PROJECT report

STAIRWAY PROJECT: NURSE-LED OUTREACH SERVICE FOR LOOKED AFTER CHILDREN AND THEIR CARERS TO PREVENT PLACEMENT BREAKDOWN AND SUPPORT TRANSITION FOR YOUNG PEOPLE ENTERING AND LEAVING CARE.

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NHS Foundation Trust

STAIRWAY - PROJECT

Newham Child & Family Consultation Service

June 2016

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Acknowledgements:

This project involved contributions from a number of people across East London NHS Foundation Trust, London Borough of Newham Children's Social Care and Community Health Newham.

First and foremost thanks to the Burdett Trust for nursing for funding the project. Without their contribution this project would not have got off the ground.

Thanks to Brigitte Wilkinson from Newham Child & Family Consultation Service, Kerry Read from Community Health Newham and Yvonne Michael from London Borough of Newham / Children's Social Care for their time and contribution to the project steering group which has been vital to the progress and completion of this project.

Thanks to Allisson Ross-John and the Children in Care Council for their kind invitation for us to join their meeting, and for sharing their thoughts about issues pertinent to the project.

Special thanks also to Sarah Campbell from City University, London who gave her time to guide the data collection and advise us on the service evaluation and report writing.

Thanks also to Rachel Trimmer, Assistant Psychologist, from Newham Child and Family Consultation Service for her input into the project report.

“Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have a far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.”

Department of Education and Department of Health, 2015

Abbreviations used in this report:

LAC – Look After Child(ren)

CAMHS – Child and Adolescent Mental Health Service(s)

NCFCS – Newham Child and Family Consultation Service

LBN – London Borough of Newham

OCNS – Outreach Clinical Nurse Specialist

BAAF – British Association for Adoption and Fostering

SDQ – Strengths and difficulties questionnaire

1. Introduction

The needs of children and young people entering the local authority care system are complex. Most have experienced abuse and neglect, loss, disability or serious illness of one or both of their parents. The journey through the care system can be challenging, and some may struggle to settle and may experience feelings of guilt at being taken away from their families. Research indicates that despite looked after children having a higher prevalence of emotional wellbeing and mental health needs than other children and young people in the general population, their needs often go unnoticed and unmet. When children enter care the social work energies are pulled in multiple directions: on finding a suitable placement, establishing contact arrangements with birth family, embarking on care proceedings, dealing with the immediate effects of neglect on health and education. All of these very important issues can mean that more detailed assessment of emotional and mental health needs is not prioritised. Local authorities and NHS trusts have a duty to provide physical health assessments but there is no such requirement for mental health assessments despite overwhelming evidence that the majority of children entering care will have mental health needs.

Children who are placed outside of their borough of origin are further disadvantaged in their access to mental health services due to cumbersome funding arrangements across NHS trusts. The guidance on responsible commissioners (NHS England 2013) places the responsibility for funding CAMHS for looked after children with their borough of origin. This has led to some areas refusing to provide treatment (and often even assessment) for looked after children until the health commissioners have agreed and made payment. This leads to delays in provision of services and can lead to social workers 'giving up' on making a referral to CAMHS. In addition as a result of budget cuts to local authority and CAMHS over the past 6 years the majority of CAMHS across the country no longer have dedicated looked after children's mental health services. The mental health needs of looked after children are almost always very complex and impacted by a constellation of severe family relationship difficulties, attachment problems, traumatic effects of abuse and neglect on top of the emotional impact of being removed from their birth family. Clearly the most important need for these children is to be provided with a stable and nurturing placement and some CAMHS will take the perspective that there is nothing that they can provide unless such placement needs are met. Furthermore they consider that the provision of good quality placements is the duty of the local authority.

CAMHS teams nationally have experienced significant cuts in recent years and have as a result raised thresholds for their service. This can lead to some looked after children being turned away from services if their symptoms do not indicate a diagnosable mental health condition and the CAMHS team considers their needs to be placement needs rather than mental health needs.

What the Newham CAMHS LAC team aims to provide a holistic service considering mental health needs within the context of the child's placement and the needs of their carers. However, the resources are limited and are unable to meet the needs of all children as they enter care or adequately meet the needs of Newham children placed outside of the borough or those who are leaving care.

This report is an evaluation of and reflection on a project that set out to trial a service model of nurse-led outreach mental health support for children in care and their carers to prevent placement breakdown for children placed out of borough and support the transition for young people entering and leaving care. The project was initiated by Newham Child & Family Consultation Service and funding was granted by the Burdett Trust for Nursing.

2. Background of the project

The proposal for this project was initiated by the Newham Child & Family Consultation Service in 2014 in response to the identified gap in the provision of mental health and emotional support services for looked after children and in particular children placed out of the borough and children at the points of transition into and out of care.

The project proposal outlined that Every Child Matters (2003) provided a new framework for improving outcomes for children and young people. Statutory Guidance (2009) on Promoting the Health and Wellbeing of Looked after Children (LAC) imposes duties on Local Authorities and providers to meet the needs of all looked after children. In 2010 (revised 2013), the National Institute for Health and Clinical Excellence (NICE) highlighted the challenges facing looked after children and issued guidance to improve the quality of services for all LAC including those placed out of area. The report acknowledged that although there was evidence of good practice in supporting out of area LAC, significant disparities exist across the country and not all LAC placed out of area receive the same level of care. Key recommendations relate to care planning, increasing professional collaboration and providing dedicated services to promote mental health and wellbeing through increasing access to CAMHS and supporting the transition to adulthood.

Young people who are referred to the local community CAMHS / LAC service have experienced severe abuse and neglect, bereavement or serious illness in one or both parents. Most have experienced poverty and educational disadvantage. Becoming looked after involves major traumatic upheaval, disrupting provision of health and education as well as therapeutic services.

Looked after Children and those who experience placement instability have greater mental health needs than other young people, 60% of looked after children are estimated to experience emotional and behavioural problems, a significant proportion with more than one condition and/or a serious psychiatric disorder (McCann et al, 1996). Services often are unable to meet the holistic needs of these user groups.

