TaMHS Evidence Paper

Scrutiny 24 3 15

Glossary

C&YP – Children and Young People
DfE – Department for Education
GP – General Practitioner
TaMHS – Targeted Mental health in Schools

Additional information regarding the concern raised at scrutiny re TaMHS via the Leeds Medical Committee and Councillor Flynn

Variability in TaMHS Commissioning City Wide

This appears to be around 2 separate issues:

1. Local cluster commissioning leading to a different offer in each cluster.

As outlined previously TaMHS is embedded in local cluster, multi professional, school facing services with a 2 year, joint funded (87% schools funding), setup and support phase that has built over time from a pilot in 2008 into a city wide service in 2014[1]. The model relies on clusters of schools being the commissioners of the service as we found this creates a stronger model of ownership, sustainability and re investment without affecting quality outcomes. It is this model that leads to a variation in commissioned providers around the city and differences in capacity as different clusters receive different levels of funding and thus money to commission local services. Each service provider, however, has set requirements around evidence based provision and set reporting outcomes built into contracts for consistency and transparent quality assurance. The original pilot model used solely CAMHS as a provider (as well as commissioning a nationally well-established Place2Be[2] model in South Leeds for comparison), intending to lead to 'one service'. For a range of reasons this was found quickly to be an unsuccessful approach so we changed to, the more effective, range of locally commissioned providers embedded in cluster multi professional teams.

This roll out has grown over time in phases due to evidenced outcomes (attached) which includes C&YP opinion and case studies. These outcomes have been chosen to measure improvement in mental health, user opinion and also the requirements of the commissioners (schools) and are quite comprehensive compared to other services. The evaluations have been commended for this by Schools' Forum and have led to both reinvestment by schools but also the seed funding from School's Forum, Children's Services and NHS Leeds. Every school cluster has re commissioned TaMHS after the 2 year joint funding stage from their own budgets (100% schools' funding).

In addition the TaMHS Leeds project has been recognised as effective practice by the (now defunct) National CAMHS support team (2010) and the DfE (2011) as well as being referred to as good practice in the upcoming reports by both Public Health England (Promoting children and young people's emotional health and wellbeing) and the Children and young people's mental health and

[1] http://www.schoolwellbeing.co.uk/pages/tamhs-leeds
[2] http://www.theplace2be.org.uk/

well-being taskforce. It is this overall evidence that demonstrates TaMHS is effective at providing a specialist mental health in-reach service that is embedded in local clusters, school facing, early intervention (plus more) and short term in nature.

This leads to a well sustained, locally owned setup that is different from a centrally commissioned, traditional service. There are many advantages to this offer including local ownership and capacity building, being part of the action focused nature of the clusters and sustainability. It is from this growth that the service has come on the wider GP radar as a source of mental health support for C&YP.

The current waiting times city wide (from TaMHS practitioner perspective) vary from cluster to cluster. The shortest time is no waiting list, the longest is 4 months with an average typically quoted of 8 weeks.

This issue of variability in provision was addressed at the LMC meeting on 29 1 15.

LMC response dated 25 2 15 stated "no comprehensive service is yet in place. The GP pilot scheme is operating in certain areas of Leeds and you informed us that it is working well" which leads to:

2. GP referral access.

This issue appears to have been mixed in with issue 1 but the GP access to TaMHS that Dr Sathiyaseelan refers largely to in his letter has been in the small pilot stage[3] and will soon be a city wide pilot expansion thanks to CCG investment of £1.5 million. This is on top of the £2.2 million overall investment in school early intervention mental health support this financial year.

Dr Sathiyaseelan is correct that 'no comprehensive service is yet in place' due to the pilot nature of the phase but the school facing service has been available to all clusters since November 2013. This next stage of direct GP referral will make a difference in providing a service to all C&YP of school age in Leeds. It appears the LMC's concerns re variability in the TaMHS service is based on both this current lack of access to all GPs and also the commissioning model outlined above. Dr Sathiyaseelan said in the meeting on 29 1 15 that he felt reassured by the TaMHS, school facing, service, but this has not been documented in his letter dated 25 2 15.

