HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Corporate Parenting Board
Date:	28 January 2021
Title:	Annual Report from the Hampshire Child and Adolescent Mental Health Service, Sussex Partnership NHS Foundation Trust
Report From:	*Ruth Hillman,* Operational Director ChYPS and Learning Disabilities/ND Services

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Purpose of this Report

1. The purpose of this report is to update the Corporate Parenting Board of the work priorities of the Hampshire Child and Adolescent Mental Health Service in relation to Children in Care.

Recommendations

2. That the Corporate Parenting Board consider the report and note the priorities for the Hampshire Child and Adolescent Mental Health Service in relation to Children in Care.

Executive Summary

3. This report seeks to highlight the priorities of the Hampshire Child and Adolescent Mental Health Service in relation to Children in Care.

4. The annual internal reporting period for the work of the children in care virtual team runs from April to March. This report has been compiled from the annual children in care report, which was presented to the Hampshire CAMHS Leadership Team in May 2020 covering the 2019/2020 reporting period.

5. The Virtual Children in Care Team in Hampshire work from within the 8 CAMHS team bases to ensure that the mental health needs of Children who have a Care Experience, are best supported locally to where the young person lives.

6. The purpose of the Child and Adolescent Mental Health Services for Children in Care (CIC) is to provide the best possible service to Hampshire's children and young people in the care system, their Carers and extended network, in order to enhance their placement stability, to promote good mental health and support them in fulfilling their potential. We aim to work in partnership with the young person, their parents/carers and professional network actively involved in the young person's life.

7. The Hampshire CAMHS Children in Care team use a trauma informed approach. The framework used to understand presenting difficulties in the young people referred is "what has (and still often is) happened to you" rather than "what is wrong with you". This is the starting point of any assessment and consultation.

8. The clinical model adopted by the Hampshire CAMHS children in care virtual team means we continue to focus on increasing understanding, knowledge, skills and confidence of the professional network. The work programme highlights the progress over the past year, as well as highlighting the priorities for 2020/21.

Contextual information

9. Across Aldershot, Basingstoke, Winchester and Test Valley, New Forest, Eastleigh, Fareham and Havant, the Service employees 6.11 whole time equivalent Children in Care Clinicians (11). This figure consists of 5.3 whole time equivalent Children in Care Therapists Band 7 (Band 8 0.4 clinical) and 1.33 whole time equivalent (0.63 and 0.6) newly created Band 6 Children in Care Practitioner development posts, where we have recruited 2 Social Workers. Some CIC Clinicians also hold other roles in teams including Art Psychotherapist, Mental Health Practitioner and YOT Lead.

10. The need to collaborate across agencies is paramount; particularly carers, social workers and education, to be able to build a working assessment about the needs of the young person and how they are best met. Whilst often the presentations are very risky and include self- harm, low mood, anxiety and challenging behaviours for carers, the umbrella behind all these is usually developmental trauma. It is important that this is recognised and understood in the assessment, risk and care plan, so as to best help the young person begin to feel safe again and begin to recover. To approach Children in Care assessments based on symptoms only, would be failing to understand what is really going on for the young person. It would likely only provide a treatment that would be ineffective at best and leave them feeling that something is wrong with them.

11. The trauma model adopted by the virtual Children in Care team is based on rethinking specialist and liaison services for young people who have experienced adversity or trauma. (Dr Nick Hindley and Dr Carmen Chan)

12. It is highly unlikely when working with young people with complex difficulties who may have experienced significant adversity, that a single intervention or agency will provide a single solution. In general, complex situations require complex solutions and good cross-agency collaboration focussed on achieving consensus is likely to have the most productive results. This requires a specialist service to recognise and consider the dynamic interplay between a young person, their family, and their social environment. Such an approach is frequently referred to as 'ecological' and planning should include assessment of risks/vulnerabilities and protective factors on each level.

13. Equally, grounded in the first phase of any trauma-informed intervention with young people, should be the development of a sense of safeness and stability that clearly takes into account the child's hierarchy of need. The importance of joint consideration of ecology and hierarchy of need is fundamental and underlines how important more general consideration of factors such as physiology, safety and social needs may be before more complex needs such as self-esteem and self-actualisation can be addressed.

14. As a result, it is often the case that recommendations involve a focus on core needs and strengths which can be provided by professionals already involved with the child (as long as they are reassured that a specialist service will continue to support them and will become more directly involved if needed). This is a key issue for the credibility and perceived usefulness of a specialist service: a service which provides advice and consultation alone without demonstrating a willingness to become more directly involved in cases when the need arises is unlikely to foster confidence or contain anxiety within professional systems.

15. In support of the above clinical model the children in care priorities for the Hampshire CAMHS children in care virtual team continue to focus on increasing understanding, knowledge and confidence.

Finance

16. There are no financial implications arising as a result of this report.

Performance

17. The Service received 136 Children in Care referrals in 2019/2020.

18. The total number of contacts offered by Children in Care Clinicians was 3722. 1538 were for Children in Care. The majority of generic contacts in these teams resulted from duty contacts and the trauma care group. There were also a further 2110 contacts provided for children in care, where the contact was not provided by a children in care clinician.

19. The average waiting time at the end of March 2020 for those waiting for an assessment was 18.9 weeks.

20. The average waiting time at the end of March 2020 for those waiting for treatment/specialist assessment was 36 weeks.

21. Waiting times for initial assessment and treatment continue to be a significant challenge for the Service. These indicators are monitored on a monthly basis. All cases, including for children in care, are prioritised following clinical triage. Young people presenting with significant risks are prioritised. When there is not enough capacity this leads to routine cases waiting longer.

22. A £6.6m investment from Hampshire Commissioners has recently been agreed, covering a range of areas including Psychiatric Liaison, enhancing crisis care in the Community, Eating Disorders, increased capacity to respond to increasing demand and a range of prevention services. Whilst this additional resource is not specifically allocated for children in care, it is anticipated that this will have an indirect impact on reducing waiting times for some young people in care, as a number of children in care tend to wait longer for specialist assessment, such as ADHD, which will be a priority area in addressing the unacceptably long waiting times for all young people.

23. Children in care will also benefit from the expanding services above, in line with our model of not creating dedicated resources for children in care. This model ensures that children in care have access to the full range of interventions, not those just provided by children in care therapists.

Consultation and Equalities

24. In preparing this report, due consideration has been given to the statutory Equality Duty to eliminate unlawful discrimination, advance equality of opportunity and foster good relations, as set out in Section 149(1) of the Equality Act 2010. No adverse impacts have been identified as a result of the information contained within this report.

25. No consultations have been undertaken and none are planned as a result of the information contained within this report.

Other Key Issues

26. There are no other key issues identified.

Conclusions

27. Adopting a trauma informed clinical model enables the team to use available resources effectively to target the widest audience of professionals in a systematic way.

28. The virtual team continue to offer a model which focuses on the first steps of the care pathway and the provision of information, advice, consultation and training.

29. Resources for the Children in Care virtual team continues to be a challenge. The Service would like to offer a greater range of service provision. Our work programme highlights how the Service will continue to work with partners through projects such as the Child in Care Pledge and Local Transformation Plan in order to work towards achieving this ambition.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	yes/no
People in Hampshire live safe, healthy and independent lives:	yes/no
People in Hampshire enjoy a rich and diverse environment:	yes/no
People in Hampshire enjoy being part of strong, inclusive communities:	yes/no
OR	
This proposal does not link to the Strategic Plan but, nevertheless, requires a decision because: *NB: Only complete this section if you have not completed any of the Strategic Plan tick boxes above. Whichever section is not applicable, please delete.*	

NB: If the 'Other significant links' section below is not applicable, please delete it.

Other Significant Links

Links to previous Member decisions:	
Title	Date
Direct links to specific legislation or Government Directives	
Title	Date

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

See guidance at http://intranet.hants.gov.uk/equality/equality-assessments.htm

*Insert in full your **Equality Statement** which will either state:*

(a) why you consider that the project/proposal will have a low or no impact on groups with protected characteristics or

(b) will give details of the identified impacts and potential mitigating actions

Sussex Partnership
NHS Foundation Trust

Children in Care Team Hampshire CAMHS

Annual Report 2019-20

2.1.

Author: Sarah Matthews, Lead Children in Care Therapist
Acknowledgements: Hampshire CAMHS Children in Care Clinicians

Contents

Executive Summary

Overview

The Virtual Children in Care Team in Hampshire work from the 8 CAMHS team bases to ensure that the mental health needs of Children who have a Care Experience, are best supported. The purpose of the Child and Adolescent Mental Health Services for Children in Care (CIC) is to provide the best possible service to Hampshire's children and young people in the care system, their Carers and extended network, in order to enhance their placement stability, to promote good mental health and support them in fulfilling their potential. We aim to work in partnership with the young person, their Carers and professional network actively involved in the young person's life. This annual report looks at the current children in care provisions, service model and delivery and suggested priorities.

CAMHS Children in Care Team Priorities for 2018/9

- Ensure Single Point of Access (SPA) processes for Children in Care referrals are being used and tighter timescales kept for return of information for assessment.

- Continue to develop a clear trauma informed service model for Children in Care (CIC). This will include consultation, assessment, trauma group, interventions.

- Trauma informed workforce: Build on the existing 3 hour Attachment training that is delivered to Hampshire to make this a whole day on Attachment difficulties and Developmental Trauma. CAMHS to be able to access this training or repeat in house. Longer term view, to run trauma group as a training package for Hampshire Foster Carers, SGO, Adopters with funding.

- Childrens homes: Develop clear packages of support to **Hampshire** homes that includes training on Attachment, Development Trauma and PACE model. Training packages to be used as resources across all homes consistently.

- **Private children homes:** To identify and meet with Heads of the Children's Home Groups whom we have referrals from. This is to establish reasons for frequent referral and contract consultation where needed.

- Out of County referrals: to further embed and maintain charging processes that reflect work being undertaken. To start to contract work from the outset when they are identified as out of county by SPA, so we can be commissioned for specific work.

- To increase the recognition and monitoring of Special Guardianship and Adoption cases in the team. This will ensure that the Post adoption services are used in the first instance in and out of county and to recognise that the CIC therapists often take this work up due to the complexity.

- Staff Well-being and training: All CIC therapists to feel they have the adequate level of support to do their work including supervision. To have a clear framework of service delivery to reduce secondary trauma. To advocate training needs are met in a timely way so as to develop a clear model of what we can offer as a CIC service.

Results & Conclusions

Focus of 2019 to 2020

In addition to the above priorities at the end of 2018 we became aware of county wide extra commitments that would add to the team priorities for 2019. These included the Children in Care Campaign, the employment and induction of the CAMHS multidisciplinary workers in the Social Care hubs and the development and governance of a service model. It has been an incredibly busy year, with increasing

pressure on resources, but one where our increased delivery of training on attachment and trauma has continued in its impact.

Action plan

Going Forward 2020/21

- Ensure spa process are maintained, timescales met and new CAMHS form is used.
- Identify consistent administration support in each CAMHS team for CIC Clinicians, to free up more clinical time. This would assist with setting up CIC assessment, diary and out of county funding returns.
- Complete Dyadic Developmental Practice training level 2 for those attending, to have a DDP informed team approach.
- Continue to co-deliver commissioned training to Hampshire Local Authority with Educational Psychology. This will happen virtually in the immediate future.
- Train generic CAMHS workforce in trauma model and trauma informed skills.
- Continue to engage with stake holders to reshape children in care placements in Hampshire with a trauma informed approach.
- Increase engagement with Virtual school to look at how best to use resources
- To increase the clinical hours available to CIC team by reducing generic duty commitments to allow for more specialist work to be offered to teams
- Consistency across teams in how CIC cases are triaged, assessed and held in teams
- For the CIC team to be identified as a separate team on Carenotes. This will allow for more accurate data collection, clearer use of clinical hours and audit.
- To aim to have 2 identified Children in Care clinicians in each team.
- To look at alternative/innovative ways to engage and work flexibly with CIC. This is to include how we may extend virtual resources and training to further support referrers and the network as well as direct work with young people.
- To look at how the out of county funding can be used for the benefit of children in care

Section 1

1.1. Introduction

This report will give an overview of the Children in Care Team work for the year 2019-20 in line with Sussex and government priorities. It will show the clinical model used to deliver work and outcomes from training and groups and statistical data. The report will look at the strategic cross agencies plans and recommendation for priorities 2020-21.

1.2. Rationale of CAMHS Children in Care Team

In 2016/17 there were approximately 96,000 looked after children in the UK. In the last five years the population of looked after children in the UK has increased by 5%. (NSPCC 2019 statistics briefing: children in care).UK Children in Care (CIC) are more likely to suffer from a diagnosable mental health disorder (45%) than the general population (10%) (Meltzer et al. 2003).Psychiatric disorders are even more prevalent among CIC in residential settings (72%).

Research has demonstrated that Children in Care are 10 times more likely to be excluded from school, 12 times more likely to leave school without a qualification, 4 times more likely to be unemployed, 60 times more likely to be homeless, 50 times more likely to go to prison and 66 times more likely to require Social Care for their own children (Briefing Paper Looked After Children: Improving Psychological Wellbeing British Psychological Society 2004).

