An evaluation of a service for young people with problematic or harmful sexual behaviours: the Child and Adolescent Harmful Behaviour Service (CAHBS)

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Executive summary

The Child and Adolescent Harmful Behaviour Service (CAHBS) is a newly developed service within the overall remit of the Thames Valley Young People's Forensic Service (TVYPFS). The CAHBS team provides advice, consultation, assessment and intervention, as appropriate, for young people in Oxfordshire and Buckinghamshire about whom there are concerns in relation to sexually harmful behaviour. The aims of this evaluation have been to:

- Review activity and outcomes from a year's operation of the new service across Oxfordshire and Buckinghamshire
- Assess responses to the new service over the same period from professionals, families and carers.

This report, commissioned by the Department of Health, has been undertaken by Solutions in Public Health (SPH). It has sought to provide an overall evaluation of the service from a variety of available information provided by the CAHBS team for the period April 1st 2012 until March 31st 2013. This includes:

- Analysis of successive cases open to the team at any time between 1st April to 31st March 2013 to quantify and describe the input provided by the CAHBS team
- Interviews with referrers to the CAHBS team from a variety of agencies to assess levels of satisfaction with the service and to highlight possible areas for improvement
- Interviews with senior managers (stakeholders) in a number of agencies who have a strategic role in multiagency service development for children and young people
- Interviews with the families and carers of service users to assess levels of satisfaction with the service and potential areas for improvement
- Summary of the range of non-clinical activities undertaken by the CAHBS team
- A number of case vignettes provided by the CAHBS team to highlight the types of clinical work undertaken.

This evaluation has demonstrated that the CAHBS service has seen the type of children and young people that the service was set up to support and has received referrals from a wide range of agencies across Oxfordshire and Buckinghamshire. The 156 children and young people that the CAHBS team worked with were complex in terms of their needs and in the number of agencies with which they had contact at the time of referral. There was formal statutory social care involvement in more than half (52%) of all cases, and 40% had statements of special educational need or were attending a pupil referral unit. A third of cases (33%) had some form of contact with the youth justice system (police or YOS). Sexually harmful behaviours had been noted between one month and one year prior to referral in the majority of cases. Over half of referrals had demonstrated more than one form of sexualized behaviour, with almost a quarter of referrals being for penetration or attempted penetration.

Input from the CAHBS team varied with the nature of the case. In cases where data were available (closed cases and some well-established open cases; n=124), the input from the CAHBS team involved advisory or consultative input which varied in levels of complexity in approximately half of referrals (54%). Direct clinical input from CAHBS team members was provided in 46% of cases and either involved assessment alone (27%) or assessment and subsequent intervention (19%). The involvement of the CAHBS team was often sustained over a considerable period of time with contact lasting between four and 12 months in approximately half of cases, and more than a year in 7% of cases. It was notable that approximately one tenth of the cases in which the CAHBS team were

involved had no agency involvement at discharge and that, overall, the remaining cases were involved with fewer agencies at discharge than referral.

Seventeen interviews were undertaken with referrers to CAHBS (n=12) and strategic stakeholders (n=5). In addition, the Participation Lead for the Child and Adolescent Mental Health Service undertook 19 interviews with a family member or carer of a young person who had been in direct contact with CAHBS. All interviewees were distributed across both Oxfordshire and Buckinghamshire and professionals came from a similar range of agencies in each county.

The feedback about the service received from the referrers and stakeholders was very positive, with multiple references to good communication between CAHBS and families and good communication, responsiveness and joint working between CAHBS and other agencies. Family members and carers were overwhelmingly positive about the services they had received from CAHBS, including their experience of the service in terms of communication and responsiveness and in terms of the positive impact on their child.

Comments from professionals in relation to less positive experiences tended to relate to single instances. However issues raised by several interviewees included some lack of awareness or understanding about what to expect from CAHBS amongst the professional community and the need for greater publicity of the service. A few stakeholders mentioned the current size of the team and the sustainability of using non-CAHBS people to do frontline work, highlighting the need for an ongoing training programme to ensure continuity of skills when trained professionals leave and new staff arrive.

This evaluation provides support from a range of quantitative and qualitative data that the CAHBS service makes a positive contribution in a specialist area of work and is valued by professionals and parents and carers.

Introduction

The Child and Adolescent Harmful Behaviour Service (CAHBS) has been developed within the overall remit of the Thames Valley Young People's Forensic Service (TVYPFS) which also includes a separately commissioned regional forensic child and adolescent mental health service (FCAMHS) and a criminal justice liaison and diversion team in Oxfordshire. The service is managed by the Children and Families Division within Oxford Health NHS Foundation Trust (OHNHSFT) and is open to all agencies working with children. The CAHBS service covers two counties (Oxfordshire and Buckinghamshire) and has clearly delineated service level agreements with joint social care and health commissioners in both counties.

The CAHBS team is commissioned to provide advice, formal consultation, assessment and intervention, as appropriate, for young people under 18 in Oxfordshire and Buckinghamshire about whom there are concerns in relation to sexualised behaviours which are seen as problematic or harmful. The service is also commissioned to provide a range of non-clinical activities such as teaching, training and supervision to professionals in both counties.

Children and young people involved in sexually problematic and harmful behaviour frequently have a range of needs and vulnerabilities which require supportive and clearly directed engagement from professionals who work with them. The complexity of their needs and of the risks associated with their behaviour requires a combination of specialist knowledge and a whole system approach to assessment and management. The service model underpinning CAHBS rests on such an approach. This involves the CAHBS team undertaking the specialist coordinating oversight within its area of expertise with collaborative support from other agencies. The team uses the AIM2[1] and associated intervention models as a core focus of multiagency working with young people and their families or carers but also draws on its experience in this field to undertake a variety of other forms of assessment and intervention as required.

The CAHBS team seeks to be accessible and responsive to concerns about sexually harmful behaviour in young people and has broad referral criteria, namely:

- The young person is under 18 years of age
- There are professional or family concerns about problematic or harmful sexual behaviour
- The young person is considered a resident in Oxfordshire or Buckinghamshire (including those who are currently in an out of county placement)

Team members can be contacted informally by anyone with concerns about a young person. Specific input from the team is subsequently based on a formal consultation and assessment/intervention model. 'Formal consultation' denotes a process which includes a case discussion with a referrer (face to face or by phone), joint agreement of an action plan and a CAHBS written summary including an agreed action plan. Broadly, clinical input from the CAHBS team can be broken down into the following categories:

- Single consultation, advice and close
- Single consultation, case kept open 3 months and closed after update
- Complex consultation (consultation with professionals in addition to referrer (and on occasions with family) and attendance at professionals' meetings and supervision of work undertaken by other professionals)

[1]The AIM2 (GMAP 2102) is the most recent version of a holistic assessment model suitable for professionals from all agencies who receive adequate training and ongoing support

- Consultation and further assessment by CAHBS team (high concern/complex cases)
- Consultation, assessment and direct intervention from the CABHS team (high concern/complex cases)

Case vignettes providing clinical examples of these different levels of input are provided in section four of this report.

The CAHBS team is a small team with specific expertise in working with young people with mental health, complex needs and high risk behaviours with a specific focus on sexually harmful behaviours. It comprises experienced practitioners (band 7 and above) with backgrounds in:

- Forensic and clinical psychology (2.0 whole time equivalents (wte) in total)
- Nursing and social work (1 wte in total)
- Adolescent forensic psychiatry (0.2 wte)

The team has dedicated administrative support.

Methods

Following the development of the CAHBS service, Oxford Health NHS Foundation Trust successfully applied for evaluation funding from the Department of Health (DH); this allowed for external evaluation of the provision to be undertaken.

Solutions for Public Health (SPH)[2] has been commissioned to conduct an evaluation of the CAHBS service. The aims of the evaluation are to:

- Review team activity over a period of 12 months across Oxfordshire and Buckinghamshire
- Assess responses to the service from the perspective of strategic stakeholders, referrers and the families of young people referred

The more general purpose of the evaluation was to identify positive aspects of the service provision and model as well as areas requiring improvement or modification. In addition, colleagues at the DH were interested in ascertaining whether, in the absence of clear, current, national professional consensus, the CAHBS service model was meaningful in terms of its possibility for replication elsewhere.

The nature of the service provided by the CAHBS team makes a direct evaluation based on patient outcomes difficult. Not only is the client group one presenting with highly complex needs and circumstances, but also much of the work undertaken by the CAHBS team is concerned with providing support, advice and specialist formal consultation to other teams and agencies. It is these teams that act upon the advice provided by the CAHBS team and who are therefore most likely to see the impact on the child or young person. Even in the most complex cases where the CAHBS team undertake assessments and direct interventions, the effects of such input are difficult to quantify.

In light of this complexity of provision and client group, SPH have used a number of different data sources to assess the impact of CAHBS. Such sources include:

[2] SPH is an NHS unit of public health professionals with wide experience of service evaluations at local, regional and national levels.