A summary of key findings from the GP pilot areas has now been collated and can be found in Appendix 1. This includes C&YP opinion. Overall it is very positive, while being clear about the challenges moving forward which include:

- Quality and variability of referral info
- Referral going to the correct place e.g. correct cluster, CAMHS or TaMHS
- Ensuring consent is sought and clarified to patient.
- Clarity of process and services
- School transition times are a time of heightened anxiety for C&YP

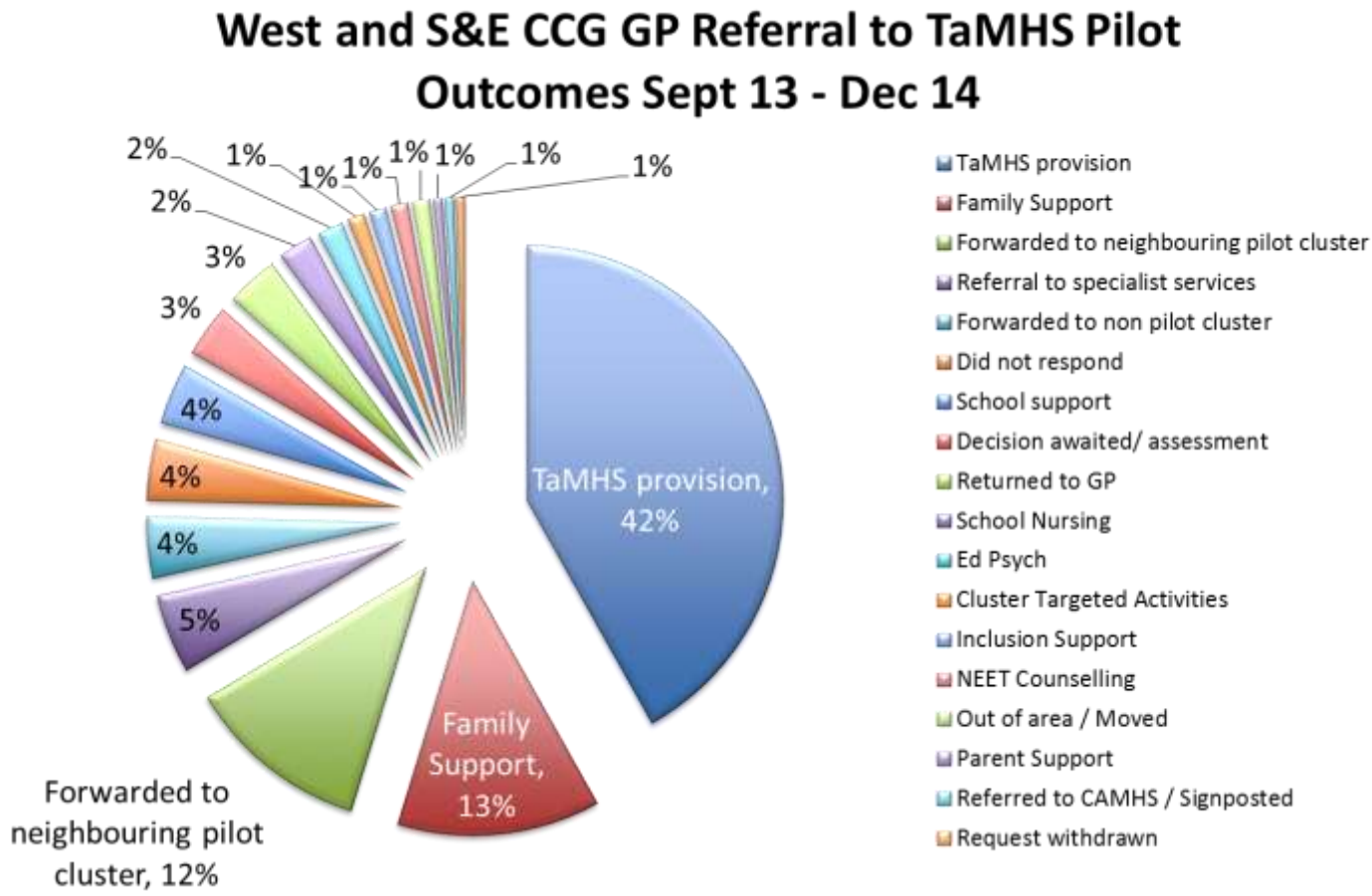
[3] Brigshaw, Temple Newsam Halton (From September 2013. Joint funded by TaMHS and S&E CCG), Bramley, Aireborough and Pudsey (from September 2014) funded by West CCG.

