Appendix 2

COMPLEX CASES IN MEDWAY

A review of local systems for supporting young people who need both social care and mental health services

FULL REPORT

By Dr Sarah Senker and Matthew Scott

TONIC

February 2021

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V1.4

EXECUTIVE SUMMARY

Appendix 2

THE NATIONAL PICTURE: The Interface between Mental Health & Social Care for Children with Complex Needs

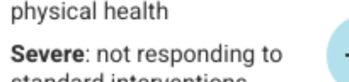
The concept of **complex needs** can be used to categorise “especially vulnerable or disadvantaged people” or people presenting “challenges to services”

What is the issue?

What are complex needs?

Multiple: not just in a single domain, e.g. mental & physical health

Persistent: long-term rather than transient, e.g. LD/A



Severe: not responding to standard interventions

Framed by family & social contexts: e.g. LAC, offending

Services struggle to meet complex needs

Silo working: Interventions are often single modality driven

Lacking **specific expertise** in existing services

interventions aren't always **adjusted** to reflect complex needs such as LD/A

Multiple agencies can lead to **inconsistency** of approach and lack of **continuity**

Definitions

Differing Definitions

Additional Needs: Such as SEN, experience of trauma, neglect, abuse

Contextual Safeguarding: At risk of harm or exploitation, self harm, suicidal behaviours

Challenging behaviour: Risk of placement breakdown, escalation to crisis

Challenging for services: YP/family not "treatment ready", unmotivated, chaotic, long-term unsuccessful engagement with services - causing workers anxiety

Barriers

Barriers to an effective response

Lack of joined-up **commissioning**

Fragmented system with unclear **pathways**

Unclear governance: strategic ownership, multi-agency meetings & data

Unprecedented **demand** and under resourced services

Waiting lists for ND assessments lead to drift & delay

Missed opportunities to intervene early leads to **escalation and crisis** - due to thresholds & criteria

THE MEDWAY PICTURE

The Task

TONIC were asked by Medway Council and the CCG to review the interface between CAMHS and Social Care in relation to complex cases for young people in need of both services

To do this, we conducted a literature summary, 6 interviews with young people and their families, 18 stakeholder interviews, a review of case file audit notes, and a review of the online support offer

Local Stakeholder Views

1

2

3

Delay & Drift

Social Care & CAMHS are experiencing unprecedented high demand and are under capacity to meet this in a timely way – leading to lengthy waiting lists for assessment and treatment (especially for ND at 2 years+)

- Causing delay & drift as YP, SW, carers, school, placement left uninformed & unsupported during these waits
- Growing capacity in CAMHS is limited by difficulties recruiting to specialist posts
- Resources are often only deployed when crisis/risk of placement breakdown is reached – even though warning signs are observed much earlier
- Lack of consistency in SW staff (high turnover)
- Single Point of Access to CAMHS is not fully utilised

An Overly Complex System

Lack of integration leads to an overly complex and fragmented service for children, young people & carers:

- Silo funding (often initiative driven)
- No multi-agency case management system
- lack of multi-disciplinary teams for complex cases
- Unclear governance for complex cases
- Gaps in data to help understand needs and whether they are being met
- Medway can get "overlooked" when commissioning on a Kent and Medway footprint
- Single issue / organisation pathways don't map onto complex cases with multiple agencies
- Lack of joint commissioning between CAMHS and social care

Different Worlds

Social Care & CAMHS have different understandings of what constitutes a "complex case", organisational priorities, understanding of risk, professional "language", thresholds and criteria

- Case holder v commissioned service – different levels of "anxiety" or concern
- Contextual safeguarding risks v diagnosable/treatable condition
- Expectation management is an issue for SW and carers – no "cure" for ASD/ADHD, formal therapy needs a level of stability to be effective
- Meanwhile, the young person/family may be ambivalent to engaging in treatment, chaotic (missing appointments), unmotivated - although there is a lack of support for getting people "treatment ready"

How young people want to be treated

They told us this was missing in their experience in Medway

Being Heard

Young people highly value being **listened to:**

- Being **consulted** with
- Being **taken seriously**
- Treated as **credible sources of information** in their own care

Someone To Trust

Young people wanted at least **one consistent professional** involved throughout their journey

Ideally this would be a consistent **multi-disciplinary team** in the community

Avoid Re-Traumatising Young People by Ensuring A More Humanising Experience

Some safeguarding measures used made them feel **de-humanised, frightened or punished rather than safe**

This included **restrictive processes**, accompanying people to the toilet, shower or being in the room while they slept

Young people highlighted **difficulties communicating** how they felt - they would welcome use of **visual aids** to support this and **staff just sitting with them**, without the need to talk or express themselves

IN THEIR OWN WORDS
What young people told us about their experiences of Tier 4 CAMHS provision in Medway

The interviews undertaken with young people and family members highlights the value in consulting with service users about the care they need and want.

Young people were incredibly articulate about what was and was not helpful to them in their journey to wellbeing and recovery, in coping with their, sometimes traumatic, life experiences and presenting needs.

3 key themes emerged from our discussions with young people

1. Having their voice heard

Young people value **being listened to**, being consulted with and getting treated as credible sources of information in their own care.

2. Having at least one consistent and trusting relationship

They respond well to having **at least one consistent professional** involved throughout their journey and, as explained by the mother of one young person, having one consistent multi-disciplinary team in the community would seem to be best practice. This model is used in hospital settings and promotes effective communication between professionals, as well as timely interventions.

3. The need to humanise the experience

Young people were candid in how some of the **systems in place to keep them safe often made them feel unsafe**, more frightened or punished rather than safeguarded.

They felt that any restrictive processes (e.g. anti-ligature suits or restraints) should be applied in a trauma-informed way wherever possible as some experiences were **re-traumatising.**

Young people highlighted their difficulty in communicating how they felt, the use of visual aids to support this would be welcome and young people often said that staff just sitting with them, without the need to talk or express themselves, was a powerful antidote.

There also seems to be **a lack of appropriate placements or resources** for young people with complex needs locally. Young people often have to be moved outside of Medway and they described how **the process of accessing a placement should be made more young people-centred**, easier and smoother. This included wanting to have oversight of the new placement, advanced warning and preparation and a buddy system in place for at least the first week of arriving.

VIEWS OF YOUNG PEOPLE (continued)

Young people discussed the fact that it felt like **things were happening to them rather than with them** – that **their voice was not heard and often their concerns were not taken seriously**.

> ***'If someone had just listened to me from the start, this could have been resolved, someone to sit down and hear what I had to say, that's all it would have taken. I feel like my social worker should have been that person, they have a lot of power'***

> ***'CAMHS were useless, they never listened, it felt like he never took me seriously. CAMHS thought it was all a joke'***

This was particularly important where **young people felt they knew themselves best** with regards to what worked for them, the timing of interventions but **their influence over their care was limited**.

Young people noted the **number of social workers** they had been allocated alongside the amount of time it takes for them to build trust in new people.

They often felt like they were being **punished rather than kept safe**. They made recommendations about how to securely transport them to new placements, how to make s.136 suites feel more comfortable, and how triggering it could be to be restrained.

> ***'The transport up here, it felt like I was in a cage, you're in this truck, two staff members from the hospital and when you went to the toilet someone had to be in the bathroom with me, in the actual cubicle, and it felt uncomfortable, watching me go to the toilet in case I hurt myself or tried to run away. You could have made it feel like a road trip rather than making me feel like a prisoner, they could have made it feel more homely on the travel'***

Young people noted that being sectioned or in care often made them **feel like they were different** to other young people. For example, one young person noted she had never had social media like her peers and that she could not go out unassisted.

Young people asked for a 'buddy' for at least a week when coming into a new placement, to help them settle. Some said the buddy they were given was only there for part of the first day.

It can be **triggering** to be around other young people who are harming themselves, so they felt care and consideration needed to go into how this is managed.

Those who had accessed Dialectical behaviour therapy **(DBT)** were very positive about this experience.

Building trusting relationships with consistent members of staff was felt by young people to be a key therapeutic tool.

Young people noted **the number of social workers** they had been allocated alongside the amount of time it takes for them to build trust in new people.

This was echoed, by one mother we spoke to, who highlighted the **challenges associated with dealing with many different professionals** for her son's complex care needs. She wanted to have one team that could cater for all his needs, made up of social workers and mental health provision.

Themes from Review of Case File Audit Notes

EARLIER INTERVENTION NEEDED TO PREVENT ESCALATION AND TRAUMA

- **Earlier intervention or preventative work would have been beneficial** - to prevent escalation and further poor outcomes or trauma
- **Preventative work for the parent(s)** - suggestions that mothers would have benefitted from support at an earlier stage
- **Responding quickly to escalating risk** - One case was identified as at risk of Child Sexual Exploitation before it happened raising questions about what more could have been done to prevent this

WAITING LISTS AND DELAYS THROUGHOUT THE SYSTEM

- Most cases had **delays in accessing CAMHS assessment** due to lengthy waiting lists or because individuals did not meet service thresholds
- Some experienced **delays in accessing treatment** or therapy
- This was sometimes given as the **reason for escalation** in risky behaviour

