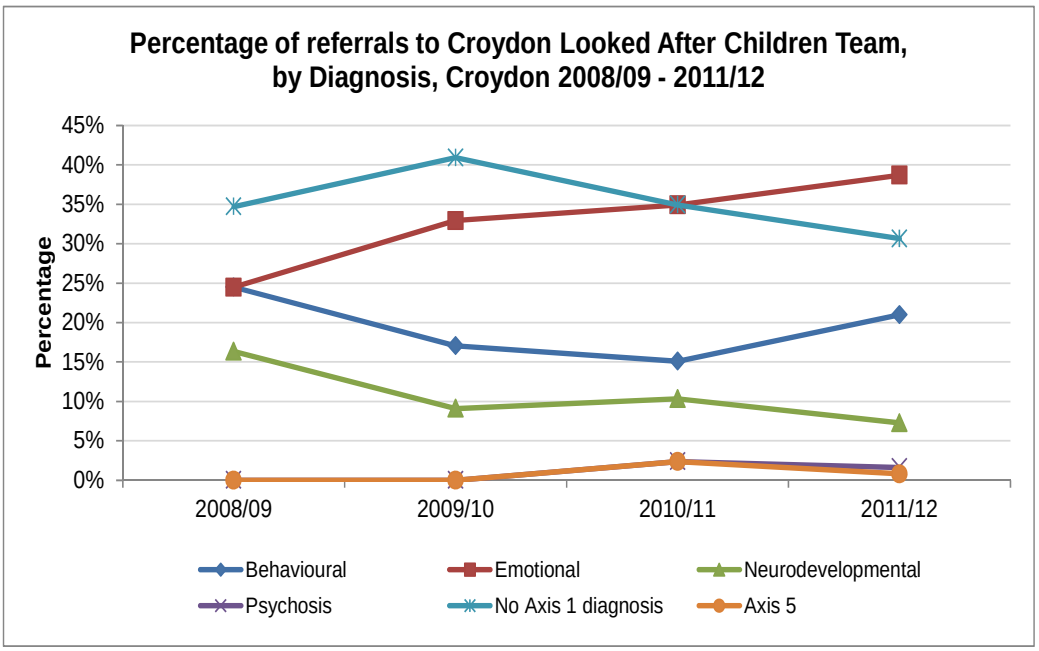
SLAM CAHMS services have seen the number of referrals received for support for looked after children have increased by 280% since 2008-9. With 87% of referrals being accepted by the service in 2011/12, and an average acceptance rate of 92% over the four year period. Two hundred and sixty eight looked after children were seen during 20011-12, of which 120 were new patients. The number of patients seen has reduced dramatically over the last three years, with a drop of 60% from the peak seen in 2009-10. The number of new patients seen has also reduced significantly from 2010-11 levels.



Waiting times for an assessment by SLAM CAHMS Looked after Children's Service were on average 5.9 weeks during 2011/12. This shows an increase in waiting times over the last three years, which is unsurprising given the increase in referrals seen during that period. Croydon Youth Offending Service has the lowest and most consistent waiting times seen over the last three years, with an average wait of just 3 weeks from referral to first assessment. The longest waiting times are for referrals to SLAM CAHMS Early Intervention (Children) and Early Intervention (Adolescents) Teams where waits were on average 17 - 18 weeks.



SLAM CAHMS Looked after Team saw the largest proportional increase in the number of patients seen over the period of 2008-12 period with an increase of 7% during that time. All other teams saw a decrease in the number of referrals, thought the Early Intervention Teams still saw the largest number of Children and Young People as would be expected. The Early Intervention Team (Adolescence) saw the largest proportion by seeing over 50% of all referrals.



Increases in the number of referrals being seen amongst looked after children for emotional and behavioural issues were seen during 2011-12, with reductions being seen in all other forms of diagnosis from 2010-11 levels.

3.5 **Key guidance**

NICE has produced considerable guidance in relation to the mental health needs of children and young people. Specific guidance around promoting the quality of life of Looked after Children was published in 2010.
NICE, Oct 2010, Looked-after children and young people (PH28) .

As part of this guidance the consideration of the emotional health and well-being needs of looked after children was also included. One of the key recommendations is to provide dedicated services to meet the mental health and emotional well-being of children and young people in care. It is recommended that these services are jointly commissioned and that they also ensure appropriate access to CAHMS services for specific groups of Looked after children such as BME, UASC and young people in secure accommodation or custody.

A self-assessment tool was produced by NICE to assist local areas assess to what degree they meet recommended guidance, in order to inform service and commissioning improvements. This self-assessment has yet to be fully undertaken in Croydon and has been included as a key priority as part of the *Croydon Children's Services Corporate Parenting Strategy Forward Plan.*

Currently, NICE are developing some proposed social care quality standards in relation to promoting the quality of life of looked after children. Consideration of mental health is one of the 12 standards being proposed, whereby looked after children and young people who are covered by leaving care arrangements who have complex emotional and physical needs can access services when needed.

Some of the other key NICE guidance in relation to this issue includes:

- Promoting children's social and emotional wellbeing in primary education;

  NICE, Mar 2008, Social and emotional wellbeing in primary education (PH12)

- Promoting young people's social and emotional wellbeing in secondary education;

  NICE, Sep 2009, Social and emotional wellbeing in secondary education (PH20)

- Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults

  NICE, Sep 2008, Attention deficit hyperactivity disorder (ADHD) (CG72)

- Autism spectrum disorders in children and young people

  NICE, Sept 2011, Autism in children and young people – Assessment & diagnosis (CG128)

- Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders

  NICE, Jan 2004, Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (CG9)

- Depression in children and young people: identification and management in primary, community and secondary care

  NICE, Sep 2005, Depression in children and young people (CG28)

- Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care

  NICE, Mar 2005, Post-traumatic stress disorder (PTSD) (CG26)

- Psychosis and schizophrenia in children and young people (not yet published)

  NICE, Mar 2011, Psychosis with coexisting substance misuse (CG120)

- Conduct disorder in children - parent-training/education programmes

  NICE, Jul 2006, Parent-training/education programmes in the management of children with conduct disorders

- Interventions to reduce substance misuse among vulnerable young people

  NICE, Mar 2007, Interventions to reduce substance misuse among vulnerable young people (PH4) ,

Additional relevant published NICE Guidance

- NICE, Aug 2011, Alcohol dependence and harmful alcohol use (Quality Standard)
- NICE, Nov 2011, Self harm (longer term management) (CG133) (8 yrs and older)
- NICE, Sep 2010, Pregnancy and complex social factors (CG110)
- NICE, Jun 2010, Alcohol-use disorders - preventing harmful drinking (PH24)
- NICE, July 2009, When to suspect child maltreatment (CG89)
- NICE, Jan 2009, Borderline personality disorder (BPD) (CG78)
- NICE, Jan 2009, Antisocial personality disorder (CG77)

- NICE, Nov 2007, School-based interventions on alcohol (PH7)
- NICE, Jul 2007, Drug misuse: psychosocial interventions (CG51)
- NICE, Jul 2007, Drug misuse: opioid detoxification (CG52)
- NICE, Jul 2006, Bipolar disorder (CG38) (Currently being updated)
- NICE, Nov 2005, Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (CG31)
- NICE, Mar 2005, Post-traumatic stress disorder (PTSD) (CG26)
- NICE, July 2004, Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (CG16)

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3. 6 **JSNA Consultation Feedback**

LAC Indigenous

In August 2012, Croydon LAC Indigenous Service undertook an emotional health and well-being survey amongst indigenous LAC aged 10 -18 years of age. A questionnaire was designed with a range of open and closed questions. A total of 46 questionnaires were returned. The ages of the young people who completed the questionnaire ranged from 9-17 years of age with the average age of those surveyed being 13.8 years old. Females and males accounted for 57% and 43% of respondents respectively. The majority of respondents were of White origin (43%), though surveys were completed by indigenous LAC from a broad range of ethnic origins. Those identified as Black British, Black Caribbean or Black African descent made up 39% of the returns. In relation to those indigenous LAC surveyed the main findings were:

- In the main, carers and relatives were cited as the people indigenous LAC would approach if they were feeling sad, angry or worried and only 4% of those questioned stated they did not have someone to talk to if they were worried about something.
- The majority of those surveyed had friends at school and felt happy about life and being themselves.
- 54% had used counseling, therapy or special support in relation to a mental health issue and 58% would recommend this to a friend.
- Parents and carers were the most popular choice of support that respondents would recommend friends approach if they were worried or troubled about something, closely followed by teachers.
- Activities and days out that were fun were identified as key elements that should be included when developing services to help support young people with their worries. Though young people were not sure where the best place was to cite such services. There was no overall consensus of whether such services should be placed in schools.

