PONENCIA: SALUD MENTAL Y DISCAPACIDAD INFANTO-JUVENIL: BUENAS PRÁCTICAS DESDE EL MODELO DEL REINO UNIDO

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Mental Health Services for High Risk Children

By Dr Jeanette Bowlay-Williams (Consultant Clinical Psychologist) and Dr Vicki Edwards (Clinical Psychologist)

About the Presenters:

Dr Jeanette Bowlay-Williams is a Consultant Clinical Psychologist who has been working with vulnerable children for the last 14 years. She is currently the team manager of The Young People's Team which is a specialist multi-disciplinary team, based within the Child and Adolescent Mental Health Service in the UK. She is also Head of Clinical Psychology within CAMHS. Her clinical interests include working with children and young people who have experienced trauma. She is trained in EMDR and incorporates this approach into her clinical work. She has also developed parenting groups for foster carers and adoptive parents to support their understanding of the impact of abuse, neglect and trauma on child development and has published within this area.

Dr Vicki Edwards is a Consultant Clinical Psychologist who also works within the Young People's Team. She is the lead psychologist for the homeless children and families service and has published within this area. Her clinical interests include; Dyadic Developmental Psychotherapy, Community Psychology and group psychotherapy. She has a particular interest in reflective practice and supervision groups and is developing a model of reflective practice supervision across the universal community services within the division.

CHILD PROTECTION AND SERVICE REFORMS

Victoria Climbié. 1991-

This is the face of a young girl whose tragic death marked the beginnings of service reforms in the UK that have shaped the services that are provided today.

Unfortunately her death was not the first and, high profile as it was, has tragically not been the last.

" For most parents our children are everything to us; our hopes, out ambitions, our future. Our children are cherished and loved.But sadly, some children are not so fortunate. Some children's lives are different. Dreadfully different. Instead of joy, warmth and security of normal family life, these children's lives are filled with risk, fear and danger; and from what most of us would regard as the worst possible source- the people closest to them" (Tony Blair- British Prime Minister)

Above is a quote from Tony Blair who was the prime minister at the time of a high profile death of a young girl called Victoria Climbié. Victoria was an 9 year old girl born on the Ivory Coast. In 1998 she was taken by her Great Aunt to Europe in order to receive an education there. She lived for a short while in France before moving to England. Victoria died on 25th February 2000, following 11 months of unimaginable cruelty at the hands of her great Aunt and her Aunts partner who were later convicted of her murder.

The subsequent inquiry was headed by Lord Laming and cited gross failures in the agencies making up the system which should have protected Victoria. Victoria was not an unknown child- in the days, weeks and months before her death she was seen on several occasions by all of the statutory agencies (social services, health, education, housing and the police) none of whom took the action that may have saved her life. The inquiry cited multiple failures but, in particular poor communication between agencies, a lack of integration and planning of services and failure to take seriously some of the warning signs that Victoria was at risk of significant harm.

Tony Blair summarised in his statement about Victoria Climbié that her case was a, " shocking example from a list of children terribly abused and mistreated. The names of the children involved, echoing down the years, are a standing shame to us all"

Each inquiry, through the years, following such a tragic loss of life has brought forward proposals for change and improvement to the child protection system. A paper entitled "Every Child Matters" was published in 2003 and presented to parliament. It was written partly as a response to the Lord Lemmings Inquiry, and is considered one of the most important UK policy initiative and development programmes in relation to children's services in the last decade and has been described as a "sea change" to the children and families agenda. It aimed to both protect children and to maximise their potential including educational achievement and access to health services. It set out a framework for services that cover children and young people from birth to 19 years of age living in England.

Before we talk about how this has shaped the provision of mental health services to children and young people, we would like to give you a brief overview of the child protection system within the UK to give you an oversight into the context which serves as the backdrop to these services.

CHILD PROTECTION WITHIN THE UK

Child protection in the UK is underpinned by the Childrens Act 1989
Section 1 of the Act contains 3 general principles:

1. The welfare of the child is paramount
2. Delay is likely to prejudice the welfare of the child
3. The court shall not make an order unless to do so would be better for the child than making no order.