BETTER INFORMATION NEEDS TO BE SHARED EARLIER

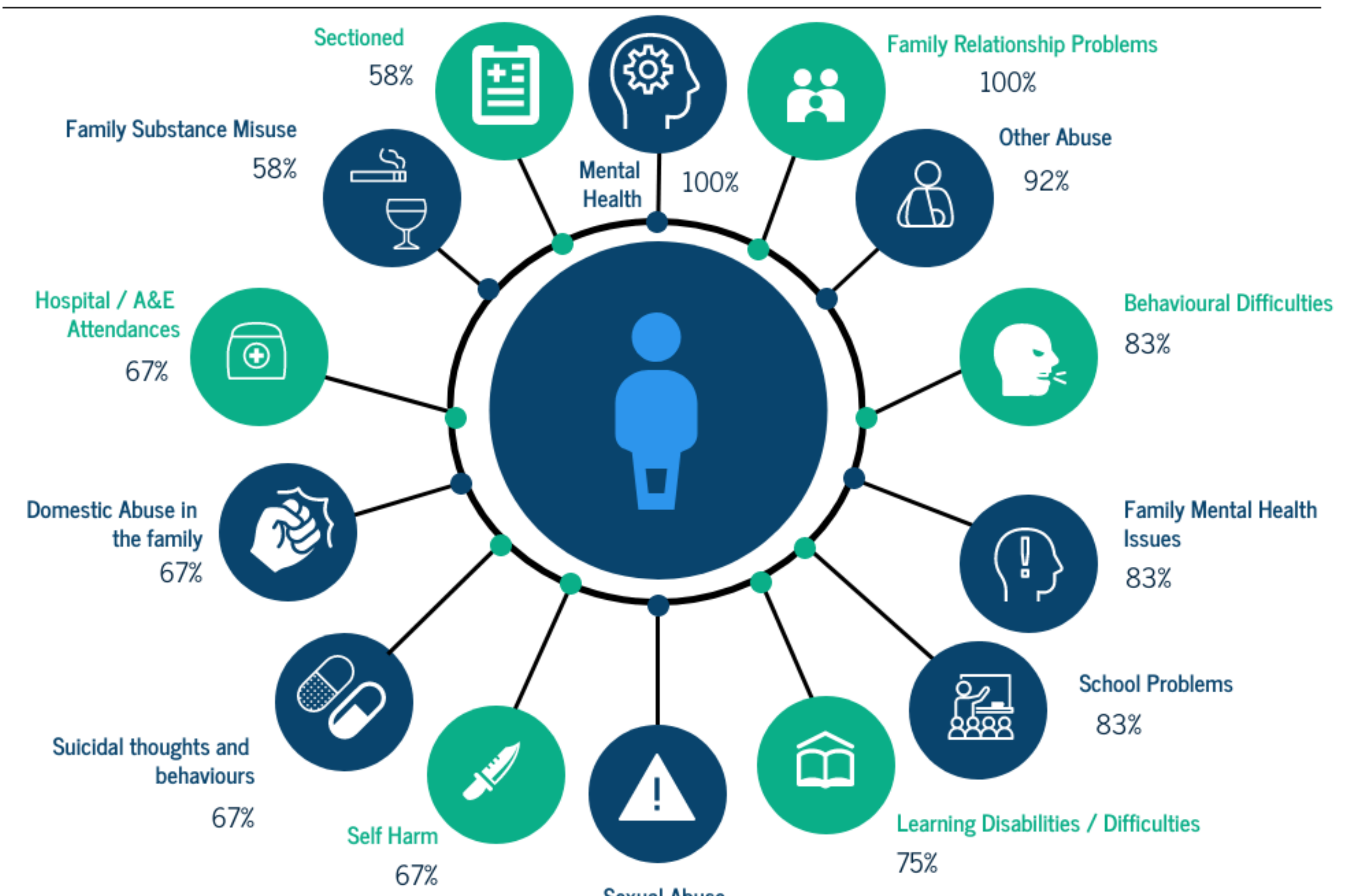
- Some cases were **unclear whether therapy had been received**
- There was **doubt about whether services communicated** with one another and had an awareness of certain issues at key times
- **Additional context** was needed to properly assess people, and having this earlier may have helped to better inform the actions taken

SLOW IN RECOGNISING AND RESPONDING TO URGENT NEEDS

- In one case. delays were potentially linked to **not recognising the signs** of sexual abuse and potential gang involvement
- Another case questioned whether **more could have been done** to spot sexual abuse earlier to enable a quicker safeguarding response

Key Issues (from Case File Audit notes)

Medway Council reviewed 12 case files for young people considered to be "complex cases" involving Tier 4 CAMHS and social care in order to produce a summary of the notes. This diagram shows the key issues highlighted and the frequency with which they were mentioned



Appendix 2

Complex Cases: What Works

Summary of evidence-based interventions & practice

BUILD ON WHAT WORKS
5 common elements in the evidence base of effective responses to complex cases:
• Problem-specific CBT
• Other therapeutic interventions
• Family and carer support
• Integrated delivery: multi-disciplinary teams
• Responsive ways of working: e.g. Intensive, child centred, shared decision making

Building Capacity for families & non-specialist staff	Social Work for complex cases	Mental Health for complex cases	ND Pathway	Complex Needs services (inc. TIA, SV)	Crisis Intervention	T4 Community Alternatives	T4 Inpatient & Therapeutic Residential Placements
Parenting courses & skills: • Triple P • Trauma Informed (TIA) group parenting intervention for foster carers	Empowerment Oriented Practice: • Address inequalities in power balance • Shared decision making • Perceived quality of services • Strength & skills building • Open access • Family strength building	Moderate to severe Depression & Anxiety: • Problem Specific CBT for 3 months+ • IPT-A, family therapy, brief psychosocial intervention, psychodynamic psychotherapy • Follow up psychological therapy sessions	Multi-disciplinary assessment - paediatrician, speech therapist & psychologist	Community Complex Needs Service: • Senior clinical leadership • YP advocates • Team in the community • Direct intervention from specialist MH practitioners • Additional expertise - e.g. for ND, speech & language • Reasonable adjustments to access & provision • Links to local commissioners • Timely responses	Suicidal behaviour & self harm: • Integrated, comprehensive psychosocial assessment • Improving social functioning • Therapeutic relationship • Joint risk management plan	Key elements include: • Small caseloads • 24/7 response • Flexible working • Multi-Modal treatment • Close partnership working • Partnerhsip with YP & family to prevent breakdown	Longer placements lead to better results
Theoretical components: Attachment, Social learning theory, Trauma psychoeducation, Positive parenting, Coaching & self reflection	Collaboration: • Co-ordinating care • Consistent, congruent or complementary treatment philosophies • Effective personal relationships with other professionals	Trauma-focussed CBT	Cognitive Behavioural Therapy (CBT): • Adjusted and modified to meet LD/A needs • Group/individual • Time limited (e.g. 12 weeks)	Trauma Informed Approaches (TIA): • Group parenting intervention for foster carers • UK examples: AMBIT, SECURE STAIRS, DART, Trauma Recover, Enhanced Case Management, MAC-UK Integrate model	Intensive Family Preservation Services	Intensive outreach & home-based teams - e.g. CAMHS Intensive Treatment Service (ITS)	Multi-Agency Planning for admission
Evidence-based treatments for mild to moderate levels of mental health disorder can be delivered by appropriately-trained non-clinical staff	Relationships: • Quality of relationship with YP Interaction style • Trauma Informed approaches • Continuity	FCAMHS multi-disciplinary team for those involved with criminal justice	Assessments for ASD should also assess mental health	Sexual abuse: • Time limited CBT • Trauma focussed CBT • Group psychotherapeutic / psychoeducational sessions • Therapeutic programmes: e.g. Letting the Future In	Brief CBT for whole family	Treatment foster care	Multi-Agency planning for discharge
Consultancy support, advice & info - e.g. recognition of symptoms, coping strategies, self management techniques	Solution Focussed Brief Therapy (SFBT) - basis for Signs of Safety	Community case management	Applied Behaviour Analysis (ABA)	Integrated Person Commissioning (IPC)	Resilient Therapy	Community case management	Joint agency commitments
Lifeskills and coping skills for young people		Solution Focussed Brief Therapy (SFBT)	Support team for the child and family/carers	Multi-systemic therapy (MST) for abuse & neglect	Telepsychiatry	Multi Systemic Therapy (MST)	Preparing a Crisis plan agreed by all agencies
Support for Carers & families			Nurse-led ADHD clinic		Self management Apps	Crisis recovery & reintegration	Support for parents/carers
Kinship Care					A&E Intervention		

Key:
- Problem-Specific CBT
- Other Therapeutic Interventions - inc. Trauma informed & lifeskills
- Family & Carers Support
- Integrated Delivery & Multi-Disciplinary Teams
- Flexible & Responsive Ways of Working: Inc. Intensive, 24/7

AREAS FOR ACTION

These broad areas for action have been generated through our analysis of interviews with young people, their parents/carers, stakeholders and a case file audit and literature review

Put the young person and their family/carers at the centre

Ensure young people's voices are heard, valued and taken into consideration. Provide consistency in key workers, ensure the process is humanised, avoid re-traumatisation and provide more comprehensive support to family/carers

Take a whole system commissioning approach with clear governance

Bring linked agendas together (e.g. Transforming Care, Access to Resources, T4 access, safeguarding), involving stakeholders to establish a long-term multi-agency response for complex cases with clear governance and accountability

Clearly define and agree the cohort, level of need and pathways

Agree what constitutes a "complex case" and gain clear commitments from agencies as to their roles and responsibilities, to establish a much clearer joint pathway that prevents young people falling through the gaps and can be widely communicated to all agencies and staff

Establish a fast track assessment and treatment pathway for complex cases

Create a prioritised assessment process for complex cases, backed up by increased capacity in key assessment and therapeutic roles to reduce or remove waiting lists

Build an integrated approach with sufficient capacity to respond to demand

Develop a new community-based Multi-Disciplinary Intensive Therapeutic offer, based on evidence-based interventions, to meet gaps in the current system, bringing together mental health and social care staff to grow capacity and change the culture and support young people and their carers

CONTEXT, GUIDANCE & PROBLEM DEFINITION

CONTEXT & GUIDANCE

Medway's Local Transformation Plan for Children and Young People's Mental Health and Emotional Wellbeing sets out the need **to review the Tier 3 offer and its interface with Social Care in the context of children with complex needs**

TONIC were asked to help collect and **bring together the insights and experiences of the many different people and organisations involved** when accessing or leaving specialist mental health services for children and young people, including services users and their families. Alongside this, we undertook an Integrative Review to summarise relevant literature and guidance

Over **150 papers were considered in the literature review** – this included research studies (including numerous systematic reviews), national policy papers, local policy documents, good practice guidance and web pages of localised projects

This report includes findings from the literature review and **interviews with 18 stakeholders** and 6 young people who have used relevant services and their families

THE CARE QUALITY COMMISSION 2017 REVIEW OF CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES CONCLUDED:

"The system, as a whole, is complex and fragmented.

Mental health care is planned, funded, commissioned, provided and overseen by many different organisations, that do not always work together in a joined-up way.

Poor collaboration and communication between agencies can lead to fragmented care, create inefficiencies in the system, and impede efforts to improve the quality of care.

As a result, too many young people have a poor experience of care and some are simply unable to access timely and appropriate support."

"Many vulnerable children who have experienced long-term neglect, and those at risk of exploitation and who go missing from home or care, live in situations of actual harm or are at risk of harm for too long." Medway's Ofsted Report, August 2019

"Too many young people have a poor experience of care and some are simply unable to access timely and appropriate support." CQC National Report 2017

PROBLEM DEFINITION

There is a cohort of young people with **"complex" needs**, which can be defined as:

- **Multiple** - not just in one domain, such as mental and physical health
- **Persistent** – long-term rather than transient, including for example learning disability, autism or both
- **Severe** - not responding to standard interventions
- **Framed by family and social contexts** - early family disruption, loss, inequality, prevalence of Adverse Childhood Experiences (ACES) – e.g. Looked after Child (LAC) or criminal justice involvement

The **concept** of complex needs can be used to categorise "especially disadvantaged people" or people presenting "challenges to services".

