APPENDIX 2

Carelink report for Corporate Parenting Committee

1. Introduction

Children and young people who are looked after by local authorities are among the most vulnerable and disadvantaged members of society (Sempik, Ward & Darker, 2008). They are at increased risk of poor outcomes in terms of mental health, educational attainment, employment and criminality (Viner & Taylor, 2005). By definition, Looked after Children have already experienced traumatic events in their lives, so it is unsurprising that they are more likely to develop mental health problems than those in stable family environments. Estimates of psychopathology among looked after Children vary between 37%-89% which compares with the estimate of 3%-18% for children outside the Care system, but Looked after Children also endure a higher prevalence of psychological adversity than even the most socio-economically disadvantaged children living in private households (Ford et al., 2007).

The mental health needs of Looked after Children often go unrecognised (McCann, James & Wilson, 1996: Richards, Wood & Ruiz-Calzada, 2006; Philips, 1997). Barriers identified include:

- The movement of Looked after Children within the care system (Richardson & Lelliot, 2003);
- Lack of Child and Adolescent Mental Health Services (CAMHS) for those without a plan of permanency (Department of Children, Schools and Families, 2009);
- Perceived stigmatisation of a mental health diagnosis in addition to being in care (Richardson & Lelliot, 2003)
- A higher turnover of social workers involved in the care planning (British Association of Adoption and Fostering, 2008; Richardson & Lelliot, 2003).

Given the high level of emotional, mental health need, early adversity and psychosocial stressors these children experience it is important that these children experience high quality care and accessible, flexible and bespoke CAMHS assessment, treatment and intervention. This view has been endorsed by the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) joint guidance; 'Promoting the quality of life for Looked after Children and Young People (2010).

Carelink is a specialist Child and Adolescent Mental Health Service (CAMHS) for Looked after and Adopted Children 0-18 years. The team is part of the South London and Maudsley NHS Trust and is one of five CAMHS teams in the Borough of Southwark. Carelink is jointly commissioned by Southwark Children's Social Care (CSC) and works in close partnership with the CSC, Child Health and Education.

The team is located at the Lister Primary Care Centre (a modern purpose built health centre) in the middle of Peckham. The majority of our sessions with children, young people and carers take place at the Lister Centre and depending on need and resources we see children in their placement (mainly foster homes) or in school.

The overarching aim for Carelink is to provide a flexible, accessible community based mental health service for Southwark Looked after Children 0-18 years (both in and out of Borough) and

professionals involved in their care. We understand that Southwark has a richly diverse population. The team aim to provide care that is sensitive and appropriate to the client's circumstances, gender, ethnicity, language and culture. The team carries out comprehensive assessments and use available outcome measures which provide evidence of benefits to our client group, and evidence of high levels of service-user satisfaction. In addition to offering a high quality clinical service the team is actively engaged in clinical research to add to the evidence base about best assessments and treatment interventions to offer to this population.

Our strong relationship with CSC is central to the team development, service planning & clinical provision and on-going research.

2. Overview of services

LOOKED AFTER CHILDREN:

Our remit is to offer a CAMHS assessment and therapeutic service to children and young people 0-18 years who are looked after by Southwark Social Services, where there is a plan for them to remain permanently in care. Given the changes in CSC and the high number of children on s20 we also offer a CAMHS assessment to children and young people, where the young person entered Care late and/or the permanency plan has not yet been fully agreed, when there are concerns about mental health and risk.

We work with Southwark Looked after Children both in and out of Borough. At any one time up to 50% of our open cases are Children who are looked after by Southwark but live outside of the Borough. Where possible we aim to work with Southwark children irrespective of address so we can offer continuity of service should there be a change of placement and to support better collaboration with the network given our close links with the CLA social workers. Where children and young people live too far to travel to Southwark for appointments we will broker referral to other CAMHS teams in their locality as requested.

ADOPTED CHILDREN:

We have close links with the CSC Adoption Team. Carelink can assist with the transition from foster-care to adopted family especially when the child has already been known to the team. We offer assessment and therapeutic services to adopted children and the family if this seems more appropriate than having intervention from the local CAMHS community team and the geographical distance for the family is not too great.

