South Essex Partnership Trust / North East London Foundation Trust

DATE: January 2016

CAMHS LD Team Outreach Nurse - South Essex Over 12 LD Population: Level 1 Project Commencing January 2015 – December 2015

N.B. please note that services are no longer provided by SEPT but from the 1st of November 2015 by NELFT. CAMHS in South Essex is now the Emotional Wellbeing and Mental Health Service (EWMHS)

1. Purpose of Report

This report is to provide the Burdett Nursing Trust with an overview of the Outreach pilot in the CAMHS Learning Disability service in South Essex for children over 12 funded with the grant from the Trust. This is an end of project report, which outlines the outcomes achieved over the past twelve months. This report must be read in conjunction with the initial report dated 09.05.2015 (included as appendix three).The post holder was in post from 01.01.2015 – 31.01.2016.

2. Background

Aims of Funding

The SEPT CAMHS LD service secured a grant from the Burdett Nursing Trust to develop a pilot outreach service to children over 12. The current CAMHS LD provision is not commissioned for this age range but there was a constant need for support of the children moving on to generic CAMHS teams from the specialised team when they turn 12 and were still on medication. The other identified need was for the generic CAMHS teams to have support in the complex cases where children with Autism and Learning Disabilities over the age of 12 had to access the mainstream teams who did not feel they had the specialised skills to deal with these very complex cases.

This project enabled the service to address some of the needs for over 12 year olds with additional learning disability, within a more mainstream CAMHS arena and disseminate the more focussed skills over a wider clinical base. It aimed to support generic CAMHS staff to develop more specialised skills and knowledge to be more confident in providing services to this client group through consultation and joint working. The aim was for the training and skills sharing from this post to have a positive impact on the practise for mainstream CAMHS clinicians in the future. Reviewing the project should also provide insight in how services need to be shaped for this client group locally in the longer term.
The specific aims of the project were:

- Development of Outreach
- Increased liaison and partnership working between generic and specialist CAMHS and outside agencies providing services to this client group.
- Improved transition that leads to equity of service.

Current EWMHS Learning Disability Provision

Background/ context

Within SEPT/NELFT there is an existing team (three clinicians) which was developed from a pilot project (2006) with Department of Heath funding , that provides mental health services to children with a severe to profound learning disability across South Essex up to the age of 12 years,. At present there is no funding available to enlarge the team's role, or enable further development in order to provide equitable service up the age of 18 years. This provision is currently part of a County wide review of learning disability services in Essex. Children with a learning disability have equal rights to a mental health service, but particularly for those with a more severe to profound learning

disability there is not staff within mainstream services who have sufficient experience and specialised training for the complex needs of this client group.

Before the current project there were varying levels of capacity to provide interventions for children over the age of twelve with additional Learning Disabilities within the mainstream Mental Health teams. This was dependent on a number of factors but the most evident reason seem to have been the availability of staff with sufficient confidence, experience and specialist skills in working with these children and their families. The other clear issue was the capacity of staff in partner agencies to clearly identify the possible mental health concerns in children with special needs. If you can not identify the problem then you cannot refer them to satisfy the mainstream mental health criteria.

National Drivers

The National Service Framework for Children, Young People and Maternity Services (2004) Standard 9: The Mental Health and Psychological Well-being of Children and Young People as Markers of Good Practice was the initial driver for improvement of CAMHS services and the quality of interventions available to children with a learning Disability and indicated:

- All staff working directly with children and young people should have sufficient knowledge, training and support to promote the psychological well-being of children, young people and their families.
- Arrangements should be in place to ensure that specialist multi-disciplinary teams are of sufficient size and have an appropriate skill-mix, training and support to function effectively.
- CAMHS professionals should provide a balance of direct and indirect services and are flexible about where children, young people and families are seen in order to improve access to high levels of CAMH expertise.
- Programmes of care should be comprehensive, structured, system orientated, specific to particular risk factors, and are relatively high intensity, and of long duration to achieve the best outcomes for children and young people with special needs.
- All children and young people with both a learning disability and a mental health disorder should have access to appropriate child and adolescent mental health services that meet their needs.
- The needs of children and young people with complex, severe and persistent behavioural and mental health needs should be met through a multi-agency approach.

3. Aims of the project

The Outreach Post was hosted within the CAMHS LD Team to enable close supervision and support to the Outreach Nurse from experienced clinicians. For the first three months the post holder observed assessments and interventions as provided by the CAMHS LD team clinicians. This included consultations, therapeutic appointments, assessments and observational interventions to gain an understanding of how the present service operated and to familiarise herself with the external networks and partners in preparation for undertaking the new role within the wider CAMHS environment independently.

