**GM Provider Annual Reporting**

**September 2020 – August 21**

**Salford Thrive In Education – CAMHS i-Reach**

## Background and Introduction

The introduction of the Mental Health Support Teams (MHST) was a much-welcomed extension of the pre-existing CAMHS i-Reach 'getting help' offer to Salford following significant investment and support since 2016. As Salford had made a commitment to the ongoing development of the Ann Freud CAMHS School Link Project with expansion of the service via the commissioning of 2 CYP IAPT post (Children and Young People's Wellbeing Practitioner's) the service was in an ideal position to build on the collaborative approaches already in place across the borough with Educational Psychology, 42nd Street, Early Help Co-Ordinators and Place2Be.

What we could not have possibly anticipated as we entered the initial stages of planning and preparation, was the global pandemic and national lockdown that resulted in us all making rapid adjustments to the way we worked and how we could implement a new model of clinical practice that relied upon outreach based whole school approaches, clinical interventions focused on 'exposure', increased behavioural activation and messages that we could contain and manage worry when the world around us was entering a much higher level of vigilance to threats, risks and worry.

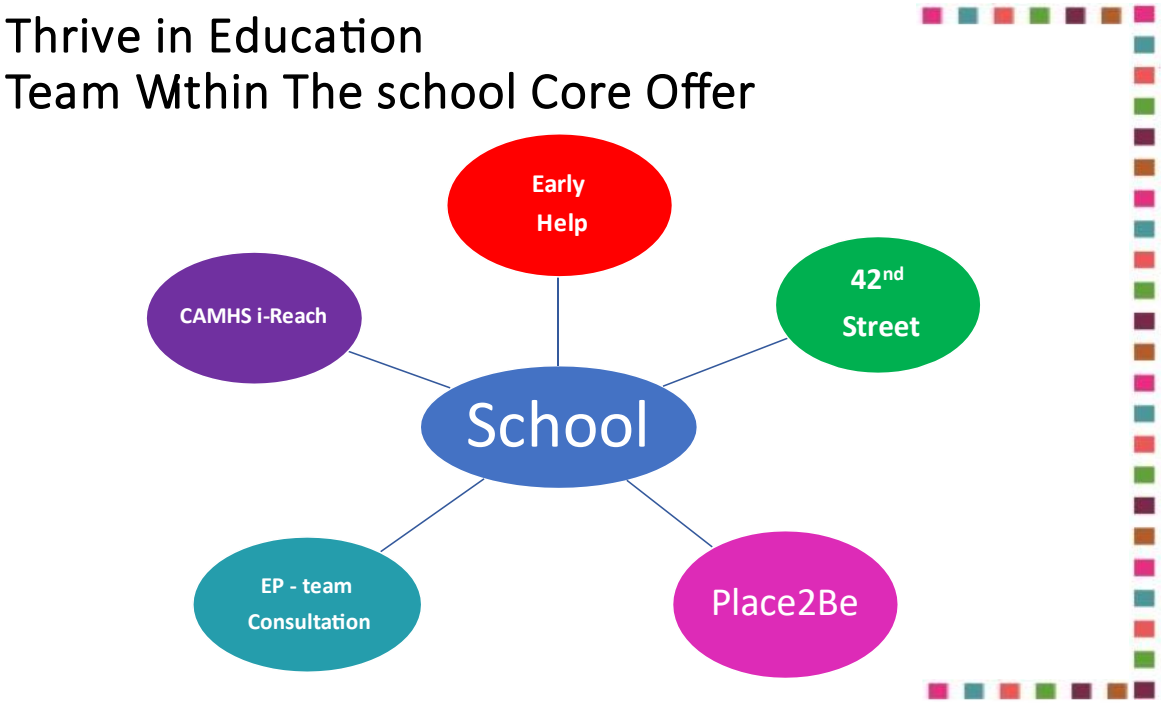
The CAMHS i-Reach team is based at Pendleton Gateway as part of the Salford CAMHS Core team which enabled us to establish a central base very quickly as well as continue close working practices with our Core CAMHS colleagues.

### Salford Thrive in Education Core Team

The core team of practitioners representing the Thrive in Education team met on many occasions to develop and operationalise the model to ensure it complimented the current offer in Salford and built on the strengths of the community. Meetings were chaired by the CCG Senior Integrated Commissioning Manager for Children and Young People's Mental Health with additional support from CCG/LA staff.