We are also referred adopted children and young people who are living in Southwark and may not have previously been known to our team when they are experiencing emotional and mental health difficulties. These young people are often not known to Southwark Social Care as the adoption may not have taken place in Southwark but the family now reside in the Borough, or the child and family were known in the past but have not had contact with the service for many years.

Foster Care Support:

Foster carers of all children and young people referred are offered therapeutic support. This includes joint working with foster parent and child if clinically indicated (often for younger children) and foster parent sessions in parallel to the child or young person's individual work.

Multi-agency review meetings:

We meet key professional in the child's network to feedback outcome of assessment. Children and young people in on-going treatment with Carelink have termly multi-agency review meetings. These meetings include foster parents, Social Worker, Supervising Social worker (SSW), Independent Reviewing officer (IRO) and the young person, Child Health and Education when appropriate. At these meetings the child or young person's CAMHS Care plan is agreed.

Staffing

Carelink is a multi-disciplinary team consisting of staff from the following specialisms: child psychotherapy, art and drama therapy, family therapy, clinical psychology, occupational therapy, nursing, therapeutic social work. We have access to psychiatry for individual cases as required. From time to time Carelink has trainees from a range of disciplines attached to the team. The team has a stable workforce with many clinicians trained in more than one assessment and treatment modality.

Carelink is committed to offering a high quality clinical service to Looked after Children and is actively involved in clinical research.

3. Presenting problems

Children and young people are referred with a wide variety of problems and these include; emotional disorders, low mood, depression, self-harm, suicidal thoughts, PTSD, developmental trauma, eating difficulties, anxiety, attachment disorder and difficulties, behavioural and conduct problems, neurodevelopmental problems, early onset psychosis. Given the trauma and early adversity experienced by Looked after Children it is more usual to have high levels of comorbidity and complexity. The children and young people are assessed by the team and Specialist assessments and interventions are requested as needed e.g. specialists neurodevelopmental assessments.

4. Carelink Assessment and Intervention Provision.

General provision:

- CAMHS assessment and treatment for children looked after 0-18 years where there is a plan for them to remain in care and if permanency plans are not yet agreed, where referral to Carelink has been agreed with the allocated social worker.
- Direct therapeutic work with children, young people and their carers.
- Advice/consultation to the professional network and especially the social work team regarding care planning, therapeutic needs, placements and transitions.
- Close links with the adoption team. More usually referrals from the adoption team are for children who are in transition from foster care to adoption however we are also referred adopted children who are living in Southwark and were not previously known to Southwark CSC.
- Provision of a continuity of CAMHS should there be a change of placement and better collaboration with the network given close links with the CSC social workers.
- Where children and young people live too far to travel to Southwark for appointments Carelink to broker referral to other CAMHS teams as necessary.
- Offer individual foster care support to Southwark carers.
- We also offer support to foster carers in Independent Fostering Agency (IFA) who are caring for Southwark Looked after Children.

- It is also possible for individual Southwark foster carers to request support/advice on the care of LAC children in placement (even if the child is not referred for therapy).
- Provide easy access to the CLA CSC teams so they can quickly access advice on a particular child and easily make a referral to Carelink or signpost to another service as necessary.
- Screening to identify any emotional or mental health difficulty for under 5's using specific screening/assessment measures.
- Promote the mental health needs of this vulnerable and marginalised population.
- In cases where a child moves from being looked after to adoption to continue the therapeutic involvement for as long as clinically indicated.
- Provide flexible and clinically sensitive service such as consultation to the SW, foster carers and Southwark Legal Department where appropriate in cases when direct work with a child is not possible due to uncertainty about long term plan.
- To prioritise work where there is a crisis, risk of placement breakdown, need for urgent response, mental health risk and unstable placement.
- Liaise with local CAMHS to offer assessment and treatment if the child is in a stable, settled placement in a neighbouring Borough and are attending a local school and involved in that community.
- Continuation of service and involvement of local CAMHS where Carelink has been involved with children and young people prior to move (depending on distance this may be less frequent direct work with the child).
- Work with the social worker in regards to child's mental health needs and placement plans where young people are out of borough and moving placements and Carelink cannot see them directly
- Take part in multi-agency review meetings.
- Contribution to placement breakdown meetings for CLA and Adopted children.
- Early support and transitional work to adopters when Southwark child is being placed e.g. together Child Health and Carelink staff meet with prospective adopters to discuss assessments and to consider recommendations for child's individual social and emotional needs.
- Contribute to CSC training for foster parents and adopters as resources allow.
- Referral to specialist's services and In-patient CAMHS admission as needed.
- Arrange transfer of care to Adult Mental Health services in young person's 17th year to ensure continuity of care. There are many challenges associated with these transitions.