The 'best interests' principle sometimes referred to as the welfare principle or the paramouncy principle- The welfare of the child is paramount in all decisions made by the court- decisions muct therefore be made on what is in the child's best interests

The avoidance of delay-In any court proceedings or decision making there is a principle of "without delay" as there is a general principle that any delay in determining the question is likely to prejudice the welfare of the child.'

There is therefore a strict principle that timetables set by the court need to be adhered to.
The third principle is

The 'no order' principle- Which states that 'Where a court is considering whether or not to make one or more orders under this Act with respect to a child, it shall not make the order or any of the orders unless it considers that doing so would be better for the child than making no order at all.'

CHILD PROTECTION PROCESS

Concerns about a child's welfare can come from a whole variety of routes. It may be a teacher or another professional raising concerns to the Local authority or concerns may be raised by members of the public, family members neighbours etc.. They can, and often are anonymous referrals.

An initial assessment of the child takes place and a decision needs to be made within 24 hours as to whether the concerns are at the level whereby they meet the threshold for the child being considered to be at risk of significant harm, which is the trigger for a section 47 enquiry. If the child is at immediate risk they can be removed immediately by the Police on an Emergency protection order

If it is deemed that the child is a child in need of support rather than in need of protection and there is no evidence that they meet the threshold for significant harm, then the child and family are assessed using the common assessment framework. A multi-agency support package to support the family can then be put in place which is closely monitored and reviewed. Support could include support with housing, short term financial support, mental health services (child and/or parents), drug and alcohol services, intensive family support e.g MST services. The monitoring of the impact of these services is always considering if the situation has deteriorated to the stage where the child is now at risk of significant harm.

If it is deemed that the child is at risk of significant harm a Section 47 investigation will be undertaken. The aim of a section 47, which is part of the act which allows an investigation is to make a decision as to whether the child needs to go on the child protection register (and under what category) as well as to inform the child protection plan.

The initial child protection conference, now known as a safeguarding conference, is a multi-agency conference with representation from the statutory services, such as health, education, and the police. The findings of the section 47 enquiry are discussed – and a multi-agency child protection plan is put in place. This will be closely monitored by the core group.

Children can remain with parents on a child protection plan or may be with family members/foster carers on a interim care order whilst either further assessments are undertaken or work is done with parents. Resolution needs to be reached within 20 weeks.

The options for resolution are either that the child is discharged back into the care of parents (possibly with a support package as a child "in need") or the child comes into the care of the Local Authority. This can occur voluntarily with parents consent under a section 20 where parental care is shared between the parents and local authority, or under a section 31 which is a full care order. The Local Authority then take over full parental responsibility for the child under this order.

A care order lasts until the child 18 years of age unless it is revoked through the court ("discharging order") or the child exits care through another legal route (e.g. adoption order)

All children on care orders have to have a care plan which is a legal document that maps out the long term plan for the child's care. This could be that they are to remain in care on a section 31 until they are 18 years old or an ecit route from the care system may be outlined in this document. Possible exit routes before the child is 18 are Adoption, Residence Order or Special Guardianship Order. Parallel planning takes place.

Case example

Jay is an 11 year old boy, who became known to our service via the homeless children and families' service. He was living in a hostel with his mother and younger brother, having fled domestic violence. They had previously lived in two other hostels. He has an older sister who lives with his father.

Jay presented with signs of PTSD and Generalised Anxiety Disorder. He appeared to have taken on an adult role; trying to manage their housing situation, care for his mother who has mental health problems and parent his younger brother. Whilst in the hostel the family was referred to Social Services by their support worker, with concerns about Jay's wellbeing. During this time Jay was not attending school. The plan was initially for the children to remain with mum and the family be supported by social services, whilst an assessment of need took place.

During this time I was working individually with Jay using Cognitive Behavioural Trauma Focused Therapy, building emotional resilience, providing family support via consultation with the family Support Workers at the hostel, liaison with education, liaison with social services and the Guardian ad litum.

