THERAPEUTIC SUPPORT FOR LOOKED AFTER AND ADOPTED CHILDREN
ANNUAL REPORT

1 APRIL 2011 – 31 MARCH 2012
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INTRODUCTION AND OVERVIEW:

Introduction:

This is the first Annual Report completed for Therapeutic Services for Looked After and Adopted Children. Therapeutic services have long been recognised as a key ingredient in responding to the needs of these children, their caregivers and the staff who work with them. In the past, local therapeutic services (including family centres, CAMHS, Community services etc) had more flexibility in terms of the way they worked and have been the main providers of therapeutic support to this population. In recent years, however, the financial climate has resulted in service contraction and greater difficulty accessing such services in a timely manner. In addition, there has been a growing awareness of the need to develop specialist services owing to the complexity in both the children and the corporate parenting environment within which they live.

Recent years has seen the development in NHSCT of some dedicated therapeutic posts for this population determined by local service needs. Restructuring within Children’s Services has provided an opportunity to develop a corporate strategy for the therapeutic support to LAAC. A key component of this has been the consolidation of the dedicated therapeutic posts into a specialist therapeutic team.

There are clear advantages in developing a specialist TT-LAAC including improved governance, equity of service provision Trust wide, Improved Quality of service provision and closer attunement to referral agents needs and a reduction in drift.

It also enables a realistic appraisal of what therapeutic resources are available and how best to use them. This is particularly important in the context of increasing pressure on Children’s Services owing to financial strain, service re-organisation and growing LAC (20% increase on last year) and Post Adoption populations.

A key element of future strategy for therapeutic provision for LAAC is attention to the interfaces this team has with the multiple services involved with LAAC and how to manage these interfaces in ways that are in the best interests of children and the limited resources available.

There are multiple elements to Therapeutic Support to LAAC. In this report I have focussed on Implementing the CARE model (objective 1), operationalising the Therapeutic Team for Looked After Children (objective 2) and the Implementation of Pilot Project: Screening of Emotional Health and Wellbeing of LAAC on entry to care (Objective 3).
OBJECTIVES FOR 2011/2012

There were a number of key objectives for this period:

Objective 1: Pilot of Therapeutic Model in Residential Childcare: Children and Residential Experiences (CARE) Model of Best Practice.

In response to a Departmental initiative, NHSCT have been involved in piloting the CARE model of best practice within its residential childcare sector since early 2009.

Following a regional launch on 1/04/2009 when Martha Holden (Director of Residential Childcare Project, Cornell University) introduced the principles behind the model, we formalised a steering group chaired by Judith Brunt (Head of Service, Residential Childcare). We developed a 2 year implementation strategy for training all levels of management (AD, HoS, SWSM, Team leaders) and staff within NHSCT residential care and also in Linden Services. We also provided orientation training to Family Placement teams and LAC Team leaders so they would be familiar with the model.

The Department had funded the Social Care Institute of Excellence (SCIE) and Queens University of Belfast (QUB) to evaluate the different therapeutic models being piloted in each of the Trusts. Their final report was made available in April 2012 and there was a Regional Launch at Stormont in May 2012.

In brief, the authors acknowledged serious methodological issues in undertaking the evaluation including the lack of universal measures of change and standards for implementing the models across Trusts. While the report was limited in its scope it did conclude that there was evidence that having a therapeutic model was significantly better than having no therapeutic model. It was unable to comment on the efficacy of each of the models relative to one another, although it usefully outlined some of the features shared by all models. It acknowledged that no residential therapeutic model was in and of itself sufficient to address all the therapeutic needs of children in residential care and that residential care ought not to be considered in isolation but as part of a network of services these children need to access. In addition it commented on factors that contributed to implementing the models.

Informal feedback from those in NHSCT trained in CARE is that it has been very helpful for practice. Evidence of its value can be found in multiple projects including the Barncourt Children’s Photography exhibition, The PAL project’s DVD for children entering residential care and the DVD of CARE made by Linden Services. Some of these were presented at a Celebration of CARE event in Autumn 2011 when Martha Holden and staff from Cornell had their final visit with the Trust.