Carelink CAMHS assessment & interventions include the following:

- Individual psychoanalytic psychotherapy
- Family and Systemic psychotherapy
- Consultations to network and carers
- CAMHS generic and more specific treatment assessments
- Sibling work
- Support Social Workers with Together & Apart assessments
- Work with carers and adopters, with children or separately looking at attachment issues
- Drama therapy, art therapy and creative therapies
- Short-term solution focused work
- EMDR
- Mental state examinations and risk assessment.
- Group work
- Cognitive behaviour therapy

- Trauma focused interventions
- Parent/child work
- Specialist assessments e.g. cognitive assessment, Story Stem Assessments, specialists assessment for under 5's (ASQ-SE, KIPS and clinical formulation of child's needs).

5. Routine Outcome Monitoring

The Carelink team uses various outcome measures, these include;

a) Strengths and Difficulties Questionnaire (SDQ)

The SDQ is routinely administered at assessment and repeated every six months. This is a brief, well validated and commonly used measure of psychopathology in 4-16 year olds (Goodman, 2001). The measures are currently not validated on children below the age of 2 years. A computer algorithm combines information on symptoms and impact from all informants to give a prediction of the likelihood of psychiatric disorder as 'probable', 'possible' or 'unlikely' (Goodman, Ford, Simmons, Gatward & Meltzer, 2001).

When examining the Baseline SDQ results for children and young people referred to Carelink the sample mean total is almost 17 (16.99). This is a point above the clinical cut off point on parent SDQ, so scores above 16 suggest significant difficulties may be seen (Table 1). We then compared the means of the Baseline SDQ to the UK National averages in order to contextualise findings (Table 1).

Table 1 – Comparison of Carelink sample against national average: SDQ mean scores

	National Average		Carelink				
	M	SD	M	SD	*t*	95% CI for Mean Difference	SE of dif
SDQ Total	8.4	5.8	16.99	7.66	**15.99***	7.54-9.65	.537
Emotional	1.9	2.0	3.59	2.62	**9.13***	1.33-2.05	.185
Conduct	1.6	1.7	4.39	2.60	**17.67***	2.48-3.1	.158
Hyper-activity	3.5	2.6	5.97	2.99	**10.29***	1.99-2.94	.240
Peer Problems	1.5	1.7	3.14	2.26	**10.42***	1.33-1.95	.157
Pro-social behaviour	8.6	1.6	6.08	2.69	**16.91***	2.23-2.81	.149

$p<.01$
National average n=10,298
Carelink n=119
Note: National norms from a national sample of 10,298 children (Meltzer, Gatward, Goodman, & Ford, 2000)

An independent samples t-test was conducted to examine these differences. A nationally representative sample of children 5-15-years-old was used (Meltzer et al., 2000), and it was found that the teams total SDQ scores were significantly different from that of the national norms, $t(10415) = 15.99$, $p<.01$, with the study's mean total SDQ scores being far greater than that of the normative data (mean difference=8.59). This finding was replicated for each of the SDQ's subscales, as seen in *Table1*.

b) Development and Wellbeing Assessment (DAWBA)

The DAWBA is a fuller on line diagnostic screening developed by Prof. R. Goodman. This is not routinely administered but recommended in certain cases.

c) Children's Global Assessment Scale (CGAS)

This is a 100-point rating scale, measuring psychological, social and school functioning for children aged 6-17. It was adapted from the Adult Global Assessment Scale and is a valid and reliable tool for rating a child's general level of functioning on a health-illness continuum.

A child or young person receives a score at initial assessment, which is a clinician rating on the basis of known information about general areas of functioning. This score is reviewed on a regular basis by the practitioner and the team, and at the point of closure of treatment, to give an indication of the child's progress in terms of their functioning.

d) IAPT measures

The Children and Young People's Improving Access to Psychological Therapies project (CYP IAPT) is a government programme working with existing CAMHS. Southwark CAMHS was one of the first implementer sites for CYP IAPT. As part of our commitment to the government IAPT initiative Carelink team members have undertaken specialist training to understand and use the measures developed and rolled out by CYP IAPT.