- 46% of respondents indicated they had ever been bullied and just 17% had been bullied via a mobile phone, social network site or computer and just 2% stated they did not have anyone to talk to if they were being bullied.
- The majority of those surveyed stated they had enough help in making choices and decisions.
- Very few of those surveyed did not enjoy school (4%) though a significant proportion (35%) did not enjoy school all the time.
- Poor self-esteem and conduct disorders were common themes identified from individual feedback. Particularly concerns about an individual's looks, personality and anger management being identified as things those surveyed would like to change about themselves in order that people would like and care for them more.

3.7 **UASC LAC**

Over the summer of 2012, feedback was gathered from individuals who receive support from Compass. Compass is a project based within Off the Record which provides counseling and support to refugees, asylum seekers and forced migrants. A set range of questions were asked within individual counseling sessions and within the Compass Boys Group, where it felt appropriate to do so. Due to the significant language and conceptual barriers and associated cultural issues, questions were only asked of those who were happy to contribute and who were also felt to be able to answer most of the questions. In total, twelve young people were consulted with a breakdown of two females and ten males. Of this eight were unaccompanied minors, with the rest within asylum seeking or refugee families or unaccompanied asylum seekers aged over 18. The majority were from Afghanistan or other Middle Eastern countries. The key issues raised which would prevent this group of young people asking for help included: language barriers, a lack of awareness of local services and the support that was available; fear and difficulty in disclosing vulnerable and personal information as well as a sense of responsibility for the feelings this may raise in the professional or '*listener'*; concerns about professionals limited cultural awareness.

Factors raised that would help improve individual's ability in asking for help included: information available in different languages and access to interpreters; availability of help and support in settings that are familiar; greater understanding and awareness by practitioners of the type of mental health problems faced by unaccompanied minors, refugees and asylum seekers; recommendations by other people. Overwhelming feedback provided showed that this group of young people preferred services to be offered in schools. This fitted in with other comments that teaching staff or agencies visiting schools and colleges were often approached when help with different problems was sought. Feedback on the key benefits that services should provide included: having someone to talk to and help with any problems, providing information and advice; help to reduce the sense of isolation and improving feelings of safety and hope for the future.

3.8 **Social Workers**

In September 2012, a questionnaire survey was developed and circulated to all social workers and Independent Reviewing Officers (IROs) over a five week

response period. Practitioners were asked to complete a short questionnaire based on the emotional and mental health needs of the children held on their caseloads. A total of 9 responses were received, with 25% of responses came from Fostering and Adoption and LAC (10-18) team, 37% came from the Assessment Team and 13% from Children with Disabilities Team. On the basis of average caseloads this reflected the needs of 100 children in need and LAC in Croydon. From the feedback provided the following results were identified:

- Of those children in need and LAC identified with an emotional or mental health need, 43% have a need that could be accommodated from universal or Tier 1 services. 26% were assessed as requiring Tier 2 services and demonstrating a higher level of need. 23% were deemed as having complex needs and requiring Tier 3 Level CAHMS services and just 9% had acute mental health needs where it was identified that Tier 4 level services were probably were required.

- Practitioners were asked for the overwhelming reason why individual cases where an emotional or mental health need had been identified, but had not been referred to Croydon Specialist CAHMS service. The largest reason (44%) for cases not being referred were due to practitioners not being familiar with what services Croydon Specialist CAHMS service provides. The second largest reason (22%) was that practitioners felt the CAHMS thresholds were too high. Of the total responses, 17% felt the emotional and mental health outcomes could be achieved elsewhere, and 7% felt Croydon Specialist CAHMS service lacked capacity. An additional 5% respectively felt the child would not co-operate or the parent would object or undermine treatment.

3.9 **Children's Social Care Analysis of the Survey**

The survey reveals a confused and conflicting picture of the expectations of CAHMS by social workers and of their working partnership with the team. Although high thresholds are stated as a significant reason for children with complex mental health needs (22.9% of caseload) not receiving a service from CAHMS (22%) social workers nevertheless report that well over half of these children (59.5%) are receiving a service from CAHMS. In contrast, at either side of this complex need, very few (2.7%) of the children identified as having an acute need (8.6%) are receiving tier 4 treatment, and an extremely low number (5.4%) of the children identified as vulnerable but with low needs (25.7%) are having their needs met at tier 2.

This might suggest that despite the critical *views* of CAHMS involvement expressed by social workers in the survey, the findings suggest that a child identified by their social worker as having tier 3 needs stands a greater chance of receiving an appropriate service than a child identified as having a tier 4 need, or a tier 2 need. However, crucially, this possibility is undermined by the fact that almost half of the social workers who participated in the survey (43.9%) say that they do not know what CAHMS provides. This in turn suggests that there may be a good deal of confusion among social workers in Croydon as to threshold criteria for referral, expectations of the CAHMS team, and, indeed, in their initial assessment of mental health need and at what tier level of need / intervention. Comments from social workers completing the survey

included:

"CAHMS threshold is too high this leaves a lot of vulnerable children who possibly need mental health support without the correct support. Social workers are left to find a service which may not accurately meet the needs of the child but is all that is available. In the short term this is ok but doesn't deal with the concern in the long term."

"Foster carers need a service whereby they can get advice on how to help the children they care for whether or not CAHMS provides a service."

"Firstly, the threshold for CAHMS is too high. I don't feel it provides a consistent or effective service for our young people. My young people who have experienced CAHMS in the past have not reported positive feedback. I often find that CAHMS can work against social workers in advice and strategies that they provide to young people and especially in terms of how this advice is delivered. With the consent of young people the majority of them are referred to other services."

"I do not believe we receive a good enough service from CAHMS. Either the child does not meet their threshold or they cannot work with the child because of not being in a settled placement."

"Experience has been of service offering medication. More behavioural work on an outreach basis would be useful."

"I do not currently have any problems with accessing CAHMS. In the past I have been told that the waiting list is very long, but they also state that they can make exceptions for emergencies. In my experience the only problem I have experienced is parents not engaging regularly or expecting the magic wand effect of a quick solution to a very complex situation."

3.10 **Qualitative studies of selected cases by Children's Social Care**

Permanence 2 Service case studies

Child A

Child A (CA) is aged 15 and subject to a Care Order, he has had a very troubled childhood and many placement breakdowns.

CA has been known to CAHMS for about 2 years for ADHD (prescribed medication) high risk behaviours (absconding from care, not following medical regime for his serious health condition). Psychiatric assessment concluded he has a disordered attachment, presents as very emotionally immature, unable to interact socially with his peers, and cannot sustain friendships. He has no family support other than his mother and father who are separated and have an acrimonious relationship. His behaviours are of such concern that he has been in secure accommodation on three occasions, the most recent ended 26.9.2012. CAHMS was asked to attend care planning meetings and offer a flexible and creative way of working with CA and his family.

Unfortunately CAHMS were frequently unable to attend meetings and would only offer appointments for CA and/or his mother at their office. In the view of the social worker it would have demonstrated a commitment to wanting to work with CA and his family if CAHMS workers had visited the family home, or visited CA at school or his placement, jointly with the social worker. The failure of CAHMS to engage with CA outside of the office was at odds with the recognition that CA had difficulty making and sustaining relationships, and that CA is of an age to feel stigmatized by attending their office. CA's refusal created a stalemate that CAHMS did not proactively attempt to overcome.

CA presented himself to hospital several times but left before a CAMHS worker/psychiatrist could assess him. CAHMS did not follow this up with CA and the social worker believes it was entirely left with CSC to manage his behaviour. The CAHMS response to offer an appointment at their office for CA, sometimes several weeks into the future rather than in the immediate situation of need is described by the social worker as "extremely frustrating". The social worker observes that in contrast, the head teacher for CA frequently made visits to him outside of school hours and worked closely with CSC to identify the best plan for his care.

Managers agreed to commission an independent assessment from a consultant child and adolescent psychiatrist to assist in identifying the best way to manage the risks for CA and this resulted in the plan for a secure placement in order to engage him in treatment. CA has now moved from secure accommodation and is in specialist unit in Derby.

In the view of the social worker, consultant practitioner and managers this was a poor response from CAHMS and a poor outcome for the child.

Child B

Child B (CB) is a 13 year old male and was referred to CAHMS because of his sexual identity confusion and risk taking behaviours of stealing female clothing and other items for his personal use. CB was frustrated and unhappy with his own confusion and behaviour and found it difficult to maintain relationships and to maintain appropriate boundaries. CB is angry and volatile in presentation. The referral was accepted by CAHMS but during the first session he became angry with the CAHMS worker and refused to engage in discussion. The social worker says that she is "very disappointed" that CAHMS then withdrew from further work with CB and made no further attempt to engage with him, perhaps in an environment that is less threatening to the child. The social worker reports that CB fails to make progress and she is very concerned for the increasing level of his emotional distress and inability to manage his anger.

In the view of the social worker and manager this was a poor response from CAHMS and a poor outcome for the child.