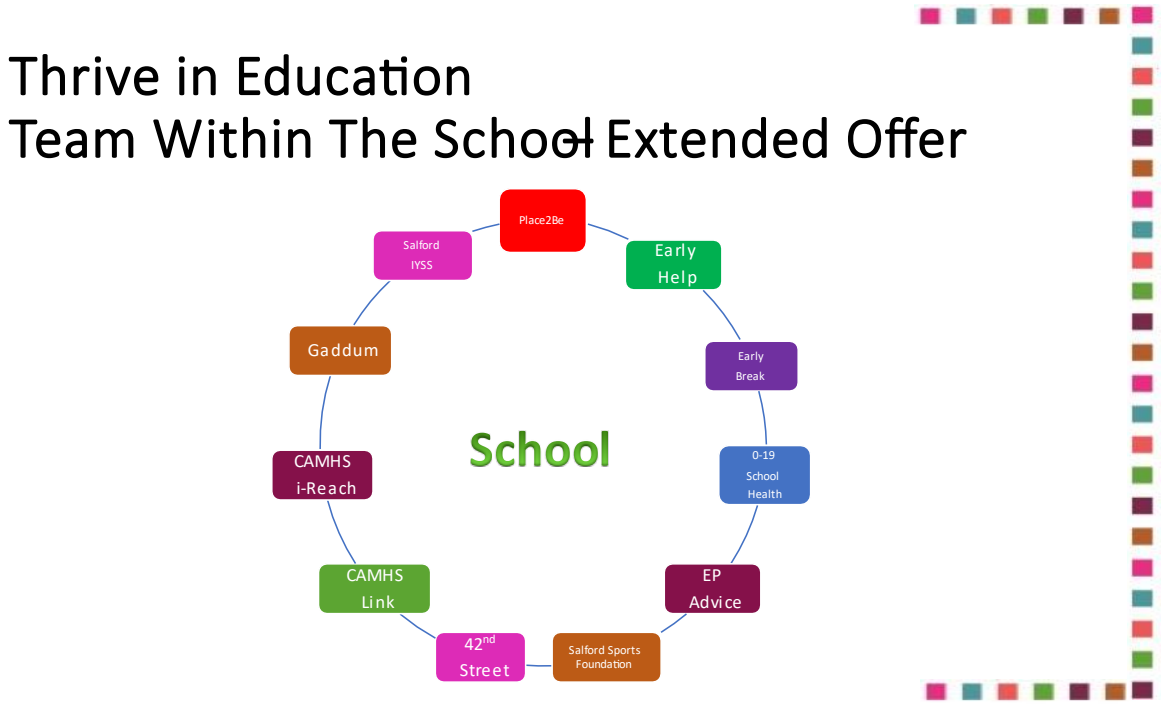
It was incredibly helpful to have staff who were able to provide historical and current narratives about schools, community projects and local developments to ensure we were able to develop an offer schools, young people and families would want to engage with.

It was agreed that the 'core' team would meet on a regular basis and develop governance via a Thrive in Education Board meeting to be chaired by senior Salford staff, with membership from a wide variety of senior professionals who could guide, advise and challenge the progression of the offer.




The implementation of whole school approaches has been an intrinsic aspect of the collaborative working models around emotional health and wellbeing in Salford for many years. This approach has been expertly underpinned by the EP's 'Emotional Friendly Settings' (EFS) project which has established accreditation and awards with bronze, silver and gold status for local schools.

As a core team, we recognised that any developments with the MHST's needed to have the EFS ethos as its foundation with the opportunity to support schools to build on their existing engagement with the project. We therefore agreed to offer termly Thrive in Education school-based meetings, using the EFS School Action Plans as a central feature on which to build the clinical intervention aspect of the project. We also acknowledge the importance of linking with other community, statutory and VCSE organisations who would be able to support the implementation of the i-Thrive model across Salford.




**Identifying and Engaging Schools**

Every school in Salford was evaluated on their level of engagement with EFS, attendance at local training (i.e. Papyrus, ACE's, LGBTQ+), CAMHS School Link status, as well as their capacity to engage and make use of the MHST offer.

Once the appropriate schools were identified by the group, a letter of introduction with a bespoke offer for each school was sent outlining the project aims as well as the expectation of schools such as attendance at Thrive in Education meetings, provision of a confidential space for clinicians.

School representatives were then invited to a number of virtual introductory workshops delivered by the team to explain the model, the offer and the MHST processes. This was followed up with the offer for schools to engage with the 'Wellbeing Return to Education' which was facilitated by the EP service and supported by members of the core TiE team over the following months.

## Referrals and Activity

As covid, lockdown and social distancing restrictions have become such a normal part of everyone's lives, it is important to report on all aspects of the TiE delivery in the context of the continuing challenges faced by schools, families, young people and clinicians.