Newham currently has 420 looked after children (data correct as of June 2016), 77% entered care following abuse, neglect or severe family dysfunction. Around 65% of the children are placed outside of the borough and often receive variable services from respective local health services. The local community CAMHS in Newham (NCFCS) has limited involvement in supporting out of borough

placements due to insufficient resources. Inconsistency in service delivery impacts on looked after children's future health and well-being (NICE, 2010)".

The project proposal also identified that the Newham CAMHS Looked after Children's team was not resourced to provide "innovative and holistic early intervention services" for children placed out of borough or at key points of transition (entry into care and leaving care). The project proposal outlined that the nurse-led service would aim to develop a holistic approach to the assessment of mental health needs for looked after children in transition or placed out of borough and develop a comprehensive best practice model.

3. Aims of this report

This report aims to describe and reflect upon the development of:

- A comprehensive entry into care assessment for children and young people entering care.
- An outreach service model which can travel within a 100 mile radius of London (additionally incorporating technology such as Skype to support service delivered nationally) to respond to requests for mental health assessment and intervention or placement breakdown risk.
- An outreach service model which can support looked after children who are leaving care through transition to alternative services by liaising with LAC, CAMHS and adult/other services to ensure smooth transition takes place.

This report aims to discuss the improvements and impact of the service model in the care and care plans for looked after children, placement stability, accessibility to CAMHS, user engagement and satisfaction and mental health outcomes.

This report also aims to describe a good practice model based on the findings from the process.

3.1 Project Description

The project started in the beginning of July 2015 when the Senior Nurse / project co-ordinator started in the post. The Outreach Clinical Nurse Specialist started in the beginning of October 2015 and the Assistant Psychologist vacancy was filled at a later date in February 2016.

The project plan was established by September 2015 and introduced to the CAMHS / LAC team and to the local authority children's social care manager's meeting in September 2015.

A project steering group was established and meetings arranged at frequent intervals for the purpose of providing direction and monitoring the progress of the project.

The project received support from Senior Lecturer Sarah Campbell from City University, London by providing guidance on data collection and outcome measures supporting service evaluation. Frequent meetings took place with Sarah Campbell to discuss the project and advice regarding research prospects arising from the themes of the project, was received from the university's research group whom the project was presented to.

The project linked with the Children in Care Council (CiCC) with the plan of having frequent input and feedback of the children / young people for the duration of the project. The CiCC were not able to provide regular access to their meetings due to substantial prior commitments but they gave thoughts and feedback to the project and chose the name: "Stairway – Project".

A snapshot for a period of 6 months was identified to describe the project for the purpose of the report. This divided the project timeframe as in Figure 1.

Figure 1

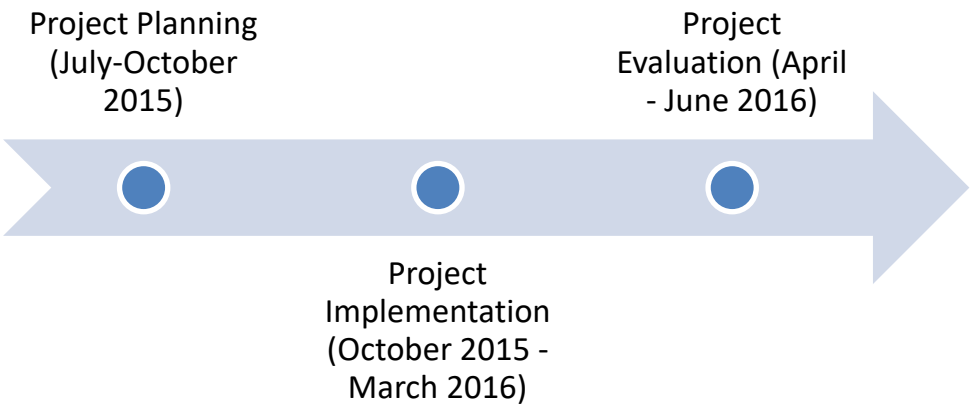
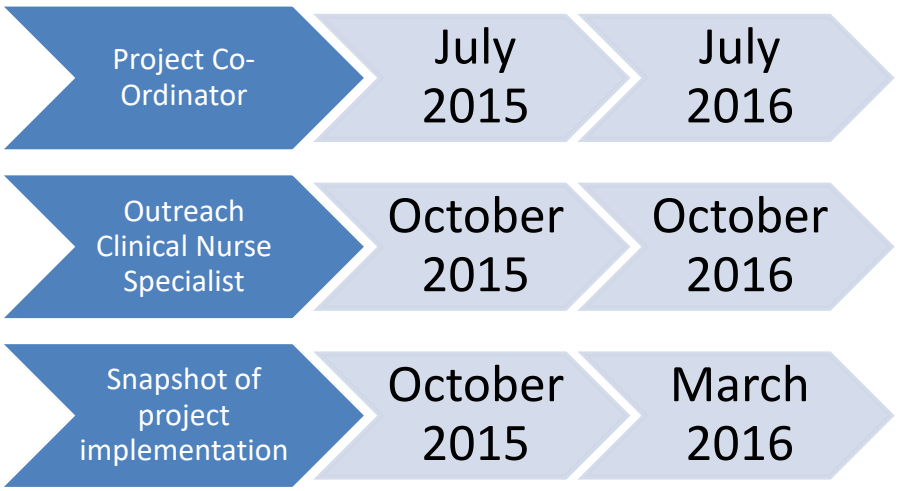


Figure 2 demonstrates the staggered project timeline. This provided some challenge in deciding the timeframe for the snapshot and evaluation of the project, which meant, that despite the report being produced at the end of June 2016, the outreach work is planned to continue until end of September 2016. The project evaluation took place between April 2016 and end of June 2016, including the writing up of the project report.