Aim 1: Development of Outreach

- To ensure Children and young people (CYP)with learning disabilities and complex needs over 12 receive high quality care within mainstream CAMHS and ensures the CYP's individual needs are met in a safe and appropriate environment.

Review of the Development of Service:

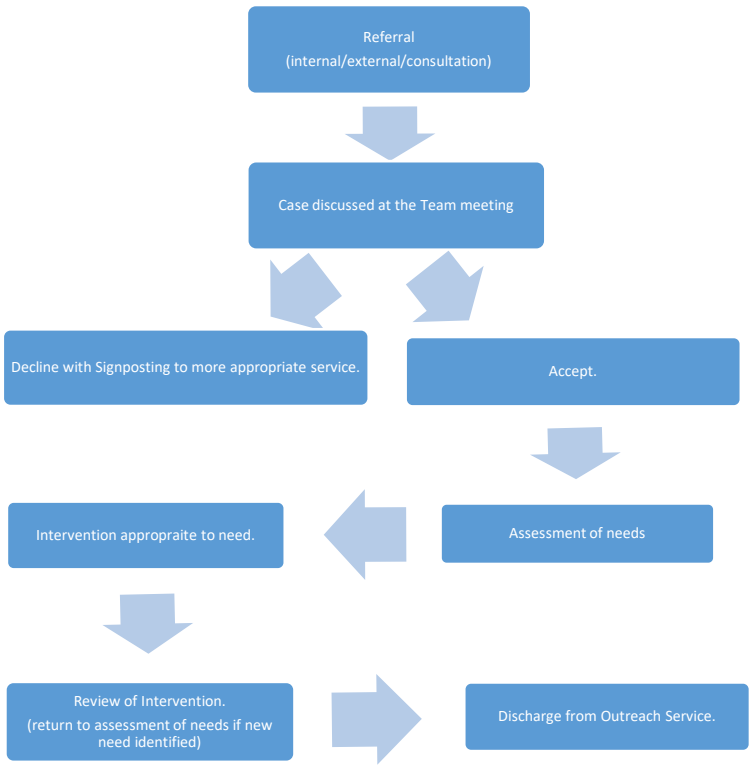
The initial focus of the post was to establish the referral pathway and then to clinically provide assessments, observations, consultations and treatment sessions to a number of CYP. Initially work was done jointly with the existing LD team staff and then these skills were independently used to implement care for the over 12 caseload in mainstream CAMHS who accesses the psychiatrist for medication for their challenging behaviours and high levels of anxiety. The average caseload through the year stood at around 21 cases at any given time although this doesn't include the cases seen for consultation only.

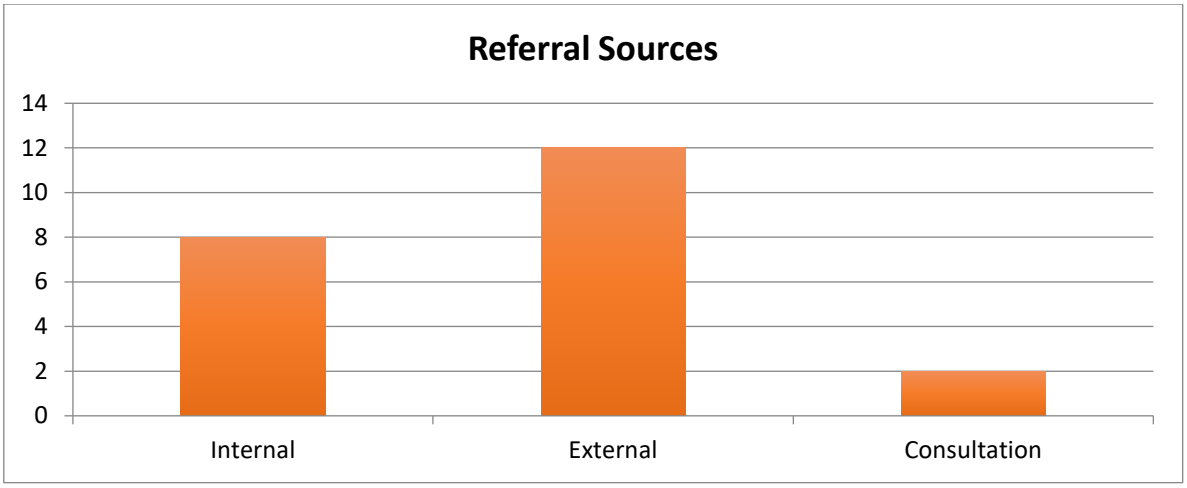
A referral pathway was created between the LD team and the Generic teams that lead to individual cases being taken on by the Outreach Nurse or in some cases a joint-working approach. Joint-

working was adopted primarily in 5 cases. The post quickly expanded to not only support children with a learning disability, but children with a diagnosis of Autistic Spectrum Disorder or complex presentations and mental health concerns. There were only three cases that were children with a complex presentation of severe Autism and no learning disability that were referred to Outreach.