Trauma impacts on many areas of a young person's life: Attachment, physical health, emotional regulation, dissociation, behavioural control, cognition and self-concept

Services across multiple sectors collectively struggle to meet the needs of young people with the most complex needs. Similarly, many young people struggle to access, respond and maintain progress with the support and interventions offered. This may be due to:

- Existing provision may **lack specific expertise** to respond to needs and presentation
- Multiple professional involvement may lead to **inconsistency in approach** and **lack of continuity** of care and that holistic needs not being met
- Interventions are **single modality driven** (e.g. 1 type of Therapy or medication), and don't address wider context
- The young person and/or family/carer may be **unwilling or unable to engage** - e.g. due to a lack of trust in statutory services or because entry points are difficult to navigate
- Services and/or therapeutic **interventions are not always appropriately adjusted** for young people with learning disabilities, autism or both

"Complex" cases can be an elusive concept, but is often characterised by one or more of the following:

- **Contextual Safeguarding Concerns**:
  - At risk of adverse and harmful experiences – risky or challenging behaviours, aggression
  - At risk of criminal or sexual exploitation - e.g. County Lines, radicalisation
  - At risk of causing harm to themselves (e.g. suicidal behaviours and self harm) or others
- **Additional Needs**:
  - Learning Disabilities (LD)
  - Special Educational Needs (SEN)
  - Autism Spectrum Disorder (ASD)
  - Experienced trauma – from neglect or abuse
- **Challenging to services**:
  - CAMHS treatment may have been tried and found to be ineffective, or the young person or family found not to be "treatment ready" or not engaged
  - High level of professional anxiety – staff feel unskilled to meet need or understand behaviours
  - Interagency working is challenged by differing thresholds & opinions about what to do
  - Risk of placement breakdown
  - Recipients of long-term, but not very successful, support from a range of services
  - Missed opportunities for earlier intervention leading to escalation to crisis
  - Misuse or poor use of residential/in-patient provision at high cost with poor results

Note: These are often adolescents but not exclusively/majority Looked After Children

PROBLEM DEFINITION

*"Many of Kent and Medway's 'tier 4' mental health beds are occupied by children and young people with a learning disability (**LD**) or autism spectrum disorder (**ASD**). Providing the right support for them and their families from an early stage will mean they do not find themselves inappropriately in inpatient mental health beds, but in community-based, supported arrangements for education and work."* Medway JSNA

"Switching from social care model to medical model at the interface causes issues. Medical approach is good for acute conditions but not so good for prevention. This drives towards a deficit model" Medway Stakeholder

Barriers to effective joined up approach

- Lack of joined-up commissioning leads to **fragmented system with unclear pathways** (e.g. regional, Kent/Medway wide and Medway exclusively)
- **Organisational fragmentation and professional silos** are obstacles to collaboration – Multiplicity of multiagency meetings, funding and assessment routes (SPA, CETR, MASH, CIN, CP, CPA, Transforming Care, SEN plans, EHCP, Continuing Care, Access to Resources Panel, JAP)
- **Unclear governance** for who holds responsibility and strategic oversight for complex cases
- The **switch between the social care model to the medical model** creates barriers and often puts the process before the person

Key Challenges for Community Services

- Social care and CAMHS experiencing **unprecedented demand and are under resourced**
- The **volume and complexity** of referrals and open cases contribute to a situation where **waiting lists** remain a challenge on some pathways:
  - Reducing but still overly long wait for treatment at T3 CAMHS
  - **Commissioning challenges for ASD assessment** - Very long waiting lists for ND assessment and interventions (2 years+) with only 22% starting intervention <18wks and high cost of assessments (avg. 13 hours of multiple disciplinary input at £650–£1,000 per child) – lack of specialist capacity even if funding is increased
- During these long waits, **carers/social workers** are left unsupported or "In The Dark" and unable to cope
- **Volumes of those in crisis is higher than expected** – people get seen quickly at A&E (95% in <4 hours) - this does not guarantee a joined up community response
- Social Care **Staff Turnover** Affects Relationship Building & Trust

Inpatient & Residential Stays

- Medway JSNA commits to **reduce use of inpatient beds**
- **Risk Management** is key in referrals to inpatient provision - but we do not have a clear picture of the impact of Inpatient stays
- Given the **high cost** of in-patient and residential placements, there is an Economic Case for Change to invest in a mixed economy at Tier 4, including **community alternatives** (inpatient admission costs avg. £33,820) & an understanding that longer inpatient T4 stays are linked with better outcomes
- **Therapeutic residential placements** are hard enough to secure when planned, but are very hard to get for crisis/emergency cases as emergency placements can negatively affect provider's Ofsted and funding

Commitments

Medway LTP commits to:

- **Ensuring specialist assessment** of our most vulnerable young people's emotional wellbeing needs including children in care, care leavers, children and young people in transition, young offenders, children with disabilities, children and victims of sexual abuse and those at risk of developing harmful behaviours
- By 2021, Medway's Young people will have access to evidence-based treatment, with minimal waiting time

Children's Services Improvement Action Plan commits to**:**

- Improve response to risk for young people in danger of exploitation (top 10 priority)
- Improve strategic relationship with health services, and operational delivery across a range of health functions to support children and young people in care and care leavers (top 10 priority)
- Fully implement an approach to contextual safeguarding
- Review commissioning arrangements to ensure quality & effectiveness of health provision for LAC & care leavers

NHS LTP commits to:

- Comprehensive offer for 0-25 year olds reaching across mental health services for Young people and adults
- 100% coverage of 24/7 mental health crisis care provision for young people - combining crisis assessment, brief response and intensive home treatment functions
- Young people mental health plans will align with those for Young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice
- South East Children in Care Pledge (NHSE): "If your emotional health or mental wellbeing deteriorates and you need support or treatment, you will be able to access help in the area you live in without delay"

Opportunities

- '**New Care Models**' Specialist commissioning for Tier 4 moving from regional NHSE-led to the **local Provider Collaborative**
- **Transformation Work for Children in Care** - integrating social care needs with mental health needs (Tier 3.5 therapeutic social work)
- Medway is a Wave 3 Trailblazer for developing Mental Health Support Teams (**MHST**) in 2021/22
- Implementation of **Signs of Safety** framework for social work practice
- Support placement stability for more difficult and challenging placements by introducing **therapeutic support for foster carers** by **increasing the number of in-house foster carers** for adolescents
- **NHSE Complex Cases** EOI
- **2020 Framework for Integrated Care** (Community) to use trauma-informed, formulation-driven, evidence-informed best practice to integrate and support services to intervene earlier and prevent progression into justice system, and unnecessary T4 admission or out of area placement
- System-wide **long-term joint commissioning** based on a thorough understanding of need
- Medway aim to **prevent escalation** of cases to T4 and enable step down
- Monitor states "Design of **payment systems** influence quality of NHS care for patients in ND"

Young People’s Experiences & Views

YOUNG PEOPLE'S VIEWS

OUR APPROACH

In order to ground and triangulate the findings from best practice, stakeholder interviews and the case file reviews, young people and their families were invited to share their experiences. Young people with relevant experience were identified by commissioners. They were contacted by their social workers to see if they would be willing to participate and, with their consent, an interview was arranged. This often involved liaising directly with the young person and/or their current placement.

Six interviews were conducted. This included five interviews, over zoom or telephone, with young people and one interview with a young person's mother. All five young people interviewed directly were female and the young person whose mother we spoke to was male. Their ages ranged from 14-18 years old at the time of interview. Some had been in care since they were six years old.

Age	reference
16 year old	Young person 1
18 year old	Young person 2
16 year old	Young person 3 (mother interviewed)
15 year old	Young person 4
14 year old	Young person 5
18 year old	Young person 6

With their consent, interviews were recorded on a Dictaphone in order to enable the conversation to feel more natural and for the research team to extract verbatim quotes from the transcripts thereafter. We have set out our findings below thematically, using Braun and Clarke's (2006) inductive thematic analysis approach. This means we were led by the data, and did not approach the interviews nor analysis with any preconceived hypotheses, nor did the researcher have prior knowledge of the stakeholder findings again, to avoid biasing or leading the interviews with young people. The three key themes we will explore here are:

1. **Having their voice heard**
2. **Humanising the experience**
3. **Consistent and Trusting Relationships**

Theme 1: Having Their Voice Heard

This theme relates to the fact that young people described that things had happened 'to' them not 'with' them. They reported that they did not feel like an integral part of care decisions and this was also echoed by the mother of one young person interviewed.

Young people reported that during their initial experiences, they felt that several professionals did not take their concerns seriously. This included being offered a 'cup of tea' when describing they felt suicidal and/or concerns being minimised or 'laughed off' as 'teenage issues' by doctors and/or CAMHS teams.

'My GP said it was hormones and age and said I was just in a bad mood. I knew I wasn't OK but if they said I was, I didn't feel like I could argue it' (Young Person 6)

In some cases young people described that this escalated their behaviour or worries because they felt unsure about how else to be 'heard'.

'CAMHS were useless, they never listened, it felt like he never took me seriously. CAMHS thought it was all a joke. If someone had just listened to me from the start, this could have been resolved, someone to sit down and hear what I had to say, that's all it would have taken. I feel like my social worker should have been that person, they have a lot of power' (Young Person 1)

This sentiment was echoed by the mother of a young person who described her frustration at particular assessments, such as occupational therapy and physical health assessments, not being done until her son was sectioned, despite calling out for them for years. The implications of not acting or listening to young people and families at early stages of support can have far reaching consequences, for example, this young person had lost nearly all of his muscle tone as a result of not having appropriate assessments prior to being hospitalised.

This theme also related to feedback from young people that they sometimes felt certain type of treatment or therapy were imposed on them. They relayed that professionals did not respect that young people were reporting they were not yet ready for certain interventions and therefore engagement was poor.

‘There are physical issues that haven’t been addressed for years, not just his mental health. What works for him is consistency and routine, he has been getting speech and language and extensive OT assessments in hospital, he has hardly any muscle tone left, which made me really sad because he has gone from low muscle tone to no muscle tone, I have been asking for five years, for please someone to assess him, but apparently the only way we could do that was for him to be sectioned. Why do these things not happen until he was in hospital? This should have been done in the community. Why do I have to fight for this for my son? And by the time we get there, it’s obviously too late. He shouldn’t have to wait the lengths of time he does to get something simple done. He shouldn’t have to be sectioned to get a full OT assessment – that is neglectful for me” (Mother of Young Person)

‘I am getting therapy in January. I have had it once before and I kicked off and smashed the whole room up, they asked me a question I didn’t like and I started crying and smashed my room up. That was 2 years ago and I haven’t had therapy since. Everyone has talked to me constantly about it since then. My mum was always forcing me to have it and then I came to my own conclusion to have it. Now it’s my decision to have it’ (Young Person 4)

Those who had received Dialectical Behavioural Therapy (**DBT**), when they felt ready, were positive about this especially where they did not have to directly talk about their feelings and emotions. Whilst some young people reported they trusted professional judgement, mainly around medication, they also were clear that they knew themselves best, what they needed to calm them down and what they would respond well or not well to. In essence, young people described a desire to be more of an author, than a reader, in their story. A participant rather than just a passenger.

Theme 2: Humanising The Experience

This theme relates to the need, reported by young people and their family members, to remember at all times that there is a 'human at the centre of all the chaos'.