Thus, as expected many of the referrals received have been anxiety related, either existing anxiety problems that have exacerbated due to Covid restrictions or anxiety tiggered by inconsistencies routine, reduced contact with friends, education, family, uncertainty about the future, safety an place in the world, disruption to usual 'rites of passage' such as transition to high school, onset of puberty not to mention the high levels of social deprivation, poverty, domestic violence and criminal activity that already existed in Salford and has continued to be negatively impacted by further social challenges over the previous 12 months.

As a team CAMHS i-Reach have also found that there has been a significant demand from parents/carers to access support for their own wellbeing, strategies to cope with managing their children's mental health difficulties and feelings of isolation.

Whilst schools were all very keen to accept the offer to engage with the TiE interventions, some struggled more than others to practically make us of it as well as develop internal pathways to identify children and young people who would benefit from a low intensity CBT informed intervention. Those schools who had previously established effective internal pathways and mechanisms to identify CYP's to refer seemed to adapt much more rapidly and confidently to the covid restrictions and challenges. However, other schools seemed to have significant difficulties to identify children with low intensity presentations as they were constantly having to manage the presentations of those children with more complex difficulties who were often more visible in school SEN, behavioural and safeguarding systems.

Again, this seems to have been compounded by lockdowns as the majority of pupils who continued to attend school, were those who had been identified as being more 'vulnerable' and ultimately having more complex presentation the i-Reach interventions were not suitable to address. Thus, in this first 12 month period, the i-Reach team has never been at full capacity in terms of referrals.

The team have continued to offer advice, training, support and consultation to schools as part of their offer which has been promoted via the termly Thrive in Education meetings chaired by the Early Help School Co-ordinator.

Significant time is spent triaging referrals, as well as discussing concerns, contacting parents/carers, or identifying appropriate services to signpost to. Once the i-Reach liaison role was established, it was also agreed that the clinician would attend the daily 'huddle meeting' alongside other members of the mutli-disciplinary team to discuss any risks, identify signposting options and transfer referrals as appropriate between teams.

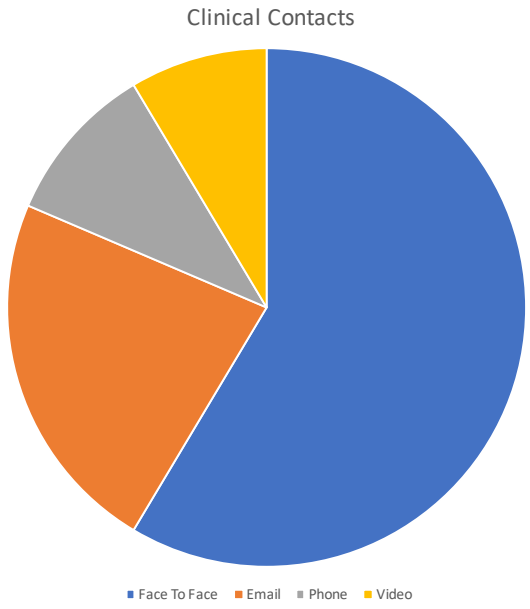
Once referrals have been accepted and allocated to clinicians, there have been has ongoing challenges actually meeting parents and young people. During lockdown, some parents wanted to delay or disengage from assessments as they were not leaving their homes, others reported that their child's difficulties improved when they were not in school and others found it difficult due to practical issues such as work commitments, working from home, childcare or children not in school, access to private places at home to meet virtually or lack of access to IT/wi-fi.

I-Reach clinicians were incredibly resourceful and flexible throughout this time, offering a wide range of options to engage parents and young people. Clinicians also kept many cases open for longer than the usual treatment period of 6-8 weeks knowing that there were legitimate reasons treatment could not be completed within the usual time frames given the very unusual circumstances in which we were trying to deliver them.

## Interventions

Young people and families have generally engaged well in interventions and the Low Intensity CBT model we offer as an intervention has been well received. Although the number of therapy sessions offered is 6-8 per young person, these sessions have often been delivered over a 10-16 week period, sometimes due to delays in access to schools, young people's absence from school, 'bubbles' or families having to isolate or families/young people needing to be re-engaged in therapy due to external stressors life events such as family breakdown, illness etc.

The majority of interventions have been for anxiety, with a number of parents also being supported via the Co-CAT research intervention from Prof Cathy Creswell's Covid related research project. This is a national research project focusing on parents of anxious children who are under 12 years old.




