Example of Interagency work and school liaison

BK

14 year old girl, only biological child of Mum and Dad, who separated when BK was 8 years old. Dad has older daughters from previous relationships. Mum from China, Dad older from the UK. BK has issues about her identity and struggles with thoughts of being different. BK doesn't speak Chinese, Mum needs an interpreter. BK previously known to CAMHS.

BK was referred by GP due to being described as a vulnerable young woman, taking part in risky behaviour, and experiencing suicidal ideas. The school had already initiated the Team around the Family (TAF) process involving Young Addaction, YPS, school and Mum. By the time CAMHS were involved so were social care and that meeting had been escalated to a Child in Need (CIN) due to domestic violence from BK towards her Mum and because BK was going missing and being found by Police in Liverpool in her 18 year old boyfriends house.

BK refused to attend the initial assessment appointment on 01/12/14 but attended a follow up appointment. At that time BK was living with Mum. Our service recommended family work that can be done with BK and her mum to improve their relationship.

After BK attended she was asked BK to keep a diary of anything that was keeping her awake at night and any worries she may experience before the next session. After Christmas BK presented in school as very upset.

I did a joint visit with social care and the result was a private fostering arrangement with one of BK's friends.

BK now reporting an increase in mood but reporting hearing voices. Family therapy or Video Interaction Guidance (VIG) still indicated between BK and Mum. Social care doing work on family relationships and parenting support.

JA

Aged six years. Example of joined up working with Social Care and Education. J has a life limiting illness as was born without a short bowel. This means lots of extra care at home and he doesn't eat. His mum is young, was adopted herself and has two older children and one younger. For as long as she has been a parent there have been come concerns around low level neglect. The two fathers of the 4 children offer no support or contact.

Original referral was around offering some work to improve the attachment in order to improve the behaviour as he was out of control when in hospital and this was impacting on his health and the decision as to whether he could have a transplant. Initially a piece of work with the Mum using VIG made a big difference to her ability to tune in to his needs and respond more sensitively to his distress (not easy when you have to do carry out painful procedures for your own child).Quite quickly the child was called for transplant where the mum and J had to live in Birmingham hospital for several months.

Social care were already involved for his health needs but CP got involved for the three siblings as they went to live with their maternal Grandfather. At this point, the action plan on the CP plan was that all three children should be referred to CAMHS for "support around the separation and loss".

Even though my piece of work had really concluded with J and his Mum and I was tempted to close I decided that this wasn't helpful to the professionals involved with the four children and wasn't going to help CAMHS if all three were referred for various different presentations. I was under some pressure to facilitate the referral but felt really strongly that this was not the way to go. So, I explained why I didn't think a referral for CAMHS for each child was helpful to them, their granddad or services.

Once I had won this battle I offered to do group consultation to the Social Worker, Family Support Worker, Edge of Care worker and School staff about the needs of the three children. We met for two group sessions where we mapped their needs, concerns about them and Granddad and used this time to action plan what everyone was going to do without the children being referred to CAMHS. This was effective in that the children needed stability and routines and nurturing and contact with their mum and brother but they did not need CAMHS.

I thought it was a good piece of joined up working to do the right thing for the kids and not use up resources that weren't necessary. Following these two consultations I went back to Core Group and told them I was discharging J. There are ongoing issues around safeguarding in that the mum doesn't have capacity to meet the needs of all four children at once and the boy is still in hospital but I said these were safeguarding decisions rather than clinical psychology or CAMHS ones.

Example of Service development through outreach to schools (ELCAS)

A number of local high schools over the last couple of years have identified pockets of particular need for young people with mental health disorders. Over a similar timeframe, within the service we were identifying higher than average referral rates from local schools/GP practices all linked to a couple of specific areas within East Lancashire.

Following discussion with one of the local high schools, we agreed to provide further input into the schools, to work alongside the teaching staff and offer a resource for teachers who had concerns about pupils to "drop in" and talk through their concerns. The worker was also able to sit in classes and do some basic classroom observations of young people (with parental consent) to identify those where further mental health intervention may be required.

As well as being able to identify young people who require Tier3 mental health services, it has also meant that young people have been able to be identified more quickly and managed in primary care with support rather than requiring referral on to specialist services.

As part of this we are also involved in school open days and school road-shows for the schools we are involved in both for pupils and for other professionals and parents.

Appendix B
Examples of improved involvement and interactivity with schools

We offer an open consultation system to schools who can ring within the working day and speak to a team member of Team-Co-ordinator to discuss any issues they have regarding children who are both referred and non-referred. This is helping with quicker referrals and more speedy response to children and families.