A number of young people discussed particular incidents which made them feel isolated, de-humanised or sometimes criminalised. For example, one young person described how she had been in secure transport for ten hours when moving to a new placement and had to be accompanied in the toilet cubicle when stopping to use the facilities.

'The transport up here, it felt like I was in a cage, you're in this truck, two staff members from the hospital and when you went to the toilet someone had to be in the bathroom with me, in the actual cubicle, and it felt uncomfortable, watching me go to the toilet in case I hurt myself or tried to run away. You could have made it feel like a road-trip rather than making me feel like a prisoner, they could have made it feel more homely on the travel. I was treated like a prisoner, sitting upright for ten hours. My social worker came in a plane, ten hours was too long' (Young Person 1)

This same young person also talked about her experience of being in a section 136 place of safety.

'I would make 136 suites feel less like a prison cell, it was just a bed, a chair and a bathroom. I was in there for 4 days with nothing, just sleeping, it wasn't healthy at all, they could make them more comfortable, maybe a TV in there, a safe box TV like we had in hospital. We did have books if we wanted to read' (Young Person 1)

Young people showed insight in terms of understanding the imperative need for safeguarding but they discussed the fact they would have liked this to have been done in a more sensitive way. In particular one young person highlighted that when being placed in an anti-ligature suit she was 'stripped naked' to do so and this was extremely triggering for her. Another described how she was 'watched' by staff when showering

'I have been through a lot in my past with men and when they put you in these suits, they strip you naked, and it brought back so many flashbacks I attacked the staff but they were stripping me naked so of course I am going to attack. Anti-lig should be used but they shouldn't, if they do it just the once, I don't think they should bung in the anti lig, talk to me, calm me down, before you put me in it. I think they just need to not use the anti lig suit unless it's desperately needed. They wouldn't talk to me after so I couldn't explain why I had acted that way' (Young Person 2)

In addition, the mother of one young person described that because there were, as she perceived it, inadequate resources in Medway to support her son's particular needs she felt he had often been left or forgotten about. In one school placement he had been left in a room on his own.

'He was literally in a room on his own by the time he left one of his schools – it was a battle for me to get them admit they couldn't meet his needs. I felt really quite upset about this as you can imagine. It took me and the social worker to go and see where he was and say 'this is what they're doing' and then they admitted it. This has always been the problem. People don't seem to have the resources to help him, but I wouldn't treat a dog like that' (Mother of Young Person)

As a result, this mother reiterated that because of the number of professionals involved in trying to find a resolution for her son's situation, she felt he often got 'lost' rather than staying central to people's focus.

'There's a lot of blame game going on, I find that as upsetting as it is to say, a lot of people that are working in these teams, they forget there is a young child involved, he gets lost in all of this' (Mother of Young Person)

It is also important to note, as part of this theme, the extent that young people described feeling 'different' to other young people. One young person discussed the fact that unlike the majority of her peers, she had never had social media until recently. Other young people described how it felt to be escorted out on visits or community trips. Therefore, there is a need for young people to feel integrated with other young people despite being segregated in hospital or foster placements. This relates to the appropriateness of placements and one young person noted how she was often triggered or re-traumatised by things she saw in hospital.

'I feel like going to hospital wasn't a good thing, it didn't help me as much as I thought it was going to. I don't get the admission, you're in hospital with other people who are unwell. You see someone else hurt themselves and you get triggered by it, it doesn't help your recovery being with other people who are unwell' (Young Person 1)

'***You see stuff in there [hospital] you shouldn't have to see – I walked into a girl's room I knew from school and she was passed out on the floor with her laces round her neck' (Young Person 6)***

The appropriateness of placements also pertains to suitable and timely assessments. It was apparent in some cases that because of young people's multiple and complex needs there was a sense of not knowing where to best place them, who could best meet their needs and very often the resources available were not local.

'The resources should be more readily available. He can't get respite, there is nothing for him, a foster family would NEVER take him because of how he presents. There isn't anywhere in Medway, not a school in Medway that is trained to support him. It's beyond a local problem, in Medway the resources for him are zero. If he stays in Medway he will need a tutor to come to him, his schools have never been in Medway, he has been to Brighton or Broadstairs, we even ended up looking in Scotland and Wales once. The resources are not there. Not for my son. He is complex, he is unpredictable, it is hard to know how to manage his needs, but are you really telling me he is the only one? And it's impossible to get something in place for him?' (Mother of Young Person)

The case above pertains to a young person, who had been in hospital for a year after being sectioned. His mother discussed how she often had to try and find him suitable placements, liaise with providers across the country and link them in with Medway's local authority placement team. She recognised not all young people would have this type of advocacy available to them. She expressed concerns about the suitability of her son's next placement on discharge from hospital, having only had one zoom assessment and there being no crisis plan in place.

'There is a new care provider that we hope he will go to when he is released from hospital…but the last couple of months it has gone downhill, after all this time, he's is near discharge, they say they need another clinical assessment, they have only met him once on a zoom call, they haven't done the work, ten minutes of a zoom call. I know it's going to be another breakdown of a placement, they are shuffling backwards, getting cold feet, I have seen it before, no one cares who it affects the most and that's my son. There is already too many red flags for me, no accountability, they are already so worried about who will help them if there's a crisis, this should be in a crisis plan, but they aren't taking responsibility for that either. Things that are majorly important they aren't covering and I don't like that' (Mother of Young Person)

'Sometimes I feel like I work for Medway council because I do a lot of the legwork myself, I don't want to rely on someone else to look for places for him to go, I find places, I speak to a provider and pass the details to the placement team so they can share the paperwork. I do get over involved but I do need to do sometimes, if I am not, things just get left. Providers will say 'we have reached out to placements team and they haven't got back to us. Things get left and I can't afford for that to happen' (Mother of Young Person)

Theme 3: Consistent & Trusting Relationships

Young people were asked about the number of placements, moves and social workers they had had in their period of involvement with social care and mental health services. It was common for young people to have had multiple professionals involved in their care, from a range of different teams with changing workers within this. The impact that this had was fairly disruptive.

'I have had about six social workers, when I am trying to grow relationships with them they just leave all of a sudden' (Young Person 1)

Young people were asked the extent that social care and mental health services communicated well with each-other.

'Social care and mental health didn't communicate well together. When I was in hospital my social worker didn't call me, sometimes on ward rounds they'd say she was on the phone and she'd say she was looking for somewhere for me to go when I was discharged. I was somewhere I didn't know, being told they couldn't find me somewhere to go, it added to the stress' (Young Person 6)

'I was in Birmingham hospital and I needed to speak to my social worker but they refused to give me my social worker's number and I really needed to talk to her and I don't know why they wouldn't and they took forever to get it and then they would let me go on leave with my social worker but not my mum and it just really hurts and they don't always keep social workers up to date with what's happening' (Young Person 2)

This was echoed by the mother of a young person who recommended having one team to liaise with, rather than professionals from different teams. This was especially important where young people had multiple needs and fell into multiple services (e.g. social care, learning disabilities, mental health, placement teams).

'There should never be so many different agencies, there should be a team of professionals that are consistent who make sure things get done. Not speaking to that one that one that one all the time, no one is together, it should be centred around that young person' (Mother of Young Person)

'Now he's in hospital it's all one team, it's in-house, not making referrals to speech and language here, this one there. At hospital they have an MDT, everyone involved in every aspect of his care meets together, they discuss him together, they are all on the same page. In the community they never meet all together, I have to share information between parties. This doesn't work, it shouldn't be like this. It's not just the parents or the young person frustrated by how disjointed it is, the professionals too and it would save time for the young person' (Mother of Young Person)

When asked what helped them feel settled and safe in new placements, young people unanimously raised their relationships with staff as critical to this. Therefore, building a trusting relationship with a consistent member of staff was highlighted as a useful therapeutic tool. One young person also highlighted that it can take a considerable length of time before trusting a professional, describing it took a year to trust her key-worker and feel comfortable. This is an important point, particularly as several young people highlighted challenges in communicating their needs, emotions and feelings to professionals. One young person suggested the use of cards that young people could show to staff in placements or hospitals to show how they are feeling without having to verbalise it.

'I think that we should have these cards that can be made to go up to staff to show how we feel. Like that say happy or sad or scared. I think that would be really helpful. Just make sure the staff are ready to listen and if a person doesn't want to talk, just sit with them and let them know they are there for them' (Young Person 2)

Several young people also highlighted the benefits of having another young person assigned to them when they move placements; a buddy system. They stated that where this had occurred it helped make them feel settled but needed to be in place long enough, for at least a week, for people to feel able to engage with this system.

'With me they put me on 1-2-1 when I first went there, but just for 2 days, I was shy and not out of my shell – should have kept that going until I felt more confident to come out of my room and stuff' (Young Person 1)

In addition to a warm reception from staff and other young people, it was suggested that young people should have a clear sense of the new place they are going to, being able to visit or see pictures ahead of arrival.

'If that person wants to know the information about where they go next, they should have paper on what to experience, a booklet about the place, photos of the bedroom and maybe visiting places to know what it looks like' (Young Person 4)

Conclusion drawn from Young People's Views

The interviews undertaken with young people and family members highlights the value in consulting with service users about the care they need and desire.

Young people were incredibly articulate about what was and was not helpful to them in their journey to wellbeing and recovery, in coping with their, sometimes traumatic, life experiences and presenting needs.

Young people value **being listened to**, being consulted with and getting treated as credible sources of information in their own care.

They respond well to **having at least one consistent professional** involved throughout their journey and, as explained by the mother of one young person, having one consistent multi-disciplinary team in the community would be best practice. This model is used in hospital settings and promotes effective communication between professionals, as well as timely interventions.

There seems to be **a lack of appropriate placements or resources** for complex young people locally. Young people often have to be moved outside of Medway and they described how this process could be made easier and smoother. This included having oversight of the new placement, advanced warning and preparation and a buddy system in place for at least the first week of arriving.

Young people were candid in how some of the **systems in place to keep them safe often made them feel more frightened or punished** rather than safeguarded. Any restrictive processes (e.g. anti-ligature suits or restraints) should be applied in a trauma-informed way wherever possible.

Young people also highlighted **their difficulty in communicating how they felt**. The use of visual aids to support this would be welcomed. Young people often said that staff just sitting with them, without the need to talk or express themselves, was a powerful antidote.