- Analysis of successive cases open to the team at any time between 1st April to 31st March 2013 to quantify and describe the input provided by the CAHBS team
- Interviews with referrers to the CAHBS team from a variety of agencies to assess levels of satisfaction with the service and to highlight possible areas for improvement
- Interviews with senior managers in a number of agencies who have a strategic role in multiagency service development for children and young people
- Interviews with the families and carers of service users to assess levels of satisfaction with the service and potential areas for improvement
- Summary of the range of non-clinical activities undertaken by the CAHBS team
- A number of case vignettes provided by the CAHBS team to highlight the types of clinical work undertaken

1) Analysis of quantitative data relating to young people referred to CAHBS

The CAHBS team set up a database to collect data prospectively on young people referred to the service. The CAHBS team supplied anonymised data from this database to SPH for the period April 1st 2012 – March 31st 2013.

The database included a total of 156 cases which fell into three categories:

- 44 cases (28%) that were opened before 1st April 2012 and closed before 31st March 2013
- 61 cases (39%) that were opened and closed between 1st April 2012 and 31st March 2013
- 51 cases (33%) that were opened either before (n=8) or after 1st April 2012 (n=43) and were still open on 31st March 2013.

a) Ages and gender of children and young people referred

Table 1: Referrals to CAHBS by age and gender

Age (years)	Female	Male	Total
4-7	6 (4%)	15 (10%)	21 (14%)
8-10	4 (3%)	18 (11%)	22 (14%)
11-13	7 (4%)	37 (24%)	44 (28%)
14-15	5 (3%)	40 (26%)	45 (29%)
16-17	4 (3%)	20 (13%)	24 (16%)
Total	**26 (17%)**	**130 (83%)**	**156 (100%)**

Table 1 shows that 28% of referrals were for children aged under 11 years and a further 28% were young people between the ages of 11 and 13. The mean average age at time of referral was 12 years and 8 months. The majority of children and young people referred were male (83%). The CAHBS team have advised that the proportion of females referred (17%) was higher than in samples reported elsewhere.

b) Ethnicity of children and young people referred

Table 2: Ethnicity of children and young people referred to CAHBS

Ethnicity	Total
White British	126 (81%)
White Other	11 (7%)
Black or Black British	5 (3%)
Asian or Asian British	4 (3%)
Other ethnic group	4 (3%)
Not known	6 (4%)
Total	**156 (100%)**

Table 2 shows that most children and young people were from a White British ethnic background (84% of cases where the ethnicity was recorded). This broadly reflects the ethnic make-up of Oxfordshire and Buckinghamshire.

c) Social care status

Table 3: Social care status of child or young person at referral

Social care status	Total
Child in Need	38 (24%)
Looked after S31	20 (13%)
Looked after S20	11 (7%)
Subject to child protection plan	12 (8%)
TAC*	6 (4%)
Core assessment only	10 (6%)
Adopted	2 (1%)
Not applicable	57 (37%)
Total	**156 (100%)**

*TAC = Team Around Child

Table 3 shows that there was some form of contact with children's social care in 99 cases (63% of all cases) at referral. Formal statutory involvement was in place in 81 cases (52% of all cases) and there was less formal involvement (TAC, core assessment and adopted) in 18 cases (11% of all cases).

d) Education status

Table 4: Education status of child or young person at referral

Education status	Total
Mainstream (no special needs)	79 (51%)
SEN*, special school or PRU*	63 (40%)
Left school	9 (6%)
Other**	3 (2%)
Status not specified	2 (1%)
Total	**156 (100%)**

*SEN=Statement of Special Educational Need; PRU=Pupil Referral Unit
** includes home tuition (n=2), hospital school (n=1)

A high proportion (40%) of children and young people referred to CAHBS had special educational needs or were in a special school or pupil referral unit.

e) Sources of referrals to CAHBS

Table 5: Sources of referrals to CAHBS

Source of referral	Total
Children's social care	71 (46%)
Education	25 (16%)
CAMHS*	38 (24%)
Police**	9 (6%)
YOS	8 (5%)
Family	1 (1%)
Other***	4 (3%)
Total	**156 (100%)**

* includes a range of CAMHS teams: primary CAMHS (PCAMHS), locality CAMHS teams, CAMHS learning disability teams, forensic CAMHS, CAMHS neuropsychiatry and in-patient teams
**includes domestic violence unit ***includes GP, health visitors and MIND

The majority of referrals came from children's social care (46%), education (16%) and CAMHS (24%).

g) Agency involvement at the time of referral

Table 6: Involvement of agencies at the time of referral

Agency	Involvement at time of referral (max=156 (100%)
Children's social care	105 (67%)
Education (additional to mainstream input)	91 (58%)
CAMHS	74 (47%)
Police	41 (26%)
YOS	11 (7%)
Other*	12 (8%)

***** includes GPs, health visitors, family, court, MIND, R-U-Safe, Addaction, Face it and One Foot Forward

Table 6 shows that social care, education and CAMHS were involved at referral in between 47% and 67% of cases. Youth justice agencies were involved in more than a quarter of cases. A range of other agencies were also involved on a smaller but noticeable scale.

Figure 1: Number of other agencies involved at time of referral to CAHBS

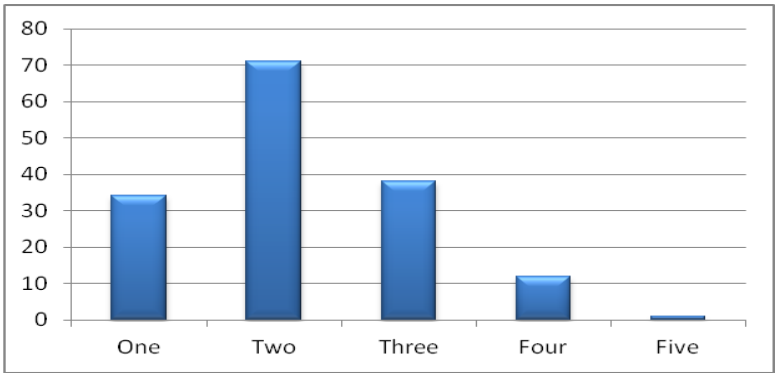


Figure 1 shows that the majority of referrals (n=122; 78%) were already involved with more than one agency at the time of referral.

h) Reason for referral

Tables 7 to 9 summarise different aspects of the reasons for referral to CAHBS. In addition to the nature and multiplicity of the behaviours themselves (Table 7), information relating to their pervasiveness over time (Table 8) and across contexts (Table 9) is presented.

Table 7: Number of sexual behaviours exhibited prior to referral

Number of sexual behaviours*	Total
One	71 (45%)
More than one	82 (53%)
Not specified	3 (2%)
Total	**156 (100%)**

* includes sexual touching, sexualised language, simulating sexual behaviour, watching or accessing sexualised materials, penetration (32 cases; 21%) or attempted penetration (3 cases; 2%).

Table 7 shows that the numbers of referrals with multiple behaviours (53%) outnumbered those with single types of behavior.

Table 8: Duration of the behaviour before referral

Location	Total
One month or less	5 (3%)
2-6 months	24 (15%)
7-12 months	26 (17%)
More than 1 year but less than 5 years	22 (14%)
More than 5 years	3 (2%)
Not specified	76 (49%)
Total	**156 (100%)**

Table 8 describes the duration of behaviour(s) at the time of referral in 80 cases (51% of all cases) where data were available. In most cases (69% of cases where data were available) the onset of the reported sexualised behaviours had occurred within a year of referral. However 31% had demonstrated such behaviours for more than a year (range 12 months to 13 years).

Table 9: Number of contexts* in which behaviour occurred

Location	Total
One context	65 (42%)
Two contexts	48 (31%)
Three or more contexts	15 (10%)
Not specified	28 (18%)
Total	**156 (100%)**

*for example: home, school, community or elsewhere

Table 9 shows that for cases for which data were available, almost equal numbers of referrals (65 vs. 63) were received for children and young people exhibiting behaviours in single environments or in more than one setting. One tenth of referrals showed evidence of particularly pervasive behaviours which occurred in three or more different contexts.

i) Diagnostic status of children & young people referred to CAHBS

Table 10: Mental health diagnosis

Mental health diagnosis	Total
Mental health diagnosis*	47 (30%)
No mental health diagnosis	61 (39%)
Not known (closed cases)**	9 (6%)
Not known (open cases)***	39 (25%)
Total	**156 (100%)**

*diagnoses included: ADHD/hyperkinetic disorders, autistic spectrum disorders, learning disability, anxiety, depression, attachment disorder and conduct disorders
** in some closed advice/consultation only cases, information about diagnosis was not available.
*** a high proportion of open cases (71%) did not have diagnostic information available because of the ongoing nature of input from CAHBS

Table 10 shows that 47 children and young people were recorded as having a mental health diagnosis (including learning disability) either before or after assessment. This represents 43% of cases for which data were available.

j) Type of CAHBS input provided

Table 11: Summary of CAHBS input

CAHBS input	Total
1. Consultation*, advice and close	25 (16%)
2. Consultation, case kept open 3 months and closed	22 (14%)
3. Complex** consultation	20 (13%)
4. Consultation and assessment	34 (22%)
5. Consultation, assessment and direct intervention from the CABHS team***	23 (15%)
Not specified (case still open)****	32 (21%)
Total	**156 (100%)**