- Total Contacts – 2812
- Face to Face -1384
- Phone – 961
- Email –390
- Video - 82

Clinical staff have enjoyed taking part in the project and the feedback from parents has generally been really positive.

The team have also offered numerous Neuro Developmental 'work-ups' for CYP's who have been referred for example with anxiety, but once assessments have been completed have formulated that a presentation of ASD needed to be explored further. This is a significant piece of clinical work the team have offered to support CYP's and families. The

team have also supported the Core CAMHS team with ND clinical workups which has been well received and an excellent opportunity to develop skills.

**Workforce (MHST)**

A full complement of staff was recruited to post and in employment by February 2021. This enabled the team to fully operationalise by the end of March 2021.

Clinical supervision has been a main feature of support for the team, especially as the expectation from the national model is for all trainees and qualified staff to be offered 1 hour of case management supervision each week. This is a significant commitment in term of clinical time and is most definitely a workforce planning issue that needs to be prioritised for future recruitment and team development.

The team have also been able to access the following support throughout the year:

- Weekly Case Management Supervision
- Monthly Clinical Supervision
- Monthly Case Note Supervision
- Weekly Psychotherapy Clinical Case Management Supervision (for 4 months as part of a specific project)
- Monthly Clinical Skills Group Supervision
- Monthly Team Meetings
- Quarterly half day Team Development Meetings
- Annual Team Away Day
- TiE Development Meeting

The team have also been supported to attend additional training as part of their CDP including the Zoe Lodrick Trauma and ACE's training, Cultural Competence Training and Risk assessment training. Staff have also completed annual appraisals and mandatory training as per MFT policy.

Staff all have their specific clinical lead areas and are encouraged to access as much training and information about these areas to support their personal development as well as feeding back into the rest of the team.

There have been a number of 'social' events throughout the year to support the team development including bring and share lunches for development days and Christmas, social outings, i-Reach picnic and birthday celebrations.

## Stakeholder Engagement

**Educational Psychology** – positive relationships with the Salford Educational Psychology Service continue with joint working on several projects such as Emotionally Based School (EBSA) pathway and Parent Anxiety Workshops for schools with specific sessions for a Primary School piloted for possible role out across the borough**.** Early Help representatives have also been involved in discussions.

The service is an integral component of the Thrive in Education offer in Salford and forms the very foundations upon which all our interventions, training and development are based. As the Thrive in Education model continues to expand, it is essential that we continue to have positive working relationships with the Educational Psychology Service and that their invaluable contribution to the Thrive In Education Model can be further embedded within the whole school approach.

CAMHS i-Reach continue to link in with the development and oversight of the Emotional Friendly Settings Panel and are keen to support the next panel meeting and school visits as appropriate.

**Early Help School Co-ordinators –** positive working relationship and joint initiatives have continued throughout the year with the team. There has been an interim review with staff in relation to the structure of the Thrive in Education meetings. This relationship has really helped the i-Reach team to think more creatively in all assessments about how to incorporate Early Help support for young people and families. Each school has had a Thrive in Education review meeting this term with follow up meetings booked for next term.

**EBSA Pathway Development –** attendance at the multi-agency EBSA pathway development meetings.

**Parent Psycho Education Workshops** – virtual workshops offered for parents on anxiety, low mood and self-harm.

**Neuro Development Hub** – link meetings with members of the multi-agency team supporting the development and progression of the ND pathway.

**Rio Ferdinand Foundation** – meeting to explore joint working, links and further referral pathway developments.

**Cognitive Therapy Centre** – ongoing links providing training for EMHP and CYWP cohorts re CAMHS, TiE and MHST's approach to Gender Identify, ADHD and Conduct Disorder.

**Team Around the School Meetings/Crisis Response Meetings** – attendance at meetings with support for schools, young people and families following critical incidents as part of a multiagency response.

**FASD Meetings and Training** – meetings with the preventing alcohol exposed pregnancy GM team re identification of presentations and links to ND pathway.

**Clinical Research Network Meetings** – linking in with local and national research leads re the development of research in education as well as opportunities for MHST's involvement in research projects.

**Schools** - have all been offered daily access to support, guidance and consultation via the CAMHS School Link offer which is part of the TiE in Salford. Schools have also been invited to attend review TiE multi agency meetings this Quarter and to follow up on the initial action plans from Quarter 3. Whilst the majority of these meetings have been very successful with further positive feedback from school regarding the support they are receiving from the TiE team, other schools have reported feeling quite overwhelmed with other essential commitments within school and have not been able to invest in further developments discussed previously.