Figure 2



4. The children / young people in care

4.1 National picture

62% of children / young people who enter local authority care do so due to abuse and neglect (Richardson and Lelliott, 2003) – a figure which has stayed approximately the same over recent years, with the 2015 figure given as 61% of children entering care due to abuse or neglect (Zyed & Harker 2015). 75% of looked after children are in foster care placements (Zayn & Harker 2015).

197 700 initial child protection assessments during 2014/2015 identified domestic violence as a factor (Puffett, 2016 in Children and Young People Now) and further refer to research by the Association of Directors of Children's Services in November 2014 which indicates domestic abuse, parental mental health issues and substance misuse as major reasons contributing to children being taken into care. Home Office statistics show that in 2015 a total of 3043 unaccompanied children applied for asylum in the UK (compared with 1945 in 2014).

Department of Education and Department of Health (2015) recognise that two out of three children in care have special educational needs of which a significant number have a statement or a learning difficulties assessment.

Department for Education, Centre for Social Justice (as quoted by Children & Young People Now, December 2015) 2/2 identified that:

- Only 12% of looked after children gained five or more A* to C GCSEs including English and Maths in 2014 compared with 53.4% of all children.

- 5.6% of looked after children aged between 10 and 17 were convicted of an offence, or subject to a final warning or reprimand in 2014.

- 20% of young homeless people were looked after children.

- 24% of the adult prison population have been in care.

- 70% of sex workers have been in care.

According to the National Audit Office (NAO) report in July 2015 there were 41% of 19-year old care leavers in 2013/2014 who were not in education, employment or training (NEET) – the highest proportion since 2001/2002.

According to NSPCC (2015) "Research indicates that poor mental health of children in care is the result of the interaction of pre-existing mental health conditions, exposure to maltreatment, the

length of exposure to maltreatment and biological risk and resilience". NSPCC identifies that looked after children are four times more likely to have a mental disorder than children in the general population and 2/5 of children in care have a diagnosis of behavioural disorder.

A literature review of 97 studies around young people's experiences in care (Hadley Centre for Adoption and Foster Care Studies, 2015) identifies themes of relationships, respect, rights and responsibility as the core issues that have an impact on their lives during their journey in care. The review identifies children / young people as being opinionated and vocal about improvements required to make the journey in care a better experience for them. The review also identifies the views of refugee and asylum seeking young people, young people with disabilities, young parents, younger children, and young people from minority ethnic backgrounds, care leavers, young people living in residential care, young people in secure settings and young people with mental health difficulties. According to the review, a survey of 2 203 young people in care said that they had emotional or mental health problems largely stemming from the experiences leading to them entering care.

According to Jones et al (2011) "Placement stability and emotional and behavioural problems were identified as key mediators between underlying risk factors and outcomes." Rock et al (2015) identified that "There was strong evidence for a positive association between child mental health problems and placement instability. The evidence was most consistent for externalising problems, with qualitative findings suggesting that disruptive and hyperactive behaviours are particularly difficult for foster carers to manage, leading to possible rejection of foster children."

The government statutory guidance "Promoting the health and well-being of looked-after children" (March 2015) identifies the importance of CAMHS role in assessing and meeting any needs of children in care identified within the SDQ screening process and in providing needs-informed, targeted and dedicated support in a tailored manner, with professionals working in collaboration with the child/young person. It is recognised that inconsistency in service delivery impacts on looked after children's future health and wellbeing (NICE, 2010).

Children in Care are a relatively small group, thus marginalising them in the planning and funding of mental health services. The ratio of looked after children is 60 out of 10 000 children under the age of 18, a total of 69 540 in the year ending 31/03/2015. There has been a gradual increase in the number of children looked after by local authority over the past few years with 38% of all looked after children within age range of 10 to 15. 77% of children in care are white, 9% are of mixed ethnicity and 7% are black / black British background. In England, looked after children's services'

gross expenditure in 2013/2014 was estimated as £2,5 billion, with £1,4 billion spent on foster care services and £0,9 billion spent on children's homes (Zayed & Harker, 2015).

"Two of the most crucial periods are entry into care during adolescence and transitions from care to independence. These are windows of opportunity for positive change, but they also carry risk. When the system works effectively it builds resilience; if not there is a danger of the harm done before entry into care being exacerbated." (Schofield et al January 2012).

4.2 Newham's Looked After Children

There were 370 children looked after by the Newham local authority on 30/11/2015 and 359 children looked after on 11/03/2016 with the figure being 420 in June 2016. 77% of these young people have experienced significant abuse, neglect or severe family dysfunction.

A total of 63 children and young people were seen within the Stairway project during the 6 months period of 01/10/2015 – 31/03/2016, 28 were seen in the entry to care assessments and 35 young people were referred to the project for outreach work.

5 Stairway Project Activity

5.1 Entry into Care Mental Health Assessments

The Department of Education and The Department of Health statutory guidance 'Promoting the health and well - being of looked after children' (2015) recognises local authorities as responsible in ensuring that each looked after child has their physical, emotional and mental health needs assessed regardless of where they live. It identifies statutory health assessment as the initial point for addressing the looked after children's comprehensive health needs; including mental health and emotional wellbeing. The guidance also advises that looked after children are provided targeted and dedicated support according to their identified mental health needs which are assessed and met in a tailored way through collaborative working by professionals.

The National Institute for Clinical Excellence (NICE, 2013) advises to "ensure that all looked-after children and young people have their physical, emotional and mental health needs assessed by appropriately trained professionals according to the statutory guidance on promoting the health and wellbeing of looked after children." The Department of Health and Department of Education (2015) state, that "local authorities should ensure that, as a minimum, the child's main carer completes the carer's two-page version of the SDQ (Strength and Difficulties Questionnaire Goodman – ref) for the child in time to inform his or her health assessment… CAMHS play a crucial role in assessing and meeting any needs identified as part of the SDQ screening process".