While each of these projects are important in their own right, Senior Management within LAAC recognise them also as signposting a change in culture within residential care. Traditionally in residential care there has been

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1 See Appendix 1 for context.
a very strong emphasis on behaviour management techniques to control children’s behaviour. While such techniques are necessary in childcare, CARE training has introduced complementary knowledge and skills. Now staff appear to be more empowered to utilise the relationships they have with children in the best interests of the children, seek the children’s personal strengths (as well as identifying the challenges they pose) and put in place scaffolding where developmental deficits are identified.

There has also been positive feedback from RQIA and Juvenile Justice about Residential Care in Northern Trust during this period.

The two year implementation strategy for CARE in NHSCT, and departmental funding, came to its conclusion in March 2011. From a Trust perspective, CARE has been a success insofar as it allowed us establish a baseline expectation for staff in residential care about their role with young people. This, in turn, has served as a platform for addressing many longstanding issues including appropriate management of children’s homes, differentiation of units purpose and function and expectations of other services that provide into residential care.

NHSCT is committed to the CARE model and have (in keeping with other Trusts in NI) dedicated an existing residential senior practitioner social worker post (available due to retirement of staff in autumn 11) to the continued implementation of the model. The post was trawled among social work staff and we appointed Gerard Donaghy in Spring 2012.

This post is managed by Cathy Jayat (Principal Practitioner) who has taken over the chair of the CARE steering group. The CARE steering group has been reorganised and is now comprised of Cathy Jayat (Chair), Judith Brunt (HoS), Dr William Coman (Consultant Clinical Psychologist), Tracy Magill (SWSM), Catherine Cassidy (SWSM), Briege Bradley (SWSM), Sean McIlmum (SWSM) and Sharon Crawford (SWSM, fostercare) and Gerard Donaghy (SP).

**Objective 2: Implement the Proposal to establish a Therapeutic Team for Looked After and Adopted Children (Dr W Coman, October 2010).**

The Therapeutic Team for Looked After and Adopted Children (TT-LAAC) started accepting referrals on 1/08/11. At that point in time the service was staffed by 1.8wte professional staff and had no admin support. The primary goal was to address staffing issues and develop processes for the safe and efficient management of the team.
<table>
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<th>OBJECTIVE</th>
<th>OUTCOME</th>
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<td>1. Recruit staff</td>
<td>TT-LAAC now has 4.55wte professional staff and 1.0 wte admin support. The staffing was largely a reconfiguration of existing resource using the Management of Change Process. Some additional funding was provided by the Commissioner for 0.5 wte Clinical Psychology to provide post adoption therapeutic support. Currently, we can only access 0.5 wte admin support as Kathleen McErlane is also providing to Amber McCloughlin (Named Nurse for Safeguarding Children).</td>
</tr>
<tr>
<td>2. Governance Structure</td>
<td>See Appendix 2</td>
</tr>
<tr>
<td>3. Accommodation</td>
<td>TT-LAAC is based in Alder house; 1 SP is based in Coleraine Family Resource Centre and 1SP in Antrim SS</td>
</tr>
<tr>
<td>4. Team Procedures</td>
<td>There is a robust referral management system in place. This includes a single point of entry to the service and screening of referrals to aid decision making. There is a waiting list management and allocations process and case review process in situ. Filing, Recording and Admin Processes are in place. Staff receive monthly clinical supervision to ensure the quality of their work and there is a PRDP in place for all staff.</td>
</tr>
<tr>
<td>5. Remit for team</td>
<td>The purpose of TT-LAAC is to support children services increase placement stability for children in care or post adoption. Placement stability is associated with improved outcomes in health, mental health, education, and other indicators of wellbeing for children in care, post adoption and care leavers. Specifically, the purpose of TT-LAAC is to increase attunement to children’s emotional health and wellbeing and to support the development of this aspect of functioning. TT-LAAC is meant to supplement, rather than replace, the existing infrastructure for support to children in NHSCT.</td>
</tr>
<tr>
<td>6. Training strategy</td>
<td>This has been developed with Social Services Training Department to complement staff skills with additional knowledge and skills for extended team remit.</td>
</tr>
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**Objective 3: Continued Implementation of Pilot Project: Screening of Emotional Health and Wellbeing on entry to care**

This Pilot project was operationalised in September 2009. It is a collaboration between the Family Resource Centres, Clinical Psychology and the Principal Practitioner for LAC. The focus is to attend to the emotional health and wellbeing of LAC on entry to care, anticipate the supports they require and advise the statutory social worker accordingly. The pilot was extended to Linden Residential Unit in Spring 2010 once this unit was identified as the Assessment Unit for the NHSCT.

