

When Amy was

- 12, was diagnosed with Autism
- 13, was assaulted and bullied
- 13, refused to go to school, had severe anxiety and was self harming
- 14, admitted to West Suffolk Hospital
- 15, assessed by psychiatrist due to further attempts to self harm and suicidal thoughts Amy was transferred to a Local Independent Hospital for Acute Mental Health as an Informal patient and later detained.
- 16, during a home visit, detainment paperwork lapsed at the start of pandemic and was unable to return to hospital
- 16, detained and admitted to a Mental Health Hospital 130 miles from home
- 16, was sexually assaulted when out on a home visit
- 16, detention and admission ended, and was discharged from hospital
- 16, 1:1 Community Support Package put in place
- 17, Regular support worker and psychiatrist left
- 17, admitted to local hospital transfer to hospital 130 miles away
- 17, discharged after 6 weeks and self harmed on way home
- 2 Months late admitted to local hospital cared for in ITU sedated for 10 days
- Discharged with safety plan

I want to live a normal life

I do not want to be in hospital

I want to sit my GCSE's

I may want to work in the police

Challenges

- The Local Authority has little education information whilst Amy was in secure hospitals
- EHCP was not issued until Amy was 16
- Social Care Involvement was not until 15 (despite previous referrals and assessments)

Involvements

- 8 Education Settings (not including Hospitals)
- 4 Different mental health hospital/wards
- Local Authority - Family Solutions, Social Care, Family Services
- Health, MDT, Psychiatrist, care coordinator, CETR NHSE & CCG
- Schools
- Police