*'consultation' denotes formal process including case discussion with referrer, action plan agreed with referrer and CAHBS written summary including agreed action plan
**'complex' denotes consultation with professionals in addition to referrer (and on occasions with family) and attendance at professionals' meetings and supervision of work undertaken by other professionals etc
***denotes specific interventions delivered by professionals in CAHBS (not interventions undertaken by other professionals under CAHBS team supervision)
****in many open cases it is not possible to characterise the final nature of CAHBS level of input

In 67 cases (54% of cases for which data were available) some form of consultative input was provided. In 57 cases (46%), in addition, some form of direct input (CAHBS assessment with or without direct intervention) from the CAHBS team was required. Direct intervention from the CAHBS team was provided in 23 cases (19% of cases for which data were available).

k) Types of assessment undertaken in 57 cases

Table 12: Types of assessment undertaken in 57 cases for which data were available

Type of assessment undertaken	Total (n=57)	Assessment undertaken by
AIM2 (structured assessment in cases of harmful sexual behavior)	50 (88%)	CAHBS and other agency* (n=20) CAHBS alone (n=22) Other agency** with CAHBS supervision (n=8)
Other generic risk assessment	13 (23%)	CAHBS with other agency(-ies)
Cognitive assessment	8 (14%)	CAHBS
ERASOR[3] (Structured risk assessment in cases of sexually harmful behavior)***	4 (7%)	CAHBS
Structured risk assessment (violence risk) using the SAVRY[4]	3 (5%)	CAHBS
Sexual knowledge assessment	1 (2%)	CAHBS

* YOS, education, children's social care, CAHMS LD team, ATTACH team
**YOS or children's social care
*** The ERASOR was used in post-arrest/pre-court cases where a specialist opinion was sought by the police/Crown Prosecution Service to assist with decision-making

Of the 57 cases for which some form of assessment was undertaken, in 50 (88%) a core sexually harmful behaviour assessment using the AIM2 was undertaken. A range of other assessments were undertaken in place of, or in addition to, the AIM2 at the discretion of the team.

[3] ERASOR = Estimate of Risk of Adolescent Sexual Offense Recidivism
[4] SAVRY = structured Assessment of Violence Risk in Youth

l) Duration of CAHBS involvement in closed cases (n=105)

Table 13: Length of time between referral* and discharge from CAHBS in 105 cases closed between April 2012 and March 2013

Time	Total (n=105)
< 1 month	21 (20%)
1-3 months	28 (27%)
4 months – 1 year	49 (47%)
>1 year	7 (7%)
Total	**105 (100%)**

*'referral' here refers to first contact with CAHBS

Table 13 shows that there was considerable variation in the duration of contact with the CAHBS team following referral. In 98 cases (93% of closed cases), the child or young person was in contact with the CAHBS team for up to a year, with equal proportions (47% of closed cases) in contact for either less than three months or between four and 12 months. A small proportion of closed cases (7%) remained in contact with the team for over a year.

m) Agency involvement at time of discharge from CAHBS (closed cases, n = 105)

Table 14: Agencies/ key professionals involved at discharge from CAHBS in 105 closed cases

Agency	Involvement at discharge (n=105)
Children's social care	50 (48%)
Education (additional to mainstream input)	16 (15%)
CAMHS	48 (46%)
Police	6 (6%)
YOS	8 (8%)
No other agencies involved	11 (10%)
Not specified	1 (1%)
Total	**105 (100%)**

Figure 2: Number of other agencies/ key professionals involved at referral and discharge (closed cases, n=105)

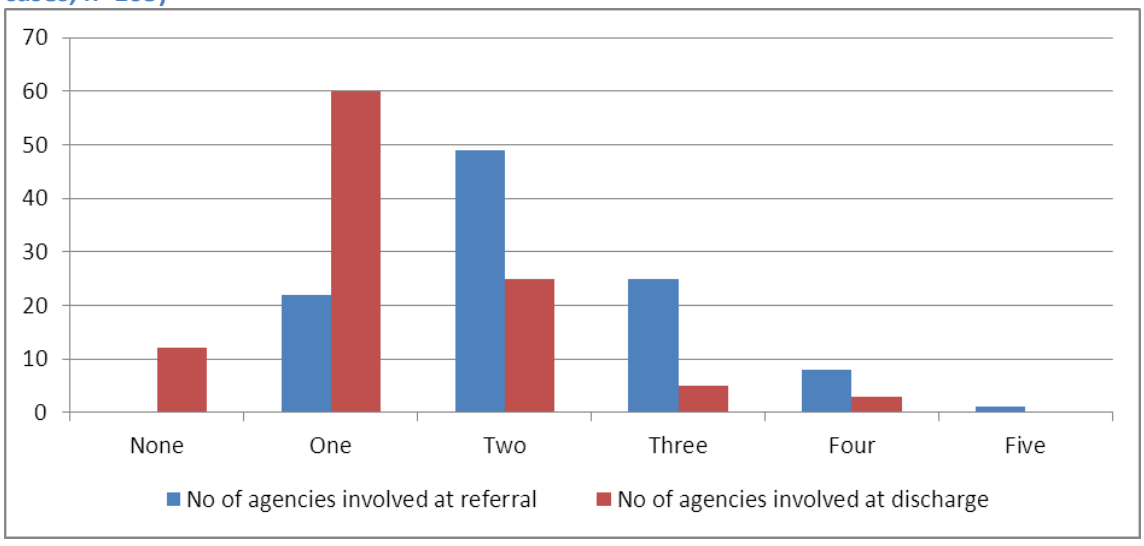


Figure 2 compares the number of other agencies involved at the time of referral and discharge for closed cases. In addition to 11% of cases not requiring any professional input by the end of CAHBS involvement, there is a clear trend towards fewer agencies being involved with young people and

their families at the time of CAHBS case closure (38% were involved with more than one agency at discharge compared with 79% at referral).

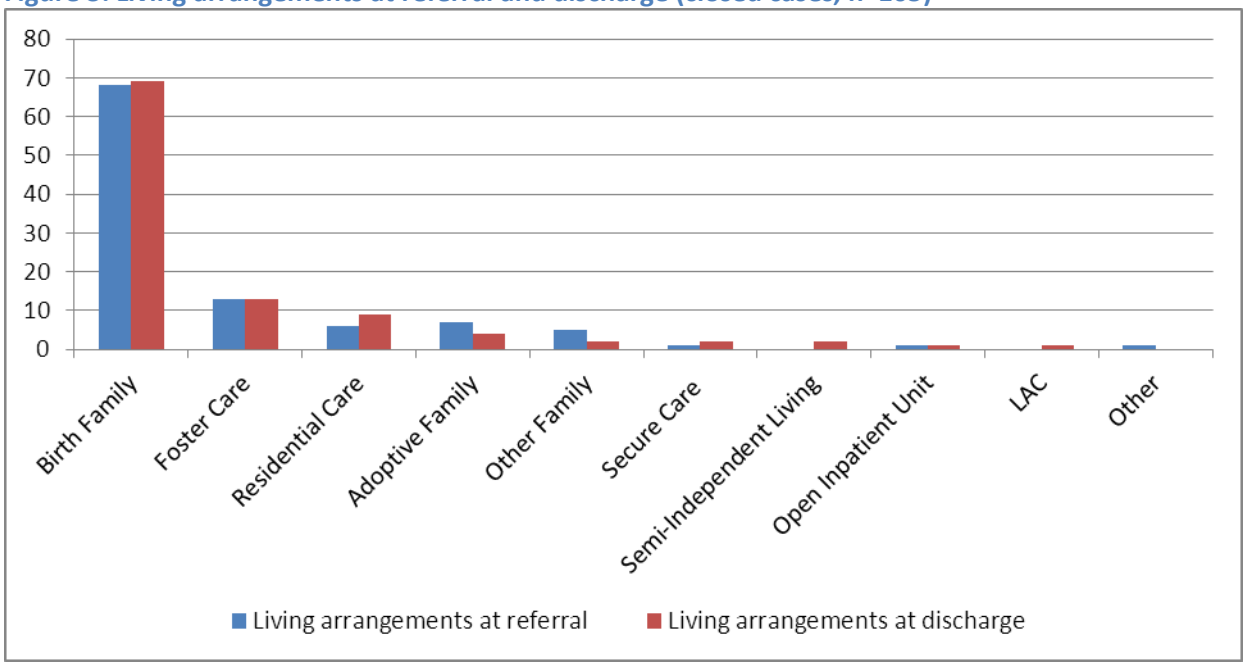
Table 15: Cases where agencies were actively involved in case management at either referral, discharge or both (closed cases, n=105)