In **March 2018** we had **1600** Hampshire placed children and **1275** placed in Hampshire from other authorities. Out of county placements had increased significantly particularly from private Children Homes. In **December 2019** the number of Hampshire Children in Care was **1673.** The number of Hampshire children placed out of county was **566** and the number of other local authority children in care placed in Hampshire was **1163.** The number in the private children's homes is unavailable (Naomi Black Lead Children in Care Nurse)

The NSPCC statistical briefing 2019 states: The majority of looked after children are in care because of abuse or neglect. In England 63% of looked after children were looked after due to abuse or neglect in 2017/18; family dysfunction England: 15%; family in acute stress England: 8%; child's disability England: 3%; Wales: parent's illness or disability England: 3%; socially unacceptable behaviour England: 1% (Sources: DfE 2018). 10% had 3 or more placement recorded over the year.

This measure is important because for many looked after children their pre-care experiences continue to affect them long after they become looked after (Rahilly and Hendry, 2014 in NSPCC statistic briefing on children in care 2019).

1.3. Clinical Approach

These findings are implicit in the trauma informed approach that we practice in the Hampshire CAMHS Children in Care team. The framework used to understand presenting difficulties in the young people referred is "what has (and still often is) happened to you" rather than "what is wrong with you". This is the starting point of any assessment and consultation. The need to collaborate across agencies is paramount; particularly carers, social workers and education, to be able to build a working assessment about the needs of the young person and how they are best met. Whilst often the presentations are very risky and include self- harm, low mood, anxiety and a lot of challenging behaviours for carers, the umbrella behind all these is usually developmental trauma. It is important that this is recognised and understood in the assessment, risk and care plan, so as to best help the young person begin to feel safe again and begin to recover. To approach Children in Care assessments based on symptoms only, would be failing to understand what is really going on for the young person. It would likely only provide a treatment that would be ineffective at best and leave them feeling that something is wrong with them.

The Social Care Institute for Excellent published a report in November 2017 "Improving Mental Health Support for our Children and Young People", found that "some looked after children and young people are not accessing services when needed, or are being told that their mental health need does not meet service thresholds."

"Other evidence in this report highlights that we must change our approach to children and young people's mental health and ensure that services are accessible, flexible and child-centred. The report also highlights the urgent need to transform how we commission, collaborate and work together in local areas to give children in care the same level of support, care and opportunity that we would wish for our own children. We need to build a community both around the child and those caring for them, to ensure that this group of young people are supported to reach their potential."

Section 2

2.1. CAMHS Children in Care Team

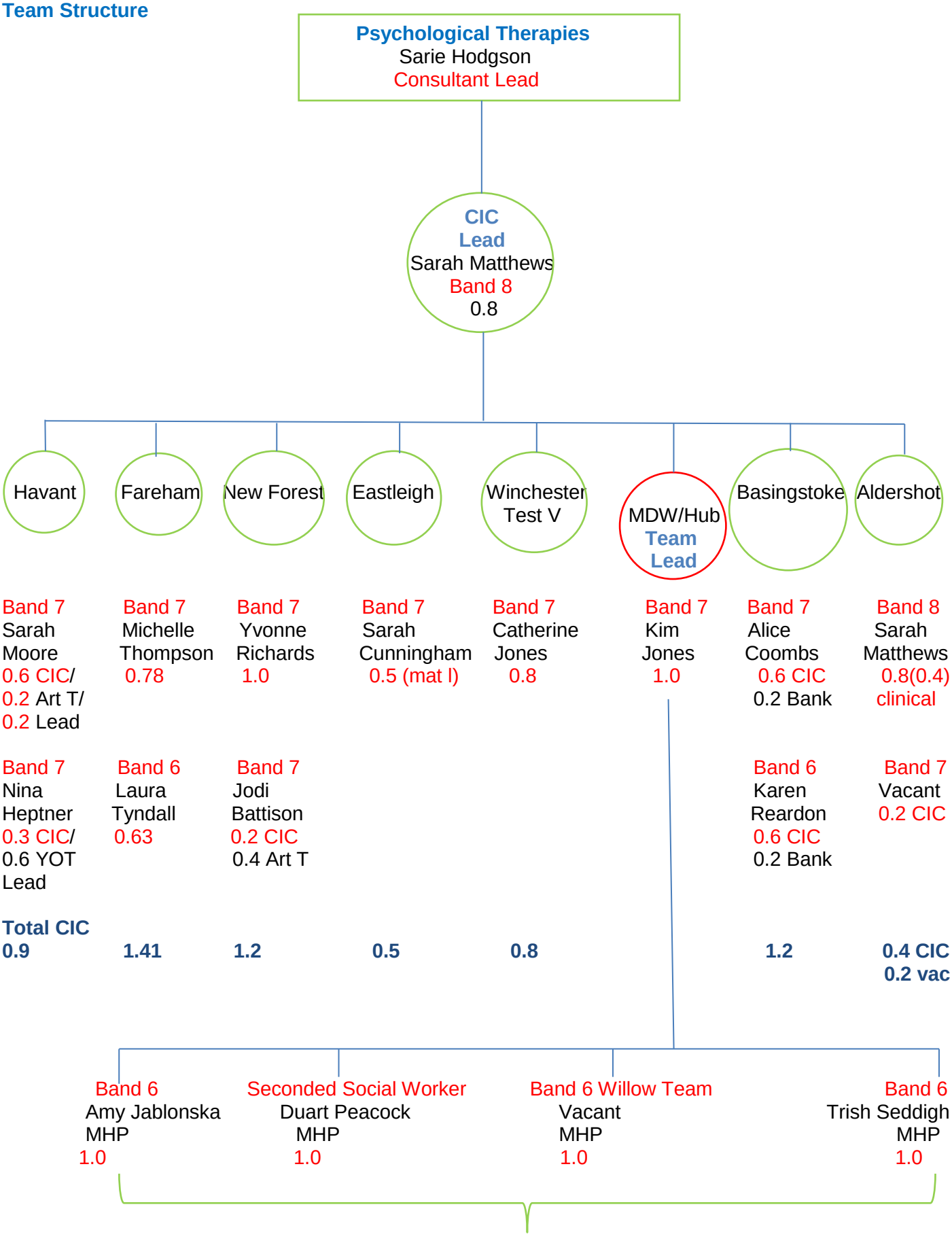
Across Aldershot, Basingstoke, Winchester and Test Valley, New Forest, Eastleigh, Fareham and Havant, we have **6.11** whole time equivalent Children in Care Clinicians (11). This is an increase of **0.11** of a post across Hampshire. This figure is made up of **5.3** whole time equivalent Children in Care Therapists Band 7 (Band 8 **0.4** clinical) and **1.33** whole time equivalent (0.63 and 0.6) newly created Band 6 Children in Care Practitioner development posts, where we have recruited 2 Social Workers. Some CIC Clinicians also hold other roles in teams including Art Psychotherapist, Mental Health Practitioner, YOT Lead, bank work.
In what has been a very busy CAMHS year, with increasingly complex referrals, the stable team has seen a number of challenges and changes to staffing, due to maternity leave, sickness, moving and new recruits. This has been added to by the present COVID 19 lockdown, where learning new ways of reaching an already vulnerable group have ensued. The team have shown great experience, resilience and tenacity throughout the year in advocating for some of our most vulnerable young people and coming up with creative ways of engagement.

Whilst the interventions for Children in Care may not be limited to the Specialist Therapists, they still provide most of the Assessments, Therapeutic Intervention, Consultation and Training and also undertake generic CAMHS teams tasks including running trauma groups and duty. The remit of the team is to take Children in Care cases, however due to a number of factors including case complexity, skills set and managerial/team pressure, the CIC team often also see Special Guardianship cases, post adoption and hold a number of complex generic cases on duty.

Due to the volume of CIC referrals that rarely come in a steady flow, some CAMHS teams have designated clinicians who are able to do initial assessments of CIC cases to prevent them waiting so long, although this is not agreed by all managers county wide. In some teams all Children in Care cases have been asked to be case held by the CIC clinician as well as generic commitments. In other teams this has not be so firmly held particularly where the volume is untenable, the young person transitions into care, or the presentation is neuro developmental.

Neighbouring counties provide a Children in Care service through a completely separate team. Whilst this may allow for stronger identity and service delineation, I think the difficulty particularly of such teams is the lack of timely access to Psychiatric time and neurodevelopmental assessment. Given the risk and complexity of the referrals we have and the vast county we work in, we would not advocate the model of being a completely separate team. We would however seek to have the CAMHS Children in Care Team recorded as such on Carenotes. This would allow for clearer reporting measures particularly.
As the generic CAMHS experience increasingly complex cases referred, the clinical model that the children in care team have in terms of service delivery could be utilised well in the wider teams. Often referrals need work from partner agencies before any intervention from CAMHS may be beneficial. A consultation model may help agencies feel more equipped to work together more, for the benefit of the young person.

2.2
Team Structure



2.3
Clinical Model

The SCIE report in November 2017 "Improving Mental Health Support for our Children and Young People" reported findings from a DfE expert working group:

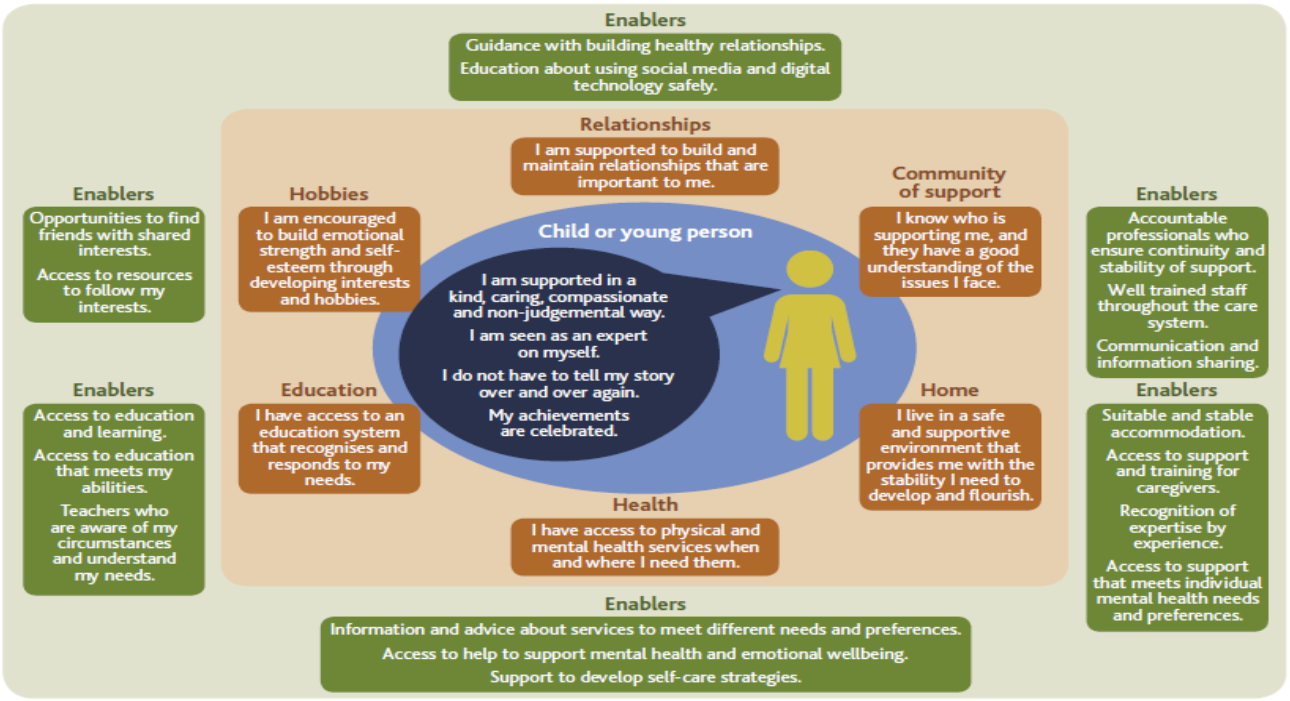
One of the key issues was that good quality ongoing assessment must be the foundation of a comprehensive strategy of support and services…. local areas need to be able to provide consistent care and support for a child, with an understanding that their diagnosis and therefore the type of support services they need can change. Therefore, assessment and services must be responsive and flexible. Mental health is a continuum and cannot be seen as a one-off diagnosis.