CASE FILE AUDIT NOTES

- **T4 Length of Stay**: 42% (5 cases) had at least one admission to T4 inpatient services for an average of 11.3 months in total which was equivalent to 6.6 months per stay at an average of 1.7 stays per person
- **Estimated Cost**: Using the mean cost per inpatient day of £3,561 these 5 cases amount to an estimated spend of £858,145 at an average of £71,512 per average stay (6.6 months)
- **Outpatient T4**: 50% (6 cases) were referred to T4 outpatient services
- **Engagement Duration**: The notes in the summaries pertaining to these cases covered periods ranging from 4 months to 14 years. The average period was 6.3 years (75 months)
- **Changing Social Workers**: Across the 12 cases, 84 different social workers were involved, at an average rate of 7.6 per person in total and 3.5 per person per year
- **Frequency of Needs Arising**: The frequency that key needs or risky incidents occurred was at an average across all cases of 1.9 per month per person for the period covered by the notes. This is shown in more detail in the following table

Case File Audit: Issues, concerns and needs frequency summary

Frequency (Total across the 12 cases)	Frequency (Average across the 12 cases)	Number of cases	Concern or Need	Explanation
58	4.8	92%	Other Abuse	Covering: neglect, physical abuse, emotional abuse etc.
54	4.5	83%	Behavioural Difficulties	Reference to behavioural difficulties or challenging behaviour (inc. aggression, violence)
42	3.5	100%	Mental Health	Mental health issues (inc. diagnoses of PD, anxiety, PTSD, depression etc.)
41	3.4	67%	Sexual Abuse	Sexual assault / abuse (including rape or assaulting others)
39	3.3	83%	Family MH	Family member mental health concerns
26	2.2	67%	Hospital / A&E	Hospital admission or A&E attendance (also whenever operation mentioned)
26	2.2	75%	LD	Learning disability (inc. Autism Spectrum Disorder, ADHD and mentions of any serious developmental delay)
24	2	83%	School Problems	Problems with school (inc. exclusion)
24	2	100%	Family Relationships	Problems with family relationships (inc. family breakdown)
23	1.9	67%	Self-Harm	Self-harm
23	1.9	67%	Suicide	Suicide ideation or attempt
19	1.6	58%	Sectioned	2, 3 or 136
17	1.4	67%	DV in Family	Domestic abuse in the family
17	1.4	42%	Family CJS	Family involvement with criminal justice system (i.e. offending or prison sentence)
17	1.4	58%	Family SM	Family member substance misuse
10	0.8	42%	CSE	Child sexual exploitation
6	0.5	17%	CJS / YOT	Involvement in crime, criminal justice system, Youth Offending Service
5	0.4	42%	Emotional / Social Difficulties	Specific reference to emotional or social difficulties
5	0.4	25%	Not allowed / unable to return home	Not allowed to live at home – either by family or social care
4	0.3	33%	SM	Substance misuse
4	0.3	25%	CP	Child Protection
3	0.3	17%	Missing / Absconding	Missing period or absconding
2	0.2	17%	CIN	Child in Need
2	0.2	17%	Parent LD	Parent diagnosed with learning disability
2	0.2	17%	Gang	Gang involvement
1	0.1	8%	Homeless	Homeless period

Themes from the Review of Case File Audit Notes

Earlier intervention / preventative work needed

- There was a sense that earlier interventions or preventative work could have been beneficial – for example that therapy was needed earlier on for the individual
- Preventative work was suggested for the parent(s) in a number of cases - for example, there were suggestions that mothers would have benefitted from preventative work
- Similarly, one case had been identified as at risk of CSE before it happened and questions were raised about what more could have been done to prevent this or any escalation.

More information needed and earlier

- There were some questions around whether work or specific therapy (i.e. attachment work, family therapy, DBT) had actually been received
- As well as questions about whether services were communicating with one another and had an awareness of certain issues at the time
- It felt as though additional context was needed to properly assess the individual cases, and that having this information at an earlier date may have helped to better inform the course of action taken

Waiting lists / delays (for referrals, receiving treatment, sometimes due to not meeting threshold)

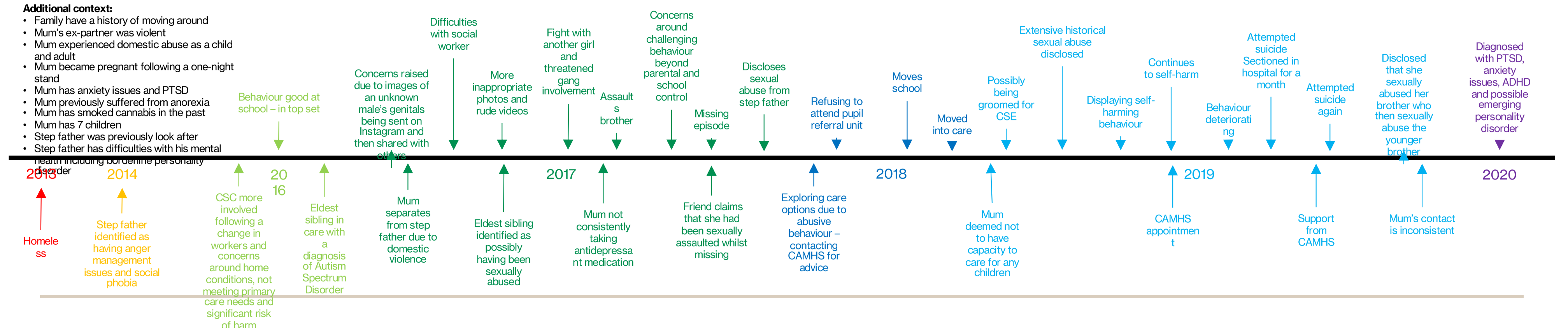
- A common theme was delays in the CAMHS referral due to waiting lists or because the individuals did not meet the threshold
- Some individuals also experienced delays in accessing treatment (i.e. DBT), or were described as being on waiting lists for therapy
- In some instances, this was the reason attributed to escalation in risky behaviour.

Delays in recognising the problem (or source of problem - i.e. sexual abuse)

- In one case, delays were said to be due to not recognising the signs of sexual abuse and potential gang involvement
- Another case questioned what could have been done to spot sexual abuse earlier

Appendix 2

CASE STUDY A: Timeline taken from the Review of Case File Audit Notes



Appendix 2

CASE STUDY B: Timeline taken from the Review of Case File Audit Notes

2008

Concerns raised around Mum for being aggressive at school

Identified as having additional needs

Uncle in prison for headbutting Mum unconscious and threats to kill

Blind in 1 eye and potentially damaging other eye from headbanging

Referral made to deaf/blind service

Abnormal brain

2009

Concerns around Mum needing help due to stress and issues with neighbours bullying

Concerns over level of meds considering age

Several concerns raised by neighbours over Mum's care for children

Doing well since attending nursery

Cochlear implant rarely being used at home

Positive progress at school

Mum referred to attend sensory training regarding headbanging

Emergency eye operation as eye was deteriorating

2010

Diagnosed with GDD and is deaf, visually impaired, cannot walk unsupported and no verbal communication

Mum has started behaviour work

Deteriorating behaviour

Self harming

Mum requesting respite

Sleep difficulties

High levels of challenging behaviour and needs constant supervision

Seen by clinical psychologist

Wearing Cochlear implant, identified that it was broken potentially due to headbanging

Concerns regarding the state of house

2011

Eyesight continues to deteriorate and no longer repairable

Started attending after school club to reduce pressure on Mum

Operation required to help breathing as trachea collapsed

Reflux issue

Learned Makaton sign language when could see, hand over hand sign language is now used to sign to him

PEG for feeding fitted for feeds at night and for fluids

Family really struggling and extreme concerns over Mum's wellbeing

Meds given for reflux

2012

Family due to see psychologist

Lost all sight from headbanging over the years

Further challenging behaviour

Mum and Dad broke up and intervenor started

Displaying massive self injurious behaviour and headbanging

House quite messy

Mum discloses overdose

2013

Housing conditions awful

Uncle threatened Mum

Concerns about neglect and emotional abuse

Concerns were around hygiene, high criticism/low warmth to children, emotional needs of Mum and its impact to care for children

Eldest daughter given responsibilities not age appropriate

Missing medical appointments

Mum says she needs additional support for challenging behaviour

Challenging behaviour from siblings

Inappropriately dressed

2014

Not consistent improvement in home environment

Mum extremely stressed and low mood

High level of support required

Inconsistent contact with Dad

Mum has thyroid problems and depression but doesn't consistently take her medication

Mum has a new partner which seems to have a positive impact

Mum has had fairly recent incidents of domestic abuse against Dad and another ex-partner

38 week residential setting – progressed well but after 6 weeks unexpected closure

2015

Mum diagnosed with bipolar

New placement, but not progressing

2016

Concerns that home life is explosive

2017

Started new 38 week residential school

2018

Reflux issue and Mum believes meds not working affecting behaviour

Mum needed operation – recovery affecting ability to comfort, support and work with children

Broke arm after falling down stairs

PBS plan supports in class in a safe and consistent manner

Anxiety high since hospital visit (pulled PEG out) – concerns that something happened at hospital to cause distress, allegations that overdosed and staff refused to sign to explain why scan was needed

Not receiving 2:1 support as specified in EHCP plan

Refusing to leave Mum

Given antibiotics

Seen by CAMHS as emergency case

Becoming increasingly frustrated, angry, upset, and struggling in school

Mum and partner assessed as having a good understanding of child's needs

Prescribed meds for anxiety and depression

2019

Worries about mental health and psychological harm as a result of not accessing education provision entitled

Appointment with deaf CAMHS cancelled

Removed from school due to concerns over school not meeting needs

Family now under immense stress

Allegations of physical abuse

Continues with self injurious behaviour

Mum needs support for own mental health

Harms Mum for challenging behaviour

Mum's relationship with social worker broke down

Displaying challenging behaviour as a result of high anxiety

CAMHS now in place

New medication

Concerns over Mum's mental health

Severe challenging behaviour

Specialist mental health input required

Spends most of time on Mum's lap

Had CAMHS appointment but resulted in restraint

Hospital

Mum refusing to leave hospital due to feeling unsafe

Mental health needs addressing but CAMHS believe PEG removal is behavioural not mental health

Removes PEG (this appears to be when anxious)

2020

Self injurious behaviour continues, especially after trying to sooth Mum

Mum extremely verbally aggressive and pushing wheelchair aggressively

Concerns about Mum regulating her emotions

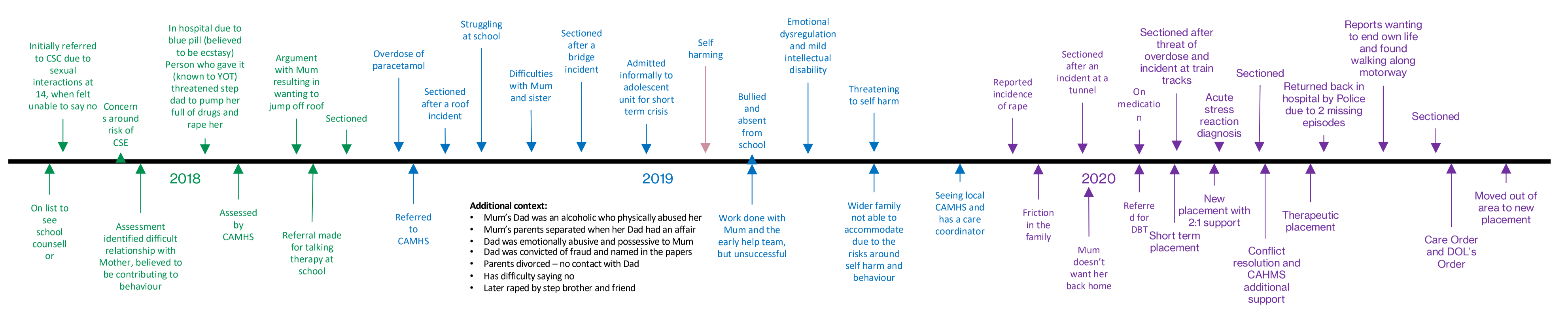
Witnessing Mum's outbursts

Child protection plan

Additional context:

- Mum has suffered depression since the age of 14 as her own childhood was chaotic
- Mum was sexually abused by her cousin at the age of 5
- Mum became pregnant at the age of 14 and suffered a miscarriage because her Dad physically assaulted her
- Uncle has a string of aggressive and violent convictions

CASE STUDY C: Timeline taken from the Review of Case File Audit Notes



Additional context:

- Mum's Dad was an alcoholic who physically abused her
- Mum's parents separated when her Dad had an affair
- Dad was emotionally abusive and possessive to Mum
- Dad was convicted of fraud and named in the papers
- Parents divorced – no contact with Dad
- Has difficulty saying no
- Later raped by step brother and friend

MEDWAY STAKEHOLDER VIEWS

”How can we make a vulnerable young person wait for two years when a week can be a lifetime for them and their family?”
Medway Stakeholder

Strengths of the current system

Appendix 2

- There is a **whole system approach** to mental health for young people in Medway
- **Common aims** to improve wellbeing and meet needs of young people with **senior leadership commitment**
- **MCH reducing their waiting list** for ND pathway
- Overall **CAMHS offer is seen to be improving** under NELFT contract, with waiting times slowly reducing (although uncertain this will continue due to covid restrictions and increasing demand)
- **Positive Behaviour Support** (PSP) programme
- **FCAMHS** - although it is felt that capacity is too limited
- They are developing a **NEST** - specialist children's homes for LD/A
- Strong **Provider Partnership** for T4 in the region
- **0-25 Disabilities Team** has a good transitions process for whole families and services
- **ADHD Triple P parenting** programme in Medway

Demand Outstrips Supply

"A 2 year wait for an assessment often means the family feels exhausted and cannot carry on – they just want to understand what is going on and what to do about it, but we keep them waiting"
Medway Stakeholder

Demand

- **Unprecedented high demand** means CAMHS and social care are very under resourced to meet the level of demand – and it continues to rise for ND and MH
- **Inappropriate referrals** to CAMHS contribute to this, where needs could be met by non-specialist services

Supply

- Contracts based on historical needs data and needs to be flexible to **respond to changing needs**
- Although there are not large gaps in CAMHS staff, it can be hard to **recruit to specialist posts**
- High **turnover of social care staff** leads to inconsistent support for Young people
- No dedicated **LAC team** in CAMHS

Governance & Accountability Gap

"Too many professionals say 'this is not my role' or 'my organisation is not commissioned to provide this' – essentially hiding behind professional boundaries" Medway Stakeholder

- Lack of **clear governance**
- It is unclear **who "owns" the agenda** for complex cases for young people:
  - at strategic partnership level; and
  - at frontline individual case level
- Gap in **Medway level data** at granular level (e.g. T4, outcomes, LAC, complex cases)

- A **complex system** built up of **historic and "silo initiative" funding** streams drip-fed by Government
- Multiple **changes to the system** in terms of pathways, funding and terminology
- **Geographical challenges** – with some services on a Medway, Kent & Medway or regional footprint

Identification & Pathways

"Sometimes CAMHS and Social Care seem worlds apart" Medway Stakeholder

"Interventions should be multi-systemic and multi-modal, provided where need is indicated, driven by the agreed formulation ('their story') and not solely influenced by a particular diagnosis or label" Medway Stakeholder

- Different groups have **different understanding** of risk, complexity & unmet need and about **what constitutes a "complex case"**:
  - **Social Care** - adolescents and contextual safeguarding, risk of exploitation, sexually harmful behaviours, suicidal behaviour and self harm
  - **0-25 Disabilities team** – Severe and profound LD/A
  - **CAMHS** – Accurate assessment and treatment of those with formal diagnoses
- young people with **challenging behaviour** can be seen as "hard to engage" or chaotic & unmotivated
- This can lead to concerns about vulnerable people "**falling between two stalls**" – e.g. Transforming Care and Tier 4, transitions, no clear diagnosis
- It can be **hard to get a diagnosis** before 18 – therefore few young people have these clear diagnosis
- Kent and Medway have **different DSR** processes leading to some confusion and inconsistency

- Differing views on **which complex cases are priorities**, with concern about Young people in one or more of the following:
  - Adolescents with complex needs
  - Transforming Care cohort - ND Pathway (ASD/ADHD) & LD
  - Sexual harmful behaviours (sibling)
  - Suicidal behaviours and self harm
  - At risk of exploitation
  - Challenging behaviours
  - Home placement breaking down with adolescents
  - Severe and complex diagnosed mental health condition
- **Unclear local joint pathways** for complex cases
- **Expectation Management**: CAMHS feel social workers and parents/carers have unrealistic expectations of what treatment can achieve or consist of. This was felt to be exacerbated by increasing trend to "disasterise" challenging behaviours that can be normal child development and desire to have "a diagnosis"

Delay & Drift – Unmet needs

"At professionals meetings everyone says they will act but no one takes responsibility or makes changes" Medway Stakeholder

"Each organisation talks their own language without putting the impact on the child at the centre" Medway Stakeholder

- Demand outstripping supply results in **very long waits** for assessment (e.g. 2 years+ for ND) and treatment (examples of 2 year+ waits for support)
- **Skills Gap**: Early Help and social workers do not have the skills to deliver mental health interventions and how best to ASD manage presenting behaviours
- Concerns over **challenging or risk taking behaviour** can lead to requests for therapy, whereas CAMHS view that the young people needs to be safe & stable before therapy is effective
- **Therapeutic Interventions**: A gap in social workers knowledge about what therapy to recommend, what is available / effective, & how to access this. Social care do not have an approved provider framework for therapists & specialist assessors
- Challenging and risky behaviours leave social workers feeling **de-skilled** and holding too much risk
- **Under use of Single Point of Access (SPA) into CAMHS** - Many social workers can be unclear on who to contact to get specific type of assessment and low use of CAMHS consultation
- For **undiagnosed or unassessed** it is very hard to get the right placement and agree funding. Lack of assessment leaves social workers holding the risk in an uninformed way

- Long waits can result in **family or placement breakdown**
- Delays in CAMHS completing **AIM2 sexual behaviour assessments** when there is no Youth Offending Service involvement resulting in victim, perpetrator & family left unsupported
- Social Care can feel CAMHS are **gatekeepers** first and the needs of children are secondary
- Professionals agree to actions at multi-agency case meetings but are is **not always actioned**
- There can be a **gap** between contextual safeguarding risk and behavioural concerns raised by social workers and CAMHS commitment to evidence-based models based on a diagnosis
- **Gaps in services to meet complex needs:**
    - Services are often too short term & not intensive enough.
    - Limited whole family interventions
    - Support for families involved in sibling sexual abuse
    - "Non-binary" gender support offer
    - Trauma Informed Therapies
    - Easy access to CBT / DBT
    - Therapy and support post ASD diagnosis

Barriers to Effective Joint Working and Intervention

"Unless we can see and understand what life is like for the child from all angles, we cannot design a personalised support plan – we try to fit children into boxes, but children cannot just be slotted into limited services." Medway Stakeholder

- **Differences** between social care and mental health – language, practice, understanding of conditions, risk and therapy
- Issues are **not understood in the same way** by all services - such as thresholds, criteria, escalations, communication between agencies, expectation management
- Lack of **understanding of ASD** in social care and foster care

- **Lack of suitable local placements** for complex needs can lead to **out of area** placements, leading to starting again with CAMHS in the new area
- **Historic risk** (e.g. minor arson when younger) can be a reason residential providers do not take young people
- Silo delivery – e.g. CAMHS often not present at **multi-agency meetings** & may not send updates or provide advice

Escalation & Crisis

"Often we wait until crisis before more intensive interventions are recommended" Medway Stakeholder

"If a young person attempting suicide is not a mental health issue, what is?" Medway Stakeholder

- **Resources can be held back** until crisis is reached rather than being deployed earlier to preventing escalation
- The crisis response tests and **fractures partnership** working
- Use of **A&E as a "back door"** to inpatient or fast track access to support or assessment.
- Young people with **suicidal behaviours** get seen quickly after an incident, but cannot get planned help to meet identified needs
- T4 can be misused to **manage behaviour** rather than treat a condition

- **Complex case management** is happening at commissioner and panel level rather than being built into local services & pathways
- **Therapy** is not appropriate during a crisis
- Lack of **community-based "safe places"** for young people – so residential/inpatient becomes the only option to keep a young people safe
- Concerns about managing **high risk LAC** in the community
- Gap in **intensive and therapeutic** social work support

Step Down & Transition

"ASD is a lifelong condition that treatment cannot 'cure'" Medway Stakeholder

"The wrong placement does more harm than good" Medway Stakeholder

"The gap between community support and inpatient is quite big – there need to be some more intensive or specialised work in the community" Medway Stakeholder

- **Lack of step down** from crisis – gaps in community-based T4 alternatives (e.g. therapeutic foster care and intensive home treatment)
- Often **families** are not capable or safe for young people to return to after T4

- Lack of **support to schools, social workers and parents/carers** on what they can do to support young people (esp. when waiting list) for ND, suicidal & challenging behaviours. This would help **manage expectations and build community capacity**

WHAT WORKS?