Agency	Number of cases involved at referral and discharge	Number of cases involved at referral only	Number of cases involved at discharge only	Total cases each agency involved with (% = n/105)
Children's social care	48 (71%)	18 (26%)	2 (3%)	**68 (65%)**
CAMHS	40 (62%)	17 (26%)	8 (12%)	**65 (62%)**
Education	12 (19%)	46 (74%)	4 (6%)	**62 (59%)**
Police	5 (20%)	19 (76%)	1 (4%)	**25 (24%)**
YOS	6 (50%)	4 (33%)	2 (17%)	**12 (11%)**

Table 15 summarises the extent to which the same agencies were involved with active case management at referral and discharge for the 105 closed cases. Children's social care, education and CAMHS were involved with higher numbers of cases when compared with the police and YOS. Social care and CAMHS were most frequently involved at both referral and discharge (in 71% and 62% of the cases that they were involved with respectively) but all agencies were involved at referral and discharge in at least a fifth of their cases. Education and the police were more frequently actively involved at referral than discharge. The CAHBS team has advised that this is understandable in the case of the police as one would expect them to have more active involvement nearer to the perceived onset of the concerning behaviours. The CAHBS team has also advised that the noticeable drop in active educational involvement by the time of discharge may indicate a reduction in concerns about the young person (i.e. education being more likely to disengage from active involvement at an earlier juncture than social care or CAMHS).

n) Young people's living arrangements at discharge (as compared with referral)

Figure 3: Living arrangements at referral and discharge (closed cases, n=105)



The living arrangements at referral and discharge for closed cases are presented in figure 3. This shows that most children/ young people were living with their birth family (65% at referral and 67% at discharge).

Of the 105 closed cases, 83 (79%) children and young people had the same living arrangements at referral and discharge and in 19 (18%) cases the living arrangements were different. In three cases this information was not specified. The direction of movement for the 19 closed cases in which the living arrangement was different at discharge is shown in table 16.

Table 16: Direction of movement for cases in which living arrangement at discharge differed from living arrangement at referral

Change in living arrangement	Total
From 'family'* to 'other care'**	4 (21%)
From 'other care' to 'family'	2 (11%)
From one 'other care' arrangement to another 'other care' arrangement	10 (53%)
Movement within 'family' care arrangements	3 (16%)
Total	**19 (100%)**

*'Family' includes birth family or other family members.
**'Other care' includes adoptive family, foster care, residential care, secure care and semi-independent living.

2) Interviews with referrers, strategic stakeholders and families

Semi- structured interview schedules based on interviews previously used in Department of Health funded evaluations of the Thames Valley and Hampshire/Isle of Wight Forensic CAMHS were developed in consultation with the CAHBS team.

Interviews were conducted with three groups.

- Direct referrers to CAHBS
- Stakeholders from children's social care, YOS, police and CAMHS who had been involved in the commissioning and strategic oversight of the service
- Family members or carers of young people with whom CAHBS had been directly involved

The interviews were designed to elicit information from families and professionals about the impact and utility of the service as well as seeking suggestions regarding the potential for service improvements. Broadly, questions covered the following areas:

- Reasons for contacting the CAHBS team
- Expectations of contact with the CAHBS team
- Experiences of contact with CAHBS including perceived outcomes for young people
- Suggestions for service improvement
- Overall level of satisfaction with the service
- Impact, if any, of the CAHBS team being no longer available
- Any other comments.

The individual interview schedules can be found in appendices 1-3 of this document.

Interview process

The CAHBS team provided SPH with lists of referrers (n=25) and strategic stakeholders (n=8). SPH then contacted these individuals to arrange interviews. Ultimately telephone interviews were undertaken with 12 referrers and five strategic stakeholders.

Families/carers of young people who had been in direct contact with CAHBS were also identified by the CAHBS team. These families were considered representative of the CAHBS client group in terms of age, gender, family/care circumstances of the children, mental health or learning difficulties and severity of presenting concern. A letter was sent to these families notifying them of the intention to contact them, emphasizing that they were under no pressure to participate and providing them with the means to contact the team to opt out of any interview (Appendix 4). None did this and 19 interviews were undertaken.

All interviews were undertaken by professionals not directly involved in the CAHBS team. The interviews with referrers and strategic stakeholders were undertaken by the team at SPH (GP, NH and MG) and the interviews with families were conducted by the Oxford Health CAMHS Participation Lead (DM); DM had had no professional involvement with the CAHBS team. Analysis of the interviews was undertaken by SPH. Tables 17 and 18 outline the professional and geographical origins of the different interviewees.

Table 17: Agency affiliations of referrer and stakeholder interviewees

Agency	Referrer interviews	Stakeholder interviews
Education	3	---
Police	2	2
Social Care	2	2
YOS	2	1
CAMHS	3	---
Total	**12**	**5**

Table 18: Geographical distribution of interviewees

Geographical Location of Interviewee	Referrers	Stakeholders	Families
Oxfordshire	6	2	8
Buckinghamshire	4	2	11
Oxon and Bucks/Thames Valley	2	1	---
Total	**12**	**5**	**19**

Interviews with referrers and stakeholders

a) Nature of contact with the CAHBS team

The nature of the contact that the professional interviewees had with CAHBS varied, with many referrers making both formal referral s and contacting CAHBS for more informal advice about particular cases. The role of stakeholders involved multiagency oversight of the service or of a team making referrals to CAHBS. These contacts are summarised in tables 19 and 20.

Table 19: Type of contact reported by referrers to CAHBS

Type of contact	Referrers
Direct CAHBS involvement with young person/family (assessment, intervention, pre-court evaluation, second opinion/ organisation of group for young people with learning disabilities)	11
Other informal enquiries including support/ reassurance and receiving information and materials to aid other professionals in their work with young person/family/carer)	5
Received training from CAHBS (including specific AIM2 training and group training as 'champion' within own agency)	1

Table 20: Type of contact reported by stakeholders

Type of contact	Stakeholders
Membership of CAHBS strategic steering group	4
Recommending CAHBS input to others/managing team making referrals	4

b) Professional expectations of the CAHBS service

Referrers were asked about their expectations of the CAHBS service. Their responses are summarised in table 21.

Table 21: Expectations of the CAHBS service

Nature of expectation	Referrers
Uncertain what to expect/few expectations	3
Assessment of risk/support for young people and family/case management advice/ experienced/expert support for assessment and risk management	3
All cases with a sexual element to be taken on by CAHBS	1
Concerned that CAHBS might be instructive towards other experienced professionals rather than collaborative	1

The interviewee who had expected that all cases with an element of sexual offence would be dealt with by CAHBS was disappointed when their case was passed to CAHMS, particularly as CAMHS has a waiting list.

The interviewee who was concerned that CAHBS might be instructive rather than collaborative was reassured that this was not the case after their contact with the team.

c) Feedback about what went well during professionals' contact with the CAHBS team

Referrers identified a number of ways in which their contact with the CAHBS team had been positive with multiple references to good communication, joint working, advice and support. Stakeholders reported examples of positive feedback about the CAHBS service from their teams and ways in which they felt CAHBS had enhanced service provision. Responses are summarised in table 22.

Table 22: Positive areas of contact with the CAHBS team

Nature of feedback	Referrers	Stakeholders
Good support, advice and reassurance on risk management	9	3
Accessibility, responsiveness and feeding back to the referrer	8	4
Joint working with other agencies	7	2
Good support, advice and/or resources for supporting families and other professionals	6	---
Adding specialist expertise and validation to court cases/ documentation	3	---
Detailed and good quality reports	2	---
Case working with particular individuals	3	3
Support with preparation for court cases and management of young people in the criminal justice system	2	---
Information, training and workshops for staff	---	3
Dedicated team with a standard way of doing things		1

Two interviewees compared the CAHBS service to previous support arrangements. One felt that the difference with CAHBS is that they worked alongside them on cases, and have taken a more gate-keeping role. The other interviewee felt that CAHBS is a more obvious resource than what was available before with a sense of expertise being available and a more clearly identified pathway.

Several interviewees stated that CAHB's involvement had improved outcomes for young people.

Illustrative examples of the full comments about positive areas of contact with CAHBS are presented as Appendix 5.

d) Feedback about what did not go well during professionals' contact with the CAHBS team

Some interviewees specified that they did not have any negatives about the CAHBS service. Other interviewees did identify examples of some issues.

Table 23: Less positive areas of contact with the CAHBS team

Nature of feedback	Referrers	Stakeholders
No perceived negatives	4	---
Referrer expectation of direct CAHBS involvement (in advice/professional consultation only cases) not realised	2	1
Delay in assessment for referral considered 'urgent'	1	---
Lack of clear communication between agencies after case passed on to CAMHS by CAHBS; CAHBS did not ensure named professional within CAMHS	1	---
'Teething problems' re dates for meetings	1	---
CABHS clinical report formats differ from AIM2 format	1	---
Name missed off list for training	1	---
Lack of awareness of CAHBS amongst some professionals	---	2
Greater rigour needed in activity reporting to strategic partners (e.g. annual report/ yearly review of service)	---	2
Concern about the sustainability of the model with a small team and a reliance on non-CAHBS people doing the frontline work	---	3

Illustrative examples of the full comments about less positive areas of contact with CAHBS are presented as appendix 6.

e) Professionals' suggestions for improvement

There were several suggestions about ways in which CAHBS could improve its service.