Case Study One:
A 13 year old boy was referred to the service by a mainstream school. He was a year 8 pupil who had a diagnosis on Autism Spectrum Disorder. He was having violent outbursts and was displaying high levels of anxiety at school and at home. Due to the child not having a learning disability but complex behavioural issues possibly related to his Autism, the school was offered a consultation regarding the child's current presentation. The child and the mother attended the consultation and an informal discussion was held with them. The feedback from that session was that the child had never engaged with anyone before and the mother was amazed that RVD was able to communicate with him at an appropriate level with obvious understanding of his difficulties. Further consultations were offered as the family was adamant that they did not want a referral to another service.

Referral and treatment Flow Chart





Referrals came from three separate sources; internal CAMHS referrals, external agency referrals and school consultations. All referrals were discussed in weekly LD team meetings to assess appropriateness. The cases were then either declined and sign posted to a relevant service or accepted for further assessment or consultation.

Internal referrals: These referrals were either children who were already receiving a service from the CAMHS Learning Disability Team approaching or exceeding the age 12 and were transitioning to the generic teams or cases where the Generic CAMHS Teams needed a more specialised service to support them with the care for a complex YP with special needs. The Outreach Nurse would collate all the information and use informal meetings with school and family to provide assessment and intervention often in the community (home or school) unlike the more clinic based mainstream teams. Observations at both home and school would be conducted if not previously done to inform the care plan.

External referrals: These children would be referred by schools, Tier 4 services, GPs and other professionals. Self-referral was not available due to the very limited resource. The Outreach Nurse would then undertake an assessment of the child's needs by collating more information from the family, school and if applicable other professionals.

Consultation with Education: These generated an opportunity for schools to discuss pupils with complex presentations and receive support and advice around potential management strategies. If it was deemed appropriate a formal referral was made to the Outreach Service for further consultation with family or to become an active case for intervention post consultation.

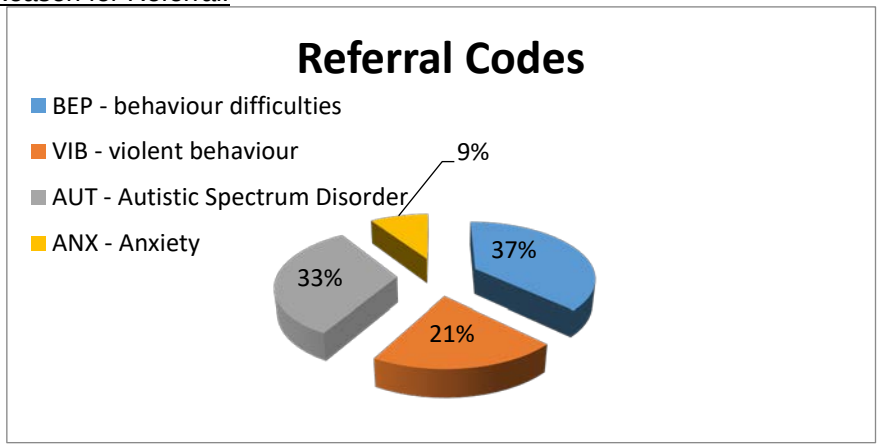
Case Study Two:

A 16 year old girl with a diagnosis of Williams Syndrome, moderate learning disabilities and severe depressive disorder was referred to the Outreach Nurse by the local generic team's psychiatrist for additional support. The mother was emotionally exhausted and was struggling to cope. The depressive state of the patient was having an effect on the entire household making the family relationships quite strained. The mother explained that she had recently became a single parent through divorce and had no family support to help her when things became particularly challenging. Although her daughter had a clear diagnosis of a specific syndrome that impacts on her mental health and learning abilities, Social Care explained that their referral criteria wasn't met as they felt it was a mental health concern. I supported the mother with making another referral but included some supporting information about the diagnosis and also made a clear request about support required by the family. The parent and child were able to be presented to a Resource Allocation Panel and were allocated Direct Payments allowing the mother to access much needed respite for the child. The Outreach Nurse was also able to arrange and attend psychiatric appointments with the family providing support and taking their cases to the MDT meetings to refer them to other members of the team for therapy.

Discharge Process

When the intervention was complete (or in one instance where the family disengaged) the child would be discharged from the service following agreement from the families. The families were notified following discussion with a letter explaining that they were being discharged as agreed and that if any issues were to arise in the future they were able to contact the team for support and guidance or to go back to their referrers and be re-referred back into the mainstream EWHS service. Those children who needed to receive care post the end of the Outreach pilot were handed back to the generic EWMHS team in their geographical area after discussion with the family and the team taking over the care.