Dates for each term are offered with a review period agreed to discuss how these meetings can be developed each session to be responsive to school's needs. The Early Help Schools Co-ordinators have been at the core of these meetings and worked exceptionally hard to chair the meetings and organise minutes, follow up etc.

**SIASS -** delivery of a Parent Anxiety and Emotionally Based School Avoidance (EBSA) session along with members of the Educational Psychology service. This was an excellent example of collaborative working between services to support over 30 families. As the session was recorded it is also available for generic viewing via the Salford Local Offer. CAMHS school referral training was delivered to the team in June.

**Primary Inclusion Team** – liaison with the Primary Inclusion Team (PIT) resulted in the delivery of a bespoke referral training package with staff from the team, all of whom are now able to make direct referrals to CAMHS. It was also agreed that the team can refer directly to the CAMHS School Link Practitioner to support Multi Agency and Professionals meetings in a consultation capacity where the CYP is known to the PIT and a specific mental health input required.

**Virtual Schools** – liaison with the inclusion lead for the team who has completed the CAMHS School Link training and liaises with the CAMHS School Link re concerns and for consultation.

**Elective Home Education Team** – positive links and communication have been maintained with the team throughout the development of the MHST and TiE project.

**Anna Freud Foundation** – further meetings have taken place with the Anna Freud Foundation in relation to future delivery of the CAMHS School Link workshops. These workshops were due to be delivered in the summer term, however given the universal delays due to Covid Restrictions, this programme is currently being planned for delivery in January/February 2022.

**Salford Integrated Youth Service** – meetings have taken place with Youth Service Staff to design and deliver this year's transition project for year 6 pupils. Rooms were booked at The Deans Youth Centre for a taster session in June with further dates throughout the summer. This project successfully supported up to 20 young people in previous years following up with support sessions in high school and in some instances, correctly identifying children with Neuro Developmental presentations. Other young people have gone on to engage with general Youth Service Sessions after attending the groups and represent their peers at the Youth Council.

**0-19 School Health Team –** liaison with the 0-19 leads has resulted in a number of 'breakfast bowl' briefings delivered throughout the year along with further Strengths and Difficulties top-up training.

**Odd Arts Theatre Group** – the team have liaised with the Odd Arts Team and worked collaboratively on the delivery of their psycho education-based theatre production for young people.

**Compass/Jewish Community –** positive relationships have continued with representatives of the Salford Orthodox Jewish Community and Special Educational Needs services, most notably members of the COMPASS service. A briefing event focusing on the new Neuro Developmental pathway was delivered as well as further meetings to establish consultation sessions for the community.

Training with the 42nd Street Mental Health project was due to re-commence earlier in the year, however this was unfortunately delayed once again due to Covid restrictions. Communications continue in relation to the next dates for delivery.

**Salford CAMHS –** the i-Reach team continue to work collaboratively with our CAMHS colleagues from the Core, Partnership, ND and Single Point of Access teams. As previously mentioned, i-Reach have also provided an extended offer of support during Quarter 4 due to available capacity offering short term intervention for low mood and anxiety. Collaborative working has also taken place to deliver Post Diagnostic and Parental Psych-Education Sessions.

**CAMHS School Link –** continued offer of advice, consultation and support for all schools who are part of the project in Salford.

**Manchester City Community Mental Health Programme** – liaison re mental health support for communities and schools continue with regular 'check in' meetings.

**Salford CCG and Local Authority –** communication, collaborative working initiatives and joint approaches continue with professionals from the Local Authority and the Clinical Commissioning Group. This support is very much appreciated as it provides further opportunities to link in with new services across the network as well as being updated about training dates and service developments.

**Mental Health First Aid** – 2 staff have completed the mental health first aid training the trainers introductory course to become part of Salford's pool of MHFT. Feedback from staff was very positive and they felt this training will prove to be of huge benefit to the schools and teams they work with.

**Co-CAT National Research** - the i-Reach Clinicians continue to be active participants of this NIHR funded study into the effectiveness of short-term parents based interventions to address the anxiety symptoms of children under the age of 12. Nationally, there have been delays in recruitment, but these figures have increased in Quarter 4 and we have successfully recruited a number of parents to the study. Clinicians have been really excited to be part of such an important study at the beginning of the teams development.