What Works?
Building Family & Carer Capacity and Resilience

Intensive Family Preservation Services

- Families in crisis – with imminent risk of child entering care
- Intensive – staff available 24/7 to the family
- Rapid response - within 24 hours
- Short term – for 4-6 weeks
- At home - support provided in the family home environment
- Small caseloads – 2-3 families
- Flexible delivery
- Develop family's skills – e.g. anger management & parenting
- Therapeutic input - CBT or motivational interviewing

Examples: Families First, Home-based Family Preservation, Option 2

Support for Carers & Kinship Care

- Strengthening **relationships** between carers & Young people
- Increasing **carers' resilience and skills** for parenting children with complex needs resulting from trauma
- Based on a range of **theoretical components**, Inc.:
  - Attachment
  - Social learning theory
  - Trauma psychoeducation
  - Positive parenting
  - Coaching and self reflection
- **Support for carers only** – can include Young people (1-1 or group)
- **Kinship Care** – high quality evidence on placement stability

Examples include: Kinship Care, KEEP and Middle School Success

What Works?
Building Capacity of Non-clinical Staff

Therapeutic Intervention from Non-Clinical Staff

- Evidence-based treatments for mild to moderate levels of mental health disorder can be delivered by appropriately-trained non-clinical staff (e.g. teachers, school nurses, counsellors, TAs) with supervision
- They can achieve outcomes comparable to trained therapists
- This can be used to deliver a number of interventions for anxiety, conduct disorder, substance use and PTSD

Advice, Information and Skills

- CAMHS can teach recognition of depression features, early warning signs, self-management techniques and subthreshold disorders to other professionals, Young people and their carers

What Works?
Social Work in Complex Cases

Collaboration

Collaboration is regarded as an important tool to avoid fragmentation:

- If **co-ordination of care** is not done actively, young people are at risk of receiving fragmented care that fails to address their needs (e.g. case management)
- Having **consistent, congruent or complementary treatment philosophies** may reduce potential conflicts and enhance co-ordination, if providers approach treatment from a similar framework
- **Personal relationships** that professionals form with each other facilitate exchange of information and referrals, benefit service co-ordination

Relationships

- **Quality of the relationship** between the professional and the young person
- Professionals' **interaction style** and relationship building skills
- Relationship-oriented practices comprises **practices based on specific therapies**
- **Trauma-informed** approaches
- **Continuity** of worker and care
- **Transparency** – sharing information
- Choice of **gender of worker**

Empowerment-oriented practices

- Address problems with **inequalities in power balance**
- **Shared decision** making
- Perceived **quality of service**
- Focusing on the young people's **life skills and strengths**
- **Open access**
- **Family strength building**

What Works?
Mental Health Interventions for complex needs in young people

Moderate to severe Depression and Anxiety

- Individual, **problem-specific CBT** for minimum 3 months
- **Alternatives** if this is not effective:
  - IPT-A (IPT for adolescents)
  - Family therapy (attachment-based or systemic)
  - Brief psychosocial intervention
  - Psychodynamic psychotherapy
- Can be combined with **medication** (e.g. fluoxetine)
- Specific **follow-up** psychological therapy sessions at a high risk of relapse

Trauma

- Trauma-focused cognitive-behavioural therapy (TF-CBT)

Criminal Justice

- FCAMHS: multi-disciplinary team

Complex Needs

- **Community Case Management** – co-ordination with a lead worker with access to a multi-disciplinary team
- **Solution Focused Brief Therapy** (SFBT) - Strengths-based individual or group approach to working with children and families (theoretical foundation for Signs of Safety)

What Works?
Neurodevelopmental (ND) – ASD and ADHD

- NICE recommend **assessment by a multidisciplinary team** including a core team of a paediatrician, speech therapist and psychologist
- Assessments should include an **assessment of mental health** given the increased prevalence in those with ASD
- NICE recommend an **integrated pathway and joined up working** for complex cases
- Monitor suggest **payment mechanisms** for ASD assessment are key to an effective system
- **CBT** can be effective in managing and reducing anxiety for Young people with ASD:
  - This **must be modified and adjusted** to the needs of those with ASD (NICE advise how to achieve this)
  - Can be **group or individual** for those with ASD
  - **Time limited** – e.g. 12 weeks
- **Applied Behaviour Analysis (ABA)** - Provides structure, direction, and organisation for Young people in addition to family participation. This encourages positive behaviours and discourages negative behaviours to improve a variety of skills. Examples include: *Discrete Trial Training; Early Intensive Behavioural Intervention; Early Start Denver Model; Pivotal Response Training; Verbal Behaviour Intervention*
- Establishing a **support team for the child and their family/carers**
- **Nurse-led ADHD drop-in** clinic – e.g. UK One Stop Shop

What Works?
Emerging Practice: Integrated Person Commissioning & Trauma Informed Approaches

Integrated Person Commissioning (IPC) – an emerging framework led by LGA and NHSE characterised by:

- Proactive coordination of care
- Community capacity and peer support
- Personalised care and support planning
- Choice and control
- Personalised commissioning and payment

Trauma Informed Approaches (TIA)

Many "complex" young people in contact with services have experienced trauma and may find it difficult to develop trust or feel safe. Promising UK examples include:

- AMBIT
- MAC-UKs 'integrate' model
- Trauma Recover Model and Enhanced Case Management
- SECURE STAIRS in secure settings
- DART Framework in secure settings

What Works?
Victims of Sexual Abuse or Violence

- **Time limited therapeutic interventions** – up to 30 sessions
- **Non-abusing parent/carer support** - Shorter interventions to run parallel around 8 sessions
- **CBT** – shows evidence of reduced symptoms of depression, PTSD and anxiety in Young people
- **Individual or in groups**
- **Examples include:**
  - **Trauma-focused CBT -** For Young people with symptoms of anxiety, sexualised behaviour or PTSD
  - **Therapeutic programme** (*e.g. Letting the Future In*) - Therapeutic relationship is crucial, providing a range of tailored support, including counselling, socio-educative and creative sessions
  - **Group psychotherapeutic and psychoeducational sessions or individual psychoanalytic therapy** - For girls showing emotional or behavioural disturbance

What Works?
Emerging Practice: Complex Needs Services and Abuse & Neglect Interventions

Interventions for Abuse & Neglect

- **Multi-systemic therapy for child abuse and neglect** - for the whole family, inc. parent/carer for 4–6 months. Address multiple factors contributing to the problem; round-the-clock on-call service to provide crisis support
- **Trauma-informed group parenting intervention** - for foster carers, adoptive parents and those providing permanence for young people aged 5–17 (parents only) for at least 4 day-long sessions. Helps foster carers develop the young person's capacity for self-regulation; build trusting relationships; develop proactive and reactive strategies for managing behaviour

Complex Needs Services

The NHSE&I Framework for Integrated Care Community suggests a complex needs service may consist of:

- **Senior clinical leadership** - oversight to influence relationships and organisational change across agencies and set up and embed credible and reflective practice
- **Young people's advocates** - trained in psychological principles, knowledgeable and skilled in engaging with Young people and the system
- **Team in the community – to** support coordination of services and provide advocacy
- **Offer of direct interventions -** from specialist mental health practitioners
- **Additional expertise** – e.g. neurodevelopmental and/or speech, language and communication therapy,
- **Reasonable adjustments in access and provision** – for Young people with LD &/or ASD
- **Clear links to local area commissioners -** to identify and address gaps and ensure a flexible response from partner organisations
- **Ensure timely responses** - across established support and services,

What Works?
Crisis Interventions

Crisis Interventions - Community

- **A&E intervention** providing patients and their families' stabilisation – e.g. Family-Based Crisis Intervention
- **Brief CBT for families** with a young person who is a suicide risk – e.g. SAFETY programme
- Developing and **improving resilience** of Young people and their families – e.g. Resilient Therapy
- **Clinical measurement of emotional distress dispositions** in assessing youth crisis events – e.g. Child and Adolescent Needs and Strengths (CANS)

Crisis Interventions - Telepsychiatry & Apps

- **Telepsychiatry** providing improved access to speciality healthcare services and increased system capacity as alternative to A&E attendance – e.g. Tele Mental Health (TMH)
- **Self-management App** for Young people experiencing a mental health crisis (e.g. suicide ideation) – e.g. MYPLAN & Australian eMental Health Clinic

Suicidal Behaviours & Self Harm (NICE guidance)

- Integrated, comprehensive psychosocial assessment
- Engage to initiate a therapeutic relationship – Care Plan
- Longer term management T2/3 CAMHS should be responsible for routine assessment and regular review (<1 year)
- Improve social functioning
- Joint working risk management plan
- Inpatient treatment - should be considered for high risk of suicide or serious self-harm/self-neglect, and/or when intensity of treatment (or supervision) needed is not available elsewhere, or when intensive assessment is indicated

Appendix 2

What Works?
"Tier 4" Options

Tier 4 Inpatient

- **Longer placements** are linked with improved outcomes
- SCIE advise **transition plans** to take account of:
  - Planning for admission
  - Ongoing communication
  - Preparing for discharge
  - Care and support after discharge
  - Crisis plan
  - Information and support for parents / carers
- **Supported discharge** provision in a mixed model of intensive and assertive community treatment – e.g. Supported Discharge Service (SDS)

Tier 4 Community - Alternatives to inpatient

- **Intensive outreach** teams
- **Multi systemic therapy (MST)**
- **Treatment foster care –** particularly for adolescents involved with criminal justice
- **Intensive home-based** services
- **Group therapy** - for self-harm, ASB or conduct disorder
- **Community Case Management** - multidisciplinary **fully integrated community-based** model, 24/7 care and treatment and availability of crisis interventions. Focus on promoting life skills development, social inclusion and the principles of recovery - e.g. York Model
- **Crisis recovery and reintegration** – e.g. New Beginnings and UK Club House
- **CAMHS Intensive Treatment Service (ITS)** – A Scottish Government study found that with close an ITS links to an adolescent inpatient unit, can provide a balanced care approach where young people with severe mental health difficulties can be treated in the community, where possible, without compromising on patient safety and quality of care

Key Components of community approaches

- Home treatment
- Small caseloads
- 24 hour rapid response
- Multi-modal treatment strategies
- Close involvement of partner agencies
- Individually tailored treatment
- Flexible working practices
- Systemic basis
- Strong partnership with young person and their family/carers
- Prevention of family breakdown

Appendix 2

What Works?
Emerging Practice: Other area examples

- **Doncaster proactive, monitoring and support group** - review and monitor Young people at risk of concerns that may escalate through CETR process
- **St Helen's ND Pathway** - multi-agency approach with short waiting times, where offer of support to families is accessible before, during and after the pathway journey and also when no formal diagnosis is mad
- **Sussex Positive Behaviour Support** – specialist worker & PBS programmes for Young people with LD
- **Hertfordshire ARC Trauma Informed Practice** – Team of specially trained ARC workers, therapists and a psychiatrist who receive ongoing specialist training delivering a range of interventions to Young people and their family
- **Treatment Foster Care Oregon UK (TFO)** - intensive support to the child, foster carer and birth family. Young people receive skills coaching to improve life, relationship & problem solving skills
- **North East Lincolnshire multi-agency LAC clinic** - monthly multi-agency clinic reviews SDQ results for LAC to to identify and escalate concerns and build a joined-up approach
- **Oxfordshire ATTACH -** assessment and intervention service for LAC & carers with a high level of need who may not meet CAMHS criteria (also review SDQ scores)
- **South London Partnership Young people MHS programme** - enhanced CAMHS T4 services and better management of existing bed capacity, including: Joint bed management service; New and expanded crisis care teams; Increased local capacity; Improved dialectic behaviour therapy pathway; Expanded adolescent outreach team; Crisis line service; Enhanced eating disorders services
- **Birmingham Youthspace** – quick assessment (<1 week of referral), rapidly responsive, youth-friendly and intervene early using a broad range of intervention
- **Fast track North East London Drop-in CAMHS** – fortnightly drop-in service for social workers to discuss concerns they have about looked after children, receive advice on actions and make referrals to the fast track LAC CAMHS
- **North Yorkshire No Wrong Door** – Alternative to CAMHS Therapeutic Provision, with key worker up to age 25, clinical psychologist "life coach" and more flexible access
- **Lewisham Virtual School CAMHS** – specialist CAMHS team embedded within the virtual school
- **Hampshire i2i** – An Urgent Assessment and Home Treatment Team provides a comprehensive out of hours' crisis service
- **Oxfordshire Intensive Support Team** - provides care co-ordination and focused support for complex needs through specialist assessment, intervention, care and support strategies
- **Gateshead Learning Disability Co-ordinator** – dedicated specialist providing extra support to stop them going into hospital unless absolutely necessary
- **East Lancashire Specialist ASD Pathway** - Action for ASD are specialists, offering Pre and Post Diagnosis Support, Pre Diagnosis and Assessment Screening, counselling and low level support
- **Integrated Personal Commissioning** – pilot sites joining up health, social care and other services at the level of each individual . LD specific versions are running in Cheshire West and Chester, Lincolnshire, Luton, Hampshire and the South West
- **Doncaster proactive, monitoring and support group** – sharing good practice and review and monitor Young people at risk of concerns that may escalate through the CETR process