Unfortunately, the situation deteriorated and resulted in increased concerns about Jay's safety and emotional wellbeing and the children were removed and placed into foster care under Section 38. 2 Interim Care Order, whilst a Section 47 enquiry is made. Jay currently has weekly contact with his mother. Restraining Order has been placed on father.My current role is to provide emotional support to Jay; helping him to come to terms with being in foster care, and supporting his foster carers to meet his emotional, social and cognitive needs through attending school, clubs and activities and relinquishing his parental role.

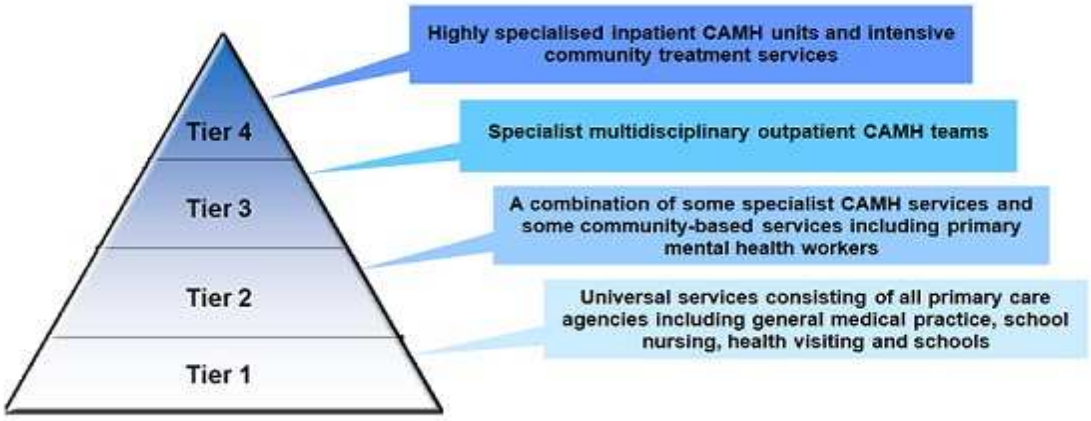
Once in the care system foster care is the most likely destination for children with 80% of children being placed with foster carers. Foster carers receive training and on-going support and supervision. They receive a foster care allowance for each child in placement. There is on-going assessment of their competency to foster which is formally evaluated annually

A further 11% of children will be placed in what is referred to as "connected placements" which is children placed with family (such as Grandparents) or friends. If appropriate family members are available to care for the children this is often seen as the best option as it typically maintains their sense of family belonging in a way that other forms of care are less able to do.

Approximately 9% of children will go into residential care in children's homes. Residential care is generally only used for children who are older than 14 years of age and due to their level of difficulty, foster care is no longer considered a viable option for them. Typically these children have therefore had multiple placement breakdowns before they are placed in residential care.

The Local Authority children's homes are usually approx. 8-10 bedded units, staffed by social workers and support workers. The statutory provision of foster carers and residential children's homes is nowhere near able to cope with the demand, hence a number of independent agencies are also providers of both foster care and residential placements. Independent residential home are usually smaller, 2-3 bedded homes. There are now a number of well established independent providers in the UK.

ORGANISATION OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN THE UK



Every Child Matters (2003) and the National Framework for Children, Young People and Maternity services (2004) defined what was required to ensure children and young people with mental health difficulties receive comprehensive care. These papers set out a 4 tier strategic framework for child and adolescent mental health services (CAMHS), which includes the provision of effective early help services which may prevent problems escalating. The structure and operation of CAMHS can appear complex at first as the organisation differs from traditional mental health services for adults and the majority of physical health services.

The structure of CAMHS is often best explained in terms of how the child or young person accesses the service, with four tiers (or levels) of service provision. There are differences in the levels of support and types of intervention offered in the different levels and also in the commissioning arrangements for the different levels. The principle of the tiered model of intervention is that children's mental health needs should be managed at the **lowest** tier appropriate to adequately address that need, with only the most severe and complex needs being managed at the higher tiers.