It is clear from this and from the recent Healthwatch report that, despite much time spent with individual schools and GP practices about TaMHS that a continued, consistent communications programme should be continued and widened[4]. The key recommendations of the Emotional and Mental health review to develop a Single Point of Access and associated communications programme in line with publicising a local offer should help resolve many of these issues.

Appendix 1

Collation of the 2 GP referral pilot areas

TaMHS / cluster Emotional Wellbeing and Mental Health support is the most likely outcome from a GP referral (but there are multiple other outcomes too as the referral is into the cluster Guidance and Support team)

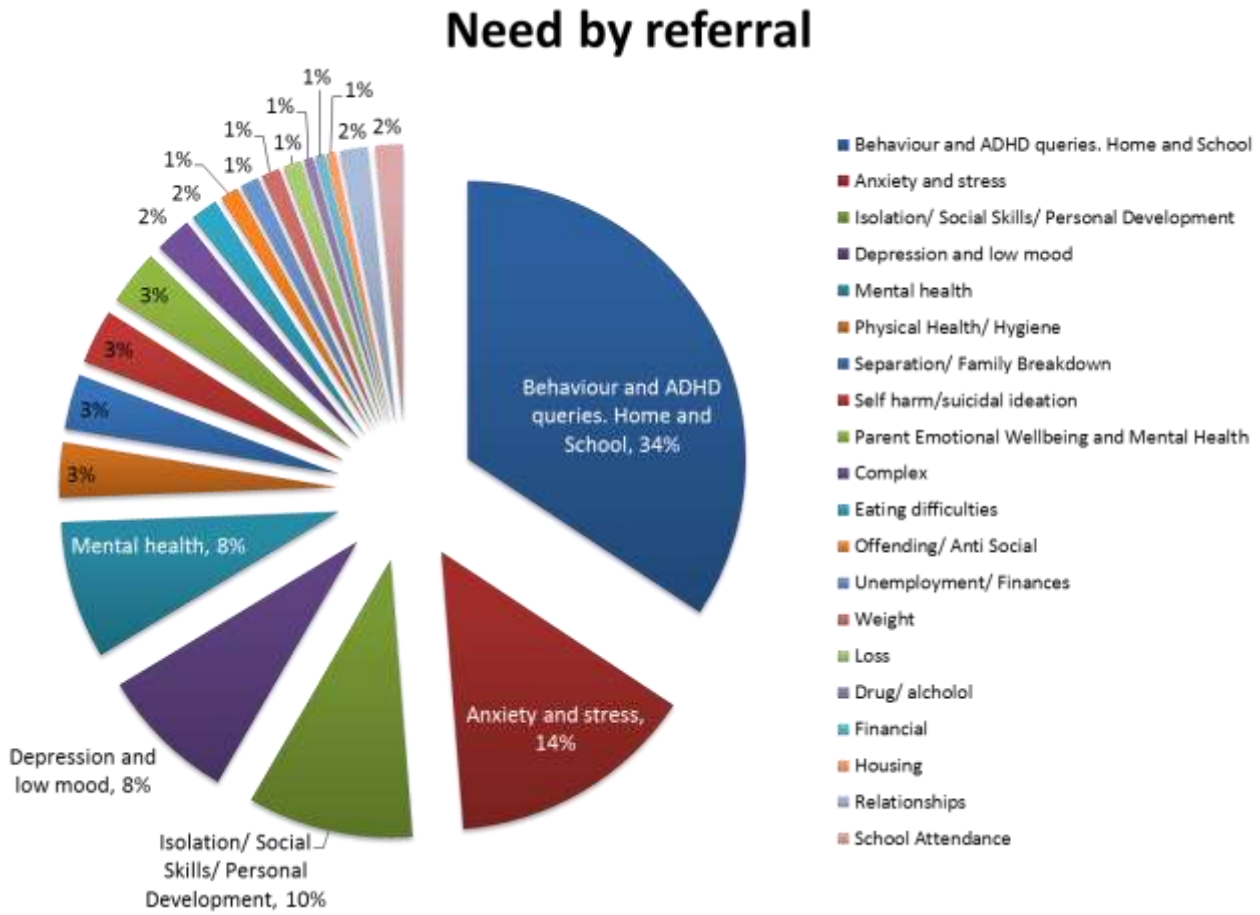


Overall Mental Health Assessment (SDQ) improvements

- Average improvement of 6 points (higher than average)

[4] This is recommended by Geraldine Strathdee, National Clinical Director for Mental Health, NHS England. Aiming for a 20% spend of total budget on a communications strategy

There is a broad range of need at referral



Unedited sample of C&YP feedback:

- *'I feel like someone wanted to listen to me, understand me, understand where I was coming from. I had a voice in my sessions which I never have at home or at school.'*
- *'The treatment was fantastic. I can't rate it highly enough, it helped meeting someone, talking, I was made comfortable.'*
- *'The support and reassurance was helpful. Also the personality and actions that made me relax more. We couldn't have done anything better, and I would definitely recommend counselling to a friend who's struggling emotionally.'*
- *'It was helpful talking about my problems and worries'*
- *BH thought that he had been treated "Very well" and said he had felt "incredibly comfortable."*
- *He had found counselling good and helpful, that "nothing could have been better for me".*
- *When asked what was good about the sessions, he said, " I felt comfortable, I could be honest, and was never judged".*
- *When asked if he would recommend counselling to a friend who was struggling emotionally, he said "Certainly, it really helped me, and I'm sure it can help others too."*

- *I liked playing hide and seek, marbles, and drawing. We played nice. We couldn't have done much better, we could have done better pictures.*
- *The support and reassurance was helpful. Also, the personality and actions that made me relax more. We couldn't have done anything better, and I would definitely recommend counselling to a friend who's struggling emotionally.*