## Whole School Approach and School Workforce Development

The following meetings have been attended to facilitate the progression of the Thrive in Education Team in Salford and embed the service into the local offer as well as link into good practice across Salford and GM:

***Thrive in Education Operational Meetings***

***Salford Thrive Partnership Meetings***

***Mental Health In Education Reference Group Meetings***

***Thrive in Education Schools Meetings***

***Wellbeing Return to School - adaptation to local offer meeting with Educational Psychology as well as attendance at delivery sessions to offer CAMHS 'voice'***

***Team Around the School and Inclusion Strategy Meetings***

***EBSA Pathway Meetings***

***Quarterly CAMHS Leads Meetings***

***Mental Health In Education – Suicide Prevention and Self Help Task Group***

***Exercise On Prescription Task and Finish Group***

***Thrive In Education Meetings***

***Thrive In Education Board Meeting***

**Schools Referral Training –** an adapted virtual version of the CAMHS School Referrals Training has been offered virtually on 3 further dates this quarter. A total of 87 schools have now completed the CAMHS School Link referral training (see attached list), with 151 staff being trained to make direct referrals to CAMHS. This breaks as follows:

| Type of Provision | Numbers of schools Trained |
|---|---|
| **Orthodox Jewish Schools** | **22** |
| **Salford High Schools** | **12** |
| **Salford Primary Schools** | **44** |
| **Pupil Referral Units – secondary** | **4** |
| **Pupil Referral Units - Primary** | **2** |
| **Specialist Inclusion** | **2** |
| **Primary Inclusion Team** | **1** |

All schools that have completed the training are able to access ongoing support, training and consultation via e-mail, telephone, video call or face to face meetings. There is currently no limit to how frequent or how much support a school can access. However, approximately half of schools rarely engage in consistent contact once they have completed training. School were all contacted with generic e-mails on 3 occasions this quarter with offers of support. The most recent outlined the 'Top Up' workshop calendar

for the summer term which includes workshops on PTSD, Self-Harm and Anxiety as well as further CAMHS Referral Training.

**Challenges –** the main challenges have been Covid related, especially for schools where teaching staff have reported that this recent lockdown has proved more challenging and stress inducing than the previous one in 2020. Another challenge has been actually being able to see young people for appointments as despite schools support to access schools, so many young people have had to isolate due to illness in their family or because they are in 'bubbles' at school that have prevented them from attending school.

Thus, this has impacted negatively on establishing a therapeutic relationship with young people and disrupted 'momentum' with a 'stop- start' approach.

School staff have also been quite exasperated at times when referrals have been appropriately signposted to other services, difficulties with waiting lists for specialist assessments, increased needs of families for support and misunderstanding about what the I-Reach team can actually offer.

Feedback from i-Reach staff has been that they have spent much longer periods of time engaging and supporting family members with their anxieties and difficulties with some parents requiring referral to support service for their own health and wellbeing.

Other comments included:

- Delays in being able to offer service due school policy on external visitors etc.
- Barriers to access if young people and families were not able to be seen in school and needed to come to CAMHS base.
- Young people and families have not always been able to/or willing to come to us due to health conditions or feeling nervous themselves.
- Young people being unable to see our full faces because of the use of masks.
- Difficulties/delays in linking in with other services who are experiencing delays and are operating differently during Covid.

Another clear challenge is being able to provide ongoing clinical supervision for staff as well as support staff to be able to access the supervisors training. There is also a significant amount of time required each year for managers to be available to support the recruitment and interviewing of trainees which takes up a significant amount of time and if often quite difficult to co-ordinate with numbers and funding being consistently confirmed at very short notice and an expectation that diaries are cleared at short notice to accommodate national recruitment expectations.

**Schools Referral Training –** schools virtual referral training and top up work-shop training sessions have been offered throughout quarter one. This has included sessions on self-harm, anxiety, low mood and ADHD. A session on PTSD was re-scheduled until next term as there were too many cancellations. Many of the training sessions have had small numbers attending as even when staff have booked onto sessions, as the date has approached there have often been multiple competing demands for staff due to safeguarding issues, covid bubbles and staff sickness. All training has been well received and evaluated and a new training calendar will be distributed to schools who are part of the CAMHS School Link next term.

## Children and Young People's Voice, Parent and School Feedback

Clinicians have continued to offer a flexible community approach including school based interventions as well as out of hours service if young people did not want to miss school lessons or if parents wanted to accompany their child to appointments.

We continue to link into the Core CAMHS Participation Group as part of an arts project with The Lowry and are actively involved in the Salford CAMHS young people's participation group.

Schools have continued to feedback via the Thrive in Education meetings and have valued the multi-agency support they have received from the Thrive In Education Team. Schools also reported that they appreciated i-Reach's continued delivery of interventions in school and the willingness of clinicians to be flexible with the families they were supporting.