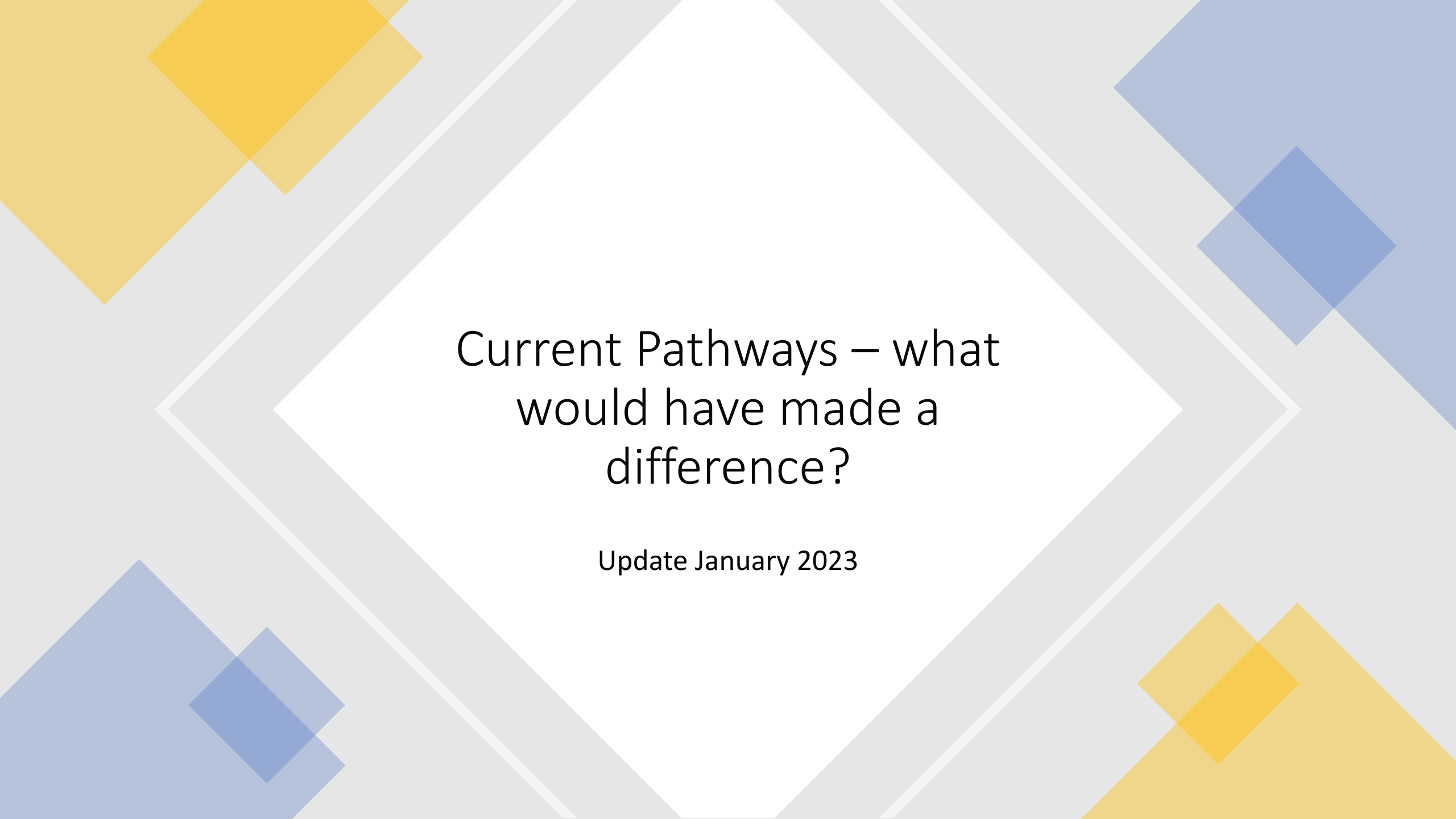
Learning Points

- How can LA services be more involved in Education when commissioned via Health?
- What could have been different for Amy at home?
- Amy feels at no point has the provision agreed in her care plan been provided?
- Workers Amy has built up relationships with have left – where was the transition
- What happens now Amy is 18?
- Does Amy have Section 117 After care order?

And Now Amy is

- in Education 4 days a week,
- has made a few friends
- lives at home but wants to move out
- has not been admitted to hospital for 8 weeks
- Taking time to develop coping mechanism and will be starting DBT





Current Pathways – what would have made a difference?

Update January 2023

Health

- **Mental Health Support Team (MHST)**
- Specialist MH support to education setting to aid containment and educational response
- Early intervention for mental health need
- Fast track escalation to community MH Team
- Development of whole school approaches to deliver interventions proactively across school communities

Intensive Support Team

- Specialist assessment, formulation and intervention for CYP with LD/NDD
- Primary focus is to prevent care, accommodation and educational breakdown, usually as a result of behaviours of concern.
- Remit to try to prevent unnecessary mental health hospital admission.
- **Dynamic Support Register (DSR) and CETR's**
 - improved and regular joined up working between Health Education And Care where complex needs or more support required by CYP with LD and/or A
 - Understanding of unmet needs to commission enhanced support for the YP where gaps identified
 - Independent review through CETR, follow up and oversight of ensuring CETR recommendations are delivered
 - Support and join up of services when a young person is 18
- **Childrens Alternative To Admission Team (CATAT)**
 - Responsive specialised home treatment service as an alternative for T4 admission

Health cont.

- Peripatetic Support Offer
 - Flexible and personalised support for CYP in their home or other community environment to meet needs for enhanced support and to avoid admission
- Tier 4 Monthly Review with Provider Collaborative
 - Regular joined up working between Health Education And Care where CYP admitted or leaving Tier4 care
 - Referrals to CYP services facilitated
 - Educational needs and planning for discharge highlighted and supported in YP's place of education by SCC with DCO
 - S117 planning triggered and supported leading to enhanced support planning in community
- Care Navigators
 - All CYP with and LD/A on the DSR have an allocated Navigator supporting the CYP and Family/carers through their care journey
 - Navigators role to challenge and escalate barriers where care not being delivered on behalf of the family/CYP across

Education

- Education Health & Care Needs Assessment, improvement of process and panel with introduction of ways forward meetings and panel approach being more person centred/
- County Independent Panel has a different approach in that they consult for Specialist Independent and will also set and follow up additional actions as identified by the professionals on the panel
- Increased support for schools on Assess, Plan, Do, Review and the Graduated Response
- Termly visits to Schools from Specialist Education Services
- Family Services having allocated 'cases' to follow up and support the CYP through their journey

CYP Services

- Support from Designated Social Care Officer (DCSO) to Social Care and Early Help practitioners
- Designated Clinical Officer & DSCO in attendance to DSR meeting and linked in with Social Care
- SEND Champions now available to support across Early Help & Social Care
- Social Care in attendance to EHCP Area Panel and County Independent Panel
- Care act assessments now completed by the transitions team for young people in Adult services for Learning Disability, Autism, physical disability, acquired brain injury and mental health
- Support can be requested by lead professionals to the CHRIS Service
- Transforming Care Navigators would now support YP on the Dynamic Support Register

What difference have they made?

- CYP with Mental Health needs have access to a greater range of needs led support which are available for all young people
- A child or young person would have been in contact with services earlier in their journey
- Consistent and regular opportunities to come together as a system meaning that a child's care can be 'held' and the system can respond quickly
- Unmet need being identified and planned for through personal health budgets
- Impact upon admissions/admission avoidance due to greater community support
- The Provider Collaborative in place from July 2022 seeks to avoid out of area (region) hospital admissions for CYP
- The Dynamic Support Register enables concerns to be picked up earlier

We still need

- What we need to know more about is if CYP and families are reporting that they feel more supported or have confidence their needs are being met and that these services are making a difference to their experience of treatment (education and care). How would we know this? What are we doing about it?
- Improve the post diagnosis offer for CYP with ASD to ensure social/emotional needs are met.