Child C

Child C (CC) was referred to CAHMS because of behaviours that included food hoarding and food stealing. The social worker was impressed by the speed of

which the referral was accepted by the CAHMS team and the care they exercised in involving the foster carer and the child in the therapeutic intervention. CC improved and is now progressing well in his placement. Both the social worker and foster carer expressed surprise, however, that there was no follow up from CAHMS after discharge to ensure progress was sustained.

In the view of the social worker and manager this was a good response from CAHMS and a good outcome for the child.

Child D

Child D (CD) is a young person who was sexually abused by her father and physically abused by her mother. She has issues with attachment, is distrustful of people and finds it hard to make and sustain relationships. When anxious, CD becomes volatile and angry; she self-harms and will masturbate using objects that cause her pain. She is compulsive obsessive and maintains her clothes within a strict order and pattern in her wardrobes and drawers. She will not allow her carer to touch her underwear. A referral to CAHMS was accepted, but in the view of the CAHMS worker the child showed no insight into her problematic behaviours and so therapeutic input was unlikely to be of help, and the child was discharged. Although the social worker accepts that at this stage in her life CD has no understanding of her disordered relationships and dysfunctional behaviours and that the primary relationship with her carer is the real possibility of her internalizing self-esteem, respect, and truthfulness, the social worker feels CAHMS could have done more to attempt to engage with CD and to provide advice and guidance to her foster carer.

In the view of the social worker and manager this was a poor response from CAHMS and a poor outcome for the child

Adoption Team case study

Post adoption referrals to CAHMS are mainly because of attachment concerns and/or ADHD. At point of referral adopters are often very distressed and fearful of the adoptive placement disrupting.

Child E

Child E (CE) had a diagnosis of ADHD; however his school expressed concerns in regard to his ability to process information, make and keep friends and because of inappropriate boundaries, the risks he posed to his peers and adults. Due to these concerns the school referred CE to CAHMS to assess his behaviours and risks but the referral was not accepted. The social worker discussed this with the school and educational psychologist, and decided to make her own referral to CAHMS on the basis that the concerns for CE were about his communication problems and not the management of his ADHD. The referral was accepted by CAHMS and the social worker was told that the school referral had been solely on the basis of ADHD assessment and had been rejected for the reason that this was previously diagnosed and managed. In the social worker's view the CAHMS intervention was quick and appropriate and helped the school and adoptive parents make progress with CE. CAHMS referred on the Maudsley Hospital team who began therapy with CE. The social worker was able to work closely with the team and felt confidence in providing

therapeutic counseling to the adoptive parents in tandem with the therapeutic intervention of the team with the child.

The same social worker also has another post adoption support case that she is progressing in close partnership with CAHMS. However, CAHMS engagement was not a consequence of CSC referral but due to their arrangement with the child's school. The social worker was told that although the child has experienced extreme physical, emotional, sexual abuse, neglect and trauma it would not meet the CAHMS threshold because the child's needs were perceived to be psychosocial rather than mental health. The referral from the school was accepted and the social worker made contact with the CAHMS worker to ensure that her therapeutic input with the adoptive parents was in parallel with the CAHMS intervention with the child.

In the view of the social worker and her manager the good service from CAHMS and good outcomes for the child and the adoptive parents were due in part to the social worker's personal knowledge and experience of CAHMS from having previously been based with a CAHMS team as a social worker.

Permanence 1 Service case studies

The Permanence 1 Service predicated their case studies with the statement that, in general, they feel that the CAHMS team do not have a good understanding of the needs of unaccompanied minors and of the racial, ethnic and cultural factors impacting on their behaviours, the presentation of their behaviours, and on their communication with workers of all kinds, and on their receptivity to intervention and the stigma of mental ill health. The team feels that acceptance of referrals and good outcomes is a lottery and dependent on the persons involved, so that, there are examples of good and poor practice.

Child F

Child F (CF) was diagnosed with Post Traumatic Disorder (PTD) and was referred to the CAHMS. He was offered an appointment within 2 weeks and an assessment was completed. He was offered medication and regularly attends counseling with the CAHMS worker. Dr Solomon is still working with this young person and there is a regular review of medication. CF is responding well to counseling and he is thriving. He is progressing to completion of his course in Motor Mechanics at Carshalton College. The social worker describes their partnership with CAHMS as a good example of joint working. There is an evidence of good partnership working in this case.

Child G

Child G (CG) is a young person who is displaying self harm ideation and was referred to CAHMS for assessment by their social worker who was told the referral did not meet the threshold. The child self-harmed and was hospitalized. A psychiatric assessment was undertaken at the hospital and CG was referred back to CAHMS and is now receiving a service. The social worker feels that the CAHMS response was poor.

Child H

Child H (CH) is a young person with PTSD. However, when originally referred to CAHMS the social worker was told the child's needs did not meet the threshold for allocation. The social worker persisted and made several further referrals to CAHMS that were rejected until she called a multi-agency meeting attended by CAHMS. At this stage (one year on from the original referral) the CAHMS team told the social worker that the child required a referral to the 'national' CAHMS service as it required Tier 4 intervention. Consequently CH was diagnosed and treated for PTSD. The social worker feels that except for her persistence CH would have remained without appropriate therapeutic intervention and describes her involvement with CAHMS as "very frustrating". The social worker feels that the CAHMS response was poor.

3.11 **Analysis of the case studies**

The main criticisms of CAHMS reflected in the survey responses; that thresholds are too high, that outreach to the child's placement is not offered, that treatment strategies are not a shared approach of CAHMS and CSC also run through the cases analyzed by social workers and managers. The case of Child A is almost a summary of the criticisms of CAHMS found in several of the other case studies; *too little, too late.* Lack of cooperation by the child is not seen as sufficient reason for CAHMS to withdraw its service and the unwillingness of CAHMS staff to meet with the child in the child's own environment is seen as another barrier to engagement with the child imposed by CAHMS.

Social workers of necessity work with families who often do not welcome their intervention and with children who may have good reason to distrust adults, and there is a frustration expressed by social workers in the case studies for CAHMS withdrawing a service when the child is uncooperative. In the same way as they have to overcome resistance in children and families to work with them, social workers expect colleagues in CAHMS to engage with this resistance proactively. In the same way, social workers recognise from experience the importance of engaging children and families in their own environment because of the stigma, and sometimes the threat, perceived by children and families in coming to service buildings and offices.

There is a sense throughout many of the case studies of social workers feeling frustrated because for all their knocking the door to a CAHMS service has remained closed, or of the need to persist against discouragement in order to eventually access the service. In a sample of 48 young people (aged 12 -18) undertaken by the LAC Team in August 2012, a total of 11 were receiving a service from CAHMS, but a total of 12 were receiving a therapeutic counseling service commissioned by the case mangers. If this was commissioned appropriately for need that cannot otherwise be met by CAHMS this would be reassuring, but managers said that in many cases they were commissioning because the high thresholds of CAHMS left them little choice. It is reassuring for CAHMS colleagues to know that of the 11 young people receiving their service, 8 said they would recommend CAHMS help to a friend with similar needs to themselves

3.12 **Recommendations from LAC social workers based on the analysis**

The social workers and managers taking part in this review have identified 6 actions to be progressed that in their view will significantly improve the relationship between CSC and CAHMS and lead to better outcomes for children:

1. A single point of contact for the child in the CAHMS team should be identified from the outset of involvement, so that the social worker and that CAHMS worker can meet and plan their intervention jointly.

2. Social worker access to a CAHMS worker for guidance and advice on a daily basis

3. Clarity about thresholds for engagement – written guidance

4. Willingness from CAHMS to engage with the child in their own environment

5. Follow up from CAHMS to establish if child has progressed or deteriorated after discharge

6. CAHMS should attempt to engage with the child again if the child's initial reaction is not to communicate or to cooperate

3.13 **Analysis from Specialist LAC CAHMS Team**

Background Information

The LAC CAHMS Team is made up of clinical staff from a variety of disciplines and with training in a range of evidence based interventions including Pharmacology, cognitive therapy, and family therapy. The team is co -located with the Community CAHMS tier 4 service which enables Looked after children to have ease of access to a variety of additional specialist services including the neurodevelopmental diagnostic team, systemic family therapy team, assessment team for children presenting with self harm within the Croydon University Hospital and the outreach team working with young people who are working with young people who have require more specialist inpatient services.

Methodology

This audit was primarily based on electronic records of Croydon children looked after in the borough of Croydon and open to CAHMS LAC team in the first quarter of 2013. Of these a sample of 37 indigenous LAC and 12 UASC were selected for more in depth analysis. An assumption was made that NHS number would be randomly distributed but further exploration of the data indicated that this was not the case and that young people allocated an NHS number more recently were not adequately sampled. A second look at the data suggested it was important to separate out information on unaccompanied Asylum seeking children (UASC) and indigenous Looked after children.