Case Studies

1

Reason for original referral

Anger and behaviour issues reported to be seen by child at home, parents requesting support and strategies having been to GP and received feedback that it did not meet criteria for CAMHS. GP recommended that parenting support and advice in the first instance would be helpful.

What long term outcome is agreed between parents, child and agencies?

For R to be able to manage angry or anxious feelings and emotions without throwing, shouting or screaming. The challenging behaviour is seen particularly at home. Parents to feel they have a range of strategies and approaches to enable a calmer interaction and in particular feel there is a more positive relationship between R and her mum.

Date of original referral: *27-Aug-14*

Date of allocation to Parent Support: *01-Oct-14*

What support has been offered?

- *R is part of a nurture group in school*
- *Allocation to Family Support Outreach Worker – # home visits have taken place offering advice, guidance and strategies. Worker has met with both parents and child and observed R in school and at home.*
- *Management of routines, tasks and bedtime/dressing/washing, etc – advice and strategies suggested – using reward charts and approaches.*
- *Promotion of play activities and approaches to provide more opportunities for relaxed interaction – rather than homework or music practice – that are areas of both strength but possible pressure and trigger points.*
- *To promote the strengths and areas of success, as well as to highlight where R has persisted with tasks despite making a mistake and managed her anxious/feelings of failure in a calmer and less destructive manner.*

How has the situation improved?

- *Parents report that it has become easier to get her to do things – basic routines are improving and doing when asked.*
- *R has been less inclined to throw things and there have been very few incidents of this since Christmas apart from once with the violin bow more recently in a moment of frustration during a home music practice.*
- *Intensity of emotion has decreased. Parents report that they feel they are managing the situation better and this has made a difference to the outcomes of potential issues that previously could have escalated.*
- *School remains a positive place and experience for R with her coming across as a good role model to others in the nurture group, having a solid group of 2-3 friends with whom she*

plays. R enjoys music and is proud of her violin playing and the improvement she has shown with persistence and practice.