Recommendations

1. *Building on the success of the virtual school head (VSH), a similar oversight role of a virtual mental health lead (VMHL) is established. This is to ensure that every child and young person in the system is getting the support they need for their mental health and emotional wellbeing.*
2. *The Strengths and Difficulties Questionnaire should be supported by a broader set of measures which can trigger a comprehensive mental health assessment. There are a range of tools in use that could support the assessment depending on the need of the young person.*
3. *Assessments should focus on understanding the individual's mental health and emotional wellbeing in the context of their current situation and past experiences, rather than solely focusing on the presenting symptoms. The young person, their caregivers, family (where appropriate) and professionals' viewpoints should be included. Young people should be able to share who they would like to accompany them to assessments, and where possible those wishes should be accommodated.*
4. *Caregivers should receive support for their own mental health and wellbeing.*
5. *Caregivers need to be informed of which statutory and non-statutory services are available when support is needed for the child or young person. This should be included in each area's local offer. It is crucial that services are funded to support caregivers' training and development.*
6. *Everyone working directly with looked after children should receive training on children and young people's mental health so they are equipped with the appropriate skills.*
7. *A needs-based model is the best way to support and respond to young people. This model places the young person at the centre of decision-making and where appropriate lets them exercise choice as to how and what support they access. This allows appropriate support to be generated by need, rather than diagnosis.*
8. *Formal services should be more flexible in who they will allow to support the young person, acknowledging that support can come from a range of services and places. Health, education and social services need to work collaboratively to achieve this recommendation.*
9. *Ministers at the Department for Education and Department of Health should work together to ensure children in care and leaving care have access to services provided for their mental health and wellbeing.*
10. *Ofsted, the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP) should review their regulatory frameworks linked to registration to ensure that equal weight and attention is being given to mental and physical health needs.*
11. *The statutory review of a child's care plan by the independent reviewing officers (IROs) must include at each meeting a review of whether mental health needs have been met.*
12. *Every school should have a designated teacher with the training and competence in identifying and understanding the mental health needs of all their pupils who are looked-after.*
13. *Existing mechanisms for capturing direct views of young people should be integral to planning and commissioning arrangements. Local Health Watch services should monitor the effectiveness of mental health care arrangements for children and young people who are looked after, and report their findings to Health and Wellbeing Boards at least annually.*

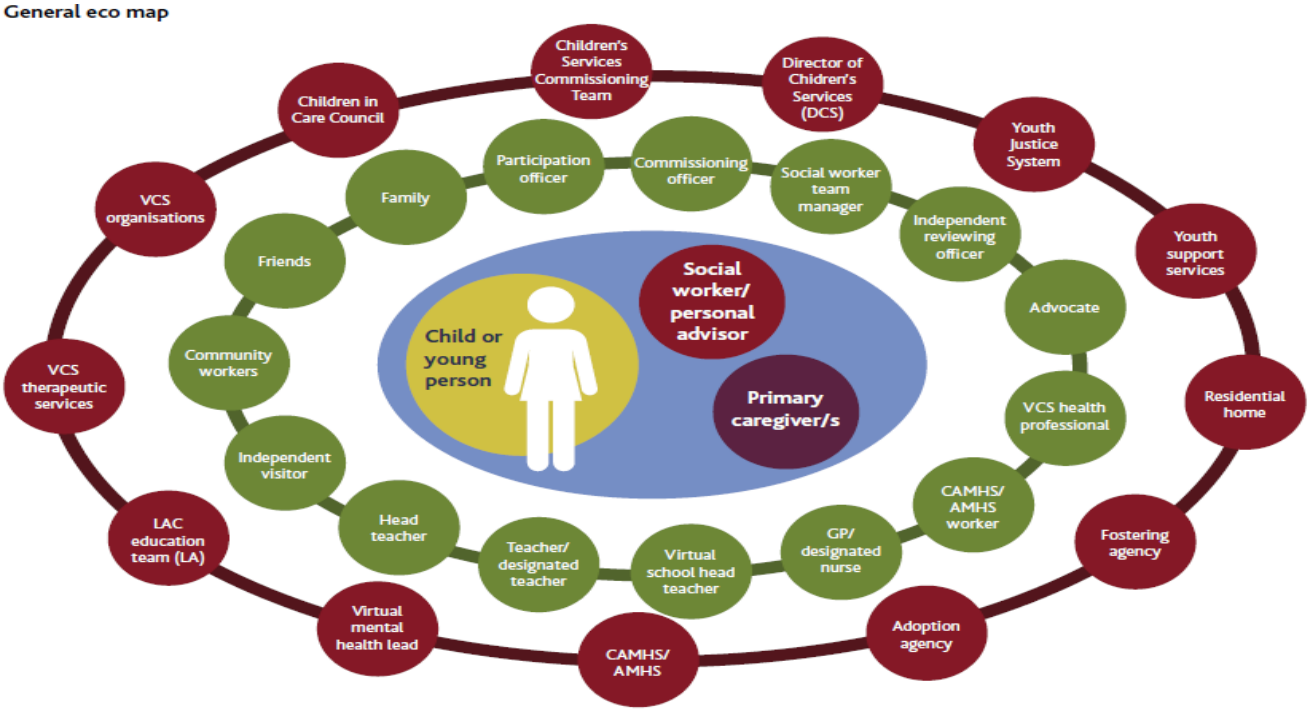
14. *Self-help, peer mentoring and community initiatives should be considered (if a young person expresses this is their preference) before a referral to more formal child and adolescent mental health services.*
15. *Clinical Commissioning Groups should ensure commissioning is informed by a Joint Strategic Needs Assessment (JSNA) which addresses the mental health and wellbeing needs of looked after children and care leavers. This should be reflected in Local Transformation Plans.*
16. *The Local Safeguarding Children Board, Corporate Parent Board and Health and Wellbeing Board should give appropriate priority to ensuring that the mental health needs of children and young people in care and leaving care are met.*

Expert Working Group model



The model highlights what good, holistic support for mental health and wellbeing looks like from the perspective of the young person, and what needs to be in place to make it happen. The ecomap is a representation of the choices that should be available to the young person and/or primary caregiver access the right support and resources.

General eco map



This report reflects our priorities in Hampshire CAMHS where people are first. The young person is at the centre of all decision making rather being system driven. The network of professionals that support a child in care, means that as a service we are constantly working with partner agencies and seek to support work that may be outside of a CAMHS setting. The report has highlighted a need for change of approach for this vulnerable group. The clinical model allows the fluidity of approach that facilitates this.
Whilst the changes are happening at a pace the future goal is outlined in the report, to have young people able to access support, but also to have all those who are involved in their care, supported and trained to help them. The approach is inclusive and the view that everyone counts for both the young person and those who can support them is implicit in the model of intervention.

2.4
Trauma Model

We continue to develop a Trauma Informed Model as a Children in Care Service, that is informed by the previous report and the **Young Minds "Addressing Adversity: Prioritising Adversity and Trauma Informed care for Children and Young People in England" 2017.** As a team we use the model shown below as a framework to underpin our service delivery.

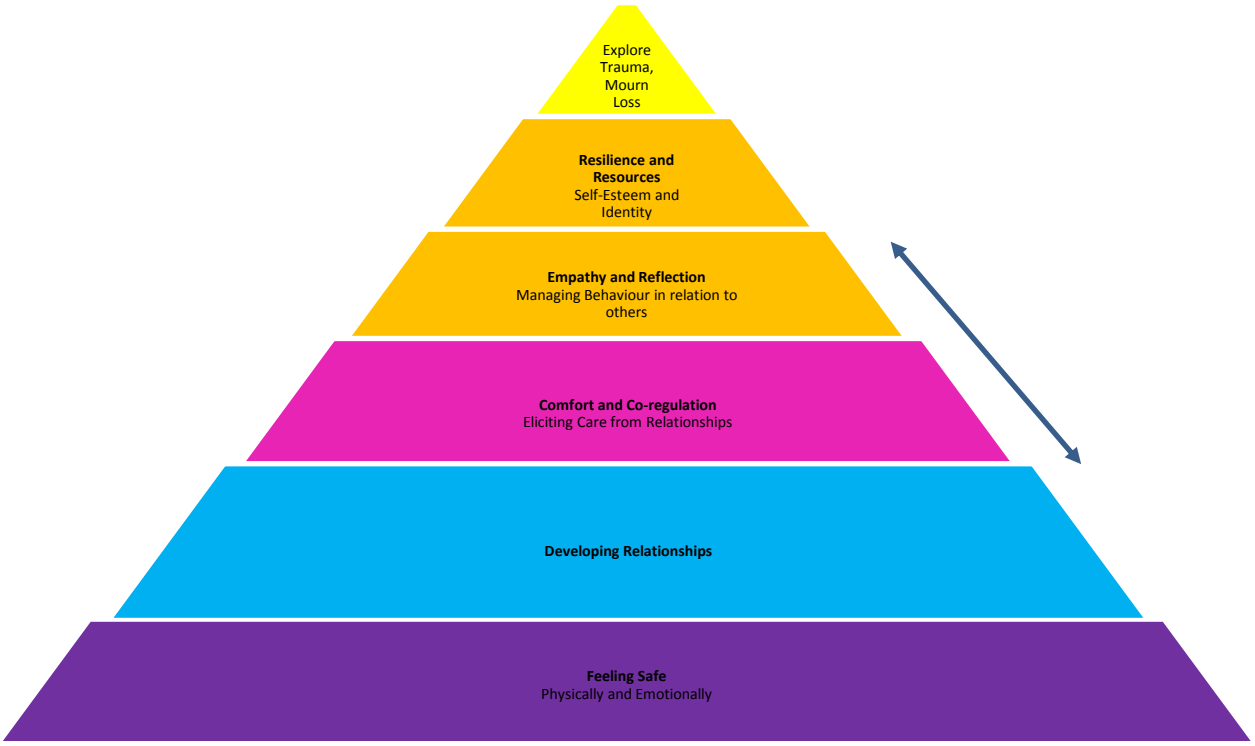
Rethinking specialist and liaison services for young people who have experienced adversity or trauma Dr Nick Hindley and Dr Carmen Chan

It is highly unlikely when working with young people with complex difficulties who may have experienced significant adversity, that a single intervention or agency will provide a single solution. In general, complex situations require complex solutions and good cross-agency collaboration focussed on achieving consensus is likely to have the most productive results. This requires a specialist service to recognise and consider the dynamic interplay between a young person, their family, and their social environment (see Figure 1). Such an approach is frequently referred to as 'ecological' and planning should include assessment of risks/vulnerabilities and protective factors on each level.

Equally, grounded in the first phase of any trauma-informed intervention with young people, should be the development of a sense of safeness and stability that clearly takes into account the child's hierarchy of need. Figures 1 and 2 highlight the importance of joint consideration of ecology and hierarchy of need and underlines how important more general consideration of factors such as physiology, safety and social needs may be before more complex needs such as self-esteem and self-actualisation can be addressed.

Thus, for example, in line with guidelines for working with complex trauma presentations, it is important to ensure that a young person is 'safe enough' to make use of specialist individual interventions (such as psychological therapy) before they are instigated. A specialist service, in such circumstances, is thus not defined by how specialist the interventions are that it can provide, but rather, by its ability to identify and recommend what may be the most useful intervention for a child given a specific set of circumstances.

Trauma Model of young person's needs. These ca e
flexible to ensure that the young person is getting the correct level of intervention



Often, such recommendations involve a focus on core needs and strengths which can be provided by professionals already involved with the child (as long as they are reassured that a specialist service will continue to support them and will become more directly involved if needed). This is a key issue for the credibility and perceived usefulness of a specialist service: a service which provides advice and consultation alone without demonstrating a willingness to become more directly involved in cases when the need arises is unlikely to foster confidence or contain anxiety within professional systems.

The diagrams allow all involved with the young person to have a shared understanding and clinical framework to be able to understand the young person's needs and the support required. The plans can range from complex multi-agency, to recommendations for basic needs of safety to be met consistently first.

With a layered/stepped approach in mind the CIC Team have delivered a number of different services related to the recommendation in the SCIE report, to support Children in Care, that follow the clinical framework outlined. The main focus throughout is physical and psychological safety. This is for the young person, carers, wider network and clinical staff involved.

2.5
Advice, Training and Consultation

This is quite rightly the largest part of the triangle in term of needs and service delivery both for children in care, whom we are often advocates for, and professionals involved. Without this, their presentation is often misunderstood and they receive misplaced support or are subject to plans that are often unhelpful and escalate the difficulties. The understanding often held is 'there is something wrong with them' that CAMHS need to fix, rather than 'what has happened to them'. When not effectively heard young people will often enforce this by increasing risk taking activity, that may achieve safety, but this will often be in a hospital or police setting. This year really has been about sharing the triangle of needs model about safety first .The team have been involved in a breadth of work over the last year that have sought to increase support and knowledge to those involved with Children in Care.

Hampshire Foster Carer network Annual Conference

The team were able to have a large stand with Trauma resources for carers, to enable support for the young people they look after. These focused on building psychological safety and emotional regulation, as well as the broader mental health issues. The team consulted individually to carers offering further advice and signposting where needed and liaised with other organisations delivering services for children in care.

Hampshire LGBT Children in Care Conference

We were invited to be part of the planning and delivery of a Hampshire Local Authority Event that was a follow up to the launch of working guidelines for staff working with LGBT Children in Care. The event in Ashburton Hall was on a similar design to the HCFN conference and the CIC team had a stand with resources and staff available for consultation.