One focus of the Stairway project was to establish a process of assessing emotional wellbeing and mental health needs as part of the statutory health assessments (Entry into Care health assessments). The senior nurse in CAMHS joined 28 entry to care health assessments within the 6 months covered by the project evaluation. The focus was to gain an understanding of the local entry to care health assessment practice and develop understanding of how the assessments are positioned in the overall journey of care for the children and young people. A further focus was on developing a holistic assessment process, including considerations of the most appropriate assessment format, timing and place for assessment and capturing a comprehensive assessment in a mindful and supportive way.

Within the snapshot 6 month timeframe, the entry to care assessments took place between three different local health centres. The assessments were carried out by community paediatricians, and three assessments were allocated for each of the 3 hour clinic slots giving maximum of one hour for each of the assessments. A standard BAAF document ("Form IHA – C" or "Form IHA – YP") is

routinely used to collate the information from the entry to care assessments. The “Form IHA – C” is for children from birth to 9 years and the “Form IHA – YP” is for young people 10 years and older. The form is 10 pages long and consists of several questions / tick-boxes around the current health of the child/young person as well as health history.

Very little information was available to the paediatricians about the events leading to a child/young person being taken into the care of local authority in the forms accompanying an assessment request. The paediatricians had access to the electronic patient records for the community health services, which formed the main and generally very limited source of information in understanding the journey for the child or young person. The paediatricians had no access to the local authority electronic records for the children or young people. For the duration of the project there were no SDQ’s available at the statutory health assessments.

The setting for the entry to care assessments was clinical and formal. Generally the assessments took place in a standard clinical examination room in a primary care health centre with plain colour walls, a desk with a computer, examination couch, sink and equipment for physical investigations. There was a difference when the assessments took place at the child development centre, where the environment was less formal and more child-friendly with toys, colourful paint, pictures and furnishings.

The main focus of the entry to care assessments was on physical health: vaccinations, eyesight, dental health, and general physical development and health state including weight and height. The assessments followed the outline of the BAAF document. For younger children and babies there was an increased focus on assessment of child development and achievement of developmental milestones.

Most children and young people didn’t appear to know the nature of the assessment they were attending when they arrived. The purpose of the entry to care assessment was always explained to the children or young people and carers by the paediatricians, often with reassurance that the focus was on their physical health assessment. The BAAF form was introduced to the carers and young people who were old enough to consent for their assessment.

All children and most young people were accompanied to the assessment by their carer; some young people attended by themselves. As the entry to care assessment has to take place within short period of time from the child or young person entering local authority care, they are often not well known to their carers and thus the carers could not contribute to the assessment by giving much information about the young person’s wellbeing or behaviour.

Some young people also had an interpreter in the entry to care assessment; these were mostly unaccompanied asylum seeking children or young people. Understandably, not much information was available for the entry to care assessment for these young people and they had limited information themselves regarding vaccinations, family health and their developmental milestones.

All carers and young people who were old enough and attended the entry to care assessment consented to and complied with the process. It was noted that privacy wasn't always well considered in the clinic setting, for instance a screen or partition was not available in some clinic rooms to provide privacy when physical health checks were carried out and in some cases there were windows facing to the front of the health centre. For those young people attending on their own there was no chaperone, although there were occasions when Stairway Project staff were present. During one of the assessments another health professional entered the clinic room in the middle of a statutory assessment to use the weighing scales.

The mental health nurse from Stairway project joined the entry to care assessments with the paediatricians firstly to observe and understand the process of entry to care assessment from the professionals as well as the children and young people's perspective, and secondly to develop and contribute to the process of increasingly comprehensive entry to care assessment. On-going discussions with the paediatricians and subsequent discussions with senior and front-line staff in health and social care occurred regarding the assessments throughout the project period, and feedback was provided to the project steering group regarding the entry to care assessments and considerations in developing and improving the process.

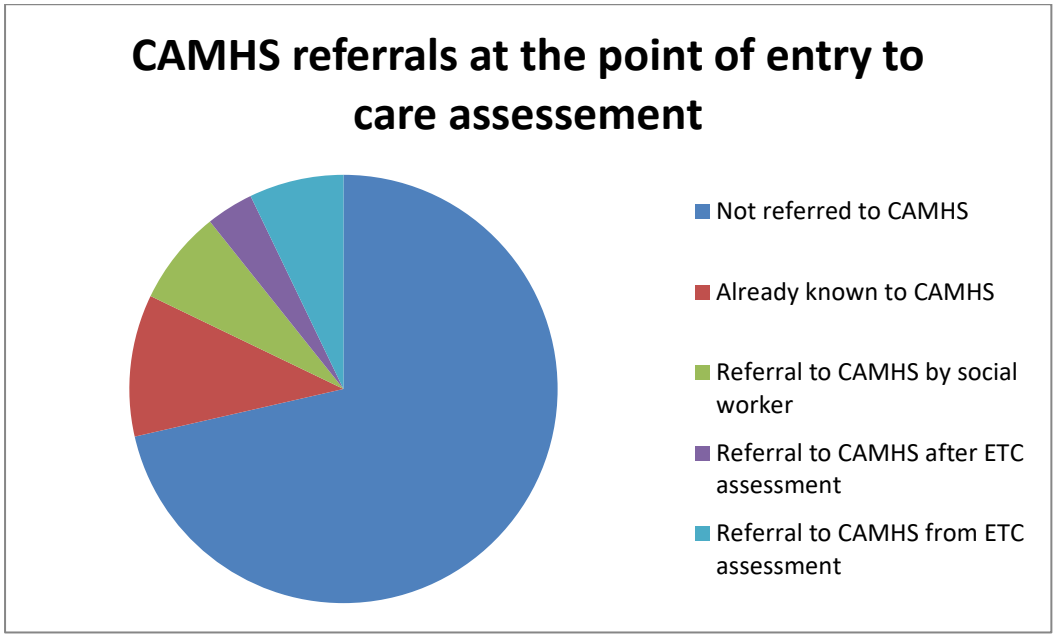
The paediatrician's plans from the entry to care assessments were clearly reiterated to the children and young people and carers. The plans were generally around obtaining childhood immunisations, accessing dentist, optician and follow up plan in years' time with Looked after Children's Nurse. Some young people were already known to CAMHS and so part of the plan was to continue engaging with the existing service.