Overview of Reason for Referral.



An audit was requested towards the end of the pilot project by the Clinical Director of CAMHS to determine the amount of hours involved within the cases (see appendix 2).

Aim 2: Increased liaison and partnership working

- Improvement in the mental health of CYP with special needs referred to the service through provision of effective service delivery and multi-agency working.
- Families and staff in universal settings have access to advice and are supported by specialist services.

REVIEW OF THE YEAR:

Brief overview of Interventions

The appointments with the patients and/or their parents took place primarily in their homes and an Educational setting with only a minimal amount of appointments taking place in a formal clinical setting. The majority of appointments that were in a formal clinic setting were medication reviews in conjunction with the Generic Team's psychiatrists. Sixteen out of the 21 cases that have been open to outreach over the course of the year have been jointly open to psychiatry and the nurse attended most of the psychiatry appointments and medication reviews providing needed support and easily accessible information. Interventions varied to meet the needs of each YP but the main themes were providing support to the child and family members, liaison with other relevant agencies to gain service input for the family and YP, and health Education and facilitation to the parents around their child's diagnoses to better their understanding and acknowledgment of the child's abilities.

Parental support was one of the key elements of the role and the most appreciated by families, young people and professionals according to the satisfaction survey done at the end of the project. Partner Agencies that were challenged in their capacity to support these families made referrals to the Outreach Nurse in the pursuit of parental support and guidance around complex issues. An often repeated theme from parents was that they often didn't feel listened to by professionals, or had

arrived at a dead end with trying to get support for their child. Initially they appeared to be quite doubtful of the Outreach nurse's capacity to support them but they also were grateful for the time limited service. The nurse was able to facilitate the help from other Services which the family required ranging from Social Care referrals to visiting potential new schools with the families. The feedback from the families is that they 'finally felt listened to'.

Contact and liaison with the local generic CAMHS teams:
One of the first tasks was for the nurse to establish contact with the generic CAMHS teams in order for staff to be to access her for advice and/or consultation and joint working. The Outreach nurse has joint-worked several cases with generic CAMHS clinicians to provide added support due to the complex presentation of the patient's behaviour and mental health. She has also provided consistent consultation to them to increase their knowledge and confidence in working with these children.

Case Study Three:

A 14 year old girl was discussed via a consultation with Education. She had recently suffered the bereavement of her father. Her mother was concerned about her self-injurious behaviour and her displays of challenging behaviour at school. The school planned to make a referral for her to the Outreach Service, but after discussion it was deemed more appropriate that a referral was made to the local generic team to carry out a mental health assessment as well as look at the potential need for counselling. The school was assisted in writing the referral to the Generic CAMHS service to ensure that they were using the correct language to ensure that the case was accepted. The Generic Team was consulted about the case and the outreach nurse spoke about her professional expectations around working with the young lady. It was decided that the Generic Team would do an assessment and offer her bereavement counselling. The Generic Team asked for a consultation to discuss possible strategies and adaptive approaches to help deliver the bereavement counselling in an accessible manner.

Contact and liaison with the Special Education schools
A process of consultation was created with several of the SEN schools and established regular consultation clinics within the schools. This was offered to all 13 special needs school within our area but only seven schools accepted. Due to the time limit and limited capacity of the pilot project only two formal consultations were offered to schools with one in the first half of the year and one in the second half either side of the summer holidays. In two of the schools that appeared to have a high level of need reflected in their referrals and use of the consultation slots, it was reported that there had been a decline of referrals to the local Generic CAMHS teams after access to the consultation sessions. The consultation process created with Education allowed schools to discuss cases that they were concerned about without having to formally refer them to a Tier 2 or 3 service. Thirty four individual children were discussed and supportive advice was offered. Out of the 34 cases discussed indepthly in school consultations, 7 were formally referred to the Outreach Service and 14 were signposted to other agencies eg. Social Care, Educational psychologists and generic CAMHS teams. With the rest school staff felt confident to manage after the consultation session.

The accessibility of the nurse to the school staff however generated referrals to the Outreach Service due to the fact that staff had someone to refer to directly where previously they had no access for these children to CAMHS Services. Support was also given to teaching staff to assist them in writing appropriate referrals to CAMHS Tier 3 with the necessary information to help indicate the mental health problems within their referrals. Outside of the formal outreach consultation process there was access telephonically to the nurse to make referrals or to discuss children if the need arose between the consultation appointments.