IAPT has been developing assessment and screening tools as well as outcome measures which have the aim of improving service effectiveness, and encouraging user engagement and feedback.

Since implementation of CYP IAPT Carelink have included the IAPT measure RCADS (Revised Child Anxiety and Depression Scale) which was introduced as a standard screening tool with carers and young people, for all children aged 8 and above. This measure has been included as a standard anxiety and depression screen for all assessments and used along with the SDQ in all new assessments. The use of the SDQ at assessment and review is also part of IAPT requirements.

RCADS is a measure which screens for indicators of specific anxiety and depressive disorders. Our initial view has been that this measure is helpful in distinguishing between different types of anxiety and depression but that it is not sensitive to the kinds of presentations most common in the Looked after Children population. We therefore have investigated measures which are more helpful to the

assessment of children and young people referred to Carelink. As part of Carelink's commitment to screening assessment and treatment review we continue to use of SDQ at assessment and review.

e) **Brief Assessment Checklist for Children (BAC-C) and the Brief Assessment Checklist for Adolescents (BAC-A)**

These measures are routinely completed on all children and young people assessed in the team and is a 20 item caregiver-report psychiatric rating scales that are designed for children and adolescents in foster, kinship, residential and adoptive care. These measures capture contextual information about the child's current experience and are a more helpful measure for this population and were developed by M. Tarren-Sweeney.

f) Adverse Childhood Experiences (ACE)

The Adverse Childhood Experiences Study (Felitti et al, 1998) is a major, longitudinal and international research study (with a large sample size), posing the question of whether and how, childhood experiences affect adult physical and mental health into adulthood. The ACE study reveals how there is a correlation between traumatic emotional experiences in childhood and organic disease and emotional disorders later in life and provides a remarkable insight into how we are affected into adulthood medically, socially and economically.

Exposure to one category (not incident) of ACE, qualifies as one point. When the points are added up the ACE score is achieved. A score of 4 or more indicates significant vulnerability. Please see Figure 1 to see results for ACE scores on open cases (n=119) in Carelink completed in September 2016. We have been collecting the data for several years and the results range between 75% - 93.3% of Carelink children having 4 or more ACE's. From Felitti's work 6.2% of the general population have 4 or more ACE scores thus evidencing a high level of need in the Looked after Children population. Further work by Van der Kolk (2005) highlights the detrimental and pervasive impact of cumulative trauma and suggests that childhood complex trauma is a severe Public Health challenge that warrants further research.

The ACE data was explored to look at the frequency of occurrence of these types of traumatic childhood events, and the results are displayed in *Figure 1* below.