What continue to be the challenges?

There are still potential flashpoints and issues when R can become frustrated or unpleasant, saying things that upset her parents, particularly towards mum. This tends to be in response to requests to tidy up/go to the toilet/get dressed. R also displays some frustration and a low level of personal ownership when she makes a mistake, does not get things right or feels that she is not able to do something she believes she can do. Mum feels that beneath the anger and frustration shown remains a level of anxiety over getting things right and a personal expectation to be perfect.

At this stage, it was agreed that R's name would be included on the TaMHS waiting list – but this would only be offered if having persisted with the parenting and school based strategies – there was still felt to be a therapeutic need that required short term one:one counselling.

2

Dear Dr.

Re: TAMHS (Targeted Mental Health in Schools) counselling referral for M (Dob:)

Thank you for your referral dated 24th June 2014. ("feels anxious when there is a discussion of menses/blood and other bodily fluids. Anxiety episodes can be associated with symptoms such as nausea, dizziness etc.")

M has attended 9 sessions of counselling in school from 8th September to 17th November.

I met initially with R (mum) who described M as a sensitive and fearful child with a good imagination. Particular fears included;

- *being alone upstairs and would routinely request for someone in the family to go with her to the bathroom and a particular fear about the bathroom cupboard*
- *the book "Room on a broom" which had given her nightmares and was removed from the home*
- *body parts (not wishing to think or talk about internal body parts in particular) – any mention of bones, blood etc would make M feel highly anxious and there have been occasional incidents at school where M has had to be removed from class.*

Mum reported symptoms of her anxiety to include:

"feels queasy and faint and goes white and clammy if anyone mentions blood, guts, heart or any other organ….has to leave science class when they learn about such things….doesn't like the veins in her eyes…vomited in class when they talked about the menstrual cycle….fainted when I put moisturiser on a bit of sunburn"

In all other respects M is a happy, healthy, confident girl achieving well academically, with a close circle of friends and enjoying many out-of-school activities.

Following advice offered to mum:

- *Parents had been avoiding exposing M to fear triggers in the hope of reassuring and minimising fear and anxiety. Explained how this was very likely to be compounding and exacerbating fear and recommended that feared objects or places should not be avoided and to encourage and invite questions and curiosity.*