Feedback from the CAMHS School Link training was very positive with teachers reporting they had found the training very helpful and informative, one teacher stated that it was obvious the trainers had a good understanding of teachers' roles and the issues schools face in relation to mental health.

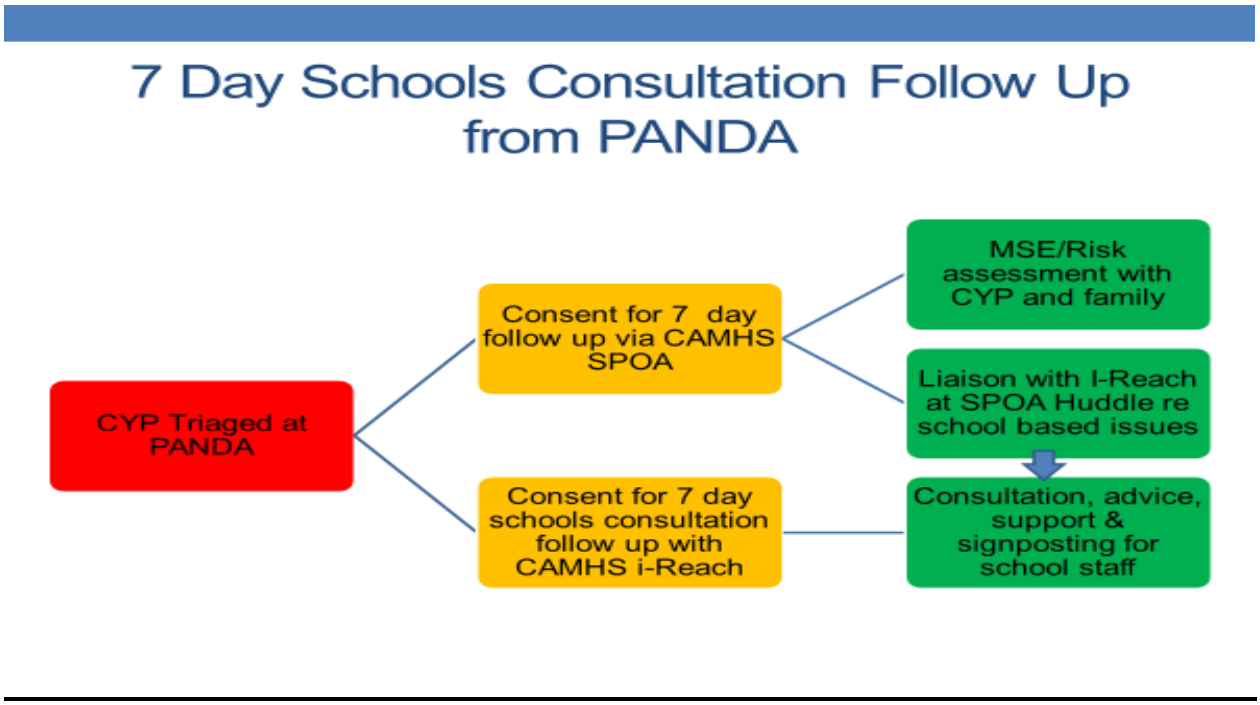
## Other Innovations

**Year 6-7 Transition Group Salford Integrated Youth Service, Salford Schools Sports Partnership and CAMHS i-Reach** - see separate report

### 7 Day Schools A&E Follow-up

Following a number of discussions with both our Core CAMHS colleagues and GMMH staff in the all-age Mental Health Liaison Team (MHLT), we identified that there have been increasing numbers of parents advised to present their child at the PANDA unit for mental health assessments where an alternative lower level intervention would have been more appropriate. On some occasions this has resulted in confusion from parents as well professionals who have expressed concern that schools have maybe not known about how to access other services or been unsure about risk assessing situations that would be appropriately supported by an urgent mental health assessment at PANDA.

As such, the CAMHS i-Reach team agreed to offer a pilot 7-day school follow up to run alongside the 7-day clinical follow up from the Core CAMHS team. This will involve the offer of a phone consultation with school on receipt of the referral from the MHLT team as outlined in the diagram below. CAMHS i-Reach staff will then offer Consultation, Advice, Signposting and Training (CAST) support to the school providing in school meetings, links with the allocated CAMHS clinician, risk assessment training as well as providing guidance on policies, safety plans and maintaining communication with CAMHS.





This is an offer to <u>all schools</u> across Salford regardless of their involvement with EFS, CAMHS School Link or Salford Thrive in Education. The pilot will run from June until November with mid-point review in September and final review in December to think about next steps.