All information was gathered via EPJS (South London and Maudsley trust

online patient database). Cases were excluded from the sample if the initial referral information was not available (n=9), or if the young person had not yet been seen by CAHMS (n=8). The sample only included children looked after by the borough of Croydon.

Findings

The number of Looked after children (indigenous or UASC) receiving a mental health service within the CAHMS LAC team

Based on the data available in December 2012 (JSNA) there were 749 LAC aged 0-18. Between January and March 2013, there were 156 open cases to the LAC CAHMS team (21% of the total LAC population and just less than half of LAC children expected to have a mental health problem). Data available from the JSNA indicated that at December 2012 55% of LAC were indigenous and 46% were UASC. In the first quarter of 2013 approximately 22% of the CAHMS LAC caseload were UASC which suggests that this group of looked after children are underrepresented in CAHMS. This may be because there is a specific project COMPASS working with this group of young people and that only UASC's with more severe mental health problem are referred to the LAC CAHMS team though it may be that there are other reasons for this e.g. that the UASC team have a different understanding of CAHMS LAC thresholds or that there is increased sensitivity about mental health stigmatization for this group and these young people are less likely to consent to be referred to a mental health service.

The number of LAC referred to LAC CAHMS, numbers accepted and declined and reasons for declining (including indigenous and UASC)

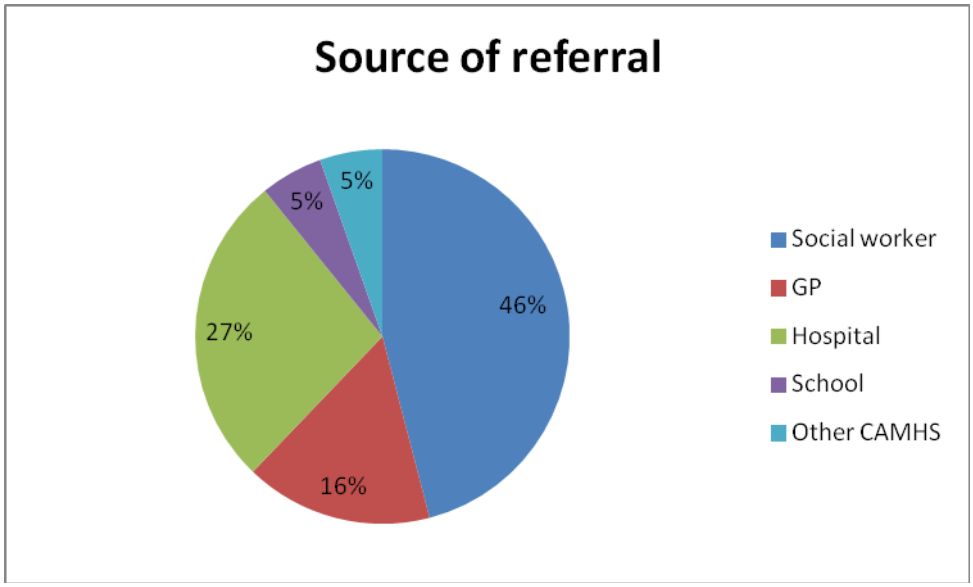
There were 24 new referrals of Croydon LAC to the team in this period. Of these 21 (87.5%) were accepted and 3 (12.5%) declined. Of the 3 declined, reasons were as follows:

- Two young people (8.4% of the total number of referrals) did not appear to have mental health problems and were signposted to other services
- One referral (4.2% of the total number of referrals) did not contain sufficient information to decide on whether the young person had a mental health problem and CAHMS did not receive any more information when this was requested.

Source of referral for Indigenous LAC

Figure 1 provides details of referral source for Indigenous LAC. The majority (46%) of referrals was from social workers in Croydon but a significant proportion (27%) was from Paediatricians based at Croydon University hospital. Of these, 4 (40%) were referred following a presentation in A&E with mental health problems which required urgent assessment or following an episode of self harm. 16% were referred directly by their GP and 5% were referred by school staff. 2 children (5%) were referred from within CAHM services, one from a tier 4 service and one from the Youth Offending team.

Figure 1. Source of referrals received



(indigenous LAC n=37)

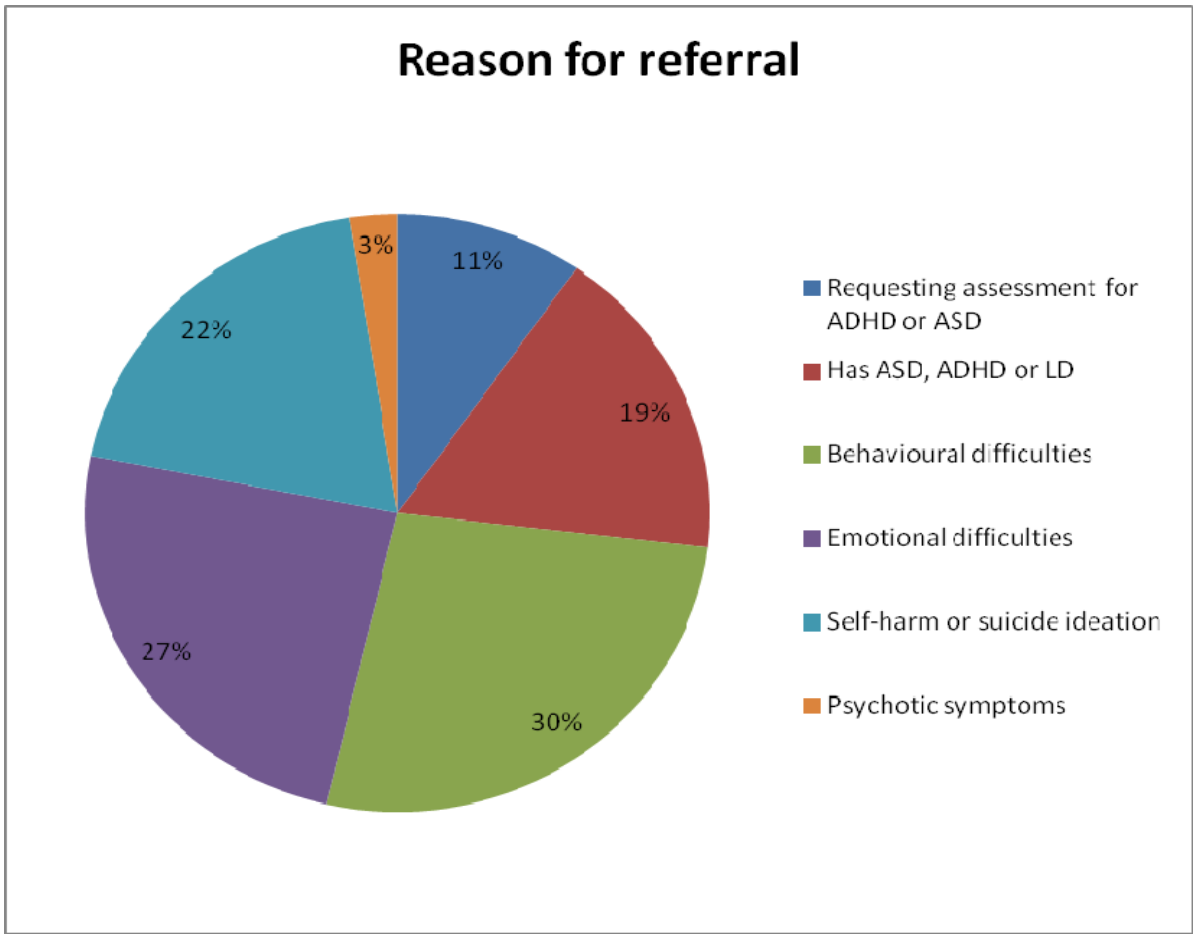
Source of referral for Unaccompanied Asylum Seeking Children (UASC)

75% (n=9) of referrals were made by social workers in the Unaccompanied Minors team. The remaining 25% were referrals made by GP, another CAMH service and the refugee council.