Tier 1 (universal services) – these are services whose primary remit is NOT that of providing mental health services, but as part of their wider duties they are involved in assessing and supporting children who may have mental health services. Universal services include General practitioners, health visitors, schools, school nurses, social workers, early years provision (e.g. sure start centres) as well as others. Universal services are commissioned by CCG's and Local Authorities as well as increasingly schools themselves (Academies), and may be provided by a range of agencies both from the statutory and non-statutory services.

Tier 2 (Targeted Services) These include services for children and young people with milder or less complex problems which may be delivered by professionals who are based in schools or in children's centres (e.g school counsellors, educational psychologists) . Targeted services also include early intervention services that are provided to specific groups of children who may be at greater risk of developing mental health problems (e.g. youth offending teams and looked after children teams, Therapeutic social work teams, Paediatric psychologists based in acute settings)

Targeted services are commissioned by CCGs and Local Authorities and schools. They are provided by a range of agencies. Arrangements vary across the county depending on local need and funding streams.

Tier 3 (specialist services). These are multi-disciplinary teams of child and adolescent mental health professionals providing specialist assessment of mental health problems and a range of interventions. Access to the team is via referral from other professionals such as GP, social worker, educational psychologist, but in

some parts of the country referrals may be accepted by schools and increasingly via self-referral. These services are primarily commissioned by CCG's, although there may be a contribution from the Local Authority.

Tier 4 (Specialised CAMHS) these include inpatient services and some highly specialist national outpatient services such as services for children with gender dysphoria, CAMHS services for young people who are deaf. Since April 2013, these services are nationally commissioned directly by NHS England. Access to these services is via referral from a tier 3 CAMHS team.

The majority of CAMHS inpatient units are general adolescent inpatient units and admit young people age 13-18 years with a range of problems, such as eating disorders, severe depression (when deemed to be at moderate-high risk of suicide), psychosis etc… There are also a small number of CAMHS tier 4 learning disability units catering for all ages and degrees of disability, although these services tend to focus on young people with moderate – severe learning disabilities, with young people with borderline-mild level of learning disability typically being admitted to the general units.

LOCAL SERVICES

Leicestershire Partnership NHS Trust is based in the midlands and provides health services for a population of one million people in Leicester, Leicestershire and Rutland. It was created in 2002 to provide mental health, learning disability and substance misuse services.

In 2011 Leicestershire Partnership NHS Trust took on the majority of community based health and wellbeing services for the population of Leicester, Leicestershire and Rutland. The Families, Young people and Children division was formed to bring together a wide range of public health, universal, targeted and specialist teams serving a shared population from birth through to adulthood.

This alignment of services into the tiered model of service provision previously outlined allows for greater integration between services, co-ordination of health needs (physical and mental health) between the levels of integration and a more seamless care pathway. The aligned management and communication systems are set up to try and ensure the systematic failures in communication between services that previous inquires have highlighted do not happen again. The structure is based around better quality care and improved safeguards for children and their families.

Leicester city is one of the most ethnically diverse cities in the UK and is the most densely populated city in the Midlands. It has a population of 329,000 living within the city. 33% of those people were born outside of the UK and moved into the city. 50% of the city residents classify themselves as white with 45% being white British. The next largest ethnic group is Asian, making up 26% of the city population of which 28% consider themselves to be British Indians. 33% of the population are Christian, 18.6 Muslim, 15% Hindu and *** Sikh.
52% of the adult population are in paid employment but there are areas of significant social deprivation were only 31% of the adult population are in paid employment.

Leicester city has the largest proportion of people under 19 with 34% of its population being children. The Local Authority has approximately 500 Looked After children. The city Local Authority have 5 residential children homes, one of which is a specialist provision for young people with learning disabilities.