Virtual School Mental Health Briefings

This is delivered to designated safeguarding lead teachers across Hampshire by a team of NHS and Education staff to ensure a sound knowledge of the mental health presentations in children in care, particularly developmental trauma and how to access services to support them. We are working with Rachel Allen the Education Officer, to look at how we better pool resource for schools in particular. The attendance/ updates at these briefings, facilitates better links with the right people responsible for CIC in schools. Currently, we are often asked to deliver more trauma training in schools individually. When young people are open to CAMHS we do include schools in the assessments. However what has emerged over the last year, is the growing need for schools to have a better understanding of how to support young people to achieve, who have a developmental trauma/attachment difficulty presentation. We are looking at how this might be most effectively delivered locally and Hampshire wide with the Virtual School and Educational Psychology. The newly recruited Mental Health Workers in schools joined the induction to CAMHS training we deliver (virtually on this occasion), that focused on attachment trauma and children in care. The need for more of this training was evidenced by the feedback which was excellent.

Hampshire Local Authority Staff Training on Attachment Difficulties/ Developmental Trauma

As part of the ongoing delivery of CAMHS training to Hampshire staff, we were successful in acquiring the paid contract to deliver 5 whole day trainings 2018-2019 with excellent feedback at each. In reviewing the training with Hampshire and to avoid duplication with exiting training, we negotiated delivery of a joint training with Educational Psychology over 2 days, 3 times a year. We negotiated being paid for 6 days training delivery and 6 days preparation time, where we combined resources. We stream lined our delivery of this in the CIC team to three clinicians, planning to deliver one training each. Unfortunately due to a clinicians leaving and sickness, we could not share this out as much. The plan for the future is again to have it shared, particularly if training staff in the CAMHS area to build relationships.

Each training was oversubscribed and we have been contacted through the year to deliver more. Whilst not in control of who attends, this year we have trained mainly family support workers and a growing number of Social Workers. Some foster carers are also returning to update training. There is a noticeable absence of supervising Social Workers, however some of the plans to transform Hampshire Children in Care placements may address this need. An example of the outcomes from the day are below, however we have seen the impact of the training particularly in how Children services staff are understanding the young

people's difficulties and in how many people still are wanting to be on the next trainings which will be delivered virtually in the new academic year.

The overall course content	9.7
Relevance of the course to my work	10
Presentation	9.7

Helpful Bits:

- "Tools/resources to use with children and families; Good interaction; Research informed practice, however, was very easy to understand and relatable; Tools-resilience ball; Signposting to books/materials".

- "Hearing examples of how other practitioners have supported families with trauma and attachment problems; Helpful to discuss examples; Interactive working; Practical activity to clarify e.g. sweets given to some not others. Group sharing experiences/situations".

- "Need to know things can improve after ACE in background; Hand model of the brain and repair of early trauma; Brain development re trauma; Understanding the importance of resilience".

- "You move between the different types of attachment; Concentrate on the foundations first when building a plan; Pyramid of need – fantastic".

- "Brene Brown 'Braving' video; YouTube videos – helped to unpick the complexities of attachment/trauma – enjoyed these a lot; Good videos."

What I will do differently…

- "Have open conversations with parents, carers and other professionals about attachment, trauma and behaviours that children may be expressing. What the meaning of this is".

- "Take the knowledge to future practice".

- "Think about starting from the bottom with trauma – children are trying to survive…".

Given this last session was delivered right at the outset of Covid, where the country was in a state of trauma, we were particularly pleased with the feedback. This was a consistent representation of all the training outcomes.

Trauma Training for CAMHS Staff

Many staff asked to come on the Hampshire training and whilst we have taken Social Work students on placement with us, this has been Hampshire staff only. The CIC team across the county have joined with other trauma specialists to deliver a trauma presentation within each CAMHS setting to help recognise and assess trauma. With the referrals becoming more complex there is a growing need of how to assess and work with trauma in the generic teams. This would help CAMHS take a more consultative role rather than direct involvement in a lot of cases on initial referral.

The nurses away day recently invited the CIC clinician Winchester and Test Valley to co-deliver training on attachment and trauma, which was reported to be one of the most informative trainings they have had (with video documentation) She was also asked to present at the Sussex Social worker forum the trauma training for use in the wider Trust.

The Partners in Practice/MDW CAMHS workers have also attended the training and CIC clinicians have co-delivered trauma workshops in frontline children services offices to help Social Care staff to think more holistically about the presentation of the young person they are assessing. All have particularly liked the triangle model and have looked at the need for safety first rather than the child needs fixing. This has meant that a lot more work is happening with parents and carers as a result.

CAMHS induction training

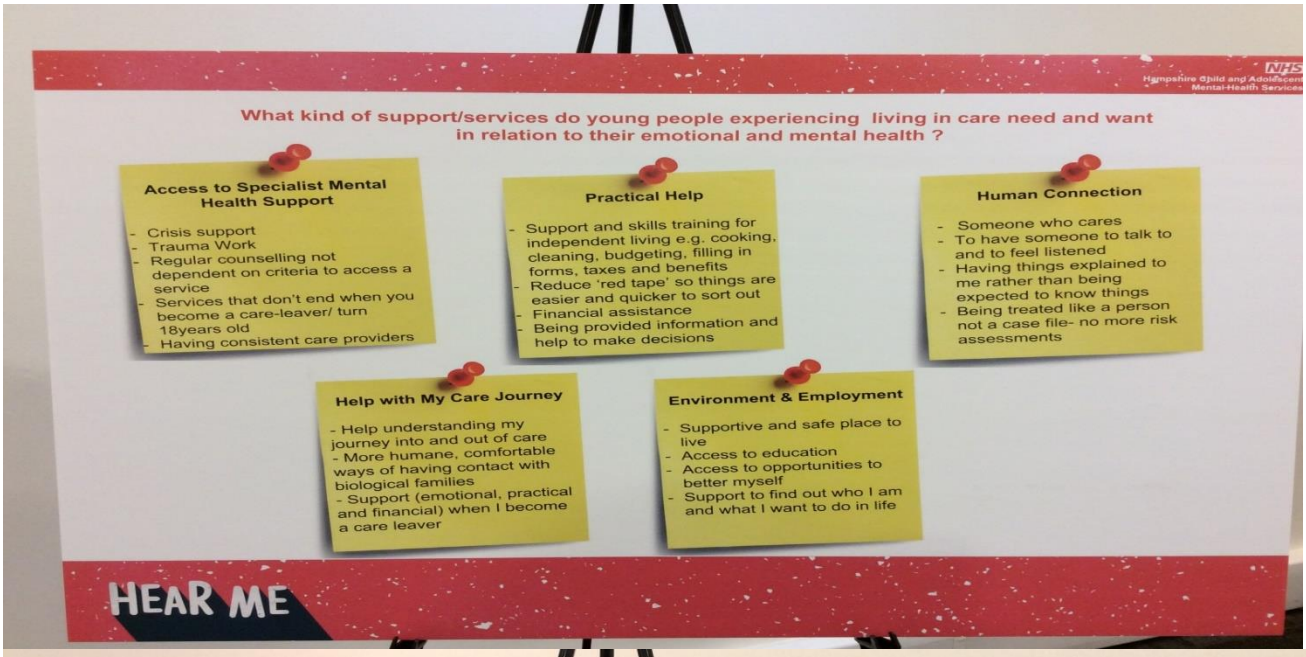
The CIC and Art Therapy Lead delivered the attachment, trauma and Children in Care training on the introduction to CAMHS program. We are working on the need for this to be a whole day training that could be accessible to wider CAMHS as the feedback was very encouraging both face to face and virtually.