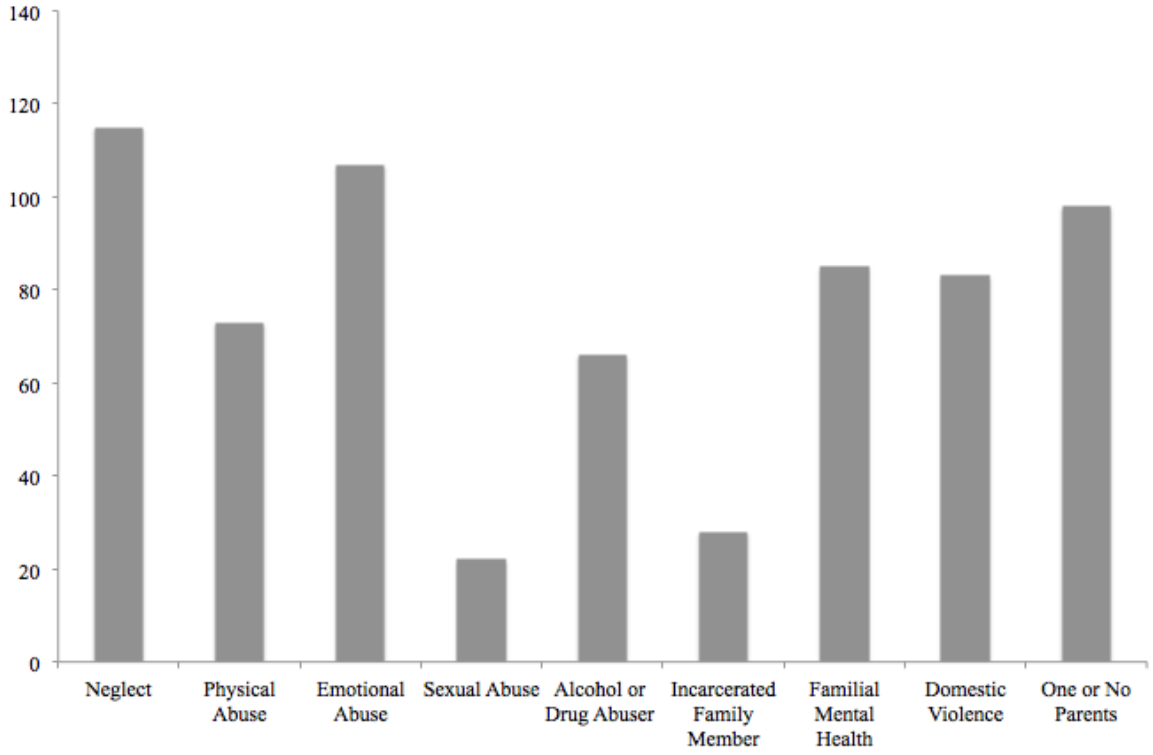

Figure 1 – Frequencies per ACE category

n=119

g) Child Outcome Rating Scale (CORS), Outcome Rating Scale (ORS) & Child Session Feedback Scale

These are measures completed by the child to capture the their view of how they are progressing and are administered at assessment and repeated at various points throughout treatment.

f) Disorder Specific measures

More sensitive measures have been developed to identify specific disorders. For example, the Moods and Feelings Questionnaire (MFQ) for depression, SCARED for anxiety, Conners for ADHD and are administered depending on the child and young person's presentation.

All measures are used in conjunction with clinical observation of child and young person and contribute to the development of the clinical formulation for the child and young person. This will guide intervention and treatment recommendations. Assessment reports are written on each child and shared with their Social Worker and key professionals as appropriate.

6. Clinical activities

On average the Carelink team has a case load between 190-220 open cases. Each staff member has an individual caseload in the region of 30-40. The length of treatment varies from assessment only which may be 3-4 appointments to several years of treatment. Given the high level of emotional and mental health need, the challenges the children and young people face at different developmental stages long term treatment for Looked after Children and support for their carers is essential.

Closure and/or transfer to other services

When C&YP are transferred to another service or discharged from the team they all have a summary of assessment and treatment in the team. This summary is routinely sent to G.P., CSC, Child Health and any others closely involved or relevant to the case.

With young people who are 17.5 years and need on-going mental health services we transfer to the appropriate AMH team. We follow guidance outlined in the SLaM Trust Transition Policy.

Management of Risk

Because of the nature of the team, risk assessment and risk management play a major part in day to day team functioning. The SLaM Trust risk assessment guidelines are used during any first assessment and thereafter. In all contacts with children and young people the level of risk will be reviewed and interventions altered accordingly. We routinely monitoring clinical risk and the team is accessible and responsive should a crisis occur.

In addition, Safeguarding is a key aspect of clinical work and the team follow the SLaM Trust Safeguarding Policy.

7. Research

The mental health needs of children in care are not routinely assessed with many children only receiving help when more intensive treatment is needed if their needs are recognised at all (Whyte & Campbell, 2008). In Southwark we agreed there was a need for systematic screening to promote early identification and intervention. In 2008 the Carelink team with Southwark Children's Social Care (CSC) successfully bid for a grant from Guy's and St Thomas' Charity to run a mental health screening programme for all young people aged 4-16 years remaining in the care of the social services department for four consecutive months over a period of 12 months.

This research is written up in an article entitled 'Evaluation of a pilot project for mental health screening for children looked after in an inner London borough', Newlove- Delgado, T., Murphy, E., & Ford, T. 2012 Journal of Children's Services, Vol 7 No 3 pp 213-225

On completion of this research in 2009 and in accordance with Government indicators, Southwark Local Authority (CSC Department) agreed to continue to support the screening of children in care. The Government only requires that the foster carers complete an SDQ and does not state what the Department has to do with this information. For the SDQ to be interpreted reliably there needs to be at least two informants (three if the child is 11+). In order to make the information clinically useful in Southwark we have agreed the following:

- On a given date once a year all foster carers are asked to complete an SDQ for all Southwark children in their care. To date the return rate has been 100%.