Leicestershire county has a growing population of approx. 649,000 people. The eastern side of the county is predominantly rural with small villages and market towns, whilst the north and north west is more urban.
Leicestershire county is relatively affluent and in contrast to the city experiences very low levels of social-economic deprivation. 42% of the county are labelled as areas of "prospering suburbs" with higher than the national average household income.

In contrast to Leicester city, 91% of the population in Leicestershire county are white, with the next largest group being Asian at 6.3%. 90% of residents were born in the UK and 60% are Christian.

There are approximately 385 children looked after by the Local Authority from Leicester county. The county local authority have 2 statutory residential children's home. However there are a growing number of independent residential children's homes being opened in the area providing placements for Looked After children from all around the county. The central location of Leicestershire and the fact it borders several other counties makes it an ideal location for the independent sector to establish services.

STRUCTURE OF CAMHS WITHIN LEICESTER

Generic outpatient teams that cover the geographical locations of Leicester city and Leicestershire county. The learning disability team is a specialist team that work with children and young people with a moderate to severe learning disability.

Primary mental health workers have a vitally important role in the successful delivery of a tiered model of service delivery. Primary mental health workers are specialist CAMHS clinicians from a variety of professional backgrounds (e.g. psychology, nursing, social work) They are senior clinicians with a high level of expertise in child and adolescent mental health. The role of the Primary mental Health worker is to work at the interface between universal/targeted services and specialist services. Their role is to support the work of the professionals working at the lower levels via advice, consultation, training, supervision and joint work in order to work in a preventative way and reduce the need for cases to be escalated to the higher tiers. Typically they also spend a proportion of their time undertaking direct clinical work with children with milder problems as part of the effective early help strategy. This work is usually focused and time limited with the aim of being able to hand back to universal services for on-going support and management if required.

THE YOUNG PEOPLE'S TEAM

The Young People's Team was established in 2000 as a result of the Quality protects Programme which was a government initiative aimed at improving the quality of services provided to children who are looked after by the Local Authority, children in child protection systems and other children requiring the support of social services. These groups of children are some of the most disadvantaged in the country, with complex social, educational and health needs. The model of the service was heavily influenced by the recommendations and drivers of that initiative as well as the Every Child matters paper which was published shortly after the team was established. The Young People's team is a tier three specialist team designed to work with children deemed to be at high risk of mental health difficulties and who are also likely to be requiring the support of social services. The higher prevalence rates of mental health difficulties in these populations have been well established in the literature, with the impact of socio-economic disadvantage, social factors such as family dysfunction and conflict, alcohol and substance misuse as well as the impact of abuse, neglect and trauma being well recognised as risk factors for psychological distress and more formal mental health disorders.

Issues of child protection and safeguarding are key issues in these populations. Homeless children are frequently children who are fleeing domestically violent homes and who are often living in exceptionally difficult social environments. The transitory nature of their accommodation puts them at increased risk of statutory services being unaware of their whereabouts and therefore less able to monitor their wellbeing. The last 50 years of criminological research has confirmed exceptionally high prevalence rates of various kinds of abuse, neglect, deprivation and misfortune in young people who offend. They have complex needs, some with a history of substance misuse, mental health needs and disrupted family backgrounds. Children removed from their family of origin and placed within the care of the Local Authority have theoretically been removed from those abusive environments, however we know the legacy of their past continues for many and indeed they remain vulnerable to on-going safeguarding issues, e.g. multiple moves within the system, increased risk of childhood sexual exploitation etc.. Adoption signifies one of the most permanent and potentially stable exit routes out of the care system. However children adopted from care have a range of needs sue to their early life experiences which are not resolved simply by being adopted. The adoption act recognises the need for post adoptions support however recent figures suggest that approx. 9% of adoptions breakdown, with violence within the adoptive home being cited as one of the main reasons for this (predominantly challenging behaviour and violence from the child with parents feeling unsupported and unable to parent- risk of this leading to more punitive and potentially inappropriate parenting strategies).