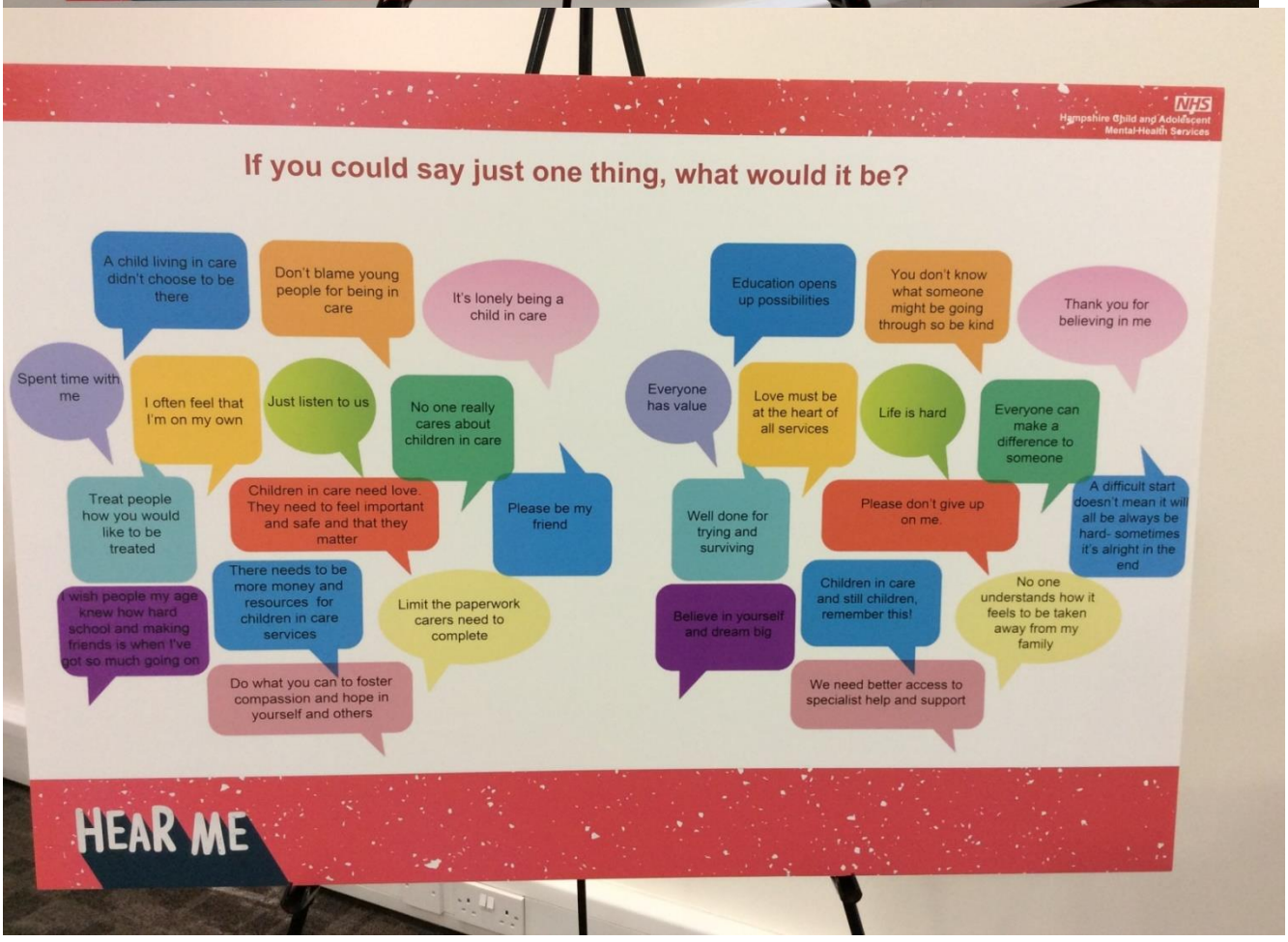
CIC Campaign 2019: Hear Me

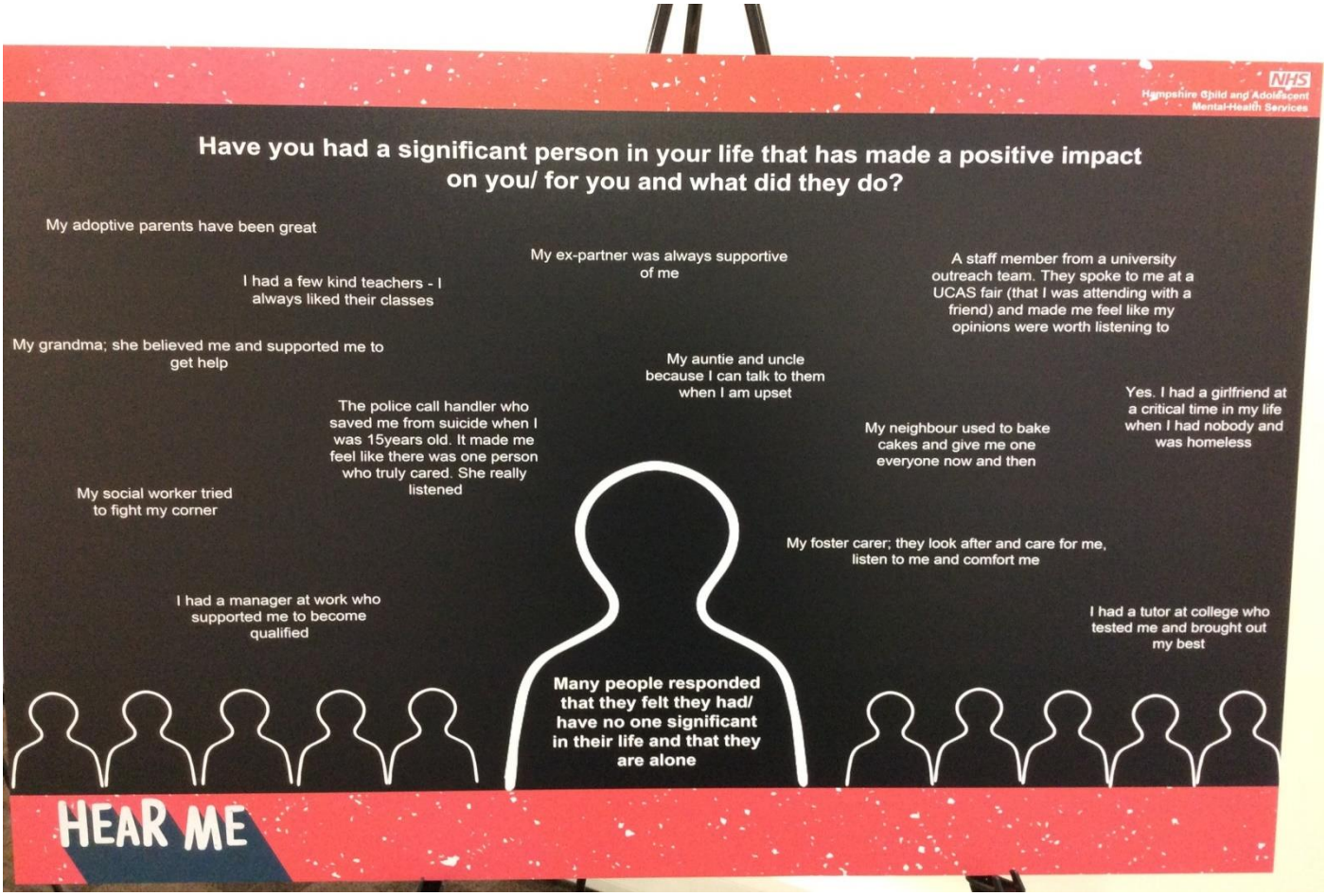
The main activities in the campaign were the consultation at the theatre performances "Rum in the Gravy Boat" and the continued delivery of training through the Achieving Better Care free training for staff across the county. This was shared between the team and a particularly brave outcome from the Eastleigh presentation, was a video recording now on out CAMHS website on trauma. It is really helpful to have the digital format as we can direct people to this and use this to a wider audience. We have thought as a team how we would like to continue developing digital material that might be accessed by our young people who have similar experiences. The current pandemic has brought that decision forward and we plan to record more material on trauma to broaden the early intervention aspects of the service.

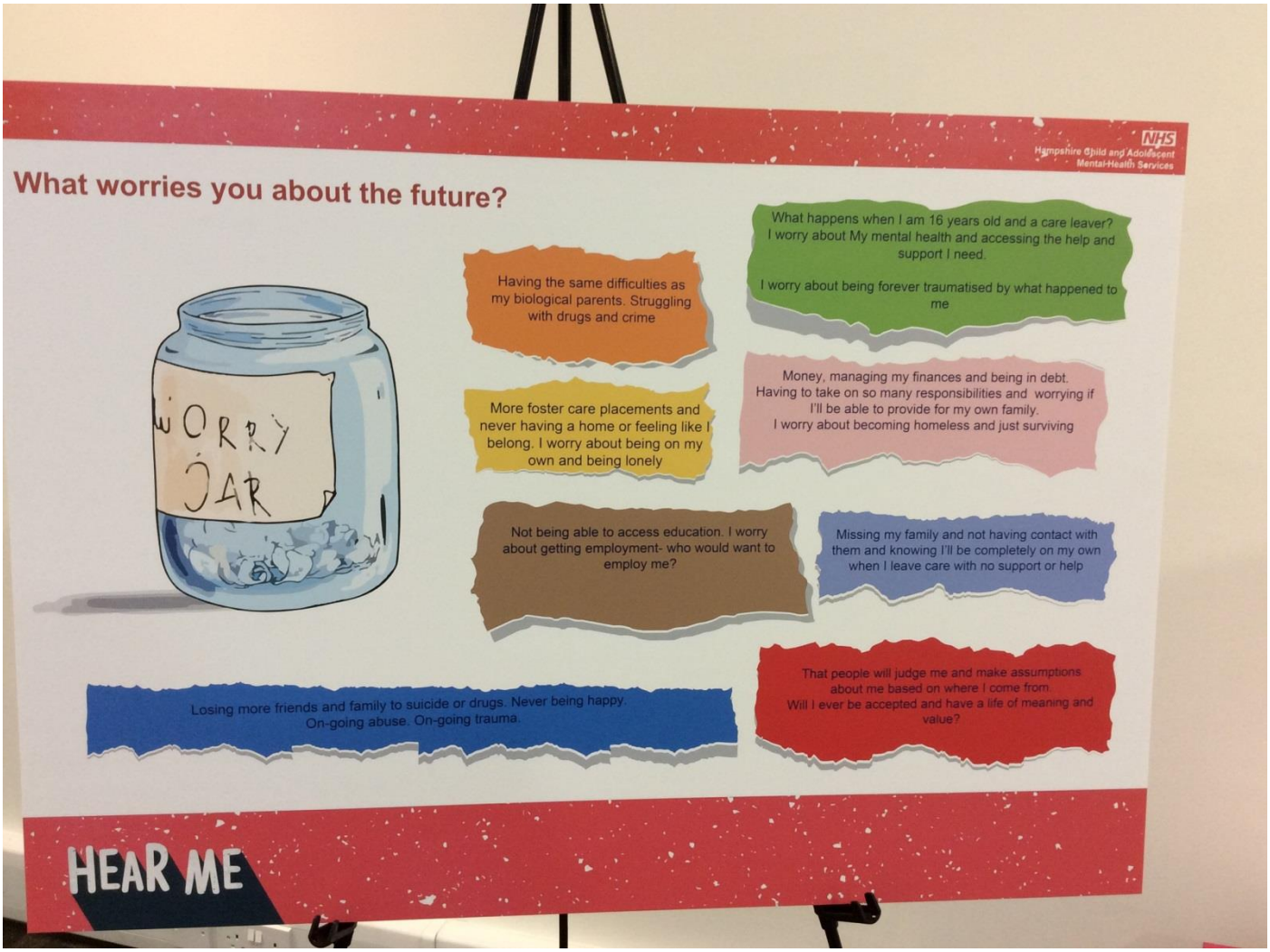
During the campaign the voice of young people with a care experience was sought. A lot of the young people we see or have contact with in the children's homes we reticent to participate in focus groups and questionnaires offered by innovations team. A lot were in crisis or did not want to answer more questions. Others offered more creative pieces such as writing a song or picture of the experiences they wanted shared, which we would like to collate as an ongoing outcome of the project.

The final exhibition in Basingstoke produced by the Innovations team collated the voices of children in care that were mostly not accessing CAMHS.


NHS
Hampshire Child and Adolescent Mental Health Services
What kind of support/services do young people experiencing living in care need and want in relation to their emotional and mental health ?
Access to Specialist Mental Health Support
- Crisis support
- Trauma Work
- Regular counselling not dependent on criteria to access a service
- Services that don't end when you become a care-leaver/ turn 18years old
- Having consistent care providers
Practical Help
- Support and skills training for independent living e.g. cooking, cleaning, budgeting, filling in forms, taxes and benefits
- Reduce 'red tape' so things are easier and quicker to sort out
- Financial assistance
- Being provided information and help to make decisions
Human Connection
- Someone who cares
- To have someone to talk to and to feel listened
- Having things explained to me rather than being expected to know things
- Being treated like a person not a case file- no more risk assessments
Help with My Care Journey
- Help understanding my journey into and out of care
- More humane, comfortable ways of having contact with biological families
- Support (emotional, practical and financial) when I become a care leaver
Environment & Employment
- Supportive and safe place to live
- Access to education
- Access to opportunities to better myself
- Support to find out who I am and what I want to do in life
HEAR ME


NHS
Hampshire Child and Adolescent Mental Health Services
If you could say just one thing, what would it be?
A child living in care didn't choose to be there
Don't blame young people for being in care
It's lonely being a child in care
Spent time with me
I often feel that I'm on my own
Just listen to us
No one really cares about children in care
Treat people how you would like to be treated
Children in care need love. They need to feel important and safe and that they matter
Please be my friend
I wish people my age knew how hard school and making friends is when I've got so much going on
There needs to be more money and resources for children in care services
Limit the paperwork carers need to complete
Do what you can to foster compassion and hope in yourself and others
Education opens up possibilities
You don't know what someone might be going through so be kind
Thank you for believing in me
Everyone has value
Love must be at the heart of all services
Life is hard
Everyone can make a difference to someone
Well done for trying and surviving
Please don't give up on me.
A difficult start doesn't mean it will all be always be hard- sometimes it's alright in the end
Believe in yourself and dream big
Children in care and still children, remember this!
No one understands how it feels to be taken away from my family
We need better access to specialist help and support
HEAR ME


NHS
Hampshire Child and Adolescent Mental Health Services
Have you had a significant person in your life that has made a positive impact on you/ for you and what did they do?
My adoptive parents have been great
I had a few kind teachers - I always liked their classes
My ex-partner was always supportive of me
A staff member from a university outreach team. They spoke to me at a UCAS fair (that I was attending with a friend) and made me feel like my opinions were worth listening to
My grandma; she believed me and supported me to get help
My auntie and uncle because I can talk to them when I am upset
Yes. I had a girlfriend at a critical time in my life when I had nobody and was homeless
The police call handler who saved me from suicide when I was 15years old. It made me feel like there was one person who truly cared. She really listened
My neighbour used to bake cakes and give me one everyone now and then
My social worker tried to fight my corner
My foster carer; they look after and care for me, listen to me and comfort me
I had a manager at work who supported me to become qualified
I had a tutor at college who tested me and brought out my best
Many people responded that they felt they had/ have no one significant in their life and that they are alone
HEAR ME



We have looked at how the feedback is being addressed in our service model. The multiagency, trauma informed approach fits with the needs voiced. It is often a service outside of CAMHS that is needed the most but to is the specialist assement that oftne has to alert others to theor need to play a part. The biggest role that the chodren in care team often play is being the advocate for the young person's needs.

One of the areas of feedback from another part of the project was reported lack of support for young people with very difficult behaviour and difficulty getting into CAMHS. This was surprising as we take most referrals unless it is clear it is not a mental health issue. The referral then receives a very detailed consultation with advice of how to help. I think what it does highlight from our experience working with our partner agencies is the tendency to want to 'fix' the young person rather than look what is being the behaviour. The lack of knowledge of trauma and attachment in those supporting foster carer has been highlighted and will be addressed further in the report with the Hampshire transformation plans.

Consultations

Children Services Consultation:

The CIC team continue to build on working relationships with Children in Care Social Work teams, offering consultation where capacity allows and sharing information. This had been helpful in terms of understanding a young person's presentation of developmental trauma and knowing what other teams such as post adoption offer so we can be more collaborative in approach. The wider consultation is now offered by the Partners in Practice Clinicians, using the same model, which I will discuss further in the report.

Trauma Consultation in CAMHS

CIC clinicians work offer consultation to generic staff on trauma assessments and are part the design, establishment and delivery of the trauma pathway.

Multidisciplinary Team CAMHS Workers in Social Care (Partners in Practice)

As the early intervention part of the CIC team we now have a firmly established team of practitioners working in the Social Care multidisciplinary working hubs across the county. This has taken a team effort to establish both practically with two computers and recording systems needed by practitioners, shared governance, getting to know social care teams and model of service delivery. Kim Jones, Lead for the Team manages three other workers. The team use the same model as the CIC team and offer consultation, training assessment and intervention to a specific high risk cohort; specific to Camhs those on the edge of care or rehabilitating back home.

We meet quarterly with the Head of transformation in Children services monitoring outcome and future planning. This has allowed for the project to continue for a further year. The key emphasis from the last review was the need to involve the Camhs workers in planning for young people, so we get this right, from the outset. This should impact unnecessary referrals to Camhs, as there has been a tendency to see everything as mental health and refer in. The feedback from both Hub managers, family support workers and families has been really positive and the workers are established well in CAMHS teams, co- running the trauma group with both CAMHS and early intervention cohort in the Aldershot team.

The CIC clinicians supervise the CAMHS workers and will clinically supervise the Willow CAMHS post when the new recruit starts. This post now sits managerially in the multidisciplinary team with CIC clinical supervision.

Childrens Homes

Private Childrens Homes

We have a growing number of private children's home in Hampshire who mainly provide accommodation, to risky out of county children in care. Whilst being advertised as a therapeutic provision, the reality of this has often meant this is sought out from the local Camhs. This is particularly prevalent in the New Forest and Havant areas where private groups have a number of homes.