The clinician worked intensively with the schools with the intended outcome that the schools would be able to support the parents better. Observations were carried out on the children and the nurse supported the school to acknowledge possible antecedents to the behaviour and relevant strategies that they could use as an intervention.

The nurse was also involved in the Education, Health Care Plan (EHCP) and Annual Review processes helping to provide mental health input into the Educational reports. She was also requested to help support children through possible safeguarding concerns that did not necessarily meet the threshold of the level 4 child protection process at Social Services. This meant that she often supported the schools to collate information and pass it on to social services with her own observations and concerns added to theirs.

Reviews with local CAMHS psychiatrists:
The clinician has worked closely with the CAMHS psychiatrists involved with these young people. She facilitated medication reviews and supported that with behavioural support plans at home and at school. She attended appointments providing support for the psychiatrist with managing complex patients and would carry out any necessary actions that came from the reviews; such as referrals to Social Care, sensory profile reports and observations. She would also help facilitate emergency appointments if the child's mental health deteriorated by creating an open channel of communication through herself to the psychiatrist and family. In one particular instance there was concern that a child was having an adverse reaction to their prescribed medication, Risperidone. The nurse was able to arrange a blood test via the GP and take his blood pressure (BP) and monitored his heart and respiration rate. She then notified the psychiatrist of her concerns which led to an emergency appointment the following week and a change in medication.

Referrals directly to the psychiatrist have also been made due to the nurse conducting a preliminary mental health assessment where the families have been at crisis point, leading to the need for medication to effectively manage the child's presentation of high levels of anxiety manifesting as challenging behaviour and violent outbursts. The amount of worked the nurse did before these referrals were done made the process of referral to the psychiatrist much easier for the families.

Contact with Tier 4 Inpatient unit regarding after care in community:
The Outreach Nurse has had varying degrees of contact with Tier 4 services ranging from referrals following discharge and facilitating an admission into an inpatient unit following a crisis intervention. The nurse has had contact and joint working with the South Essex Crisis Team to help facilitate appropriate care.

Three of the 21 cases open to the outreach project were referred from Tier 4 services. Two were following discharges back into the community following a stay in the local inpatient unit. One was a transfer of service due to being referred to a specialist service as the local Generic CAMHS were unable to meet his needs and provide adequate mental health support.

Following a complex crisis situation (see Case Study Three, Appendix 1) an inpatient admission was arranged for a further period of observation and intervention. During the period of admission the outreach nurse was required to attend and provide input to Care Plan Approach (CPA) meetings, Reviews, Discharge Planning, telephone conferences and Care and Treatment Reviews. The clinician has had to provide written supporting documents and facilitate any actions that were deemed necessary in the MDT to her post. Due to the large amount of input and the lack of Social Care presence to begin with she was deemed to be the care co-ordinator for this patient. This developed into liaising with Social Care, Education, family and the Tier 4 service on a regular basis. At the time of writing this report the patient remains in the inpatient unit (see Appendix 1 for Case Study Three).

Liaison with Social Care:
Multi-agency working with Social Care was essential to provide a holistic and person-centred service. The Outreach Nurse found that most children that were referred already had Social Care input however four children on the open caseload needed Social Care referrals. Three of the four were accepted into the Children with Disabilities Team, but one remains unallocated to a social worker as he does not meet the higher thresholds for a Level 4 service. Three of the children on the open caseload were raised as safeguarding concerns to the local social services teams due to concerns around the children's social situations and their challenging behaviours.
The clinician was involved in many Social Care processes such as being part of Team Around the Child meetings (TAC) and Child In Need (CIN) forums. She has also worked with Social Care Resource Allocation Panels (RAP) to obtain funding for families to access additional funding for them to access respite care facilities.

Aim 3: Improved Transition leading to Equity of Service

- Equitable access to CAMHS for children and YP with complex needs of all ages.
- Improved mental health and wellbeing for vulnerable groups including Looked after Children.
- Services that continually improve in quality by making best use of existing evidence, information and emerging insights from the evaluation of interventions.

REVIEW OF THE YEAR:

Equal access to Mental Health services for children with special needs over the age of 12 years old through support to mainstream CAMHS.
As this was a singular role and there was a strong awareness of the limitations for the clinician and this client group, concerted efforts were made to make the best use of resources and best evidence regarding interventions and plans were made and implemented to develop this post's capacity to its maximum.
The equitable access was acknowledged by providing this service across the whole geographical area covered by the previous trust. The service was offered to all the local teams, primarily through to the psychiatrists and then to the rest of the generic CAMHS practitioners. Out of the five locality teams the Outreach nurse worked primarily with four however was always available for all of them. It is not clear why this service was not as actively used by one team as by the others.