The reason for referral (Indigenous LAC)

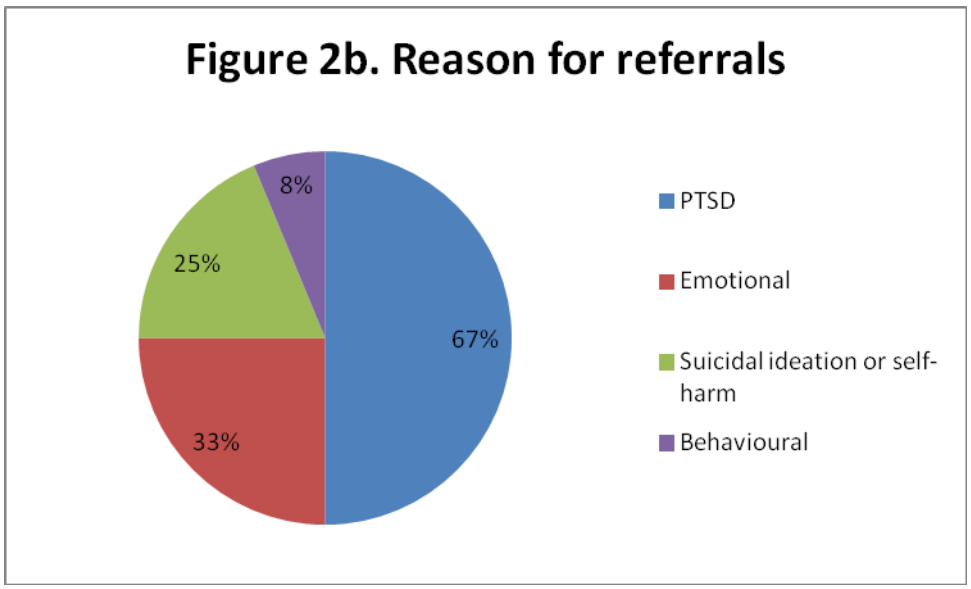
The reason for referral is provided in figure 2a. In 22% of referrals concerns were raised that the young person's presentation was suggestive of a neurodevelopmental disorder, (Autistic Spectrum Disorder or Attention Deficit and Hyperactivity Disorder). An additional 19% of referrals were requesting further assessment or intervention of young people who already had a diagnosis of ADHD, ASD or a learning disability. 30% of the referrals but raised concerns about behavioural difficulties 27% about emotional difficulties, (including anxiety, depression, OCD, and trauma related symptoms) 22% about self harm or suicide ideation and 3% reported concerns about symptoms suggestive of psychosis.

Figure 2a. Reason for referral of indigenous LAC



The reason for referral (UASC)

Figure 2b shows the reasons for referrals. The majority of referrals were querying Post Traumatic Stress Disorder. Other reasons include emotional difficulties (N=4), suicidal ideation and self-harm (N=3) and behavioural (N=1).



Time between receipt of referral, first appointment offered, and first appointment attended (indigenous LAC)

The average waiting time for an initial assessment appointment was approximately 5.6 weeks with 49% of the sample waited less than 4 weeks to be seen. The longest wait was 23 weeks and for those waiting longer than 8

weeks, there was some form of clinical contact with the social worker or referrer (42%) or the foster carer (8%) prior to the initial appointment. Information relating to the reason for longer waits was not felt to be entirely robust on the electronic system but included delays in discharge from an inpatient setting, a young person going missing for several months just after the referral was received and in one case waiting for more information from the referrer about the presenting problems. Anecdotal information suggested that there was often some form of clinical contact between the CAHMS clinician and the referring social worker. Table 1 summarises waiting times.

Table 1a. Average waiting times (Indigenous sample)

Average wait for first appointment offered (weeks)	Average wait for first appointment attended (weeks)	Longest wait to be offered first appointment (weeks)	Shortest wait to be offered first appointment (weeks)	Percentage waiting under 4 weeks to be offered first appointment	Percentage waiting under 8 weeks to be offered first appointment
5.6	7.8	19	< 1	49%	78%

Time between receipt of referral, first appointment offered, and first appointment attended (UASC)

Table 1b outlines the average waiting times in the UASC sample. The majority (58%) of young people are offered an appointment within 8 weeks. The average wait to be offered an appointment is longer than the indigenous sample; this is in part likely to be due to the smaller sample size.

Table 1b. Average waiting times (UASC sample)

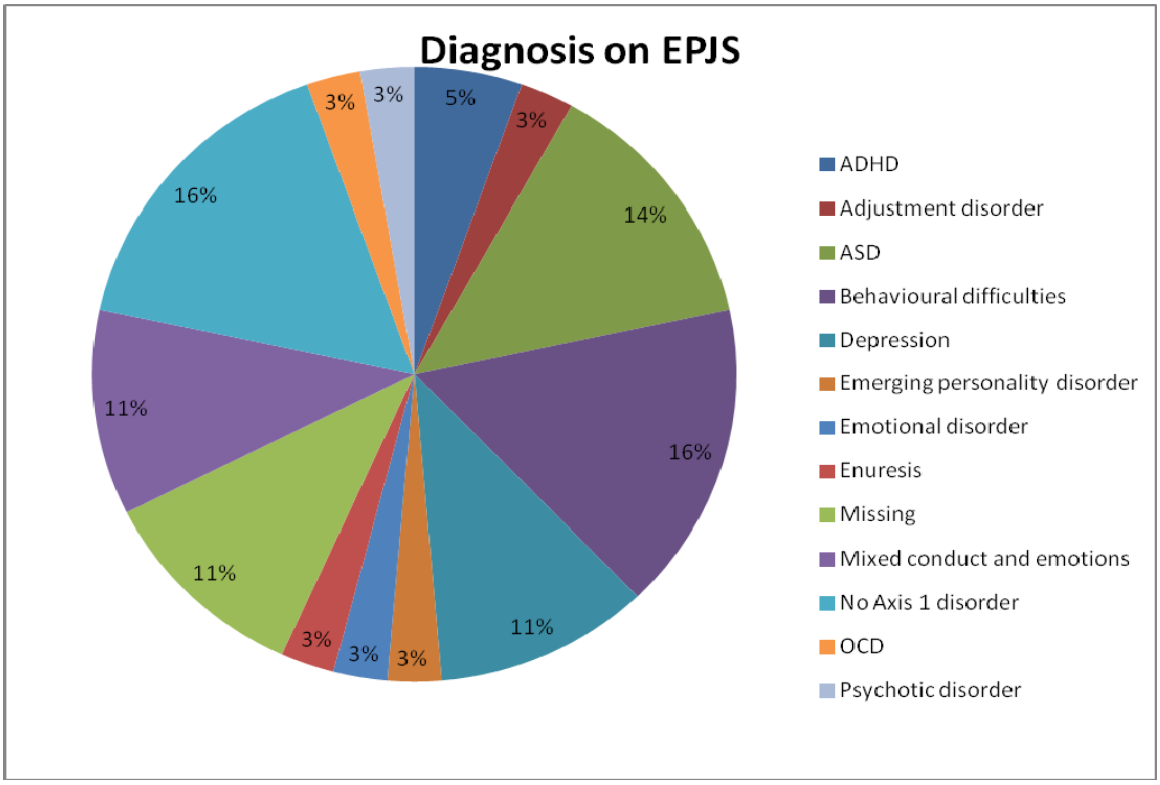
Average wait for first appointment offered (weeks)	Average wait for first appointment attended (weeks)	Longest wait to be offered first appointment (weeks)	Shortest wait to be offered first appointment (weeks)	Percentage waiting under 4 weeks to be offered first appointment	Percentage waiting under 8 weeks to be offered first appointment
9	10	22	2	42%	58%

Diagnosis *(indigenous LAC)*

Figure 3a shows the range of primary diagnoses given following assessment. 19% have a neurodevelopmental disorder (either ADHD or ASD). A significant proportion (16%) had a diagnosis of behavioural difficulties which included conduct disorder and oppositional defiant disorder. And a further 11% had a diagnosis of mixed conduct and emotions. None of the indigenous LAC within this sample had given a primary diagnosis of Post Traumatic Stress Disorder. though it is recognised that PTSD symptoms often present initially as an Adjustment disorder and where young people have PTSD symptoms in combination with marked behavioural difficulties, they may receive a diagnosis of a ‘mixed disorder of conduct and emotion’. The EPJ recording system allows for recording of a maximum of two diagnoses. For the purposes of the current

audit, only the primary diagnosis is outlined.

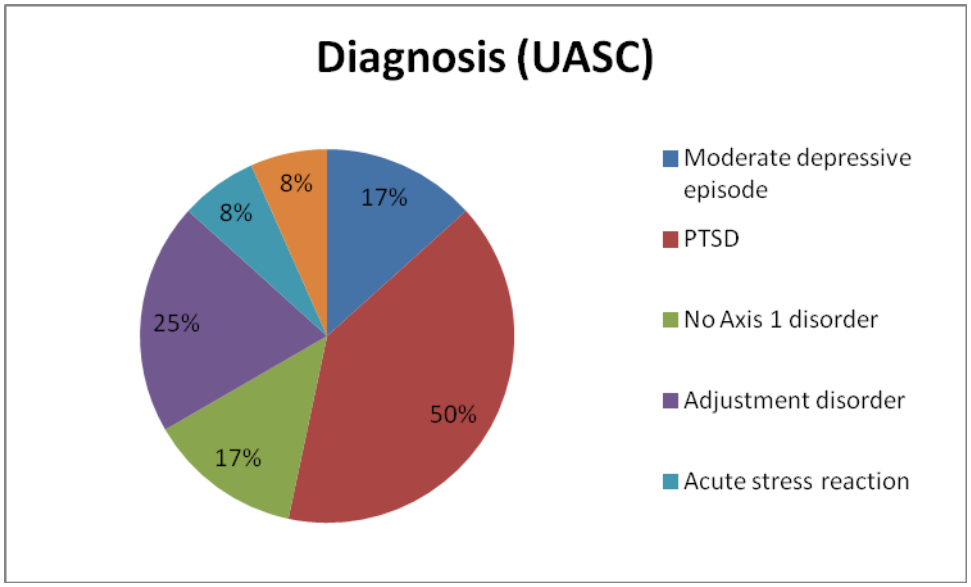
Figure 3a. Primary Diagnosis for Indigenous LAC



Diagnosis *(UASC)*

Figure 3b shows the range of diagnoses in the UASC sample. The majority of young people (N=6) have a diagnosis of PTSD. Other young people have a diagnosis of adjustment disorder (N=3) or Acute stress reaction (N=1). These diagnoses have similar symptoms to PTSD.