AREAS FOR CONSIDERATYION

Areas For Action

1. Put the Young Person and Their Family/Carers at The Centre

- **1.1 Make sure young people's voices are heard, valued and taken into account** – greater priority must be given to ensuring young people are active partners in their own care, with their views being consistently sought, valued and having influence on decisions relating to their lives. KPIs for both CAMHS and Social Care should include measures around young people's satisfaction with services they have received and ratings on whether they feel they have been listened to
- **1.2 Give greater consistency in key workers** – work towards an approach that can guarantee greater consistency in social worker and mental health worker allocated to a young person so that trusting relationships can be built up over time. This is essential to many of the evidence based approaches with complex cases
- **1.3 Humanise the Process** – Review how some safeguarding measures are applied during the process of accessing Tier 4 services and changing residential placements to ensure they are not dehumanising. In addition, the journey into Tier 4 provision and between residential placements should be humanised as much as possible to ensure it is caring, nurturing and takes the feelings of the young person fully into account
- **1.4 Support the family / carers** – A single multi-agency team to support the young person & their family/carers was requested
- **1.5 Review the online mental health and safeguarding offer** for young people in Medway

2. System Change through Whole System Commissioning

- **2.1 Bring different agendas together** (Continuing Care, Transforming Care and Complex Cases) for future commissioning – get on a longer journey to re-commissioning over a number of years to align budgets and programmes based on need. Commissioning needs to be joined up, proactive and needs based
- **2.2** Medway needs a **systems approach** to embed complex case management into commissioned services. Make the most of future commissioning opportunities to **design services around the child** rather than around the services and pathways
- **2.3** Involve **NHSE&I** in future developments as "critical friend"
- **2.4 Incorporate learning** from Medway Social Care & CAMHS review of 12 cases of suicidal behaviours
- **2.5** Consider what is best provided on a **Medway footprint** - gain agreement with Kent about future contracting boundaries
- **2.6** Consider developing a wide pool of potential providers in a **framework of approved providers** on a call-off contract for a range of services in addition to core CAMHS to fill gaps, add capacity and provide alternatives that may be more responsive to individual and changing needs – to include step up and step down provision, community alternatives to T4

3. Identification

- **3.1 Define and agree the cohort and the level of need**: What do we mean by a “complex case”? All partners must agree criteria or a process to determine who is in this category & whether an individual meets this “criteria” or description
- **3.2 Merge lists** of young people “at risk of exploitation”, “complex cases” and DSR to a single process
- **3.3** Increase awareness of agencies of what constitutes ASD and knowing when to refer (“**Triad of Impairment**”) – help parents and agencies feel more confident to manage behaviour and know when and if to refer
- **3.4** Create a **central resource and training** for social workers and CAMHS to show relevant pathways, terminology, exemplars and processes. To include examples/templates for T4 requests to help social workers provide the right information. Help social workers know what they can deal with themselves and what needs a referral

4. Quicker Prioritised Assessment

- **4.1** Create a **Fast Track pathway** for priority assessments – define and agree the needs / criteria and ensure quick follow up with support/care/treatment packages (e.g. Passport to Support for the most vulnerable or at risk) – add this to contracts with timescales and targets linked to payment
- **4.2** NELFT & commissioners to undertake a **demand and capacity assessment** to identify issues and define demand for ND pathway, mapping out what is needed to meet demand – e.g. triage, speed of assessments. Future commissioning and service arrangement to be based on these findings. Incorporate learning from MCH activities to reduce waiting times
- **4.3** If **additional Government funding** is coming to tackle waiting lists – deploy this in the ND pathway first
- **4.4 Additional dedicated ND/complex case capacity** is required to reduce waiting times to assessment and treatment
- **4.5 Multi-agency holistic/contextual assessment** (social workers/MH) at an earlier stage in complex cases to determine which pathway to follow – to include crisis management in the planning at this stage rather than waiting until it becomes an urgent issue
- **4.6** Clear **sexual violence pathway** when there has been no “finding of fact” in court (for perpetrator, victim & family), inc. AIM2 assessment within 6 weeks
- **4.7** CAMHS to support social care to build a **framework** of local providers for specialist assessments and therapeutic provision
- **4.8** CAMHS to offer consultation on **specialist assessment recommendations** and advise on suitability or options

5. Multi-Agency Case Management to Support Whole Families

- **5.1 Make best use of what we have**: Look across relevant teams to identify potential for a better joined-up response within existing resources. Including clearly allocating a place within current multi-agency case management structures
- **5.2 Accountability**: The process must hold agencies and individuals to account for actions / progress. A named, suitable experienced person should be holding the case at all times
- **5.3** Ensure a **contextual safeguarding** approach to complex case management and consider a **Family Safeguarding Model**, such as the one used in Hertfordshire
- **5.4** Agree a joint approach for cases of **suicidal ideation** and repeated self harm – inc. support for the family
- **5.5** Learn from the approach to **missing young people**

6. Effective Complex Case Interventions

- **6.1** Build capacity of **in-house social workers therapeutic** delivery – including specialists in behaviour, suicidal/self harm, ADHD and ASD, trauma informed approaches, risk taking behaviours & exploitation
- **6.2** Capitalise on / link to "new money/initiatives":
  - **Transforming Care** NHSE developments to invest in therapeutic T3.5 social care [link]
  - **Complex Care Co-Ordinators** coming into Medway SEN team
  - **Safeguarding** developments in social care
- **6.3 Multi-disciplinary "Taskforce"** around young people for complex cases – inc. therapists, specialist therapeutic social workers, mental health role, PBS, intensive community support
- **6.4** Clear **community alternatives to T4** – inc. expanding home treatment, and more intensive multi-agency response with CAMHS & social workers for young people and families
- **6.5** Increase access to **CBT** (individual, groups, whole family) – build therapeutic capacity

7. Early Intervention

- **7.1 Build capacity in the community** by providing a more comprehensive package of information and support to parents/carers, schools and social workers for complex cases to prevent escalation
- **7.2 Mental health specialist role** within Early Help to advise and support workers
- **7.3** Ensure Medway **social workers induction** covers how the CAMHS service operates, use of SPA, service model etc.
- **7.4** CAMHS to provide **more information & advice** to enable providers & social workers to find the right school/carers and support complex cases earlier
- **7.5 Improve communicate** about what mental health support is available (inc. online) – how to access support, consultation & advice, referrals to assessment, pathways, what to expect and how to manage their cases better
- **7.6** Agree criteria for those young people who “bubble under the radar” that should **trigger a more intensive early response** to prevent escalation, by acting on warning signs rather than waiting for threshold criteria to be met
- **7.7 Train up** specific social workers roles into more mental health & therapeutic specialists

8. Step Down, Sustainable Long Term Support & Transitions

- **8.1** Ensure there are multi-agency **transition processes** in place for complex cases to adult services - inc. developing a LAC life course mental health pathway with adult services
- **8.2** Jointly review **transitions** arrangements to ensure they are fit for purpose for complex cases
- **8.3** Create a more **intensive community Tier 4 offer** as an alternative to inpatient provision

9. An Agreed & Managed Approach to Escalation & Crisis Management

- **9.1** Provide a more **intensive** support offer for **families** before care is looked at
- **9.2** Consideration of the pros and cons of **mental health workers embedded in social workers teams** – define which disciplines are needed (e.g. clinical assessors, psychiatrists, specialist mental health nurses). If it is not NELFT staff this may not facilitate better access to CAMHS and could cause confusion
- **9.3** Ensure **fast track assessments** on higher risk/complex cases to avoid getting to emergency placement stage without an assessment
- **9.4** Agree a multi-agency **escalation process** for complex cases that is pre-crisis

10. Use of Tier 4 Inpatient Provision When Appropriate

- **10.1** Agree **criteria and pathway** across key agencies for access to and step down from T4 inpatient and therapeutic residential provision
- **10.2 Avoid re-traumatisation** - The appropriateness of placements and actions within placements should be carefully considered by staff and detailed with a clear rationale in young people’s care plans to avoid unnecessary distress – for example, young people reported that they found it triggering being physically restrained or being around other young people who were harming themselves.
- **10.3** Explore which specialist inpatient services could be made **available in the community** at a pre-crisis stage
- **10.4** Expand access to **Treatment & Therapeutic Foster Care**
- **10.5 Merge Access to Resources Panel & JAP** ensure
- **10.6 Ensure better evidence at panel** - through more information on the process and training, plus ensuring the social workers practice manager reviews applications before they go to panel

11. Addressing the Governance Gap

- **11.1 Strengthen the Governance:** Strategic oversight of the needs of complex children should sit with either Safeguarding Board or Corporate Parenting Board linking with STP ICS mental health Board - to ensure connectivity of mental health to safeguarding developments
- **11.2 Improved use of data:**
    - Better use of data to **clarify levels of need** for complex cases and waiting times plus other KPIs
    - **Measure and track outcomes for complex cases**: e.g. Social Connectedness Scale for Inpatient Stays, and CGAS/HoNOSCA/ORS for all LAC
    - These can contribute to **greater accountability**
- **11.3** Implement the **iTHRIVE** model – including joint training for social workers & CAMHS
- **11.4** SCIE recommend each locality to have an accountable, **independent virtual mental health lead** responsible for MHEW of young people & LAC. This person should provide leadership and oversight of the local system and ensure an holistic approach is in place
- **11.5** Create clear **joined up pathways** for complex cases - owned and agreed by all relevant agencies, clearly defining roles and criteria

Appendix 2

TONIC

Insights, Public Consultation, Research, Evaluations, Surveys

FOR MORE INFORMATION CONTACT:

EMAIL: ENGAGE@TONIC.ORG.UK

FREEPHONE: 0800 188 40 34

WEB: WWW.TONIC.ORG.UK