The Pilot was initially well received by staff and there has been positive feedback also from the Guardian ad Litem agency about work completed. The context within which the pilot was developed has changed, however, with organisational restructuring and the development of TT-LAAC and significant revisions are required.

One part of the proposal for the establishment of a Therapeutic Team for LAAC was that the therapeutic provision by family centres be crystalised and re-located, along with the remit for same, into TT-LAAC. While this was acknowledged as useful, there have been significant delays in progress owing to the context within Family Resource Centres.

More recently, however, there has been agreement that the Family Resource Centres will transfer 1.2 wte staffing to TT-LAAC and will no longer accept referrals for therapeutic work for LAAC; referrals will now be redirected to TT-LAAC.

It has been agreed within LAC SMT that this resource will be a Senior Practitioner Social Worker who in addition to managing a caseload, will have the remit of revising the screening project and attending to the interface with other agencies (Paediatrics, Health visiting and CAMHS).

The transfer of staffing will be achieved through the Management of Change process and it is hoped the resource will be available in Autumn. In the interim, the screening pilot will continue but it will be stood down once the staff transfer is complete.
On 1\textsuperscript{st} August 17 referrals from legacy services were transferred to TT-LAAC. An additional 22 referrals were received in the course of the month.

Over the 8 month period there were 169 referrals received in total. After some initial work by the referral co-ordinator, 22 required no further action from TT-LAAC. Some were duplicate referrals to CAMHS but the vast majority were referrals for the Pilot Screening service where the referring Social Workers had interpreted the referral criteria as indicating that all children coming into care should be referred for screening.

22/169 referrals were managed using the Pilot Screening of Emotional Wellbeing Service.

2/169 referrals were managed using a joint consultation with CAMHS to determine which service was most appropriate to manage the case.
Figure 2: The source of referrals:

It can be seen that the vast majority of referrals were made by FSIT and LAC Teams.

Seven referrals were made by the Post Adoption Team and this figure is lower than one would predict given the need post adoption. That said, TT-LAAC facilitate a case supervision group for the Post Adoption Team on a monthly basis and this is expected to reduce the need for some referrals for consultation. It is important to contextualise this also in the excellent work done by the Adoption Support Team:

“The Northern Trust is acknowledged as being the most successful Trust in Northern Ireland in the recruitment and support of adoptive carers. In the audit of child care services conducted by Ernst and Young in 2011, they commented that the adoption recruitment processes and support practice was amongst the best they had seen in the United Kingdom” (Foster care services and foster Panel Annual report, 2012, p.11)

Four referrals were accepted from the Children’s Disability Team. While the referral criteria for TT-LAAC excludes children with an IQ below 55, it was felt that the presenting issues would best be dealt with by TT-LAAC in these cases. 3 were a sibling group and all four children required an age appropriate explanation for being in care. There was a high degree of complexity surrounding the cases.
Table 1: Referrals by Geographical Area

<table>
<thead>
<tr>
<th>Area</th>
<th>FSIT</th>
<th>LAC</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Antrim</td>
<td>18</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Ballymena</td>
<td>13</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>Newtonabbey</td>
<td>11</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Cookstown/Magherafelt</td>
<td>17</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Larne/Carrick</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Causeway</td>
<td>9</td>
<td>8 (LAC1)</td>
<td>28</td>
</tr>
<tr>
<td>CDT</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>16+</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Adoption Support Team</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>169</td>
</tr>
</tbody>
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It can be seen from Table 1 above that TT-LAAC has provided a Trustwide service. Particularly high rates of referral in some areas appear to reflect a wider issue of exceptional pressure on those teams currently.

Table 2: Referrals by Placement

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<thead>
<tr>
<th>Category</th>
<th>FSIT</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>NHSCT Foster Carers</td>
<td>74</td>
<td>42%</td>
</tr>
<tr>
<td>Birth parent</td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td>Residential Unit</td>
<td>16</td>
<td>10%</td>
</tr>
<tr>
<td>Kinship</td>
<td>41</td>
<td>25%</td>
</tr>
<tr>
<td>NHSCT Specialist Foster Carer²</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Dual Approved</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Adopted</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td>Independent Service Provider</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>Secure Accommodation</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Specialist Residential</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Shared Care</td>
<td>2</td>
<td>1%</td>
</tr>
</tbody>
</table>

The vast majority of referrals are for children placed in foster care and kinship care.