The CIC lead and Havant CIC Clinician met with the Hillcrest group manager and Therapy lead, as this group of home in Haling Island had been calling CAMHs on a daily basis. The meeting was productive and there is now a pathway for referral to come to CAMHS that has to go through their in house lead for therapy first. The Havant CIC clinician liaises regularly with her to establish which children actually do need a CAMHS service.

We will meet with the next big group this year to set up a similar process where there are particular companies frequently referring.

Hampshire Children Homes

The team continue to offer 4 hours a month to Hampshire Children's homes, which have been in the process of refurbishment and reopening over the past two years. This has now meant that in 2 CAMHS areas there are 2 homes to consult to which does put a strain on the existing CIC hours.
We have sought to have consistent approach based on the needs of the homes. The Lead CIC Therapist met with John Stacey, Hampshire County Service Manager for residential services at the residential manager's team in October 2019. The outcomes of the meeting at the time, were wanting a bite size training in some of the mental health presentation that they were being faced with and how to help therapeutically parent them. Following this meeting, training has been delivered in homes both individually

and jointly with Education psychologist on therapeutic parenting and the overwhelming response was they wanted more of this.

Modernising Placements Programme

At the beginning of March 2020 the CIC Lead joined a multiagency stakeholder meeting lead by Hampshire's Head of Resource and Partnership, Amber James to look provision of placement across Hampshire for Children in Care. It was recognised that the current placement planning was out of date and service led, rather than the needs of the young person. A pilot project was discussed that involved the Basingstoke Childrens home Cypress Lodge working differently with hard to place young people.

The meeting was extremely productive particularly as the evidence collated from children services suggested that 100% of the young people in the residential homes had a mental health diagnosis. Both CAMHS and Virtual school advocated assertively for a trauma informed model, with the need for training and consultation. We were clear that this would need extra resources to deliver.

The programme is now at the point of finalising the business case for the service developments which require funding to proceed. These are:

- Trauma Informed Parenting and the Psychological Service
- The Hampshire Hive (foster carer network model)
- The Cypress Lodge Urgent & Extended Care model
- Simplifying foster carer skills fee payments

The business case will be presented to the Children's Services Departmental Management Team (CSDMT) on 27 August and from there, with relevant approvals, in the near future will be taken to the County Treasurer for funding approval.

Subject Matter Expert Group

The Programme requires a group of professionals to call on who are invested in the vision and able to bring expertise, challenge and an ability to influence others to realise the vision. This group will support developments through evidence, knowledge and championing of the vision. The Children in Care Lead will represent Hampshire CAMHS on the group.

2.6
Complex Liaison and Assessment

SPA

The Children in Care Pathway in the SPA has allowed easier access to a CAMHS service so that we can offer services that range from advice and consultation, which can be delivered at first point of contact, to highly specialist interventions. We revised the pathway to include the CAMHS referral form that has a designated section for Children in Care. The form is now to be sent in by Social Workers only to both capture consent and also the background information at first contact.

Enhanced assessment

As stated in the clinical model, the children in care assessments review not just the presenting symptoms and behaviour, but the context that the young person is currently in and has come from. This involves initially a 2 session assessment, 1 with the network of professionals including school, social worker, carers and the second with the young person. The initial trauma informed assessment is a working hypothesis of what the issues may be. We have seen an increasing amount of young people involved in county lines, sexual exploitation and are out of school, or who are on full care orders at home, that need further planning with the network to ensure the safety if the child. We have also seen increasing risky presentations, often in private children's homes where staff are not trained to understand what is behind some of the behaviours.

We have also had a number of Hampshire children who have very complex backgrounds and who are frequently moving placements, in and out of Hampshire. These presentations mean that creating a shared understanding of the young person's fluctuating needs is paramount.

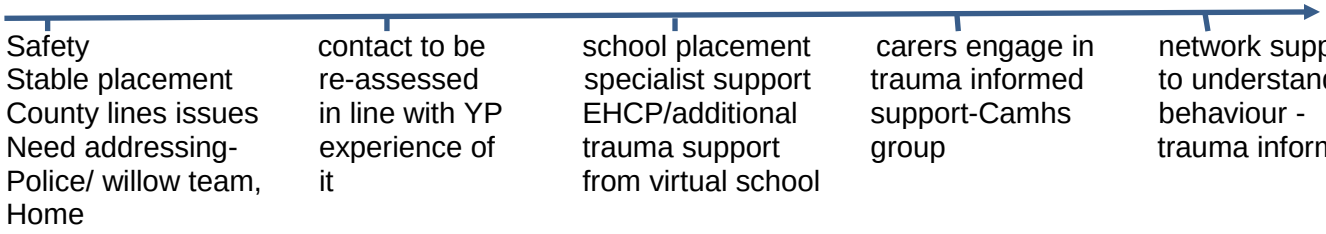
We have also started to see more referrals for refuges, and young people on section 20 placements at residential schools in the south and west of the county.

The work includes attendance and reports at children's services and school meetings to present an understanding of the young person's needs. As stated earlier in the report, the background the young people have before coming into care still impacts. The CIC therapist may often be assessing a child who has experienced high levels of neglect, abuse and trauma for a significant part of their child hood, so the work is complex. Yet it is often simpler solutions that may have the biggest impact eg. contact arrangements with family. More commonly are placement support issues where a young person is displaying behaviour that carers do not understand and feel unable to manage.

Time Line Approach

Whilst CAMHS pathways offer a framework for intervention, the children in care presentations are complex and often risky and take time to fully understand. This is not just from mental health perspective but also the risk of their placement or education breaking down, which will impact mental health. They also cannot be sat on a pathway waiting list, but need something to happen by someone straight away. Whilst most come under the umbrella of complex/developmental trauma, the pathway needs to be used to scaffold any intervention rather than dictate it. As we have discussed previously in the clinical model, the needs are often changing. It is important to think in the network what intervention by what agency will have the most impact first in order to bring the risk down and help a young person feel safe. This may well be children's services addressing unhelpful contact arrangements or communicating clearer plans to the young person; or school starting an EHCP or having virtual school involvement; carers needing therapeutic parenting training, or the young person needing help from their personal advisor due to anxiety about where they will live post 18.

Due to the multiagency complexity, the time line facilitates decisions and action to be made as part of a working care plan, where otherwise thinking gets stuck or seen as only one agencies responsibility. When a few areas of the timeline have been populated by what the highest needs are, then we can look at where Camhs need to sit in this order, much as the triangle in the clinical model shows a young person's needs: For example:



The multiagency planning is something we have seen an increasing need to be involved with due to less experienced staff in Hampshire and limited trauma informed thinking. The knowledge base is changing in the multidisciplinary hubs due to attendance on the Attachment and trauma training and the Camhs worker consultations, however the Social Workers involved in planning and decisions often have less knowledge about a trauma presentation. We are frequently sent referrals to 'fix the child', rather than understand what is behind the behaviour. Following a consultation/ assessment, we may offer a plan and resources for the network and close the case at that time if the support needed is not from a mental health provision. If open to CAMHS, generally they are seen under the trauma pathway. Any neuro- developmental assessment will be considered after we have assessed the trauma. Two thirds of ongoing children in care work is case holding and supporting the network as most often from a trauma perspective the issues of creating safety and stabilisation across the network are the most therapeutic intervention needed at the time.

CAMHS wide trauma pathway

We have contributed to the practical outworking of a CAMHS wide trauma pathway stepped model that addresses the need for a young person to feel safe before engaging in any intervention.

Step 0: The information about the young person context is gathered as part of the referral process to the SPA. We continue to monitor how we are able to consistently receive this is a timely way in order to be able to offer a trauma informed assessment.

Step 1: Trauma informed assessment using checklist to assess trauma symptoms. We are working hard a as a virtual team to get this to be as consistent across the county, using CIC team meetings and supervision to review this.

Step 2: When a young person has been assessed as presenting with trauma symptoms, the first step for a young person is care is creating safety and stability in the network. They often out of education, involved in risky behaviour that is alarming the network so CAMHS is referred to as a recommended option often by the courts, or out of not knowing what to do. It is important to have a shared understanding of their presentation that is trauma informed. Supporting the network and addressing basic needs in paramount to recovery as a young person needs to feel safe. This task is also ongoing in case management and attendance at multiagency meetings.

Whilst the CIC team are very aware of this, waiting list in the wider CAMHS setting have meant that this task has not often been picked up in a timely way for those who are not CIC.

Recognising the need for psycho-education in stabilisation, a **workbook** about trauma has been created to help cares and young people feel safer by recognising and understanding their difficulties as a natural adaptation in order to survive. This has been used widely by the CIC team over the past year in training, with professionals, carers and young people. We use it help to stabilise a young person, both through psycho education about trauma and how to help regulate emotions. It helps a young person feel safer by understanding and normalising what is behind some of the feelings but also alerts carers to what they need to do to support them.

Step 3: Trauma Care Group: The outline for this 8-9 week group was adapted from Kim Goldings Nurturing Attachments training, that uses Dyadic Developmental Practice, to help young people feel safe and recover from trauma. This has been delivered in 5 CAMHS by CIC clinicians, mostly on a termly basis. Parent/Carers were asked to attend the group to help them learn about developmental/complex trauma and to actively engage in helping the young person to feel safer as they are more attuned to their needs. The outcomes for this group have continued to be positive. The carers felt they had a tool box of skills to use now with the young people rather than being reactive to their difficulties. They have recognised that they are an important part of their recovery rather than the young person being sent to CAMHS to be 'fixed'.

We continue to fine tune the format of the group across the county, to be able to have a consistent approach and train others in delivery. The group varies locally in its cohort in that smaller teams will offer a trauma group to both parents and carers, whilst larger teams will separate the cohorts. I Aldershot, we join both the CAMHS and PIP cohorts to allow the early intervention CAMHS worker to co run the group and keep it running on a termly basis.

As CAMHS referrals become more complex, the trauma group has become needed for generic cases. The groups have an increasing number of adults who have experience domestic violence, where the young person has been in the house at the time. The young people who are referred are often the most risky and using hospital as a place of safety. The group has been effective in teaching the impact of this but also in the group members continued support of each other.

Step 3: Intervention:

2.7
Direct Intervention (explore trauma)

This is a trauma specific intervention that can be delivered both by CIC therapists but also the wider CAMHS team. Often young people still feel unsafe and this often presents as very risky behaviour. Continued working with the network to stabilise the child is an important part of the continued work with complex cases. Where the young person is safer, DDP informed work with the young person and carer, psychotherapy-Child and Adolescent, Art, Play, Systemic, EMDR are approaches to dyadic and individual work. In the clinical model this is the higher end of the triangle, so the direct work is less often on CIC case-loads due to the need to support the network.

As a CIC team with differing clinical backgrounds, it has been important to develop a consistent trauma informed clinical approach. We have appreciated the funding support for Dyadic Developmental Practice level 1 and 2 trainings which have been partially completed by over half of the team (Covid delayed). The DDP training informs both the trauma care group and direct intervention. We have found that offering this intervention after or instead of the group positively impacts placement stability and the relationship with the carer. This has a positive impact on their mental health presentation and facilitates the carer continuing the work as they have a better understanding of the young person.

2.8
Transitions

Transitions are often a trigger in trauma presentations and as a CIC team we experience needing to support the young person and network in increasingly complex situations where often access to services is not timely. We have had a number of complex cases in Hampshire that have outside of the county, who have been on medication, but have not been able to access services due to funding issues, being on a waiting list, or the delivery of services is limited due to being out of county. We have continued to support the young person on these situations until a service has been provided, but it has entailed a large degree of case management.

We also have experienced discharge from hospital for children in care to be unequal to those who are not in care. They are often moved to a new placement on discharge or have no discharge summary, or no planned follow up. We have been left with risky cases that then come in from another county to be seen quickly to assess the risk, but with very little information. The time following these up is extensive.

We have also considered the provision of service for Care leavers in Hampshire. The transition to 18 is often the most risky for children in care often fearing being homeless. Their mental health presentation between16-18 is the most risky often with exams and placement moves. Where enduring mental health difficulties have presented it has been difficult to get adult mental health support as their difficulties are often seen as behavioural or as personality disorder, rather than continuing to use a trauma informed approach. We are also aware that neighbouring counties have a post 18 provision for care leavers and would like to consider this further with commissioners for Hampshire.

2.9
Adoption and Children in Care Regulations 2020

As a response to Covid 19, these came into force on 24th April and are due to expire on 25th September. "These regulations make significant temporary changes to the protections given in law to some of the most vulnerable children in the country….Children in care are already vulnerable and this crisis is placing additional strain on them- as most are not in school, less able to have direct contact with family and other professionals and facing the challenges of lockdown and anxiety about illness- all on top of the trauma they have already experienced. If anything I would expect to see increased protections to ensure their needs are met during this time" (Childrens commissioner Aril 30th 2020 Statement in changes to regulations affecting children's social care).

We have experienced supporting the impact of this where young people in residential setting, already struggling are confused why some see their social worker, have calls from and others don't. The

consultation to one home has gone up 4 fold during the lockdown due to the impact of lockdown on young people and staff.