These involved guidance and training, for example:

- Flowcharts/ scenarios for referrals on the CAHBS website so that the initial referral goes to the right team
- Additional training opportunities for CAHBS awareness, on the process of recognising and assessing risk, therapy/intervention work.
- More practitioners trained to do assessments.
- Training around lower risk cases, for example, encouraging protective behaviours and helping schools spot behaviours.
- If possible, to do something on prevention.

There were also several comments about the reach of the service:

- Advertise the CAHBS service more, for example, write to head teachers and SENCOs or do more leaflets or presentations with CAHMS, schools and GPs.
- Screen all referrals to CAHMS to see if it would be appropriate to have CAHBS involvement
- More 'hands-on' involvement, for example in providing courses of treatment
- Potentially have follow-up 6-8 weeks after last contact to address the feeling that there is a bit of a 'hole' once CAHBS involvement has ended.
- Extend the CAHBS service into adjacent county.

Some of the comments from the stakeholders specifically related to the CAHBS model:

- Double the size of the CAHBS team and do more delivery on a face-to-face level, and re-model the service delivery so that it does not rely so heavily on non-CAHBS frontline staff.
- Bring in CAHBS early to minimise potential risks (e.g. working with the Child Abuse Investigation Unit and people being released on bail).

f) Professionals' views about how CAHBS has contributed to service provision and effect on wider systems if team were no longer in place

Interviewees were asked whether they felt the CAHBS service had improved outcomes for young people. Examples of ways in which CAHBS had improved outcomes for young people included:

- A young person who was reported [by the interviewee] as thought to be not best placed in a mainstream school is has remained in the mainstream system to do GCSEs.
- Only short term results so far but outcome has been positive with the CAHBS input prior to sentencing potentially leading to a fairer sentence in the most appropriate setting.
- In two cases the CAHBS psychologist's cognitive assessment picked up learning disability issues with the children that had not been detected by the school or educational psychologist. That input was crucial to what eventually happened in these cases.

Interviewees were also asked what, if any, impact there would be if the service were no longer in place. Although there was an acknowledgment that other services would continue to work with the group or children and young people and manage risk in the absence of CAHBS, most interviewees felt that the CAHBS team are providing an additional service that is not available elsewhere, that it is valuable to have advice and support from a specialist team about issues involving sexualised behaviour and that the absence of the CAHBS team would be a loss. Some interviewees felt that the absence of the CAHBS service would increase the pressure on other services such as social services, YOS and CAMHS.

g) Referrers' overall level of satisfaction with the CAHBS team

Interviewees were asked about their overall level of satisfaction with the CAHBS service. All responded that they were either satisfied (50%) or very satisfied (50%).

h) Final comments from referrers about CAHBS

The interviews ended with a chance for referrers and stakeholders to make any final comments about the CAHBS service:

"CAHBS were very helpful throughout the case, their input was very useful and I learnt a lot from the process"

"CAHBS has improved provision for services for this group, particularly for children and young people"

"Thank you – very grateful for the support provided by CAHBS

"Has good relationships with CAHBS team. No problem with response times and provides a service that was not there

"CAHBS is a really excellent service and the most positive experience that I have had of a CAMHS type service – hope that it expands"

"Would recommend colleagues to contact CAHBS for cases with sexually harmful behaviour"

Interviews with Families Referred to CAHBS

Responses from parents/carers are cited below:

a) How did you find out about the CAHBS service?

The most common ways for finding out about CAHBS were via the school (8 participants) or via a referral to CAHBS from CAMHS (7 participants). Other participants found out about CAHBS through social care, the police and a hospital admission.

b) What were your expectations of the service?

Nine participants stated that they did not know what to expect or did not have any expectations, one further participant stated that they did not have any advance information about CAHBS.

Five participants stated that they had some information about CAHBS in advance, one participant stating that this was through the school. One participant stated that that they received information in advance but did not really understand it, although this became clearer as they attended.

One participant felt quite daunted, but stated that CAHBS had helped him/her to understand. Other participants hoped for help and professionalism from the CAHBS team.

c) How did you find accessing the service?

The feedback from this question was very positive. Some participants just stated that their experience was good or excellent. More detailed responses included:

- Didn't have to wait/ surprised that is was so quick/ very quick to be seen.
- Good times to be seen.
- Always easy to contact/ easy to get hold of.
- Always ready or available to talk/ there if I needed help with a situation.
- Good at calling back/ always good at returning calls.
- Got back to me if they weren't available when I rang and also called between times to 'check in' which reassured me.
- Kept me in the loop.
- Some sensible and helpful advice.

d) How did you find feedback from the team?

These responses were also positive. Again some participants just stated that feedback from the team was good or excellent. Others provided more detail:

- Always informative and useful.
- Felt included and informed.
- Pretty good, kept me informed.
- Responsive and proactive.
- Good communication at all times.
- Open.
- Brilliant communication with CAHBS, can't fault [CAHBS team member].
- Long phone calls to help us with understanding.
- Some questions from social care were difficult to answer so really helpful to get feedback which I could pass on and helped my understanding.
- Very good and consistent.
- Helpful and quick.

e) What went well during your contact with CAHBS?

Some participants simply re-stated that they had had a positive, excellent or informative experience. One participant stated that they could not really remember. More detailed comments included:

- Really changed child. Easy to understand and support for us.
- Had a positive effect on child who understood meaning of visits. Helped us enormously.
- Other parents experience – this is really helpful to know.
- Taught child skills which he can pass on and use.
- Really helped to change family life.
- Huge impact on child. Relieved that it's not only me experiencing this.
- Child learnt specific information in an appropriate way which he has used since.
- It has had a massive impact on child who has had his questions answered.
- Whole thing has gone brilliantly. What a difference it has made.
- Really pleased I had help and someone to talk to.
- Can't believe how smoothly it has gone. Great help.
- Had someone to talk to about difficult issues.
- I found it helpful to meet other parents who had been in the same situation.
- Good feedback.

f) What didn't go well during your contact with CAHBS?

Eight participants did not provide an answer to this question and nine participants stated that there was 'nothing' that didn't go well during their contact with CAHBS. Other responses included ' some difficult things talked about' and ' I didn't have enough time to attend and wish I had been able to attend more. Young person got so much out of it'.

g) How could the CAHBS service be improved?

Some participants did not provide an answer for this question or specified that they could not think of anything. Some suggestions for improvements were provided which included:

- Learning disability children need constant reminding and it would be good to be able to go over everything again in the future.
- School could be liaised with. Information which has been lost (by child) could be said again as it's so helpful to repeat it.
- Follow up after a year – explore retained information.
- Teach more young people, maybe in schools.
- Would be great if service was offered in schools.
- Age group was quite broad. My child was young and as parents we found it very worrying that he was with much older children. Might need to split group by age.
- Having more of you (CAHBS team).
- Should be used more widely.

h) Additional comments

Participants were asked if they had any additional comments, the vast majority of which were very positive.

- Has been a huge help and support.
- Think the service is excellent.
- Overall pleased how it went.
- All very positive and it went well.

- My child enjoyed going and his questions were answered. He got a lot out of it.
- Excellent service. [CAHBS tem member] was brilliant. Really friendly, understanding and supportive.
- Originally seen in [location] but moved location to accommodate us which has been so helpful.
- Changed child in a positive way.
- The experience has really helped.

One respondent however said that their child had not changed.

i) Family/carers' overall experience of the CAHBS service

Participants were also asked to rate their overall experience of using the CAHBS service. Seventeen participants (89%) stated that they were 'very satisfied'. One participant was 'satisfied' and one was 'neither satisfied nor dissatisfied'.

3) Summary of non-clinical activity undertaken by CAHBS (April 2012- March 2013)

1) Formalised meetings with professionals across different agencies

- Quarterly operational meetings with senior practitioners in relevant agencies in Bucks and Oxon: review of service delivery and address of issues arising (8 meetings per year)
- Regular bi-monthly supervision meetings with YOS teams in Oxon and Bucks (12 supervision sessions per year)
- Regular quarterly 'practitioner network meetings' for all workers across agencies trained within CAHBS assessment or intervention framework: on-going education and information sharing in relation to clinical work with young people with sexually harmful behaviour.

2) Promoting the service

The team have worked to promote the service through attendance at multiagency meetings and team discussions, and more generally through direct contact with referrers. In addition, the team has met with a range of services to continue to promote understanding of its work. These services include:

- CAHMS teams in Oxon and Bucks
- Oxon Social care looked after and fostering/adoption support team ('Attach')
- Safeguarding in education leads, Oxon
- Clinical psychology doctoral students, Oxford
- Oxfordshire early intervention hub managers
- Oxfordshire Social Care (North, City & South Oxon)
- Buckinghamshire YOS team
- Amersham Adoption and Fostering team
- Psychology special interest group, Oxford & Bucks
- Buckinghamshire GP study day
- 40, The Moors Children's Home, Oxford
- Thames Valley Police (Oxon and Bucks)
- Primary and secondary schools in Oxon and Bucks.