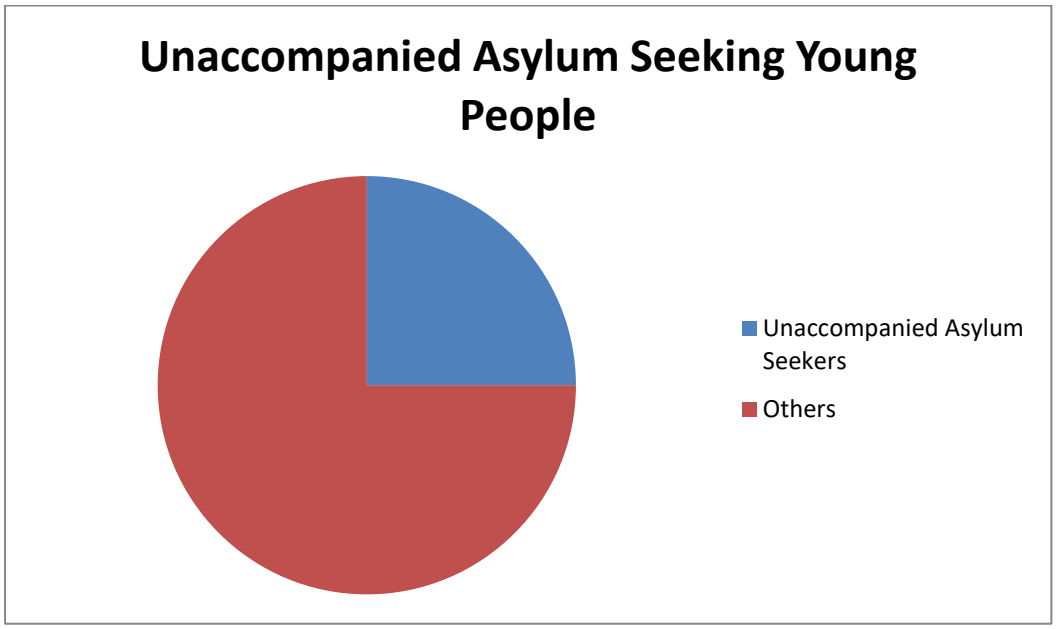
Two young people were referred to CAMHS from the entry to care assessments and both of these young people were followed up by the Stairway project outreach nurse. Two young people were referred to CAMHS alongside the process of entering care by their social worker, and were followed up by the Stairway project outreach nurse. One young person was referred to CAMHS and specifically the Stairway project outreach nurse after the entry to care assessment by their social worker where no immediate mental health or emotional wellbeing concerns were raised in the entry

to care assessment. Three young people were already known to CAMHS and had an identified care coordinator prior to the Entry to Care assessment.

Two mothers under the age of 18 were seen during the entry to care assessments. One of these mothers attended on their own whilst her children were looked after by the foster carer. The mother was looked after herself and attended her own entry to care assessment. The second young mother (looked after by local authority herself) attended her baby's entry to care assessment with the baby and foster carer. A third baby with mother under the age of 18 did not attend the entry to care assessment. One of the young mothers agreed for a follow up telephone discussion due to concerns about her emotional wellbeing but she was uncontactable although separately referred to CAMHS in her local area. Neither one of the young mothers and their babies seen at entry to care assessment had family-nurse partnership involvement.

One quarter of the entry to care assessments were for unaccompanied asylum seeking children of four different ethnic backgrounds. One of the unaccompanied asylum seeking children were referred to CAMHS from the entry to care assessment. All young people who were considered as requiring further referral to CAMHS services or mental health follow up within the Stairway project, engaged in a discussion about it and agreed to the plan.




Unaccompanied Asylum Seeking Young People
Unaccompanied Asylum Seekers
Others

5.2 Outreach – out of borough and leaving care

"There is a clear need for appropriate and bespoke care pathways that incorporate new models of providing effective, evidence-based interventions to vulnerable children and young people to provide a social and clinical response to meeting their needs."

DOH and NHS England 2015

"Most young people who have been in care continue to cope with the lasting impact of a traumatic childhood. They can suffer from depression and anxiety, on top of dealing with the challenges of living on their own for the first time."

"Young people who have been in care rarely have the stability or support networks that most teenagers take for granted. Without that safety net, every poor decision can have serious consequences and prevent the most vulnerable young people from achieving their potential."

Action for Children 2014

The main purpose of the outreach work was to provide early intervention to young people where concerns were raised regarding their emotional wellbeing or mental health needs, in order to improve mental health outcomes, but also to facilitate access to other services such as specialist CAMHS. A total of 35 referrals were received for the outreach work for young people placed out of borough and/or transitioning to adult services.

Most of the referrals that were received came from the consultations that were provided by the outreach clinical nurse specialist (OCNS) for the LBN Children's Social Care / LAC "16-18" team. A total of 19 referrals were received from the team consultations.

For duration of 5 months (from January 2016 to May 2016) the OCNS attended one of the local authority "16-18" team meetings every other week. Sometimes the meetings were aimed for the whole team which included the Manager, Practice managers and Social workers whilst at other times the meeting was structured for 1:1 consultations between Social Workers and the OCNS. From some of these consultations it felt appropriate to attend PEP (Planning of educational provision) meetings in school to gather more information and understanding of the difficulties that young people presented with. At other times the OCNS attended LAC review meetings at placements to collect more information for considering further support needs of the child or young person. For

children or young people with complex needs, OCNS attended professionals' (network) meetings to aid in assessing the needs of these children or young people with the view of co-ordinating the assessment or intervention process more efficiently. The majority of the young people referred to the Stairway project from this particular team, were about to turn 18 within a few weeks. The transition to adulthood appeared to be one of the most difficult periods in the lives of these young people.