The timescales to review plans for children in care have been relaxed, so placement planning has experienced significant delay. Children who came into care during lockdown has to have 2 weeks of isolation- an already traumatic experience made more traumatic and have no idea of plans and timescales to move. The pressure has been shifted to CAMHS to work with the child during this time and the lack of face to face being questioned.

Foster placements have received less scrutiny in terms of assessment and in a county where placement are limited, the increased risk of placing children without proper assessment is incredibly worrying in terms of basic safety. Whilst the regulation amendments have been temporary, there is a drive for these to remain beyond the September date due to the positive impact on already stretched Social Work case load. We are already supporting carers to understand the young person's behaviour from a trauma informed perspective, but the growing number of private homes and unregulated placements impacts on the young person's sense of safety, but is only seen as their mental health problem that CAMHS needs work with. We have been, as a team over the past year, the strongest advocates for where the environmental context for the child, is what is behind the presentation.

2.10
Adapting work during Covid

We have experienced an increase in work during lockdown. Whilst it has been possible to use Attend Anywhere with some young people, particularly where less school pressure had increased placement stability, many have refused and preferred phone. Given the cases are all trauma presentations, to continue therapeutic trauma work in this way at this time would destabilise further. What has been happening is a lot of innovative ways of 'keeping a child in mind' and supporting the network. Where young people both due to risk or therapeutic need have required face to face, this has been offered in settings often outside of CAMHS. Some carers have favoured a less clinical setting and we have been able to discharge. Others where there has been disengagement, we have reviewed to see if CMAHS is actually what is needed. The most difficult to get adults to facilitate have been appointments virtually in the residential settings. The appointments have net been kept, or young person reminded as still in bed, IT equipment has not been set up or a phone has been removed and private space is not provided.

Some of the changes have been positive and will remain. Children in Care meetings will remain virtual, to reduce travel time and supervision which was by skype before Covid, will remain. We have also found the network meetings easier to organise through the social worker using 'Teams' and have been able to have better contact with the network by email. This has meant an increase in administration for CIC clinicians but a more timely response to multiagency work.

The increased pressure on the generic duty commitment in teams has seen CIC clinicians in some areas having less time to do CIC work. Whilst discussions have been had with team managers about easing the pressure of duty, the CIC clinicians remain caught between the demands of the CIC and generic work.

Section 3

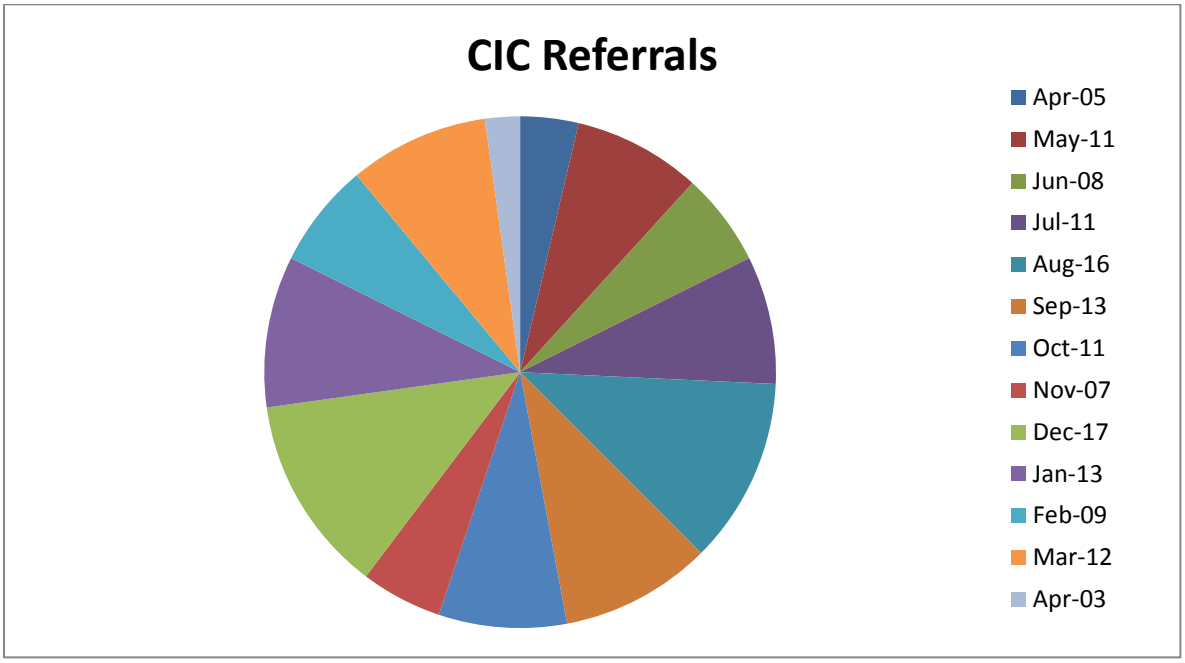
3.1. Statistical Reporting

This is particularly important both in terms of access to a service but also staff well-being and retention. In the proposal we identified the need for more than one CIC Clinician in each team so that the often complex risky work is not held in isolation.

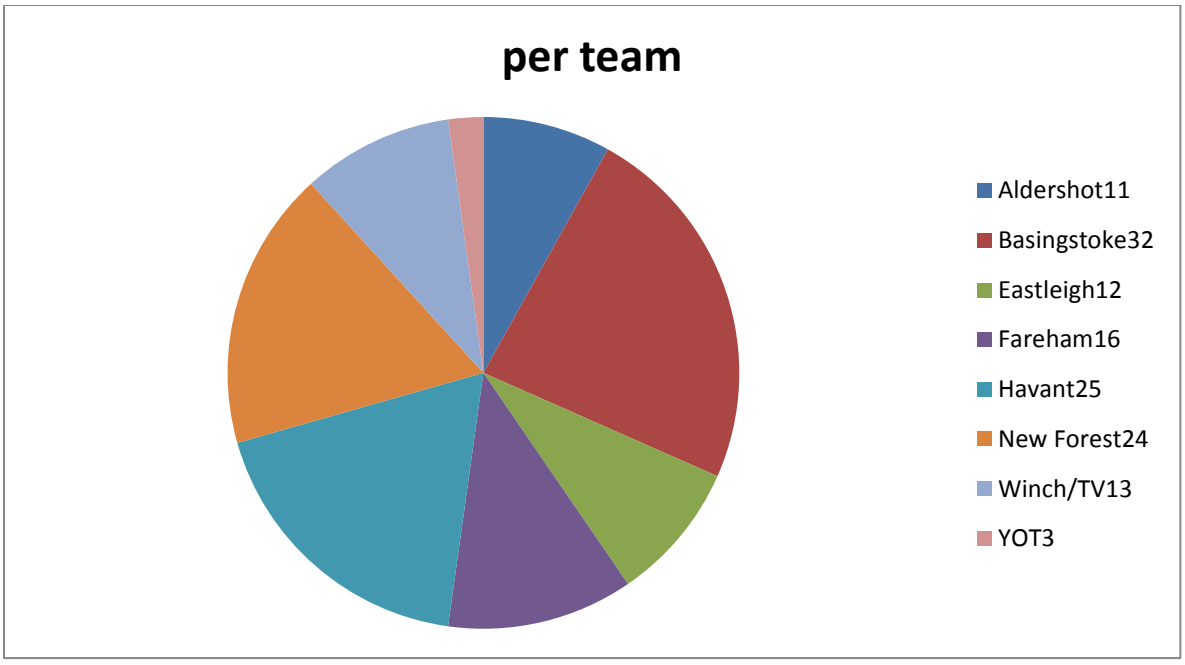
The figures do not include the increasing number of Special Guardianship and adoption cases which CIC Therapists are currently holding. We are seeking a way to pull these figures more easily from caseloads across CAMHS particularly as they are seen as a vulnerable group. CIC therapists are being asked to work

with these case post generic assessment as the skill set needed to work with them is not available in the wider CAMHS team or the wait means the placement is at risk of breaking down.

There were **136 CIC Referral April 2019-2020.** These figures include Section 20/31 only, not Adoption/SGO.



Looking at the trend in referrals, this does not always follow the generic CAMHS referral pattern with August being the second highest referral month. 40% of these were for Havant CAMHS. There are a large number of private Hillcrest homes in the area which often contribute to the figures in general. It is also a time of school holidays where carers may struggle more with a young person at home. It could also be the delay of an end of school referral asked for by school as they have concerns about the young person's welfare over summer holidays. September is also high but spread across the service as is December and January. Schools asking for referrals can often contribute to the term time figures, but there is a general steady flow across the service all year with spikes in individual teams that increase figures for the month.



If we compare the referrals per team to the amount of CIC hour available:

Basingstoke 32 referrals 1.2 CIC hours

Havant 25 referrals 0.9 CIC hours

New Forest 24 referrals 1.2 CIC hours

Fareham 16 referrals 1.41 CIC hours

Winchester/TV 13 referrals 0.8 CIC hours

Eastleigh 12 referrals 0.5 CIC hours

Aldershot 11 referrals 0.4 CIC hours (from 0.8 Lead role)0.2 vacant and time limited until April 2021

What is obvious is Basingstoke has significantly more referrals than other teams in Hampshire, yet the resource does not reflect the increasing work. Havant is significantly under resourced being the second highest in referrals. Both areas have been impacted by staff longer term sickness which has in part been made worse by the volume of work.

The hours also reported contribute to the generic team duty tasks and in Basingstoke which generally a day every other week and also taking some SGO and post Adoption work, post assessment, where teams have requested.

As referrals often come in groups then quiet, Children in Care are waiting longer than 2 week for assessment. This is often as a social worker is not available to meet before but also a capacity issue. In high referral teams, generic clinicians also assess CIC where skills have been identified, or if there is a vacant post. However this is not consistent in the management group so in some teams they are waiting much longer for assessment. This is particularly reflected in under resourced teams.

Children in Care Clinicians Case Load as Lead Practitioner April 2020

Count of CIS_ID	**Stated as LAC**					
Row Labels	**No**	**Not Known**	**Yes**	**Yes - Out of Area**	**(blank)**	**Grand Total**
Alice Coombs	2		4			6
Catherine Jones	4	1	8			13
Harriet Badman	7		3		2	12
Jodi Battison	15		1	1		17
Karen Reardon			18	1		19
Lorna Taylor	11					11
Michelle Thompson	5		22		1	28
Nina Heptner	8		2	1		11
Sarah Cunningham	1					1
Sarah Matthews	5		10	1	1	17
Sarah Moore	6	1	9	1	1	18
Yvonne Richards	14	1	20	1		36
Grand Total	**78**	**3**	**97**	**6**	**5**	**189**

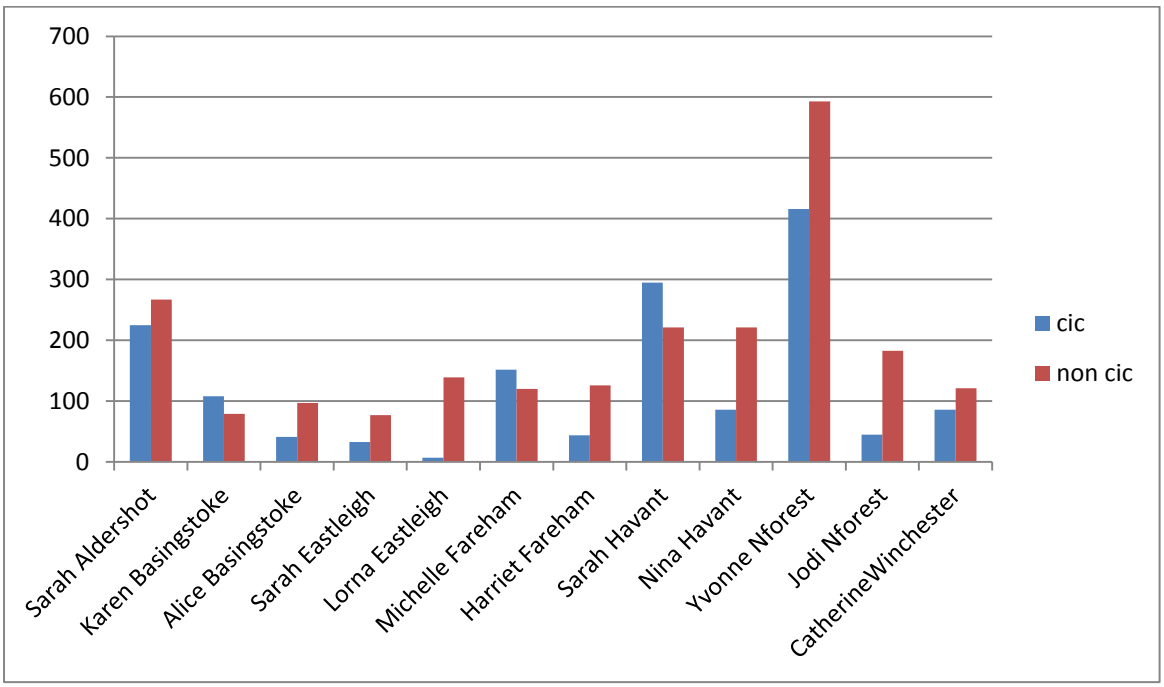
The volume of non CIC varies across Hampshire. Some posts are split so there would be non CIC cases expected. The areas where there is the biggest percentage of non- CIC is in Aldershot, New Forest and Fareham. This would account for some of the post adoption and SGO work, but also where cases have been allocated from generic teams for the purposes of risk assessment.