The Young People's Team is unique within the CAMHS structure, as it is the only team in the service that is jointly funded by health and social services. All the members of the team are employed by the health service and managed within that structure but the strategic vision and direction of the team is a joint initiative. The team is made up of psychiatrists, clinical psychologists, community psychiatric nurses and primary mental health workers. We also have trainee clinical psychologists, trainee specialist registrars and student nurses on placement with the team.

The role of the Primary Mental health worker is key to the strategic vision of the young people's team. The team needs to be able to respond in a helpful way to children often living in unstable and chaotic social circumstances, children in transition and children who are difficult to engage in services. The traditional organisation and referral route into mental health services has historically meant that often the young people who need mental health services the most are the least likely to engage in mainstream services.

Primary Mental Health workers have two key roles that try and address these issues.
The first is that of developing community capacity to manage mental health difficulties in young people by skilling up and supporting those people who are working and caring for children and young people on a day

to day basis by offering advice, support, consultation and training to those people. The team therefore offers training and group work on a variety of subjects to the carers and other professionals involved in the lives of these young people, such as the impact of abuse and trauma, the impact of neglect on child development, working with children who have been sexually abused, working with children who self-harm and mental health awareness. Regular "consultation clinics" are also offered as well as an advice line for professionals. Each of the statutory Local Authority children's home have a Primary Mental health worker attached to them who will go to the home, at least monthly, to meet with the staff, discuss any concerns they have regarding any of the children within the home and offer advice about mental health issues in general.

The second role is that of assertive outreach and trying to engage, to some degree with children and young people at significant risk of having mental health difficulties but who are unlikely to engage in mental health services. This has resulted in a range of creative projects that children and young people are more likely to tolerate and be willing to engage in. e.g. the "zone", street dancing group, fitness groups. These projects allow mental health professionals to interact with young people and develop relationships with them. Some metal health difficulties can be managed at this level but the relationships developed with the Primary Mental health workers mean that these young people are more likely to engage with the rest of the team should that be required.

Typically the children that are referred to the team have difficulties that can be understood by conceptualising them into three main, overlapping categories.

Many of the children we see are deemed to be at risk of mental health problems due to the inconsistent, unresponsive, insensitive or even abusive parenting that they have received as very young children and the impact that this has had on their social and emotional development. Attachment theory is hugely helpful in helping us to conceptualise these difficulties as well as giving us direction in how to intervene to ameliorate some of these difficulties. Interventions which try and address specifically attachment difficulties include interventions that help parents and carers to understand the impact of early developmental history on children's attachment relationships and general development, interventions such as theraplay which aim to strengthen relationships and interventions which help children to question and challenge some of the attributions about relationships that they have made.

Case Example

The majority of the children we work with in the Young People's Team have a history of neglect, abuse and trauma, which has affected their capacity to form and maintain close attachment relationships. This relates to their beliefs about themselves, others and the world around them, which has been shaped by their early experiences.

Let me introduce Martin. He was 9 years old at the time of referral. He was referred for assessment of behavioural problems; lying, stealing, breaking his own and others' possessions, over eating, hoarding food, and frequent angry rages. He was having problems at school with making friends but was academically on target. Martin had been adopted aged five. He had a history of chronic neglect and abuse before being placed in foster care aged three. He had two foster placements before being adopted. Martin presented as a bright articulate serious boy, who believed that he was 'bad', and that ultimately his adoptive parents would give up on him. Martin had low self-esteem, blamed many external factors for his behaviours; seeing other people as 'mean' and life as 'unfair', which indeed it had been to him. He struggled to see much good in himself, and therefore struggled to believe that others saw him as good and special.

After the initial assessment using clinical interview, questionnaires and liaison with school, a treatment plan was agreed. It began with inviting Martin's parents to attend an eight week (one morning a week) training group for adoptive parents exploring and understanding the Impact of abuse and trauma on the developing child and its implications for parenting. This group aims to examine the role of attachment in child development and how early trauma and neglect disrupt this process, the impact this has for the child socially, emotionally and cognitively and how to adapt traditional parenting approaches to meet the needs of the child.