Two referrals were received from the Entry to Care assessments. Both were young people placed out of borough and over 17 years of age, making them new to the local authority care whilst care leavers at the same time. One of these young people was an unaccompanied asylum seeker presenting with emotional wellbeing difficulties. A further two referrals were received from the Looked after Children's Nurse at Community Health Newham.

The local authority LAC Intervention Team provided 6 of the referrals to the Stairway project. One of those referred, was an unaccompanied asylum seeker with emotional wellbeing needs, 2 young people were referred because their placements were at risk of breaking down and 3 referrals were for assessments of mental health needs.

A total of 6 referrals were received from the LBN / Children's Social Care LAC 18+Team. The Stairway project OCNS attended the team meetings for consultation purpose every 2 weeks and also every 2 weeks for a meeting with the practice managers to discuss the referrals. From the referrals it appeared, that most of the young people struggled with transition to independence. The reasons for the referrals by large, was a request for assessment of mental health needs and support for these young people with the anxieties and worries brought about by the transition process.

CASE 1

Referral was made by social worker from the Intervention Team. The reason for referral was due to the placement being under a lot of pressure; the young person had started to self-harm and family did not know how to respond to this. The foster carer found it helpful to discuss the challenges presented by the young person with the Stairway Project OCNS. Four visits to the family were made; one meeting was individually with the young person. The young person started to communicate verbally with foster parents instead of using self-harm as a way to communicate her needs. Foster family were more able to understand difficulties and behaviours displayed by young person and change their communication and support towards young person. Despite the significant concern about the placement being in danger of breaking down, with the intervention there was

improvement in the carer – young person relationship and subsequently the placement was maintained.

CASE 2

The reason for one of the referrals to the Stairway Project Outreach work was because social worker's concerns for the 'odd' behaviour displayed by a young person over 18 years of age without history of previous mental health needs. Referral was made by social worker from the LAC 16-18 Team. The young person was reported not engaging with social worker and presented as withdrawn and no responding to professionals. A joint visit was made with Social worker and the young person engaged very well. From the assessment it was very clear that the young person presented with psychotic symptoms and risk of harm towards others was identified in the subsequent risk assessment. Once the mental health assessment was completed, the OCNS liaised with the local Adult Mental Health Crisis team and a further assessment of their needs as well as a mental health act assessment was carried out.

CASE 3

Young person was referred by inpatient CAMHS service at discharge. The young person was supported for four months through weekly contact until they were transferred to Adult Mental Health/Adult Social Services in in their local area. The young person had very complex needs (including learning difficulties and mental health needs) often resulting in crisis presentations to local A&E department and consequent short admissions to in-patient CAMHS. The transition included liaison with the local adult community mental health services and Adult Social Care learning disabilities team. The project also provided recommendations for ongoing support and follow up of the young person by the appropriate teams.

CASE 4

Referred by the LAC Nurse Community Health Service due to concerns around difficulties coping with college work, poor motivation, increased alcohol and cannabis consumption and self-harm.

After 9 appointments (initially weekly, then reduced to monthly) young person felt confident about college work, stopped self-harming and reported that overall their wellbeing/mental health had improved. The young person did not feel needing further support and was aware of the different services that could be contacted if need arose.

6. Reflections

6.1 Set up and management of the project.

Evidence and clinical experience strongly suggest that looked after children often have the most complex emotional wellbeing needs. They are also a very resilient group of children and young people. The services around them are multi-layered, and at times difficult to navigate, even as a professional. It takes a long time to map these structures that provide the support network for children in care. Working across two main service provisions, namely the local authority and community CAMHS, is challenging, and establishing professional networks, contacts, promoting change and innovation within two such complex organisations with on-going changes is a difficult and sometimes protracted process.

The Stairway project was set up for the duration of one year, with senior leadership and vision provided by the community CAMHS / LAC team. The running of a project and bringing new innovation within two large organisations proved that a year is really not a very long time at all. It took several months to establish the project structure within the services, and even then, there were challenges in embedding innovative practice into the existing structures. Both health and social care have been subject to funding and staffing cuts in the recent years, which mean that the staff and services across both organisations function at their maximum capacity. Both the local authority and community CAMHS team experienced changes during the project time period with some of these expected and others not. Alongside this, certain changes were welcomed whilst some were met with resistance and this required a lot of focus by the staff, including senior management. This in turn had an impact on the project, with management and leadership changes and structural changes impacting on priorities within both services. There were also a number of other projects and service developments ongoing in the services, which meant that priorities often had to be negotiated.

It is interesting to consider the dynamics of organisations and teams around the children and young people in care and how much the complexity of the needs of these children is reflected upon the structures around them or even more meaningfully for us, a reflection of it. During the journey in care, the child or young person is likely to have several social workers and may meet several other professionals over time. There are some examples of children in care whom are known to the community CAMHS for a prolonged period of time, and the CAMHS clinician may be the most consistent figure for them over the years.

Some of the challenges within the project were seemingly small but proved to have a significant impact on it. For instance, recruitment of the staff proved to be challenging due to the time limited one year funding and resulted in delay in the project start up and a staggered start and finish to the different parts of the project. Establishing systems such as room booking for Entry to Care Assessments was challenging to such a point that there did not seem to be way of proactively booking a space for separate emotional wellbeing and mental health assessments within the clinics. It was also not possible to have regular and consistent contact with the Children in Care Council as there were other themes and projects taking up their time. Arranging meetings with professionals with existing busy schedules and varying priorities is always a challenge, and was no exception for the Stairway project, however with some perseverance certain regular meetings were maintained.

One of the biggest changes during the project and also one of the biggest challenges affecting the project was an unexpected long term absence due to serious illness affecting the senior manager in the community CAMHS team and who was the main driver for the project and part of the staff team who initiated it. This change had a significant impact on the vision of the project, and meant that another manager had to pick it up and re-establish contacts with the local authority services for looked after children.