Cathy Jayat (Principal Practitioner) provides monthly consultations to each of the residential units and this helps determine which children from the Units gets referred onward to TT-LAAC for direct work – these are not treated as referrals to TT-LAAC in and of themselves. Cathy completed 36 consultations during this period; 16 Children in Residential Care were referred on to TT-LAAC.

² The term Specialist Foster carer refers in this instance to two Social work qualified Foster carers.
Only 3 children were referred from secure accommodation – this refers only to those children referred while placed in secure accommodation; some children are referred prior to or after secure placement. Those in secure accommodation, however, can access therapeutic support from Lakewood and do not necessarily receive support from TT-LAAC. Given there is a 12 week waiting list for TT-LAAC, however, referrals are encouraged at admission in order to ensure timely access to TT-LAAC and support on return to the community.

There is a service dilemma in extending TT-LAAC to Independent Service Providers. In some cases they have their own therapeutic support service (ie: Foster Care Associates have a Psychotherapist). In some cases the placements are located outside trust boundaries adding significantly to costs (travel and time resource).

Figure 3: What happened to the referral

123/169 referrals to TT-LAAC were managed by consultation in the first instance; 72 of these required further therapeutic input by TT-LAAC post consultation (approximately 58%).
OTHER ACTIVITY

Post consultation activity: At present there is no data system in place for gathering information about the therapeutic work undertaken by TT-LAAC post consultation. It is hoped this issue will be addressed by implementing EPEX over the coming year.

Court Work: The nature of LAAC service is that many children are involved in care proceedings and the work of TT-LAAC is often before the courts. This is an interface that can require considerable time in terms of reports and attendance at court on occasion.

Training Given: TT-LAAC provide a range of training both through the Social Services Training, ACPC, to foster carers through the Recruitment and Initial Assessment Team and to residential childcare staff through CARE events.

TT-LAAC are also involved in the strategic development and support of training. For example, Cathy Jayat (Principal Practitioner) leads on the CARE program. Dr Coman leads on strategy for Dyadic Developmental Psychotherapy.

Enhancing Senior Practitioners in Children’s Services: Cathy Jayat (Principal Practitioner Social Worker) facilitates a number of monthly support groups for senior practitioner social workers to enhance their practice and support the development of their roles:

- Senior Practitioners in Residential Care
- Senior Practitioners in Family Placement and Post Adoption Teams

Lynda McGill (SP) is currently developing a resource library for Senior Practitioners from existing resource.

Contribution to Decision Making Meetings: Staff from TT-LAAC attend professional meetings associated with corporate parenting including LAC reviews when this is required.

Contribution to Trust Management: Dr Coman and Cathy Jayat both sit on the LAC SMT group. Both sit on sub-groups with purposes including Foster care Restructuring, Therapeutic model for new Intensive Support Unit and Governance.

Regional: Dr Coman, Dr Dickson (Specialist Clinical Psychologist) and Cathy Jayat participate in a number of regional groups.
OBJECTIVES 2012-2013

Children and Residential Experiences (CARE)

1. Write paper for publication on implementation process to date and present at conferences for peer review in order to systematically reflect on process and identify next steps.

2. Develop a training strategy to aid the continued implementation of CARE in residential childcare within resource

3. Develop CARE informed tools and protocols to aid clear goal setting at admission to residential care to increase congruence among all parties involved in the admission

4. Develop a vision for extending CARE to fostering, agree strategy and begin implementation

Therapeutic Team for Looked After and Adopted Children (TT-LAAC)

5. Increase admin support to team from 0.5wte

6. Introduce Data Management System (EPEX or LCID)

7. Introduce Service Satisfaction Questionnaire

8. Recruit Senior Practitioner SW from Family Centre

9. Stand down Pilot Screening of Emotional Health and Wellbeing when SP in post

10. Adjust TT-LAAC provision to foster care in keeping with modernisation agenda and according to resource available

11. Development of service roles for Senior Practitioners within TT-LAAC in addition to their clinical roles

12. Interface with Adoption – Dr Dickson to become member of Pre-linking Panel and contribute to development of model for matching LAC and prospective adopters