Equal access in the true sense of the word can obviously not be obtained through a one person service. The needs far outstrips the capacity.

Consultation with Education and Social Care for children where concerns are expressed to access Mental Health services more effectively.
The nurse has worked closely with Education in special and mainstream settings to meet the needs of as many children as possible within the capacity of a singular post. The Outreach Nurse has provided informal training discussions to help provide Education staff with the ability to support the parents in the longer-term with episodes of challenging behaviour and to make adequate and appropriate referrals to the mental health services.

The Clinician has worked with Social Care on many of the cases as 18 out of the 21 cases have Social Care input. This has been either on an intensive basis due to the level of impact the child's mental health was having within the Educational and home settings or in a supportive sense in regards to continued maintenance and support with their mental health and compiling reports and providing information to all involved in the children's care..

Assisted transition process to adult services through supported consultation.
This aspect of the pilot project has not been assessed because there were no opportunities in the last 11 months to support a patient into adult services.

4. Key Issues and Challenges

There were many issues and challenges that presented themselves throughout the duration of the post as would be expected in a pilot project with one clinician.

The initial challenge faced by the Outreach Nurse, was the building of professional relationships with other professionals in all settings including the other practitioners in the local teams. This was particularly challenging and crucial due to the time limited nature of the post. The general consensus among the professionals was that they were sceptical about the impact one professional would have on a very large and complex population of children. There was also the concern about when the post finished about what would happen to the complex cases that were accepted by the Outreach Nurse. The concern that they would eventually be handed back to the Generic Teams with no further specialist provision to support the patients and their families prevented some initial referrals.

The post took on a care co-ordinator role in quite a few of the cases. Facilitating referrals to Social Care and inpatient units and completing outstanding actions from the various professionals involved. This was deemed appropriate by the clinician to ensure the continuity of care and ensuring that all of

the patients social and health needs were met in a person centred and holistic manner. This is also a role taken on by the CAMHS LD clinicians as they have found that their input around co-ordinating care and other professional's input impacts directly on the family's ability to support their child/YP and in turn helps to manage the child's own mental health.

Social Care referrals were always a complex issue. The referral criteria of the Children with Disabilities (CWD) Teams in Social Care were changing. Reductions in funding were making it harder to get a referral accepted although the child's and parent's needs for support was more than apparent and not something that could be met by a mental health service. In some cases the clinician was able to make successful referrals but in other instances her referrals were declined due to the children not meeting the referral criteria threshold. This will be an ongoing issue for all clinicians due to the limited resources and funding available to people with a learning disability.

Another issue that links in with Social Care is the views around safeguarding issues and concerns. The safeguarding teams have set criteria and support guidance for children at risk of harm or abuse but things become more complex when the child is presenting with violent and challenging behaviour and is targeting the parents. The risk is not deemed appropriate as the child is not at risk of harm, unless the situation deteriorates but they acknowledge the potential for placement breakdown. The Social Care system in place does not fully understand the impact that children who target their parents and siblings have on the mental health of the parents which in turn can make them vulnerable.

During the time in post the Outreach nurse had contact with the Crisis Team with one case (see appendix one) and it was found that the team did not have in-depth knowledge of people with a learning disability and their presentation of mental health as challenging behaviour. There was also limited knowledge on appropriate places to access for inpatient beds. The limited knowledge also stemmed from there being a limited number of places that provided specialist inpatient beds for CYP with mental health problems. In the end it was the CAMHS LD manager that advised of a possible appropriate placement due to a previous patient needing admission several years previous, allowing the Crisis team to then approach the hospital and facilitate admission through commissioners. The patient was admitted to a unit over 100miles away from their home, which has caused the mother long hours of travelling to attend all the necessary meetings and therapy sessions and attempting to balance the needs of her younger child that is at home.

From the 1st of November 2015 South Essex Partnership Trust were no longer commissioned to provide the CAMH Service instead the tender was awarded to the North East London Foundation Trust (NELFT) to provide the Emotional Well-being and Mental Health Service (EWMHS). This transition of service is also a transformation of service and has a planned pathway system yet to be implemented due to a period of consultation. Unfortunately the future if the CAMHS LD team is at this point unclear. Within the new service model for NELFT EWMHS it is not yet clear as to what specialised service children with complex needs and disabilities will be receiving from the local mental health teams.

The Outreach Nurse has endeavoured to help minimise/avoid these challenges in the future by consulting and providing informal teaching to other professionals to help build their understanding and knowledge on the individual cases that they can hopefully apply to others that may be referred to themselves in the future.