3) Establishing/maintaining links with key local and national organisations:

- National Organisation for the Treatment of Abusers (NOTA)
- NSPCC
- SWAAY (national residential provider, Reading)
- Community Care Conferences
- Thames Valley Police
- Buckinghamshire and Oxfordshire Safeguarding Children's Boards
- AIM Project, Manchester.

4) Formal training for professionals in other agencies

- AIM2 assessment and GMAP intervention packages provided to identified practitioners in CAMHS, police, children's social care and YOS in both Oxon and Bucks. This training consists of two formal training days for assessment and three formal training days for intervention.
- Additional one day training events for AIM2 assessment training also completed.
- Proposal to Oxon Safeguarding Children's Board for 2 hour introductory, multiagency seminar covering normal sexual development in children, unhealthy/harmful sexual behaviour and how to contact CAHBS. Proposal accepted and first seminar delivered with positive participant feedback. Similar training proposed to Bucks Safeguarding Children's Board.
- Supervision of forensic psychology trainee research project

4) Case vignettes illustrating the work of CAHBS

Advice only cases

a) Contact from a teacher at a special school about a 13 year old boy with learning difficulties. He was reportedly drawing penises, refusing to stop doing so and showing them to his peers. Staff were very concerned about this and feared it might be a precursor of later sexually abusive behaviour. There were no other concerns and the boy had a supportive family. Staff were advised on the nature of normal sexual development, and its manifestations in learning disability and how to manage such behaviour within the school day. Specific training needs were identified for this school; such training was subsequently provided by the team during an inset day for staff.

b) Enquiry from CAMHS outreach team worker. He raised concerns regarding sexualised interest in younger children arising in an individual session at special school with a 14 year old boy with Asperger's syndrome. This appeared to be an isolated episode. Outreach worker advised to liaise with school and family regarding potential safeguarding concerns and to discuss with experienced occupational therapist working at the school who had received AIM2 and intervention training from CAHBS. Occupational therapist coordinated further input with awareness that she could CAHBS if further concerns were identified.

c) Contact from safeguarding lead in secondary school. 15 year old girl using sexualised language in school and placing herself at risk by sending explicit photos to boys in school. CAHBS provided advice and school arranged four sessions of protective behaviour work with local organisation providing support to vulnerable young people. No further contact required.

Formal consultation cases

a) 10 year old boy referred by safeguarding lead in primary school. During telephone case consultation with the school he was reported as saying that he wanted to have sex with his younger brother; there were also reports that he had been exposing himself to his younger sister. Mother reported to have learning difficulties and there had been previous concerns about neglect of the children. Subsequent school and CAHBS liaison with children's social care resulted in escalation to child protection with children being placed with other family members or in foster-care; boy did well in foster-care with no further concerns. CAHBS kept case open pending outcome of care proceedings and potential need for direct intervention.

b) 5 year old girl referred by social worker in family support team. CAHBS phone case consultation was undertaken. The girl was demonstrating highly sexualised behaviour at school and in settings outside of the family home. CAHBS attended professionals' meeting where further information regarding neglect within the family and concerns about domestic violence and mother's multiple male partners were raised. Social worker requested that sexualised behaviour be addressed by CAHBS but this option not felt to be felt to be viable given the girl's situation. CAHBS recommendation that child protection concerns needed to be addressed before any form of direct therapeutic work could be undertaken were accepted. Care proceedings were subsequently rapidly instituted with the girl being placed in foster care. CAHBS continued consultation and support to foster carers.

c) 14 year old boy referred by social worker in children's assessment team following his arrest and section 47 strategy meeting. CAHBS phone consultation was undertaken. The boy had been involved in sexual touching of 13 year old friend of his sister whilst she was asleep during a sleepover at his home. His parents were both supportive and concerned and

acknowledged likelihood that alleged behaviour had occurred. The boy himself was doing well at school, was popular with peers and there were no concerns regarding other sexualised behaviours. It was agreed that the social worker would undertake protective behaviours work with the family and that CAHBS would keep case open until this was completed. Police did not proceed. No further concerns were raised. Case closed after further liaison with social worker.

Assessment and intervention cases

a) Referral by police of 15 year old boy on police bail for pre-court assessment following disclosure of attempted rape of younger children. The boy had acknowledged the alleged offences in police interview. He had supportive parents who also acknowledged his alleged behaviour. A CAHBS assessment undertaken whilst he remained on police bail identified previously unrecognised learning disability, absence of multi-agency risk management and on-going high risk in absence of clear multi-agency planning. The identification of special educational needs identified and led to a placement in special school and children's social care became involved in family/community assessment, risk management and on-going family support. CAHBS remained involved and provided report for Crown Court outlining issues of risk and need and coordinated a proposed multiagency plan. The boy was sentenced to 3 year community supervision order. CAHBS continue to supervise sexually harmful behaviour intervention work provided by YOS.

b) 17 year old boy referred to CAHBS by social worker in children's disability team because of separate incidents of concern: he had asked boys under the age of 8 to take their trousers down and had received a recent police caution for downloading indecent images of children. He was recognised as vulnerable by police. The boy had moderate learning difficulties associated with autism and attended a specialist school for communication problems. He was in long-term foster care and subject to a full care order. CAHBS and CAMHS LD team jointly undertook AIM2 assessment which identified clear sexual preoccupations with younger children. CAHBS provided a series of intervention sessions undertaken with CAMHS LD team which clarified pervasive nature of sexual preoccupations with young children. All parties contributed to clear arrangements for transition to adult services to a highly supervised placement.

c) 9 year old girl referred by social worker in family support team because of sexualised behaviour reported within school. Such behaviour included: stating that she sucked her thumb because it was like a man's willy; asking boys to take their trousers down so she could suck their penis; talking about wanting to have sex and have a baby; explicit drawings and writings of a sexual nature. CAHBS undertook an AIM2 structured assessment jointly with the social worker which identified significant vulnerability and significant strengths. CAHBS and social worker undertook joint sessions with the girl focusing on understanding relationships; sexual development; consequential thinking; relapse prevention planning and support network development. Social worker also completed family work and work with school supported by CAHBS. Case eventually closed to CAHBS but social worker maintained support with girl as a 'child in need'.

d) 14 year old boy referred following concerns regarding sexualised behaviour by social workers and police following section 47 planning meeting. The boy had been remanded into custody following an alleged serious sexual assault on elderly female. He was subsequently sentenced to indeterminate custodial sentence and was placed in an out of county secure children's home. CAHBS undertook joint assessment with YOS and the team providing psychological intervention at the unit. CAHBS continue to monitor progress at request of children's social care and YOS and case still remains open after 2 years.

e) 16 year old boy referred by YOS and children's social care. He was accused and charged with multiple sexual assaults against female peers. He had a history of parental neglect and his mother refused to acknowledge longstanding professional concerns about him. He was recently recognised as aggressive and intimidating to teachers in a pupil referral unit. Social care and YOS requested CAHBS assessment and, in particular, suitability for therapeutic engagement/placement in lieu of custodial disposal. CAHBS undertook joint assessment with forensic CAMHS, which revealed the boy to be at high risk of future harm to others with few protective factors and little scope for therapeutic engagement. CAHBS recommended strict risk management approach in community and, in the event of a custodial sentence, further assessment of sexually harmful behaviour. The boy refused further assessment in custody and, following release 6 months later, multiagency community risk management approach continued including oversight by MAPPA. CAHBS remain involved in multiagency oversight.

5) Summary of main findings

Quantitative data

The Child and Adolescent Harmful Behaviour Service (CAHBS) was in contact with 156 children and young people from Oxfordshire and Buckinghamshire in the year April 2012 to March 2013. This figure includes cases referred before April 2012 and during the evaluation period which were either closed before April 2013 (105 cases) or remained open beyond that time (51 cases).

The team became involved with the cases of children between the ages of four and 17. Almost half of the children/young people were in the 14-17 year age range (45%), however, more than a quarter of referrals were for children between the ages of 4 and 10 years (28%). Most referrals were for boys (83%), but the CAHBS team have advised that the proportion of girls (17%) referred was higher than samples reported elsewhere. The ethnic mix of the caseload was broadly representative of the populations of Oxfordshire and Buckinghamshire.

The children and young people referred to the service were complex in terms of their needs and in the number of agencies with which they had contact at the time of referral. Large numbers of children and young people referred to CAHBS had some form of contact with children's social care (63%) with formal statutory social care involvement in 81 (52%) of all cases. Furthermore, 40% had statements of special educational need or were attending a pupil referral unit.

At the time of referral, 22% of the cohort was in contact with one other agency and the remaining 78% were in contact with at least two other agencies. The principal agencies with which young people had contact at the time of referral were children's social care (67%), education (58%; additional to mainstream input) and child and adolescent mental health services (CAMHS) (47%) with a third of referrals (33%) having had some form of contact with the youth justice system (police or YOS). Almost all referrals to CAHBS were received from five different agencies: children's social care (46%), education (16%), CAMHS (24%), Thames Valley Police (6%) and Youth Offending Services (5%), although referrals from other sources (GP, health visitor, MIND and young people's family) were also received.