13. Target interface with CAMHS and Health Visiting for development of clear pathways for LAC

14. Principal Practitioner to develop governance model for managing professional practice issues that are encountered by TT-LAAC in their work with social work teams

15. Consolidate TT-LAAC and write operational policy
CONCLUSION

This has been a challenging year for those providing therapeutic support to Looked After and Adopted Children. Staff have had to manage the process of change moving from 5 existing services into one multidisciplinary service. In some cases this has involved change of team, management and base in addition to changes in remit and ways of working and caseload. This at a time of considerable pressure on Children’s Services Teams owing to increased number of children being admitted to care and the associated pressures, the financial climate and wider service re-organisation.

That said, there is now a specialist Therapeutic Team for Looked After and Adopted Children that has a clear place within the governance structure of the Trust. There is a robust referral management system in place with a single gateway to the service, a waiting list management system in place and quality assurance of the therapeutic input.

There is a high level of motivation within the team and recognition that there are synergies achieved by both being in a multidisciplinary team and working the three client groups (foster care, residential care and post adoption). A clear conceptual model of working has developed for the team that targets the ‘relational skills deficit’ owing to the abuse and neglect Looked After and Adopted Children have experienced prior to coming into care. First and foremost TT-LAAC intervene in the ecology of child to enhance the skills of those in relationship with the child (caregivers or social workers) or the child themselves, to optimise the chance of ‘good enough’ relationships developing. It is within the context of ‘good enough’ relationship that children recover from past experiences of neglect and abuse enough to engage with present experiences of education, health, mental health services and other life opportunities and are thus better equipped for their future.

Within this context of service change and development TT-LAAC has delivered a high quality Trustwide service to social care staff, children and their caregivers.

Dr William Coman  
(Consultant Clinical Psychologist)
Appendix 1: CARE

“In 2006, a regional child protection report Our Children and Young People – Our Shared Responsibility, highlighted inconsistencies in practice across Northern Ireland, including within the residential care sector (RQIA 2006). In response to the challenges set out in the report, and others, the Children Matter Taskforce (NI) commissioned a regional review of residential child care, specifically to consider the strategic direction of this sector. Broadly, it aimed to ensure that wider reforms within children’s services were reflected in residential care. The report underlines the contribution of trauma to the emotional and mental health problems of looked after children and the impact this can have on a range of other outcomes. It also emphasises the impact on residential care staff of working with traumatised children, and the need for this to be recognised with ‘appropriate support from the whole organisation, accompanied by good levels of specialised training and high quality and regular supervision’.

One of the proposals in the report was the adoption and promotion of ‘therapeutic approaches’ to residential child care, in order more adequately to address the range of emotional and mental health needs of looked after children” (McDonald, Millen and McCann, in press, p.5). In 2008 the Department of Health, Social Services and Public Safety made available monies for piloting a therapeutic model in each of the five trusts.

In NHSCT, the Emotional Health and Wellbeing Group, chaired by Marie Roulston (AD), considered the task and identified the CARE model as the best fit for residential care in NHSCT. We agreed the model would be taken forward and implemented by Judith Brunt (HoS for Residential) and Dr William Coman (Consultant Clinical Psychologist for LAAC).

There was a regional launch on 1/04/2009 when Martha Holden introduced the principles behind the model and we formalised a steering group chaired by Judith Brunt. We developed a 2 year implementation strategy for training all levels of management (AD, HoS, SWSM, Team leaders) and staff within NHSCT residential care and also in Linden Services. We also provided orientation training to Family Placement teams and LAC Team leaders so they would be familiar with the model.

This is from ‘Therapeutic Approaches to social work in residential care’ by SCIE and QUB who were commissioned to evaluate the projects.
Appendix 2: Governance of TT-LAAC

TT-LAAC is accountable to Marie Roulston and is managed by Dr Coman. It is a multidisciplinary team and each professional within the team requires access to regular professional supervision in addition to line management.

The diagram below illustrates line management in black and professional management in different colours (blue for Psychology, orange for Social Work). Dr Coman is the professional lead for Psychology and accesses professional supervision from Dr Karen McWhinney (Psychology Lead for Children’s Services). Ms Cathy Jayat is the professional lead for Social Work for the team and accesses professional supervision from Ian Allen (Head of Service).