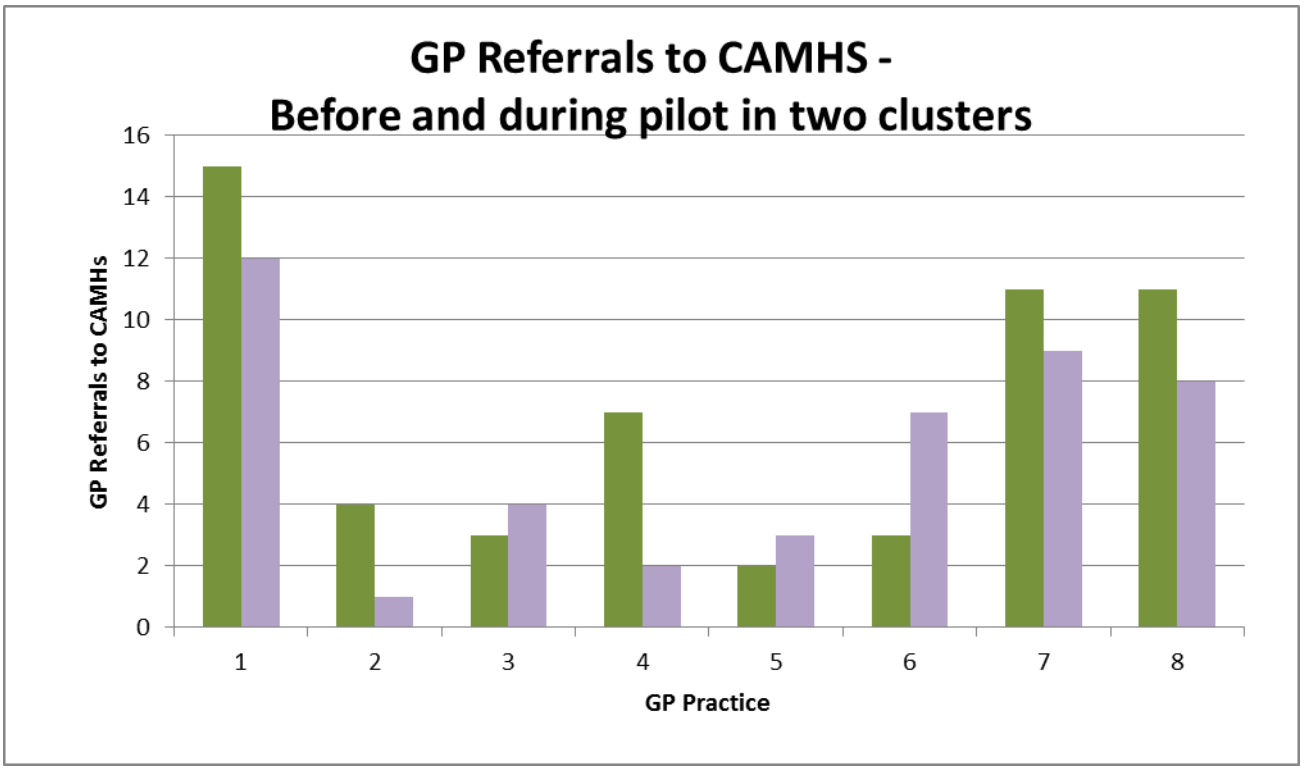
- *Offering opportunities for exposure eg. Inviting Martha to help with cooking to minimise her fear of raw meat.*
- *Reinforce and explain difference between irrational thoughts and reality.*

M identified the fears listed above and explained how this distressed her greatly because she felt she was different from others and wanted to be 'normal'. We discussed strategies for exposing herself to her 'fears' where M was very proactive and creative in coming up with ideas.
Together we devised strategies for exposure to feared things which M appeared to handle easily and without apparent anxiety allowing us to consider other 'underlying' issues such as a fear of drawing attention to herself and being 'told off'. We considered the impact of imminent puberty and feelings around this but was not felt to be a significant factor in her anxiety episodes. This did allow M opportunity to explore her emotional responses in a much wider context which was helpful to her. It is likely that M's 'phobias' were a way of externalising and managing some difficult emotions. Once she had an opportunity to explore, question and challenge these she was able to feel much less frightened.
Relevant feedback was also offered to M's teacher in order to support her in class when there is likely to be 'trigger' discussions or topics.
Outcomes:
The strengths and difficulties questionnaire was given to mum at the start of counselling at again at the end of counselling. SDQ (parent) pre score = 7 ; follow up score = 3 (-5 decrease within the normal range).
Feedback from mum: Counselling had helped 'a lot' particularly with being happier, more settled, less worried and better able to communicate. "M enjoyed meeting each week with Rachael and she can talk openly about body parts and internal organs now."
Feedback from Martha: "It has helped me with my problems and worries"
Given the positive outcomes above the family are not seeking any further help and support at this stage.

GP feedback

- *As a practice we have found this service extremely valuable for our patients and received good feedback from patients that have accessed the service.*
- *Very useful service for GP's*
- *Patients are seen quickly*
- *Positive feedback from children to GP's*
- *None of the children referred have disengaged*
- *There seem to be less need for GP referrals into the service - because the schools know they can refer.*
- *Less workload for us as the schools seem to be using the service*
- *Please can we have up to date leaflets re the service.*
- *Please continue with the service as very positive that schools know they can refer.*
- *Not had any dealings with the service but am aware of it should I need to use it.*

Early signs CAMHS referrals may reduce



Known Issues

- Quality and variability of referral info
- Referral going to the correct place e.g. correct cluster, CAMHS or TaMHS
- Ensuring consent is sought and clarified to patient.
- Clarity of process and services
- School transition times are a time of heightened anxiety for C&YP