Figure 3b. Primary Diagnosis for UASC LAC



Number of sessions attended and not attended (both samples)

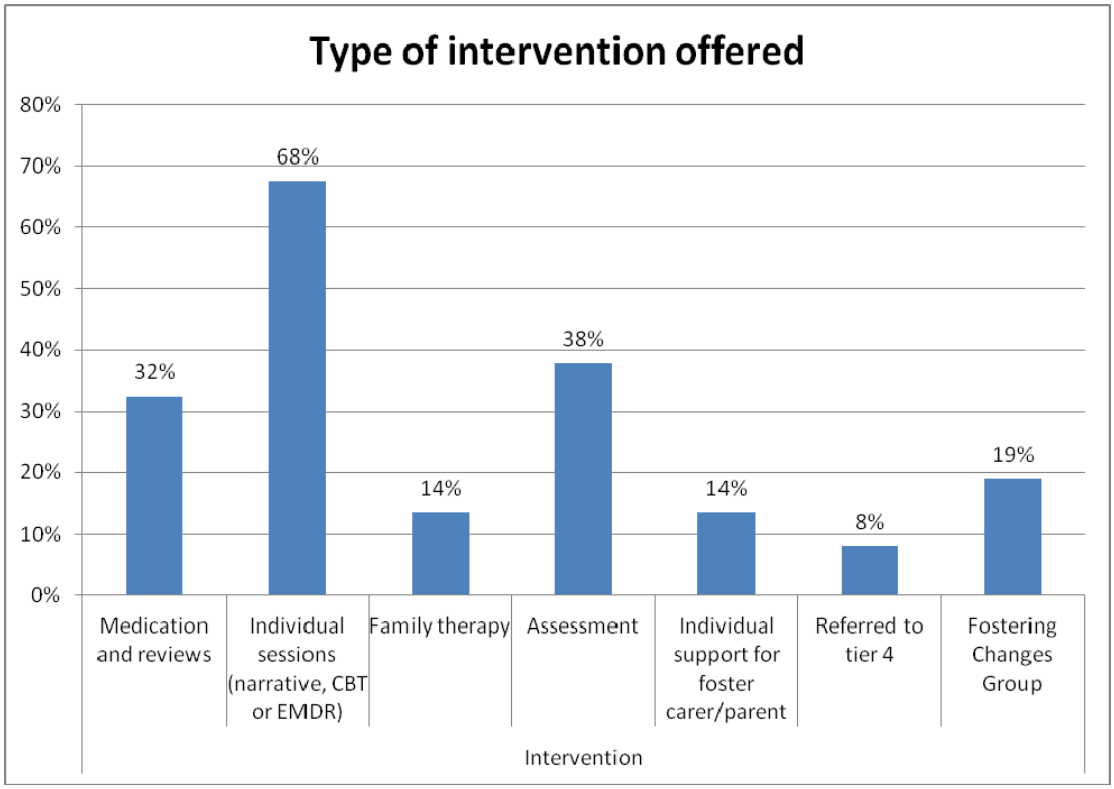
In both samples approximately 20% of appointments offered were not attended. 30% of the indigenous sample and 42% of UASC did not attend 3 or more appointments.

Types of intervention offered (Indigenous LAC)

In addition to individual appointments with the young person, the Croydon LAC team also met with foster parents alone (35% of cases). Support/advice on parenting was offered to 14% of foster parents and 19% of foster carers attended a Fostering Changes Group. It is important to note that parenting/behaviourally based interventions for children with behavioural difficulties are recommended by Nice guidelines rather than individually based interventions. LAC CAHMS clinicians attended a LAC review for 38% of young people and attended a professional meeting for 36% (including professionals meeting, network meeting, missing person meetings or school meeting).

The information in figure 4a provides an outline of the range of interventions offered following initial assessment. The team adhere to NICE guidelines and use evidence based intervention, usually CBT, family therapy or structured parenting groups. Over half of the young people seen received individual sessions, with 38% seen for a specialist assessment (11% receiving an ASD assessment, 5% an ADHD assessment, 3% a cognitive assessment and 19% an extended therapeutic/engagement assessment. The team is multidisciplinary and children and young people with complex problems are seen by more than one member of the team. The average number of staff being involved was 2.6. 3 children were referred to specialist tier IV services. One to a Specialist OCD team, one to the Autism and Related Disorders clinic, and another to the National and Specialist CAHMS Developmental Neuropsychiatry and Neuropsychology Service.

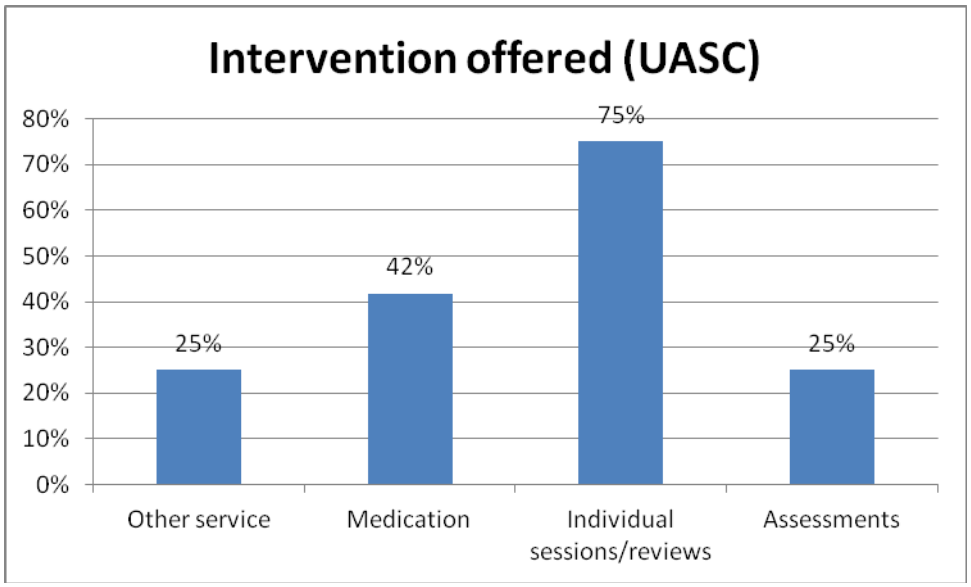
Figure 4a. Intervention offered (Indigenous LAC)



Types of intervention offered (UASC)

Figure 4b below outlines the range of interventions offered. “Other service” refers to a referral to counseling (COMPASS n=1 or Off The Record n=1) or tier IV service (n=1). Assessments include 1 cognitive assessment and 2 extended therapeutic assessments.

Figure 4b. Intervention offered (UASC LAC)

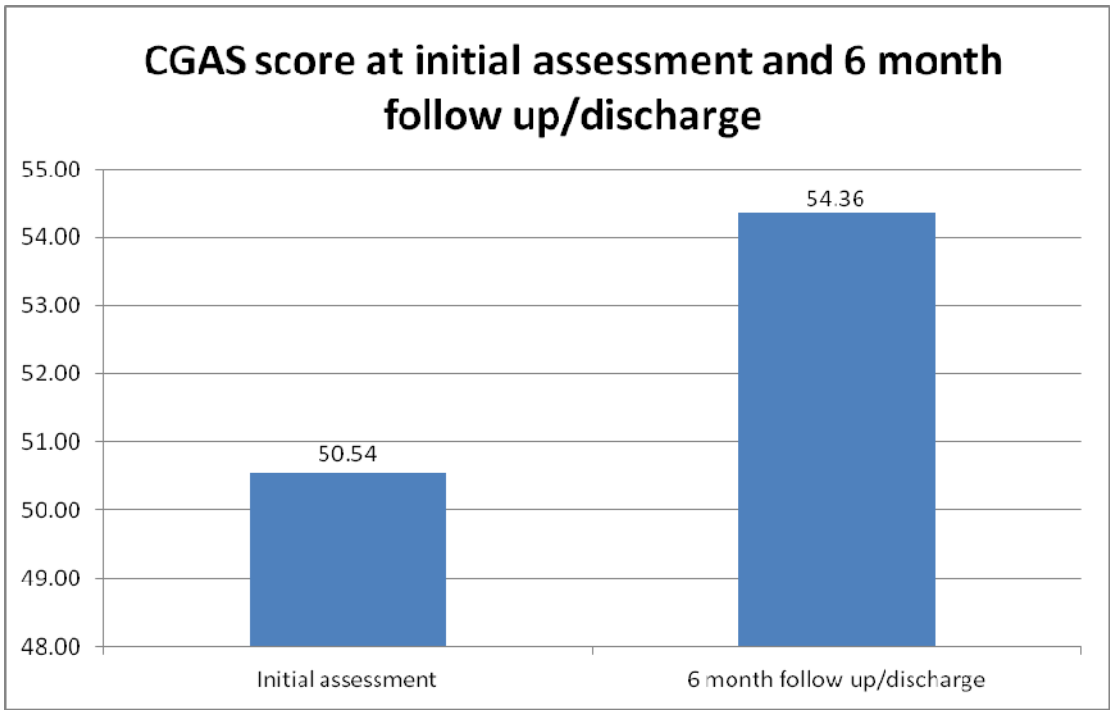


Global outcome data (Indigenous LAC)