The case load also varies according to hours worked:

Basingstoke	0.6 CIC	6 New staff member
	0.6 CIC	13
Winchester	0.8 CIC	13
Fareham	0.78 CIC	28
	1.0 split post	12
Havant	1.0 split post	18
	0.9 split post	11
New Forest	1.0 CIC	36
	0.6 split post	17
Eastleigh	0.5 CIC	1 (mat leave)
	0.6 split post	11
Aldershot	0.4 CIC	17

Case is always a difficult subject and especially so with CIC. Job plans can help and hinder, but simplistically the work should fit in the hours employed.
What is noticeable is the range in volume of cases that does not fit in line with the hours employed. The large case load in Fareham is a reflection of a glut of referrals coming in but also holding non CIC cases for risk assessments.
A smaller case load is not always reflected in the hours or split post, but maybe due to complexity or leadership tasks in the role also.
The general reflection, not matter the figure is the cases are becoming increasingly complex and time consuming in the multiagency component and risk, which often happens with little notice.

Total Team contacts for Children in Care Team Clinicians

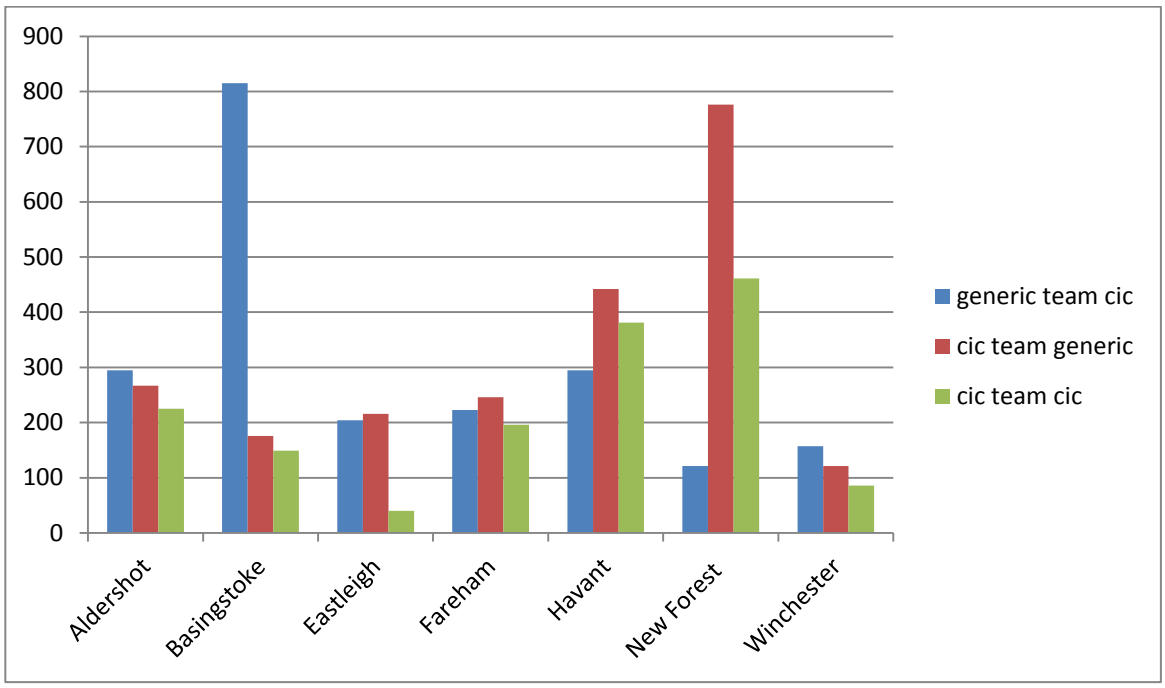


Total contacts for Children in Care Clinicians is 3722. 1538 are Children in Care Cases and 2244 are not children in care.

In some teams where therapists have split roles such as Sarah-Havant, Nina - Havant, Jodi- New Forest, Harriet-Fareham and Eastleigh where there had been maternity cover for Sarah, by a team member Lorna. In the other teams where the roles are not split, the generic contacts are mostly higher, or nearly as high as CIC contacts.

We can account for some of these in Special Guardianship cases and post adoption cases which we are currently trying to identify separately on Carenotes. There is a growing amount of referrals for SGO's whom are not eligible for other support.

The vast amount of generic contacts in these teams results from duty and trauma care group.



Generic CAHMS teams provided **2110** contacts for Children in Care cases. CIC team provided **1538** contacts for Children in Care cases. They also provided **2244** contacts for generic case

Some of the high generic team figured for children in care contact are due to gaps in staffing- recruitment and maternity. The other are where there are a high level if referrals into the team in addition to absence.

However the number of contact that the Children in Care Team provide for generic CAMHS is still vastly more that the CIC contacts and more than the generic team provide for CIC. A consideration would be that if CIC clinicians were removed from generic work, there would be more capacity for the children in care cases to be seen in a more quickly

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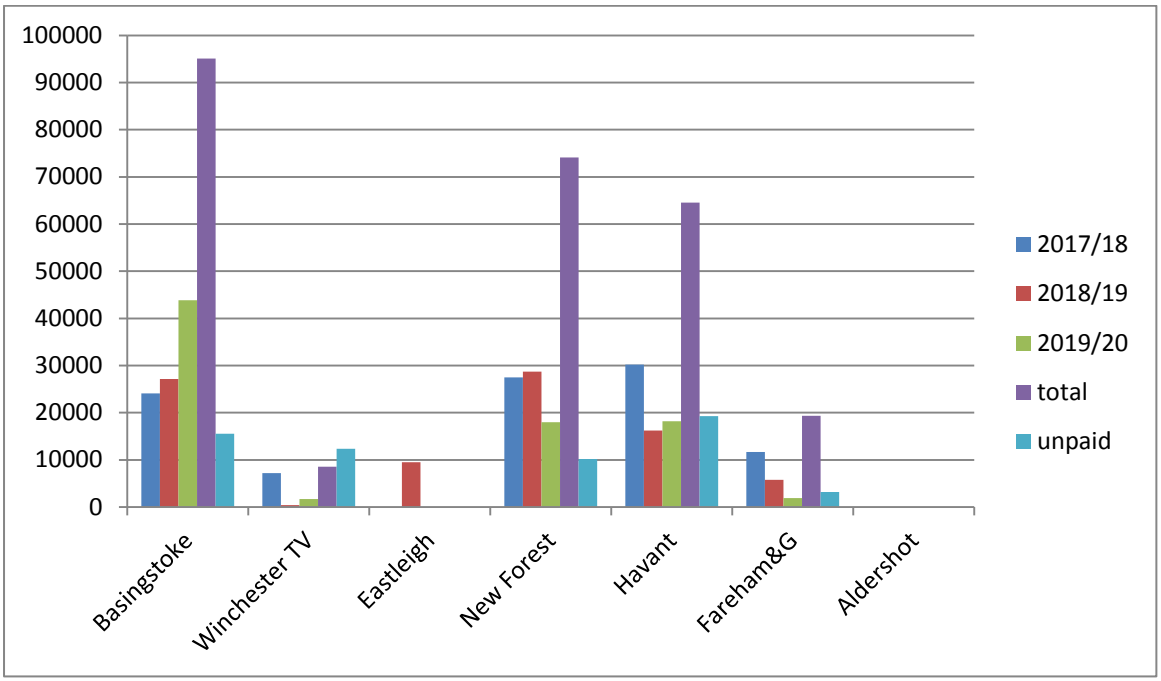
Out of County Placement Invoicing



There has now been 3 years of evidence particularly in Basingstoke, New Forest and Havant of a large cohort of out of county work being invoiced. Aldershot has no out of county work invoiced but since the writing of the report had 4 out of county referrals.

Due to the placement being away from the placing authority- the needs are often complex with high levels of risk. We offer a service to out of county young people that is consistent to Hampshire children, which can place extreme pressure on resources. This is particularly difficult when young people move across counties or close by to Portsmouth and the same level of service is not available due to protection of resources for own young people.

Some managers have been looking into how we may access the money claimed back from other CCG's to support the CIC work. We understood that 3 years of evidence was needed for this to happen and may not support a substantive post but could be used in other support functions. This is a discussion we would like further as a team, particularly as CIC clinicians have used substantive amount of time filling in the claim forms for this purpose.

Section 4

4.1. Conclusion

It is clear that a clear trauma informed approach for the Children in Care team, allows us to offer a consistent, timely and sustainable service, that is in line with trust and government and Sussex Partnership priorities. By using a stepped/layered multiagency model, we are able to best use our specialist expertise to target the widest audience of professionals in a systematic way. The work is complex and clinicians and professionals need to feel safe in the delivery of this to enable the young person to be kept in mind. The trauma formed model ‘makes sense’ of the work we do and provides necessary boundaries to this.

The team have worked hard over the past year, maintaining a multiagency approach in consultation, assessment, training and direct work, often when others services, with equally limited resources, have a view that therapy from CAMHS is only what is needed. It has been the absolute advocacy of a child centred, flexible and accessible approach in the multi-agency plan that has brought about change in the lives of the young people we have seen.

Resources across the county have been stretched for a long time both in generic teams and Children in Care. The reality is that referrals for children in care are not seen as quickly as we would want them to be down to the extensive remit of the team both Hampshire Children and out of county placements. The trauma skills of the clinicians are also in high demand across CAMHS and other agencies, which is encouraging but also difficult to meet. An increase in funding for posts, particularly where clearly under resourced and the removal of generic duty tasks, would allow this vulnerable group to access support more quickly.

Despite the enduring and increased difficulties for children in care during Covid, the team have adapted ways of working, keeping the young person in mind, whilst managing high levels of risk and supporting placements. It has been particularly encouraging in the midst of this to be invited to contribute to the Modernising Placement Plans that are being proposed in Hampshire. Trauma informed placement support has been a major task in all referrals so far. Supporting carers to recognise what is behind the behaviour is paramount in helping a young person to feel safe and begin to recover. Our aim as a Children in Care Team has always been that wider workforce have a greater understanding about "what has happened to the young person, rather than what is wrong with them" as a starting point. Together we may then provide the support that will help them feel safe, and achieve their potential.

4.2. Recommendations

Going Forward 20/21 priorities

- Ensure spa process are maintained, timescales met and new CAMHS form is used.
- Identify consistent administration support in each CAMHS team for CIC Clinicians, to free up more clinical time. This would assist with setting up CIC assessment, diary and out of county funding returns.
- Complete Dyadic Developmental Practice training level 2 for those attending, to have a DDP informed team approach.
- Continue to co-deliver commissioned training to Hampshire Local Authority with Educational Psychology. This will happen virtually in the immediate future.
- Train generic CAMHS workforce in trauma model and trauma informed skills.
- Continue to contribute to Hampshire's Modernising Placements Programme, ensuring a trauma informed approach to CIC placements and planning.
- Increase engagement with Virtual school to look at how best to use resources
- To increase the clinical hours available to CIC team by reducing generic duty commitments to allow for more specialist work to be offered to teams
- Consistency across teams in how CIC cases are triaged, assessed and held in teams
- For the CIC team to be identified as a separate team on Carenotes. This will allow for more accurate data collection, clearer use of clinical hours and audit.
- To aim to have 2 identified Children in Care clinicians in each team.

- To look at alternative/innovative ways to engage and work flexibly with CIC. This is to include how we may extend virtual resources and training to further support referrers and the network as well as direct work with young people.
- To look at how the out of county funding can be used for the benefit of children in care

.

4.3. Expected Improvements to Service-User Experience

With the above priorities we would expect more timely access to support from a number of sources, with a shared trauma in formed approach.

Those working with children in Care will be able to access training and support from to help better understand the young person they are caring for.

Young people will be able to have episodes of intervention from CAMHS when most needed and are able to access ongoing support trauma informed support from the wider network.

4.4. Action Planning

	Action	Lead Name	Deadline
1.	Discuss with SPA dissemination of new form prompt with local authority offices	Sarah Matthews	October 2020
2.	Meet with Andy Muskar: • to look at creating a separate team on Carenotes for CIC • out of county funding matter and process • Admin support for CIC	Sarah Matthews	October 2020

3.	Complete DDP training Oct 2020 and set up supervision group to work toward accreditation	CIC team	November 2020
4.	Train teams in trauma assessment virtually and Hants training package to be made virtual	CIC Team	Starting October 2020
5.	Contact Virtual school to look at how to best use resources	Sarah Matthews	November 2020
6.	Attend Expert by Experience Steering group for Hampshire Modernising placements programme	Sarah Matthews	September 2020

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