Conclusion from the Outreach Nurse

In conclusion of this report it is important to highlight the main themes that have run throughout this report and the project. As the appointed clinician I have found it incredibly rewarding to work with the parents and families and the young people themselves. It became apparent from the start that family support was the most pressing need for the schools and families and was welcomed hesitantly due to

the short length of the project. The parents felt that they had been let down by a large category of services and whether they felt listened to or not there appeared to be little action from professionals previously. I feel this is possibly due to the lack of funds and resources around people with a learning disability and will only increase in severity as more service cuts are implemented. The service cuts will potentially mean less support for children with learning disabilities and their families and as seen throughout this year could potentially result in more mental health referrals and need for intervention. As the Outreach nurse I feel that I have openly listened and acted on each parent, family and children's needs appropriately enlisting the professional support of other services and helping to reduce the level of mental health issues presented. The many professionals that I have worked with around the children on my case load have been of same/similar opinion as me, and it appears to be the systems that are failing the children and not the clinicians.

Another theme that appeared whilst I was working across the five locality teams is the lack of specialist knowledge and experience with regards to learning disabilities. Practitioners didn't feel able to engage with children with significant learning disabilities as they didn't feel equipped to deliver appropriate therapy to children with limited or no verbal capacity. The specialist qualification and skills acquired through specific learning disability training appears to be a necessity when providing a good and an appropriate service which in turns helps to empathise with parents and support them on a day to day basis with the complexities they face with their children. The additional knowledge that a specialised clinician offers to professional practice may be able to offer potential support strategies resulting in less children being medicated through lack of understanding and resources, or potentially delaying medication by putting in preventative strategies.

When I initially commenced this post, I was from a behaviour background and felt that medication could be avoided with the necessary positive behaviour support. I hoped to advocate against the need for medication, but as a sole practitioner providing a service for the over 12's therapeutic intervention was not possible on a long term basis and due to the complexity of the referrals, I found myself advocating for medications as suitable management for challenging and violent behaviour in some of the cases. My professional opinion is that when the children are referred to the service they were beyond preventative interventions and needed reactive strategies to prevent further escalation, which due to limited resources was medication and some behaviour strategies that the parents could manage within the home. Puberty and adolescence plays a huge role in challenging behaviour and sometimes due to the limited understanding of the child it can result in a display of violent and aggressive behaviour. Overall the current mental health service does not have the capacity to manage this without specialist support from clinicians like the LD team.

Appendix 1 -

Below is a case study that outlines every aspect that the Outreach Post covered. It was a particularly complex case and it was felt that this needed to be included within the report. The aim of this case study is to bring to people's attention the need for specialised staff with expert knowledge to be employed in all roles. It also highlights some of the short comings of services and resources available to families and children with a learning disability.

Case Study Three:

***names have been changed in accordance with the Data Protection Act 1998.**

Complex referral:

Through the setting up the school consultation process with one of the local SEN Schools a direct referral to Outreach was made by the Head of Key Stage 4. The referral was for a fifteen year old boy, Scott, who was displaying violent and challenging behaviour at home and in School. He was described as having 'a turbulent start in life' and he was 'subjected to an environment of abuse and neglect at a young age'. This had led to the need for additional support around associated mental health issues. Scott had been diagnosed as having Attachment Disorder, Opposition Defiant Disorder, Moderate Learning Disability and Attention Deficit Hyperactivity Disorder.*

The School's main concern was that Scott's foster mother, Holly, was at crisis point and was saying that she could no longer cope with or manage his behaviour any more. The referral stated that the placement was at risk of breaking down if things didn't improve rapidly. At home he was reported to be displaying 'very aggressive, violent and confrontational behaviour to his mother on a daily basis' which included physical aggression, swearing and absconsion from the family home. At school he was reported to be verbally aggressive and disruptive in lessons which led to the school introducing a reduced timetable.*

Holly was contacted by the Outreach Nurse to accumulate more information and it became evident that the family were at crisis point. Holly was emotionally exhausted with little support and Scott was beginning to target his five year old younger brother and the family pet dog.

Family Support – during a crisis:

A few days before the initial visit Holly contacted the Outreach Nurse and explained that there had been an incident that led to the police being involved. Scott had been threatening to kill Holly with a machete in the early hours of the morning and was harbouring a crowbar in his room. This had led to Holly calling an ambulance for help and consequently police attended also. The police that attended managed to get control of the situation, confiscating the crowbar and speaking to Scott at length about his unacceptable behaviour. The next day the Outreach Nurse attended to do an initial assessment.

When the Outreach Nurse attended to do an initial assessment Holly provided her with the background information, whilst Scott was upstairs in his bedroom and shouting expletives at Holly and the Outreach Nurse through his bedroom door. The Outreach Nurse listened to Holly's concerns and feelings of being let down by everyone. Holly explained to the nurse that she had asked Social Care for support, CAMHS and the GP but no-one was able to offer her help, instead declining referrals or closing the case after assessment. The Outreach Nurse spoke at great length about Holly and her family's needs and explained that she was going to go away after attempting to speak to Scott again and make referrals to multiple agencies to attempt to get the family some much needed support and input.