For cases in which data were available (n=80), children and young people's behavior had generally been first noted at least one month prior to referral and for less than one year in most (69%) cases. However 31% had demonstrated such behaviours over a longer period of time. Over half (53%) of the referrals had demonstrated more than one form of sexualized behaviour, with 21% being for penetration (21%) and 2% for attempted penetration. Sexualised behaviours had been exhibited in more than one context in 41% of cases. Of the cases for which data were available (n=108) 43% fulfilled the criteria for at least one mental health diagnosis, such as ADHD/hyperkinetic disorders, autistic spectrum disorders, learning disability, anxiety, depression, attachment disorder and conduct disorders.

In cases where data were available (closed cases and some well-established open cases; n=124), the input from the CAHBS team involved advisory or consultative input which varied in levels of complexity in approximately half of referrals (54%). Direct clinical input from CAHBS team members was provided in 46% of cases and either involved assessment alone (27%) or assessment and subsequent intervention (19%). A variety of generic assessments or specialist assessment tools were employed by the team with the AIM2 assessment being used, often in association with other assessments, in the majority of assessment cases (88%). The assessment was often performed jointly with a partner agency. For closed cases, most young people were in contact with the service for less than one year (93%) with half being discharged within 3 months. A few cases remained open for over a year (7%).

For the majority of young people (79%), living arrangements remained consistent during their contact with CAHBS. However, for about a fifth of young people, this was not the case with those experiencing changes from family to foster/residential care and within foster/residential care outnumbering those who changed circumstances within family arrangements or returned to a family setting from foster/residential care.

At the time of discharge from CAHBS, the principal agencies involved with young people were children's social care (48%) and CAMHS (46%) with other agencies taking an active role in a smaller numbers of cases (education 15%; police 6% and YOS 8%). It is notable that approximately a tenth of young people had no agency involvement at discharge and that, overall, the remaining cases were involved with fewer agencies at discharge than referral. Social care and CAMHS were most frequently involved at both referral and discharge (71% and 62% respectively) but all agencies were involved at referral and discharge in at least a fifth of their cases. Education and the police were more frequently actively involved at referral than discharge.

Qualitative data

Twelve interviews (a response rate of 48%) were undertaken with referrers to CAHBS and five interviews (a response rate of 63%) with strategic stakeholders. In addition, the Participation Lead for the Child and Adolescent Mental Health Service completed 19 interviews with family members or carers of a young person who had been in direct contact with CAHBS. All interviewees were distributed across both Oxfordshire and Buckinghamshire and professionals came from a similar range of agencies in each county.

The feedback about the service from the referrers and stakeholders was generally very positive, with multiple references to good communication between CAHBS and families and good communication, responsiveness and joint working between CAHBS and other agencies. The comments made suggest that the support, advice and reassurance provided by CAHBS, particularly around assessing and managing risk, dealing with distressing cases and discussing sexually inappropriate behaviour with families and other professionals were particularly valued. Interviewees also gave positive feedback about training and workshops provided by CAHBS. Some interviewees provided examples of ways in which they felt CAHBS had improved outcomes for young people and all referrers reported that they were either 'satisfied' or 'very satisfied' with the service. Stakeholders generally felt that CAHBS has made a positive contribution to multi-agency case management and risk management, that it is valuable to have advice and support from a specialist team about issues involving sexualised behaviour and that the absence of the CAHBS team would be a loss.

Family members and carers were overwhelmingly positive about the services they had received from CAHBS, including their experience of the service in terms of communication and responsiveness and in terms of the positive impact on their child. Of the nineteen parents or carers interviewed, seventeen (89%) stated that they were 'very satisfied' with the service, with one interviewee 'satisfied' and the other 'neither satisfied nor dissatisfied'.

Comments from professionals in relation to less positive experiences tended to relate to single instances. However issues raised by several interviewees included some lack of awareness or understanding about what to expect from CAHBS amongst the professional community and the need for greater publicity of the service. A few stakeholders mentioned the current size of the team and the sustainability of using non-CAHBS people to do frontline work, highlighting the need for an ongoing training programme to ensure continuity of skills when trained professionals leave and new staff arrive. Both referrers and families suggested that further follow up after last contact with CAHBS might be beneficial and also suggested that CAHBS involvement in some preventative work, if possible, would be useful.

6) Conclusion

This evaluation has demonstrated that the CAHBS service has seen the type of children and young people that the service was set up to support and has received referrals from a wide range of agencies across Oxfordshire and Buckinghamshire. The children and young people referred to the service were complex in terms of their needs and in the number of agencies with which they had contact at the time of referral, and a third of referrals had some form of contact with the youth justice system. Sexually harmful behaviours had been noted between one month and one year prior to referral in the majority of cases. Over half of referrals had demonstrated more than one form of sexualized behaviour, with almost a quarter of referrals being for penetration or attempted penetration.

Input from the CAHBS team varied with the nature of the case, involving advisory or consultative input which varied in levels of complexity in approximately half of referrals. Direct clinical input from CAHBS team members was provided in just under half of all cases and either involved assessment alone or assessment and subsequent intervention. The involvement of the CAHBS team was often sustained over a considerable period of time with contact lasting between four and 12 months in approximately half of cases, and more than a year in 7% of cases.

It was notable that approximately a tenth of the cases in which the CAHBS team were involved had no agency involvement at discharge and that, overall, the remaining cases were involved with fewer agencies at discharge than referral.

The feedback about the service received from the referrers and stakeholders was very positive, with multiple references to good communication between CAHBS and families and good communication, responsiveness and joint working between CAHBS and other agencies. Family members and carers were overwhelmingly positive about the services they had received from CAHBS, including their experience of the service in terms of communication and responsiveness and in terms of the positive impact on their child.

This evaluation provides support from a range of quantitative and qualitative data that the CAHBS services makes a positive contribution in a specialist area of work and is valued by professionals, parents and carers.

Appendix 1: Interview schedule for direct referrers to CAHBS

Interviewee:

Organisation, location (Oxon or Bucks) and position:

Date of interview:

Name of interviewer:

1. Which service did the referral to CAHBS come from?
2. Why did you have contact with the CAHBS team?
3. What were your expectations of contact with the CAHBS team?
4. What went well in your contact with the CAHBS team?
5. What did not go well in your contact with the CAHBS team?
6. Are there ways in which the CAHBS team could improve its service?
7. In terms of the following roles of the CAHBS team, how has it helped you, and how could it improve its service?

Functions of the CAHBS service	How has the CAHBS service helped you in this area?	How could the CAHBS service improve its service in this area?
Communication and liaison across agencies		
Taking a lead in the field of sexually harmful behaviour in young people in Oxon/Bucks		
Training for frontline staff in this area of work		

8. In terms of the clinical benefits anticipated from the CAHBS team, how has it helped you, and how could it improve its service?

Clinical benefits anticipated from the CAHBS service	How has the CAHBS service helped you in this area?	How could the CAHBS service improve its service in this area?
Advice and consultation for professionals working with young people with sexualised or sexually harmful behaviour		
Joint or supervised assessment of complex cases		

Supervision of professionals providing interventions		
Identification of a range of needs of young people (e.g. safeguarding, mental health, learning difficulties, etc)		
Assessing and managing risk of harm to others and vulnerability in young people.		
Improving outcomes for young people in this area of work		
Any Others?		

9. Overall how satisfied have you been with the response(s) you received from the CAHBS team?
    - Very Satisfied
    - Satisfied
    - Neither satisfied nor dissatisfied
    - Dissatisfied
    - Very dissatisfied

10. If the CAHBS team no longer existed, what impact would this have on your ability to work with concerns about sexual behaviour in young people?

11. Are there any other comments you would like to make about this service?

Thank you and Close

Appendix 2: Interview schedule for stakeholders involved in the commissioning and strategic oversight of CAHBS

Interviewee:

Organisation and position:

Date of interview:

Name of interviewer:

1. Do you work in Oxon or Bucks?

2. What is the nature and extent of your involvement with the CAHBS team?

3. Do you consider that the CAHBS team has enhanced the provision of services for children & young people with sexually harmful behaviours in Oxon/Bucks*?
    - If so, in what ways?
    - If not, why not?

4. Have you received any feedback either positive or negative from individuals or agencies who have accessed the service since it was set up in 2009/10?
    - If so, what has the feedback been?

5. Do you think the service has improved the ability of frontline practitioners appropriately to manage this client group?
    - If so in what ways?