The most robust outcome measure on EPJ is the Children's Global Assessment Scale (CGAS). This a clinician rated numeric scale between 1 and 100 that is used by clinicians to rate the general functioning of a young person. Young people with scores below 60 are considered to have significant difficulties. Figure 5 shows the average CGAS score at initial assessment and 6 month follow up or discharge. There was a 3.9 point increase over this period, suggesting improvement.

Of the sample, 20 cases showed an increase in CGAS scores over this period (54%), 1 had a decrease in scores (3%); in 4 cases the CGAS score stayed the same (11%) and 32% had missing data.

Figure 5a. CGAS scores

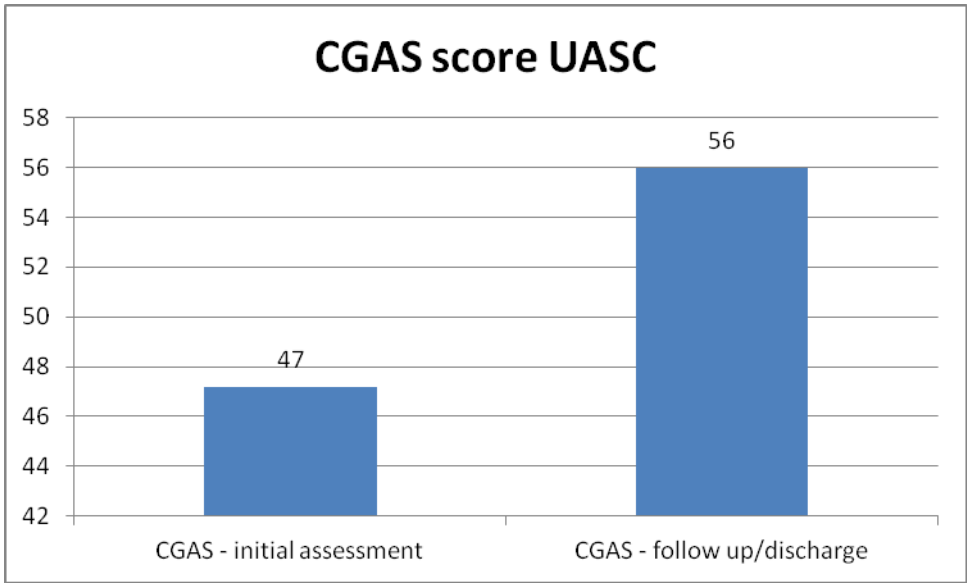


The strengths and difficulties questionnaire (SDQ) is a questionnaire completed by parents/foster carers and young people over 11 years old at initial assessment. Of the 37 referrals reviewed in this audit, only 35% had an SDQ. These were all completed by either the young person, a teacher, a parent or the foster carer prior to or during the initial assessment and none were received at the point of referral.

Global outcome data (UASC)

Figure 5b outlines the average change in CGAS scores from initial assessment to follow up or discharge with an average increase of 9 points. 88% of the sample had an increase in scores (suggesting functioning improved) whereas only 12% of the sample scores decreased.

Figure 5b. CGAS scores at initial assessment and follow-up/discharge in UASC



There was only one case in the sample with a Strengths and Difficulties questionnaire completed. One possibility for the low numbers could be difficulties completing questionnaires in English. Translated versions of the SDQ can be found www.sdqinfo.com in a range of languages.

3.14 **CAHMS LAC Case Discussion feedback**

Comparison of CSC and LAC CAHMS perspectives on Child A

CSC Perspective

Child A (CA) is aged 15 and subject to a Care Order, he has had a very troubled childhood and many placement breakdowns.

CA has been known to CAHMS for about 2 years for ADHD (prescribed medication) high risk behaviours (absconding from care, not following medical regime for his serious health condition). Psychiatric assessment concluded he has a disordered attachment, presents as very emotionally immature, unable to interact socially with his peers, and cannot sustain friendships. He has no family support other than his mother and father who are separated and have an acrimonious relationship. His behaviours are of such concern that he has been in secure accommodation on three occasions, the most recent ended 26.9.2012. CAHMS was asked to attend care planning meetings and offer a flexible and creative way of working with CA and his family.

Unfortunately CAHMS were frequently unable to attend meetings and would only offer appointments for CA and/or his mother at their office. In the view of the social worker it would have demonstrated a commitment to wanting to work with CA and his family if CAHMS workers had visited the family home, or visited CA at school or his placement, jointly with the social worker. The failure of CAHMS to engage with CA outside of the office was at odds with the recognition that CA had difficulty making and sustaining relationships, and that

CA is of an age to feel stigmatised by attending their office. CA's refusal created a stalemate that CAHMS did not proactively attempt to overcome.
CA presented himself to hospital several times but left before a CAHMS worker/psychiatrist could assess him. CAHMS did not follow this up with CA and the social worker believes it was entirely left with CSC to manage his behaviour. The CAHMS response to offer an appointment at their office for CA, sometimes several weeks into the future rather than in the immediate situation of need is described by the social worker as extremely frustrating. The social worker observes that in contrast, the head teacher for CA frequently made visits to him outside of school hours and worked closely with CSC to identify the best plan for his care.

Managers agreed to commission an independent assessment from a consultant child and adolescent psychiatrist to assist in identifying the best way to manage the risks for CA and this resulted in the plan for a secure placement in order to engage him in treatment. CA has now moved from secure accommodation and is in specialist unit in Derby.

In the view of the social worker, consultant practitioner and managers this was a poor response from CAHMS and a poor outcome for the child.

CAHMS perspective

The social worker and care coordinator of Child A requested an appointment with a CAHMS psychiatrist to prescribe ADHD medication. This was to be in conjunction with a therapeutic assessment carried out by the care coordinator. The working diagnosis from CAHMS initially was hyperkinetic disorder and attachment difficulties and conduct disorder. The work was hampered by non-attendance and non-engagement, but CAHMS felt it was important to persist because of the level of risk that he presented with.

In order to engage this young person, Child A was seen by his care coordinator in a number of different settings, on two occasions at the family home and once in school. CAHMS made many attempts to see Child A in clinic and he did not attend a good proportion of them for various reasons (being away with his mother, his girlfriend and also his ADHD symptoms interfered with his ability to focus and organise himself). There was no indication from Child A or his carers that he felt stigmatised by attending CAHMS but there was close liaison with his residential placement following a breakdown in his placement in the family home, and staff there was made aware that they could telephone when in need of advice on mental health issues.

Child A had many visits to A&E related to physical symptoms and clearly saw A&E as a place of safety. His presentation at A&E was understood in the context of mental health issues but he was not presenting with self harm and was not therefore seen by mental professionals within A&E or offered routine 7 day follow up appointments following his presentation there as is customary with children presenting with self harm. However appointments by CLCAHMS clinicians were offered as soon as possible.

CAHMS attended a number of professional network meetings arranged by CSC and also held a TAC meeting, (arranged by CSC) and at that meeting a mutual

arrangement was made with the network to a second TAC meeting. There was some confusion about arrangements for this follow up TAC meeting with invitation letters not being received by CLCAHMS clinicians. CAHMS were also invited to a network meeting, which we could not attend within the notice period given. .

A request for a specialist psychiatric report was requested from Croydon CAHMS. It is considered good practice to refer to highly specialist teams for complex forensic assessments and a recommendation was made for a referral to the SLAM tier 4 forensic team.