Martin's parents reported that they found he group very helpful in understanding Martins behaviour, they felt more empathic and compassionate towards him, and felt better equipped to deal with some of his challenging behaviour.

The next stage of treatment was Dyadic Developmental Psychotherapy (DDP) Dan Hughes developed this approach in the United States in (2003). This is treatment for children with Complex Trauma and disorders of attachment. It is based on the work of Bowlby and Stern. DDP involves creating a "playful, accepting, curious and empathic"(PACE) environment in which the therapist attunes to the child's subjective experience, co-regulates their emotions and co-constructs an alternative narrative

We began by gently exploring some of his behaviours and how they may be linked to beliefs about himself and other people because of what he had experienced as a younger child. We considered some of his false beliefs about his adoptive parents and

Continued…
his mother was able to challenge these and provide evidence to the contrary, whilst also acknowledging his anxiety and empathising with how distressing it must be to have these thoughts and feelings. Alongside this his parents worked on his emotional literacy i.e. understanding facial expressions and feelings. DDP continued fortnightly for six months. Martin also attended a social skills group which helped him to understand the social rules of play and friendships in a supported environment.

At the end of treatment Martin's behaviour had improved; he had stopped taking food, his lying was less frequent, his parents reported feeling that their relationship with him was improved- they were able to have fun, and enjoy spending time together. School remained difficult but he had begun to attend a nurture group at school to help him build friendships.

Another frequently used intervention with children who have experienced trauma and neglect is Theraplay. This technique is used to replicate healthy parent-child interactions in order to build healthy attachments. It is a short-term structured approach that is physical, personal, engaging and enjoyable. The Marshack Interaction Method (MIM) is used to assess four dimensions of the parent-child relationship; these are structure, engagement, nurture and challenge. Subsequent theraplay sessions builds on the strengths of the relationship and addresses the difficulties through helping the parent attune to their child.

In addition to the impact early experiences have had on attachment relationships, some of the young people's presenting difficulties are not addressed purely by addressing relationship factors with current carers. Developing these positive attachments certainly can act as a protective factor and make it more likely that they can engage in other therapeutic work. Some of the young people referred into the team have developed mental health or psychological difficulties due to other factors and these need to be addressed independently of the work done on addressing attachment difficulties. Due to the nature of the client group we see, we are often working with trauma, e.g. witnessing domestic violence, war trauma etc… and frequently work using trauma focussed CBT, narrative approaches or EMDR to address symptoms of PTSD. Clearly these two categories are not mutually exclusive, as we are often seeing young people who have experienced trauma in the context of an attachment relationship

Case Example

Phoebe was a 14 year old child who was in foster care. She was referred to the YPT by her social worker due to concerns about her behaviour- social withdrawal, self-harm, and poor school attendance. She had been removed from her birth mother 6 months before referral to our team, due to her mother's failure to protect Phoebe from her violent partner, and maternal use of drugs and alcohol.

At assessment Phoebe said she was having difficulty sleeping due to intrusive images of her mother's partner assaulting her. In an attempt to avoid these images Phoebe was trying to stay awake, which led to her being tired and reluctant to attend school. She described feeling paranoid i.e. that people were talking about her so she had begun to withdraw from social situations. She described physical symptoms of anxiety and she self-harmed in an attempt to manage her distress.

A treatment plan was formulated to primarily address her symptoms of Post Traumatic Stress Disorder. She undertook 18 sessions of Eye Movement Desensitization Response (EMDR) with a good response in reduction of intrusive images, Cognitive Behaviour Therapy to address her anxiety, and she attended a social skills group within school. PMHW's supported her foster carer in understanding and managing Phoebe's behaviour, particularly with regard to her self-harm. Treatment lasted overall approx. 14 months with an overall reduction in symptoms, and increased attendance and engagement in school.