6.2 Developing a comprehensive entry to care assessment for children and young people entering care.

Assessment of emotional wellbeing and mental health needs of children entering care is a complex and delicate process. Joining the entry to care assessments provided an insight into the journey that the children and young people face when becoming looked after by the local authority and the observations of the process provided a picture of varied stories with common themes around trauma and loss. The entry to care health assessment took place soon after the young person entered local authority care, during a time that is difficult and distressing in the life of the children or young people.

The SDQ scores were not available at the entry to care health assessments and therefore repeat scores were not possible to obtain within the 6-month snapshot. The appropriateness of the timing, environment and arrangements for collecting outcome measures at the entry to care assessments was questioned as these factors were felt to have significant impact on the children and young people. Ethically it wasn't deemed appropriate to carry out assessment where for instance sibling groups attended the assessment together or there were recent significant traumatic events leading

to the child or young person being taken into care (such as violent abuse which was still being investigated by the Police).

It would have been desirable to have a specified space for the Entry to Care mental health and emotional wellbeing assessments to be carried out. Due to the assessments rotating between different health centres, within the project timeframe it was not possible to establish a routine booking of an adjacent room and therefore assessments were carried out jointly with paediatricians apart from on two occasions where a separate room was identified on an ad hoc basis. The joint approach limited the time available, thus not allowing a thorough assessment process. It was also apparent that a number of factors impacted on the dynamics of the entry to care assessment, namely the complex and traumatic journey of the children or young people, which called for more thoughtful consideration of the assessment process itself. The CAMHS initial assessment format was trialled during some of the assessments but this was considered too lengthy and much of the information required was not readily available. In exploring options for the assessment of emotional wellbeing and mental health needs, the BAAF Forms for "Profile of behavioural and emotional wellbeing of a child (young person) aged 0-9 years / 10-16 years" were identified as worth due consideration. Within the project timeframe it was not possible to trial these forms however this would be a priority for trialling in the future as the BAAF captures information pertaining to emotional, behavioural and psychological difficulties that can be difficult to elicit in interview conversations and furthermore are specific to the needs and experience of young people in the care system.

There was lack of age-appropriate, creative engagement materials for the children although drawing materials were purchased to facilitate this towards the end of the snapshot period. Some of the older adolescents were able to express themselves by using written outcome measures – tools such as RCADS (revised childhood anxiety and depression scale).

The role of the senior nurse was combined with the project co-ordinator role and limited to two days (15 hours) per week. This restricted the developments within the entry to care assessments – particularly providing the limited timeframe for the project as a whole.

6.3 Developing an outreach service model.

6.3.1 Outreach for children placed out of borough.

The feedback provided by some of the young people who were placed out of borough during the project indicated that they valued an outreach approach, particularly the flexibility of services provided in a familiar environment. Above all, the young people's feedback highlighted the

importance of feeling listened to, and being “taken seriously”. The young people also mentioned that they found the type of service helpful with the challenges they were experiencing.

6.3.2 Outreach for young people leaving care.

One of the main drivers for consideration of outreach for young people leaving care is the significant change and indeed reduction of available community health, education and social care support services for this group. Furthermore, the thresholds for accessing support are generally considerably higher in terms of the care leavers than for young people in care. The difference in thresholds between Child and Adolescent (CAMHS) and Adult (AMHS) Mental Health Services are considerable and this needs to be understood when thinking about how care leavers access appropriate support. The care leaving population are less likely to access primary care services. These issues strongly indicate the need for specialist outreach provisions for this population.

6.4 The impact of the service model in the care and care plans for the looked after children, placement stability, accessibility to CAMHS, user engagement and satisfaction and mental health outcomes.

The feedback by some of the young people about leaving care indicated that they found it “useful to have somebody to talk to in a safe and familiar environment” (home – usually foster placement). It appeared to be important to facilitate a safe space where the young people could talk about their experiences and anxieties about the future. Not only do they continue having to cope with the lasting impact of a traumatic childhood, they also have to deal with the challenges of living on their own for the first time. The young people also indicated that there was not enough preparation or support offered for them during this crucial period. One young person residing out of borough and known to local CAMHS there, who subsequently returned to Newham at the point of turning 18, was not supported in transitioning to Adult Mental Health services by their previous locality’s CAMHS. This is not the practice in Newham CFCS which has a policy of a 6-month transition process to adult mental health services.

The Stairway project was prepared to use teleconferencing systems, such as “Skype” to improve service user experience by enabling them to access care and support quicker than having to travel to or wait for appointments. The three young people it was offered to, declined this method of communication. For one young person using “Skype” represented “having fun with friends” so they didn’t want to use it for formal purposes. Another young person found it difficult to talk on the phone and said that they would prefer text messages instead of “Skype”. One young person said: “Human contact is important and makes it more real having someone to talk to close to you”. It may

be that the use of Skype with foster carers or residential care staff for children placed out of borough would be more welcome than it was with the young people themselves. However there were no referrals during the project period where such a service was deemed appropriate. Skype and similar technology have not yet been utilised effectively by CAMHS community services and the fact there was no uptake throughout the project period is more an indication perhaps of the need to introduce this more systematically across our services as opposed to any comment about its appropriateness for the Stairway Project. Indeed for the out of borough outreach work we considered it a priority for development of future services.

Some young people although wanting the support for their emotional wellbeing and mental health needs, often struggled to attend appointments and preferred being seen at home or even at school or college. They also identified the financial element of travelling to appointments being a concern and this was particularly the case for young people in independent or semi-independent placements.

A number of young people raised concerns about the stigma of having mental health services' support and therefore preferred having appointments at home to avoid being seen attending mental health services or clinic. Furthermore, some young people reported having been referred to local CAMHS services but had been deemed not to meet their threshold, subsequently leading to worsening of their emotional wellbeing, as there are generally no in-between services available. Some young people had worries about refusing a service following a referral if they felt they did not need a service as this may restrict their ability to access these services in the future should their needs increase.