6. Are there any ways in which you feel that the service could be improved?
    - If so, how?

7. What do you think the consequences would be if the service ceased to exist?

8. Are there any other comments you would like to make about this service?

Thank you and Close

Appendix 3: Interview schedule for families or carers of young people with whom CAHBS has been directly involved

To whom it may concern,

You recently had contact with the Child and Adolescent Harmful Behaviour Service (CAHBS). We are interested in your views regarding the service and would be grateful if you could answer the following questions:

1. How did you become aware of the CAHBS service?

2. What were your expectations of the service you would receive from CAHBS?

3. Please comment upon your experience of the following:

    a. Accessing the service (seeking advice, making contact and receiving a response)

    b. Feedback / communication from the CAHBS Service to you

4. Please state what went well during your contact with CAHBS.

5. Please state what did not go well during your contact with CAHBS

6. Please let us know how you think we might improve our service

7. If you have any additional comments, please add them here.

8. Overall how satisfied have you been with the service you received from the CAHBS team?
    - Very Satisfied
    - Satisfied
    - Neither satisfied nor dissatisfied
    - Dissatisfied
    - Very dissatisfied

Thank you and Close

Appendix 4: Letter of invitation sent to the families/ carers of CAHBS users

Oxford Health NHS
NHS Foundation Trust

Child and Adolescent Harmful Behaviour Service
Boundary Brook House
Old Road
Headington
Oxford
OX3 7LQ

Tel: 0845 219 1459
Fax: 0845 219 1444
CAHBS.Team@oxfordhealth.nhs.uk
Web: www.oxfordhealth.nhs.uk

Our Ref: CAHBS/sjb

Dear family member

In the course of the last year your family has been in contact with our service, the Child and Adolescent Harmful Behaviour Service (CAHBS) and the key clinician whom you met was XXXXXX.

We are currently undertaking an evaluation of our service and would like to get feedback from families regarding their experience of input from our team. We are planning to contact you in the near future to undertake a brief questionnaire with you and hope that you would agree to this. The interview will be conducted by an interviewer who is specifically trained to obtain feedback from families about services provided by Oxford Health Children's Services but who is not a member of our team. Her name is Donna Mackenzie In this way we hope that you will feel able to be as honest as possible about your experience. Any feedback that we receive will be anonymised and your identity protected.

We hope that you will feel happy to participate in this evaluation which will help us improve our service for young people and families in the future. If you do not want to participate in this study please could you contact our team administrator, Sam Blacker, on 0845 2191459 so that we know not to contact you.

Many thanks for your help in this matter.

Yours sincerely

The CAHBS Team

Appendix 5: Illustrative comments about positive contacts with CAHBS

Positive experiences of communication between the CAHBS team and the referrer:

- CAHBS team are good at passing on information and chasing up information.
- CAHBS team provided a direct contact number and have always phoned back when a message has been left.
- Communication with CAHBS team was very good with lots of feedback, detailed reports and the CAHBS team were happy to attend meetings with the school.
- Communication and follow up on all actions was brilliant. CAHBS team were approachable and good at pulling multiagency professional together.
- CAHBS team have been very clear about what they can offer and in doing what they said they would.
- Very swift referral process with someone contacting her immediately for further information. CAHBS very clear about their remit and what they would be able to offer and provided feedback on every stage about what had been discussed and done.

Positive comments relating to joint working with other agencies:

- CAHBS will attend multidisciplinary meetings, or if they can't attend will send a report in.
- Very good joint working. Saw the young person in their establishment, attended risk management meetings.
- CAHBS helped in interaction with social care.
- Experience of case working with CAHBS has been good.
- Very helpful in liaison with social services in a case where a placement had broken down and there were concerns about what to do for the young person.
- Reports produced by CAHBS were of excellent quality and very presented without too much jargon.

Positive comments relating to the support, advice and reassurance provided by CAHBS:

- CAHBS provided reassurance that they were doing the right things with the young person, for example looking at the risks involved.
- CAHBS were able to confirm that way the practitioner was thinking about the child was correct and enabled her to discuss the case with the multi-disciplinary team with more confidence and authority, and to provide more support to the other agencies involved.
- CAHBS helped with risk assessment, confirmed the practitioner's view about the risks.
- Good to get a different perspective and second opinion from CAHBS about risk.
- CAHBS involvement adds weight and validation to the assessment of risk and harm for cases that are going to court or have Multi-agency public protection arrangements (MAPPA).
- CAHBS involvement an advantage in documentation to demonstrate that the issues and risks have been thought through and discussed with a specialist.
- Specialist knowledge and different experience of CAHBS team useful.
- CAHBS team have been supportive, and reassuring to talk through risk with a specialist team and to know that they are doing the right things with regards to risk.
- Very helpful to be able to refer to a psychiatrist at CAHBS and get help with risk issues.

Positive examples of support provided by CAHBS in relation to advice on how to discuss or explain issues to families or other professionals:

- CAHBS provided advice about how to discuss issues of sexualised or sexually inappropriate behaviour with the family, school and other professionals.

- CAHBS acted in an advisory capacity providing tools and literature to help support the family and signpost them to other services. This was particularly useful for family support workers working directly with the family.
- CAHBS provided consultation, advice and support to other agencies and the teachers dealing with the young person and the victims of their behaviour.
- CAHBS very helpful in liaising with the school and were open to the school contacting them if they had any further concerns
- CAHBS provided advice and really helpful practical and personal support for a practitioner dealing with a difficult case where a young person had been arrested following a serious assault.
- CAHBS were very good at reassuring a teacher that the case was upsetting and that her as a professional that her reaction in finding it difficult was appropriate.

Positive comments relating to the management of cases, including cases which have gone to court:

- CAHBS helped to get proposals to court, identify what facilities would best suit that individual and could link in with CAHMS where needed.
- CAHBS were able to look at appropriate placements for the young person and develop supporting information that could be presented at court.
- CAHBS did some one-to-one work with the young person and observed his behaviour at school.
- CAHBS put a good plan together, with very specific and tailored advice about how to deal with potential situations and be more prepared in the future.
- CAHBS have done very specialist work on screening for disability and cognitive functioning related to intent.
- The group supervision sessions with all case workers every two months ensures continual development rather than only getting involved when they have a case to deal with. Provides ongoing training and provides a specific opportunity to reflect on cases where there are sexual offences which they only come across periodically.
- CAHBS gave her confidence in what she has been doing and in planning future interventions, managing risk and taking things forward once CAHBS involvement has ended. She knows that she can contact CAHBS at any time in the future for further help.

Positive comments from stakeholders about service provision:

- CAHBS has given the police a better understanding of what they should put in place for these children/ young people which helps them make the best decisions.
- Their team more confidence in dealing with cases where there is sexual offending.
- YOS team had lacked clinical support before CAHBS and had learnt a lot from doing joint assessments and having joint meetings about particular cases, combining the CAHBS team's specialist training in working with this group of children and young people, but also recognising and using the YOS teams existing skills.
- CAHBS is a dedicated team with a standard ways of doing things, in contrast to some services where there are multiple teams each doing things in different ways.
- Can refer to CAHBS and get feedback directly, rather than CAHBS just being part of the wider system.
- CAHBS is a more direct connection for agencies and families by providing a team that people can make direct contact with for input, or advice and consultation when there are issues with sexually harmful behaviour.

Appendix 6: Illustrative comments about less positive contacts with CAHBS

Expectations of the service:

- Some colleagues were a bit confused about why CAHBS could not get involved in their cases- perhaps some more work could be done about setting realistic expectations about what CAHBS can and can't do.
- Disappointed that their case was passed to CAHMS despite the fact that they had had a conversation with CAHBS to check it was the right place before making the referral.
- Disappointed about how long the process was with a young person still waiting for assessment 5-6 weeks after an urgent referral. Aware that it takes time, but thought it would be quicker and has had an issue with the young person reoffending since referral.

Communication issues:

- Lack of communication between the agencies involved after the case had been passed from CAHBS to CAHMS. Had not been given a named contact for CAMHS and had not been contacted by the CAHMS team or notified when there were meetings about the case. CAHBS has assisted in chasing up details from CAHMS but this was not ideal.
- A few teething problems about setting dates and times for meetings or receiving late notice for meetings but was not sure if the problem was at the CAHBS end.
- Although the AIM assessment is the same the findings of the CAHBS assessment are written up in a different format in reports which can make it difficult to convert to the correct format. However, the issue was easily resolved with a phone call.
- They were on a waiting list for AIM2 training. They did not hear anything from CAHBS but heard via colleagues that the training session was taking place.
- Has come across people who should have been aware of the CAHBS service but were not.
- Delay in producing an annual report on the service due to the CAHBS systems not being set up to collect the data that they wanted reported.

Comments on the CAHBS model of service

- CAHBS service is different but not necessarily better than the previous system - previous system had not been 'broken'.
- Concern about the sustainability of the CAHBS model and reliance on non-CAHBS people doing the frontline work rather than CAHBS doing it directly.
- Size of the CAHBS team – i.e. not enough of them.
- Perception that success of the CAHBS service is driven by their leader and was not sure that the model would be as good or sustainable without that.
- Intention to set up a professional network of workers who were trained in AIM2 assessment has not worked so well in their area (Oxfordshire), although they had heard that it works better elsewhere. The problems identified included the fact that the staff who had received training had less hands-on experience than they were expecting and therefore had less experience and confidence if they were called on to do an assessment later on. In other cases people had moved on to other roles.