Due to the nature of the client group we see, many of the children have been exposed to multiple risk factors that may have an impact on their neurodevelopment, e.g. exposure to drugs and alcohol pre-birth, severe neglect, Traumatic brain injuries etc.. Some of these children may fulfil the diagnostic criteria for a neurodevelopmental disorder such as ASD or ADHD, but many of them do not fulfil these strict diagnostic criteria, despite clearly having difficulties. Specialist psychological assessments can help identify in which specific areas a child's neuro-development has been compromised and specific guidance and advice can be given to carers and, perhaps more importantly to schools. The education system is the system where much of the rehabilitation takes place but it is a system which is largely untrained to assess, identify or know how to manage such difficulties without support.

Case example

Jamie was an 11 year old boy who was adopted along with his twin brother Robbie when he was two and a half years of age.Jamie's birth mum was well known to social services, having had a care history herself as a child. She had problems with alcohol and drug use. She did however accept pre-natal care and worked with drug and alcohol services to limit her usage during pregnancy. After the birth of the twins a comprehensive support package was put in place due to concerns about mums ability to care for the boys. Her parenting skills were very limited and her engagement with services was inconsistent. Mum reported to find Jamie hard to bond with, saying he was a quiet and unresponsive to her. When Jamie was 20 months old, mum called the emergency services saying that he had stopped breathing. The paramedics were able to revive him at the scene and he was admitted to hospital. His injuries appeared to be consistent with being shaken. He had other injuries that were considered to be non-accidental. He was in a medically induced coma for a week whilst the swelling in his brain subsided.

Jamie and Robbie had two foster placements before being placed with their adoptive parents at age 2 years.Jamie was referred to CAMHS initially due to parental concerns about his mood. He was described as "flat" with little expressed emotion. He had very few friends and preferred to play alone. He was academically average but found it difficult to organise his work and often got overwhelmed by school work. This was in contrast to his twin brother who was described as academically gifted, accomplished at sport and very popular amongst his peers.
During assessment it was felt that there was no evidence of a low mood but rather Jamie appeared to be presenting with signs suggestive of a neurodevelopmental disorder. A battery of neuropsychological

tests were undertaken which highlighted some very specific learning needs as well as executive functioning difficulties.Jamie also had significant difficulties in the areas of social and emotional communication. He also had some intense and obsessive interests and preoccupations. A formal assessment of Autistic Spectrum Disorder was undertaken, which included clinical interview, school observation, theory of mind assessments, assessments of social and emotional functioning and an ADOS assessment (which is a structured observation). Following which Jamie was given a diagnosis of Aspergers Syndrome.

The intervention plan for Jamie was that detailed assessment of his learning needs were provided to school with recommendations as to the support Jamie would need. In addition a referral to Autism outreach was made who are a service who will go and work with schools to help them support young people with a diagnosis of ASD. Jamie was maintained at mainstream school with additional support. Jamie was also able to find an opportunity to make use of his technical interests as the school supported him to join a drama company to do the sound and lighting for their productions.

Work was done with Jamie's parents and also Jamie's brother to help them to understand and adjust to Jamie's needs- psychoeducation group for the parents and 2 follow up family sessions. Following this work, parents accessed support through the National Autistic Society and made social links with other families with children with ASD.

Jamie attended a group at CAMHS for children with ASD called "navigating the social world" to develop his social communication skills.

REFERENCES

Luke, N, Sinclair, I, Woolgar, M and Sebba, J (2014) What works in preventing and treating poor mental health in looked after children? NSPCC

Vostanis, P and Cumella, N. (1999) Homeless Children: Problems and Needs.

Vostanis, P, Grattan,E and Cumella, S (1998) Mental health problems of homeless children and families: longitudinal study. British medical Journal. Mar 21, 1998: 316(7135): 899-902

Vostanis, P (2007) Mental Health Interventions and Services for Vulnerable Children and Young People.

Vostanis (2014) Helping Children and Young People Who Experience Trauma: Children Of Despair, Children Of Hope

Hughes, D (2009) Principles of Attachment-Focused Parenting: Effective Strategies to Care for Children

Golding, K. (2012) Creating Loving Attachments: Parenting with PACE to Nurture Confidence and Security in the Troubled Child

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