The outcome for this case was considered to be poor. The uncertainties about and changes in his placement and contact arrangements with mother exacerbated his distress, agitation and ADHD symptoms. The evidence base for treatment of ADHD is for medication and implementation of consistent parenting/behavioural advice. Child A did not agree with the diagnosis of ADHD and did not comply with medication recommendations. His symptoms of impulsivity and restlessness did not change. These symptoms interfered with his ability to engage with CLCAHMS and the focus of intervention therefore needed to be in providing support and advice to those most closely involved with him including his family, residential staff, school staff and his social worker.

CAHMS clinicians felt the communication between them and the responsible social worker was good and had regular telephone, e-mail, paper correspondence and face to face contact.

Child I

Child I, an unaccompanied Asylum seeker, was referred to CAHMS by her social worker with a request for support in managing her grief experienced from not having contact with her family. CAHMS offered a consultation appointment with the social worker but they did not attend. CAHMS then sent a letter offering the social worker to contact CAHMS, no contact was made and therefore the case was closed. Subsequently the young person was re-referred a few months later. CAHMS offered another consultation appointment with the social worker. The young person attended alone but was still seen. Following the assessment, it was agreed that the young person did not meet the criteria for a mental health diagnosis and did not wish to engage with CAHMS. They were signposted to a more appropriate service (counselling) and discharged from CAHMS.

CAHMS feel this is a good example of the importance of social workers attending consultation meetings prior to meeting the young person. This is partly to gain more information about the young person and to avoid unnecessary upset for the young person having to share their stories with a stranger and then be discharged or signposted on.

Child J

Child J was referred to CAHMS by her social worker due to a history of self-harm, substance misuse, symptoms of depression and severe conduct issues. An initial discussion with the social worker immediately after the referral was received highlighted significant risk due to regular periods of absconding for

months at a time. Therefore, the young person was offered an initial assessment within 10 days and a diagnosis of a depressive episode was made. In addition there was significant evidence to suggest Child J had an emerging personality disorder. The evidence based intervention for young people with personality disorder is Dialectical Behaviour Therapy and Child J was referred to the tier 4 DBT service for further confirmation of the diagnosis with an expectation that they would offer intervention if indicated. In the interim child J was offered short term Cognitive Behavioural Therapy within LAC CAHMS.

Shortly after the assessment, Child J absconded. Discussion with all mental health professionals involved focused on how to best engage Child J once she returned. Child J's care coordinator and CLCAHMS psychiatrist took a lead role in supporting and advising the network regarding Child J's mental health, risk and future planning. This involved attending a number of missing person's meetings, placement planning meetings, LAC reviews, general network meetings, and regular liaison with the social worker and broader network. The day Child J returned, her care coordinator arranged an emergency review. Since this time, extensive work has been done to engage the child and continue to support the network in managing child J's complex mental health needs.

Although the immediate outcome for Child J was poor, in that she required accommodation in a secure unit in a neighbouring borough, CAHMS have continued to provide individual therapy, support to the staff team in the care home, attendance at a variety of meetings and regular written advice and recommendations. This has enabled Child J to be engaged with the most effective interventions, with the expectation that her longer term outcome will be positive. CAHMS feel that this demonstrates positive working between social services and CAHMS and an example of CAHMS' commitment to engaging and supporting young people and their networks in highly complex situations.

3.15 **Conclusions from the analysis**

Approximately half of the looked after children in Croydon, expected to be displaying mental health problems were open to LAC CAHMS in the first quarter of 2013. Appointments were offered in a timely fashion with 5.6 weeks being the average waiting time and 49% being seen within 4 weeks and 78% were offered an appointment within 8 weeks. It is important to note that there may be misunderstanding with colleagues in CSC teams and the waiting times for routine appointments in the community CAHMS tier 3 teams are much longer.

The vast majority of referrals to the LAC CAHMS team are accepted (87.5%) and the majority of those declined are where another service has been recommended and seen as more appropriate to meet a young person's needs. Again, it is important to note that there may be misunderstanding with colleagues in CSC teams about high thresholds being applied. The Community tier 3 CAHMS team is tasked with providing a service for children with moderate to severe mental health problems and declines referrals that do not meet these criteria. The LAC CAHMS team provides an inclusive service for children who have mild to sever mental health problems.

Although the majority of referrals of indigenous LAC children are received directly from social workers a significant proportion are referred by other professionals. LAC CAHMS clinicians find an initial consultation with referring social workers very helpful in understanding the context for the referral and in ensuring that all relevant information is obtained prior to the initial assessment appointment. Data was not available on the number of consultation appointments offered or attended. Completion of SDQ's for all Looked after children has been agreed within the CSC protocol and rates of completion have been increasing. However these are not routinely included with referrals and it is often the case that key information in relation to a child's developmental history and reasons for being looked after, are not included. This sometimes results in young people being seen without clinicians having sufficient information and reduces efficiency.

3.16 Recommendations from LAC CAHMS clinicians based on the analysis

The CAHMS clinicians and managers taking part in this project have identified a number of actions from their analysis and including the views and recommendations from the LAC social workers that in their view will significantly improve the relationship between CSC and CAHMS and lead to better outcomes for children requiring a tier 3 service:

1. That all looked after children are screened for mental health risks using the SDQ and that this information is provided at the point of referral.

2. That LAC CAHMS and CSC jointly develop a new referral form.

3. That CAHMS offer an initial face to face consultation appointment with referring social workers for all cases unless the young person is considered to be at immediate risk of harm to themselves or others, in which case an urgent face to face appointment with the young person will be offered. The focus of this consultation is to develop a shared view of the aims and expectations of CAHMS involvement. A CAHMS care coordinator will be allocated at this stage

4. That LAC CAHMS continues to offer drop in consultation appointments to CSC social workers at JWH. In addition LAC CAHMS will recruit a full time member of staff who, in addition to providing assessments and interventions, will in principle be available to discuss any referral queries on a daily basis.

5. That LAC CAHMS share information on duty systems to reassure CSC staff that urgent concerns will be dealt with on a day to day basis, when a young person's care coordinator is unavailable.

6. That LAC CAHMS undertake some joint training on partnership working to include:
    - sharing of helpful referral information for CAHMS, capacity to consent to treatment and issues relating to confidentiality.
    - Nice Guidelines and Evidence based interventions for mental health disorders

- Outcome measures.
- Transition to adult services and the implications for both services.

7. That CAHMS continue to expand the range of outcome measures used and in particular increase the number of paired ratings for the child and carer SDQ.

8. That CAHMS retain flexibility on where the first assessment is conducted. Where young people are not willing to engage in a mental health setting careful consideration to seeing them in a different setting is given and discussed with referring social workers.

3.17 **Next steps**

Since this review of LAC CAHMS began the partnership between services have been strengthened by the LAC CAHMS presence at JWH an attendance at LAC Management and Team Meetings by Marion Drennan and her colleagues. Marion also offers consultation and advice to social workers when available at JWH. From the perspective of social workers clear guidance from LAC CAHMS about the services they provide, their thresholds and their criteria for engagement or disengagement (something similar to Birmingham NHS "Access Criteria for Specialist CAHMS for example) would be immediately helpful.

The recommendations from the analyses undertaken by CSC LAC Services and by LAC CAHMS were reported to the CAHMS PCG Meeting on 4th June 2013 and accepted for progression. It was a decision of that meeting to make recommendation to the CCG for a joined up offer to LAC from health of the services they can expect to receive locally to ensure they achieve best health outcomes.

4. CONSULTATION; This report is based on consultation with a range of looked after young people, social workers from Children's Social Care, foster carers, and clinical practitioners from the LAC CAHMS Team.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

1 Revenue and Capital consequences of report recommendations

	Current year	Medium Term Financial Strategy – 3 year forecast		
	2013/14	2014/15	2015/16	2016/17
	£'000	*£'000*	*£'000*	*£'000*
Revenue Budget available				
Expenditure				
Income				
Effect of decision from report				
Expenditure				
Income				
Remaining budget				

Capital Budget available				
Expenditure				
Effect of decision from report				
Expenditure				
Remaining budget				

2 The effect of the decision: None

3 Risks; None

4 Options; None

5 Future savings/efficiencies: None

6. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

6.1 (Approved by: *A N. Other*, Lawyer on behalf of the Council Solicitor & Director of Democratic & Legal Services)

7. HUMAN RESOURCES IMPACT: None

8. EQUALITIES IMPACT: LAC CAHMS is a commissioned 3 tier mental health service for looked after children only and to which only looked after children have access by referral. There is no equalities impact of this report as no changes to these criteria of eligibility will be made.

9. ENVIRONMENTAL IMPACT: None

10. CRIME AND DISORDER REDUCTION IMPACT: None

CONTACT OFFICER: Paul Chadwick, Head of Service for Looked After Children

BACKGROUND DOCUMENTS: Safeguarding and Looked After Children Inspection Report, Ofsted, May 2012.

[1] Croydon Children and Families Partnership (2012) *Croydon Children and Young Peoples Plan 2012-15*, available at http://www.croydon.gov.uk/contents/departments/healthsocial/pdf/ccfp-plan-2012-15