- The SDQ is returned centrally and forwarded to the Carelink team where they are reviewed.

- When the SDQ is reviewed if there are concerns we complete the rest of the screening and where indicated ensure that a clinical service is offered to all children and young people with identified mental health need.

The CSC Department will continue to ensure foster carers complete the SDQs annually and the Carelink team will clinically review to ensure early identification of need and accessibility of service to children in care to Southwark.

Emotional / mental health screening study –
Southwark Carelink Screening and Intervention Project for 0-4 LAC

Project Synopsis

The aim of the Southwark Carelink project was to screen all children aged 0 to 4 years who became looked after by Southwark Children's Services in a 12 month period in order to identify early social/emotional or mental health difficulties and to formulate an appropriate intervention for those children with specific needs.

The screening used a combination of standardised and clinical observation measures to assess the child's social-emotional development and quality of relationship and attachment to their foster/kinship carer. Observations of the child took place in their LAC medical and in the foster home. Information regarding their social-emotional development was considered along with their general health and development and a profile of their specific needs formulated in a written summary to the professional network. The brief intervention was tailored to maximising healthy emotional and social development and the child's attachment to key caregivers.

Improved outcomes

- Significantly improved levels of identification of social-emotional difficulties in under fives LAC population, 67% in screened group compared to 10% previously. Increased knowledge of prevalence and type of difficulties.

- Targeted interventions were taken up in majority of cases, in context of significant time pressures for carers managing intensive Contact schedules for infants/children.

- On 5 point scale, foster carers and social workers positively rated the usefulness of intervention with 4.6 and 4.3 average scores respectively.

- Social care professionals, including those on Adoption Panel, positively rated usefulness of the child's screening profiles in Care planning and when thinking about placement matching and the child's long-term needs.

- Increase in referrals to CAMHS, both following the screening/intervention and to the existing LAC CAMHS team where social workers sought a similar assessment for young children who were already in care and not part of the initial screening cohort.

This research is described a chapter "Social-emotional screening and intervention for 0-4 year old children entering care', Hardy, C., & Murphy, E. in a book entitled 'Mental health services for

Vulnerable Children and Young people' edited by Tarren-Sweeney, M & Vetere, A. (2013) Routledge, Taylor & Francis Group.

Since the pilot study we were awarded another research grant to carry out a two year study described below;

Social-emotional Under 4's Screening and Intervention; A study of Emotional Health and Development in Babies and Young Children (S.U.S.I.) - an interagency collaboration in Southwark.

The purpose of this clinical research study was to carry out a feasibility study to evaluate the impact of specific mental health interventions for the children, parents and carers in three high risk groups of children under the age of 4 years in Southwark.

The study replicated the screening method that was first developed and successfully implemented in a pilot project in Southwark in 2010-2011, combined with the delivery of new specific longer term interventions to investigate the impact of this approach on the social-emotional development of the child and the quality of the caregiver -child relationship in the 'looked after children' population. The screening method and an extended intervention will also be offered to two further groups in Southwark, with the aim of building more robust evidence on the outcomes for children and the effectiveness of early interventions that target their emotional/mental health and the methods by which we can successfully engage with children and their caregivers.

In the new study there were three groups:

- Group 1 Children in Care (CiC)
- Group 2 Children whose parents are known to the Parental Mental Health Service (PMH)
- Group 3 Children on initial Child Protection Plan (CP).

We recruited children and caregivers from all three groups to the study in a 16 month recruitment period, and implemented regular reviews of the child's social-emotional development and mental health at 6 months interval for the duration of the project.

The screening helped the parents and primary caregivers have a greater understanding of their child's needs and social-emotional development. The intervention was tailored to the individual needs of the child but also gave significant direct support and advice to the parent or carer in addressing the child's needs. The focus was on the parent/carer-child relationship. The feasibility study has now ended and was supported by a grant from Guy's & St Thomas' Charity. The results are promising and will be published this year.

All of our research has been actively supported by Southwark CSC and could not have happened without their help and involvement.