7. Recommendations

7.1 Recommendations for future Entry into care mental health assessments

7.1.1 Appropriate timing and location of entry into care mental health assessments:

This project found that it was difficult to combine the mental health assessment with the physical health assessment for a number of reasons. The physical health assessments take place very soon after the child enters care and the child may often still be experiencing emotional distress following their removal from their family of origin, they may not fully understand their circumstances and their carer still has very limited knowledge of them. We would recommend that (unless there are clear urgent mental health needs) entry into care mental health assessments take place a minimum of 2 weeks into the child's placement and possibly longer so that the child has had a chance to settle a bit and the carer has got to know them. Furthermore, we recommend that these assessments take place on an outreach model with the child and carer being visited at home with scope for the individual needs of siblings to be considered.

7.1.2 Further evaluation of the child's experience of entry into care mental health assessments:

The function of the entry to care assessment may be beneficial to explore further, in order to consider how the assessment makes sense in the overall care journey for these children and young people and how they can have better ownership of their journey. Further development of Newham's development of entry into care mental health assessments must include dedicated input from representatives of the Children in Care Council.

7.1.3 Longer term funding commitment:

Further funding will be essential to support the on-going development of specialist services for looked after children. The project found that a year was not long enough to develop and produce

sustainable changes, and further funding to enable on-going development of these services is paramount. The young people and carers should be recruited as active participants in this process from the onset of such changes.

7.1.4 Build on joint working established between physical and mental health services:

Joint entry to care assessments between CAMHS nurse and community paediatrician were helpful in thinking about the needs of the children and young people and reflecting on the assessment process, with a potential of developing the assessment process . There was also improved communication between the community paediatricians and CAMHS through the project nurse. It is essential to consider mental health professionals input into the process of entry to care assessments further and to continue exploring a good practice model.

7.1.5 Use of the BAAF Profile of behavioural and emotional welling of a child:

We recommend that the BAAF Profile forms be used with carers to guide the mental health assessment of all children and young people entering care. Consideration was given as to whether this form should be targeted to carers where there are existing concerns about possible mental health problems for a young person in care, however, given the need to identify the many unmet psychological needs amongst this population the recommendation is to use it for all carers of children and young people entering care. This model of screening for young people at greater risk of mental health problems has been successfully piloted in other areas of CAMHS multi agency working e.g. Youth Offending Teams.

The assessment forms are available to all social workers on the LBN intranet site and would help to inform Entry to Care Assessment about the emotional wellbeing of the child/young person, particularly when coupled with the completed SDQ form. The forms are carer's reports and when supported by either social worker or mental health professional to complete, can provide a process more sensitive and mindful to the needs of the children and young people during the time of entering care.

We recommend that CAMHS and the local authority LAC managers agree a process by which these forms could be used to inform an entry into care mental health assessment. They could be completed by the social worker as part of their assessment of the child as they enter care or CAMHS could be funded to complete this task. Gathering sensitive and detailed information from a carer under the headings outlined in the BAAF form will often be a delicate process. The information collected will need to be analysed in conjunction with information gathered from assessing the child or young person directly and information on their developmental and family history.

7.1.6 Use of the SDQ for screening and Entry to Care assessments:

One of the main recommendations to the local authority is to consider changing the way the SDQ is used with children in care. It was clear that SDQ data was not available at the Entry to Care assessments and discussions took place around how the tool can be used to assist social workers in identifying increased likelihood of emotional wellbeing and mental health needs. Alongside the regular use of BAAF form for carers as a screening tool we would also recommend that the SDQ is used at the earliest opportunity to inform the Entry to Care assessments.

7.2 Recommendations for children and young people placed out of borough:

7.2.1 Importance of a multi-disciplinary 'core' CAMHS LAC team:

It is of great importance that community CAMHS teams continue to have a specialist LAC team within their structure. These teams should be multidisciplinary in nature and prepared to work in innovative and creative ways in engaging these often considered "hard to engage" children and young people. From the experience of this project, an outreach model that is flexible and reflective, that engages the young person and their social network in a setting and manner in which they feel comfortable enough to make the most of the support offered, is paramount. The nursing profession is well equipped to carry out practical and therapeutic support within an outreach model, encouraging engagement through daily activities and informal channels such as games and other creative pursuits. The nursing profession is also equipped in assessing mental health risk and providing risk management planning and interventions for looked after children and as such is an asset to CAMHS, the local authority as well as the benefit of the looked after children / young people. The interpersonal skills demonstrated by CAMHS nurses are viewed to be essential tools in engaging and working with this client group.

7.2.2 Importance of a flexible outreach model:

The project outreach model enabled positive engagement with the young people and carers, which otherwise may have been missed. Based on the feedback provided by the young people, it has

emerged that the process of assessing emotional wellbeing throughout their journey in care may be best carried out within an outreach model, rather than in formal, clinical settings including the entry to care assessments.

7.2.3 Importance of joint working across agencies and services:

In the experience of the project team, joint working by different professionals, for instance social worker and outreach nurse, particularly during initial assessment following referral to the team was very helpful. However, the structures and the pressures of the different organisations make it challenging to ensure this is common practice model. The project team believes that further development of joint working and considering joint funding for nursing role(s) within an outreach model for assessments and interventions for looked after children would be hugely beneficial in the development of services supporting and enhancing the wellbeing of children in care.

7.2.4 Further trialling of use of Skype technology with carers:

Skype was not favoured as a method of communication by the young people to whom it was offered during this project. They preferred face to face meetings and visits in their own homes. However, further trialling of use of Skype for provision of support to carers may yield different results and should be incorporated in a wider health initiative around utilising these technologies.

7.3 Recommendations for young people leaving care:

7.3.1 Need for service that cuts across age boundaries. We recommend the funding of a specific leaving care mental health project overseen by the Newham LAC CAMHS team.

7.3.2 Personal advisers for leaving care young people are faced with an extremely difficult job in their efforts to support their clients. The personal advisers themselves need to be supported with good supervision structures including regular consultation with mental health professionals.

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