The Outreach Nurse spoke through the bedroom door to Scott for over an hour trying to get him to engage with her and eventually to try and encourage him to go to his counselling appointment that was scheduled for that afternoon, but Scott refused.

Holly was provided with the Outreach Nurse's contact details and was informed of the necessary steps to take if the situation deteriorates overnight and to contact Outreach with any questions, concerns or development.

Holly contacted the nurse on many occasions via phone and text for support. The Outreach Nurse always made herself available to Holly as she was fully aware on the emotional strain that she was facing.

Co-ordinating key services:

The Outreach Nurse initially contacted the Children with Disabilities Team to make an urgent referral to them, however as Scott had been open to another team within the past six months it was procedure to redirect the referral to that Social Care department. The Outreach Nurse spoke with the manager of the Initial Response Social Care team and the manager gave the impression that she didn't feel that it was a Social Care matter but a mental health one. The manager explained that the risk presented by Scott was aimed at the mother and the younger sibling so to reduce that risk they would remove the younger brother for his safety. The Outreach Nurse explained that that wouldn't be appropriate and that the family required an assessment of need to highlight their difficulties. It was requested whether their team could arrange emergency respite and the response was a firm no and the manager explained that Holly was in receipt of Disability Living Allowance, meaning she had enough money to access it on her own. The Outreach Nurse asked whether the Social Care team could offer direction to emergency respite units in the locality but the manager was unable to offer that advice. It was agreed that a social worker would attend with the Outreach Nurse tomorrow at Scott's house and carry out an assessment.

The following day the social worker and the Outreach Nurse attended Scott and Holly's house and commenced an assessment. Unfortunately Scott was in a highly anxious state and had locked himself in the toilet. Scott began shouting verbal and racial abuse at the social worker, Holly and the Outreach Nurse. He began threatening to kill Holly several times over the duration of the meeting. The social worker attempted to engage Scott in conversation when he moved from the toilet to his bedroom, but Scott refused to open his bedroom door and continued to shout abuse at everyone in the house. He then began to get incoherent and started humming a strange tune. The Outreach Nurse and the Social Worker deemed the situation to be at an elevated level of risk and decided to request a Mental Health Act (MHA) Assessment. She was directed by several individual teams to contact other professionals to assist her, explaining that they didn't have specialist Learning Disability knowledge and that the only option available was to take him to A&E. The Outreach Nurse was directed to contact the police by the Clinical Director as a last resort due to the local Generic team's psychiatrist being unavailable and if the police were to deem it appropriate they may detain him under Section 136 of the MHA.

After the police arrived at the house it was agreed that they would help to facilitate taking Scott to the local A&E department to have as assessment if the Outreach Nurse was able to co-ordinate the on call psychiatrist and the crisis team. The Outreach Nurse was able to contact the crisis team and inform them of the plan and received the contact details of the on-duty psychiatrist, who was then contacted and made aware of the planned admission of Scott.

Support to other services/agencies due to specialist role:

The Outreach Nurse provided additional support to all the services that were involved with Scott; the police, social services, the on duty psychiatrist and the paediatrics A&E department.

The Outreach Nurse was able to provide the other professionals and clinicians with support around communication and the level of functioning of Scott and also an immediate history of events whilst Hollie was able to give a full chronology. A professional opinion was also given upon request which appeared to be acknowledged and respected in such a complex situation.

Appointments were facilitated by the Outreach Nurse making them accessible for Scott and also taking some pressure off of Hollie and the other professional by being able to manage Scott's behaviour, provide background information or ask appropriate questions. This happened on several

occasions, firstly when Scott was admitted to A&E, secondly when the Crisis Team came and did an assessment and thirdly when Scott was assessed for the inpatient unit.

Advocacy role:

The Outreach Nurses role became an advocacy role for both Scott and Hollie in a very challenging situation, information had to be explained and shared in an appropriate manner and decisions needed to be made in Scott's best interest. Throughout this whole process the Outreach Nurse was able to voice the opinion and needs of the patient, Scott, and his family in the appropriate professional forums.

Positive Outcome:

The Outreach Nurses input prevented the initial situation from escalating, which with the level of violence being displayed would have resulted in Scott being detained by the police on a domestic violence charge. The intervention supported by the Outreach Nurse enabled Scott to receive the services and support that he needed in a safe and secure environment. At the time of writing this report the team around the child are discharge planning for his return into the community into a supporting living unit.