8. Service user Involvement

The Carelink team believe that constructive dialogue with service users is integral to the success of the team. The team actively maintains links with and encourages feedback and advice for children, young people, their carers and other professionals to ensure continuing good practice. Care Plans are agreed with children, young people, foster parents and allocated Social Workers

Regular written and verbal feedback is requested and results of feedback made available in poster form in the waiting room. The team coordinates this information and thinks of creative ways to involve children and young people in activities in the clinic.

9. Challenges and Issues for Consideration

Waiting List
The team work hard to ensure children referred do not have to wait for assessments but over recent months we have found that we have not been able to respond as quickly as we would like, due to the pressure on caseloads of existing on-going work for the clinicians and trends whereby whole sibling groups (4-6 children) are referred at once and general pressures on resources.

We do now have a waiting list for assessment and treatment.

Access for children out of Borough
For Southwark looked after Children placed in neighbouring boroughs or in a placement and/or school which is reasonably accessible then Carelink can offer a therapeutic service. However if placed further away it is often difficult for them to access a timely or appropriate CAMHS service for various reasons, including;
Variability of delivery of CAMHS services across the country, with different resource pressures, length of waiting list and accessibility criteria (often high MH presentation thresholds). There are significant resource pressures on CAMHS services in other areas which mean sometimes the services are much reduced.
Rapid movement between placements, for YP who have frequent placement breakdown
Reluctance of services to see Looked after Children who they see as transient or too complex, or that they may move in an unplanned way
Some CAMHS services seem to have a policy of not accepting looked after Children placed by other boroughs for treatment but operate with consultation to the network alone.

This means that it is very difficult for us to help access CAMHS for this group.

Issues for Care Leavers
Emotional wellbeing problems and mental health difficulties can escalate at this stage for our children as the transition to care leaver status is a time of high anxiety, major changes in living arrangements, less general support available and high stress for the YP generally having to rely so much more on their own internal resources. CAMHS is not commissioned to support this group at a time of high need.
As much as possible the team try to support the network with consultation on a case by case basis, particularly if we have known the YP in the past. Carelink can assist with advice on referrals to AMH services.

Transfer to AMH
CAMHS are not commissioned to work with patients once they have reached their 18th birthday, so a transition to other services will be in the planning stage from 17.5 years. This is often not straightforward and some of the issues are:
High thresholds of mental illness to obtain a service from AMH
YP needs to consent to referral to other services, which may not be forthcoming despite their high need for MH intervention sometimes and high risk behaviours (e.g. self-harm)
We may not know till near or after 18th birthday where the YP will be living, or even which borough they will remain in, which presents a challenge in working out which AMH area can be approached. If the AMH team is aware the YP may be moving they are often reluctant to give an immediate service or will delay their involvement until certainty of where YP will be residing. AMH referrals may be tied to which GP the YP is registered with and this could be in another area (YP often left registered with a GP from previous foster placements in other areas and reluctant to change).

The transition will also include a difference for the YP in service delivery as AMH services more likely to quickly close the referral if YP misses an appointment or demonstrates any reluctance in engagement.

SGO's

Carelink is not commissioned to work with children placed on special guardianship orders (often with family members) or some kinship arrangements and these referrals should be taken up by the community CAMHS teams, who may have different thresholds of need.

Ensuring stable service

Maintaining a stable service is an on-going concern given uncertainty in the financial climate. As an NHS team we are required to make year on year CIP savings which means a reduction in core budget.

Increase in risk management

In the past year Carelink have had more 'high risk' referrals, often adolescents where there is self-harm and suicidal ideation. These young people need an urgent response which means that staff resources are stretched and the work with the younger children to support their development and stability can be compromised.

Conclusion

Integral to our work in Carelink is good multi-agency collaboration and support. All CAMHS team working with Looked after Children need to have a close relationship with CSC on both a strategic and operational level. Support from Social Workers strengthens treatment outcomes given the complex networks around our children. In addition, close working relationships with Child Health and Education is important to facilitate joint assessment and better plans for our Looked after children and young people. We are grateful to our Southwark colleagues for their ongoing support and are keen that where possible integrated multi-agency work and practice continues to support our vulnerable children.

Elizabeth Murphy
Consultant Child & Adolescent Psychotherapist
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