**Establishing the Single Point of Access –** having a full complement of staff this quarter we have been in a position to launch a dedicated referrals team within i-Reach which we have named i-Reach Liaison. The team consists of 3 clinicians who offer a telephone

triage and initial risk assessment of all referrals received. A i-Reach clinician also attends the daily 'Huddle' meeting with the Core CAMHs duty team to discuss any concerns or referrals they have received.

Where the Core CAMHS team receive referrals from GPs for young people attending Thrive in Education schools, there are discussions re any appropriate liaison which may support the young person, family or team around the child as well as identifying signposting or joint working.

The Huddle meetings have been a really positive method of ensuring communication is maintained between clinicians and managing risk between teams appropriately

Challenges identified by the i-Reach Liaison clinicians continue to focus on the poor quality of some referrals including missing information such as date of birth, not recording risk or safeguarding issues and not seeking consent from parents to make referrals. Staff continue to offer support, training and guidance to all referrers to address these issues and positively, report that the majority of referrer's do engage well to explore the barriers to completing referrals.

**Supervision of Supervision –** Clinical Supervision of Supervision is a 'gold standard' in terms of good clinical practice within CBT frameworks. As part of on the ongoing positive relationships developed with the Cognitive Therapy Centre, there has been a joint 12-month pilot with the Centre and the MFT CAMHS Thrive Supervisors. The sessions have been taking place monthly and are delivered face to face at Pendleton Gateway. Sessions are facilitated by Cognitive Therapy Clinical Supervisor Tutor/Trainer, John Storey and Jane Davies and include the opportunity for role play, application of supervision theory to practice and development of supervision skills.

A mid-point review is scheduled for October with the pilot being fully reviewed in March 2022. The pilot was also featured as part of the Innovative Practice training at the Cognitive Therapy Centre.

## Case Studies – Provided by Elliot Griffiths, EMHP

Case Study: The success of treating a young person with trauma using low-intensity evidence-based interventions.

Introduction and Assessment

The pseudonym "Jake" will be used to protect the identity of the young person. Jake is a 13-year-old male who was referred to the I-reach team at Salford CAMHS by the Special Educational Needs Co-ordinator at his school. He was referred for support with anxiety, worry and school-based avoidance. His assessment showed that he had the following symptoms:

- Persistent and severe worries regarding the safety of his family.
- Absences from school due to acute anxiety and severe physiological symptoms. I.e. panic attacks, nausea.

- Anger and irritable behaviour at home.
- Difficulties sleeping. Jake was sleeping downstairs at home, instead of his own room. Furthermore, Jake often had difficulty going to sleep,
- Separation Anxiety. Jake had stopped going out with his friends because he was worried about the safety of his family. Jake had also stopped sleeping round at friends' houses. His mother reported at assessment that when the family had been away on holiday, Jake was extremely distressed about being away from home for a long period of time.

At assessment Jake's mother explained that 16 months ago, their neighbour's home had been attacked. Jake started presenting with severe anxiety and worry after this event. Jake's mother thought that the anxiety and worry was linked to this event. Both Jake and his mother completed the Revised Anxiety and Depression Scale (RCADS) at assessment. The table below shows their respective scores.

| RCADS Subscale | Parent Score | Young Person Score |
|---|---|---|
| Social Phobia | 14 | 1 |
| Panic | 9 | 3 |
| Major Depression | 15 | 5 |
| Separation Anxiety | 13 | 4 |
| Generalised Anxiety Disorder | 14 | 3 |
| Obsessive Compulsive Disorder | 8 | 7 |
| Total Anxiety Score | 58 | 18 |
| Total Anxiety and Depression Score | 73 | 23 |

Key:

| | |
|---|---|
| Below clinical threshold | |
| Borderline clinical threshold | |
| Above clinical threshold | |

Scores on the parent-completed version of the RCADS suggests that Jake was struggling with severe anxiety.

Formulation

The practitioner discussed this case in clinical supervision. Based on the information in the referral and the information gathered from the parent assessment, the practitioner and clinical supervisor agreed Jake's symptoms could be underpinned by post-traumatic stress following the event Jake's mother described in her appointment. The clinical supervisor suggested the practitioner should explore responses on the RCADS with Jake

that pertain to post-traumatic stress. The clinical supervisor went on to say that the assessment and formulation may indicate Jake has undiagnosed Post-traumatic Stress Disorder and will require a higher level of intervention then I-reach are able to provide.

The practitioner explored certain items on the RCADS with Jake in the first and second face-face appointment.

For example, Item 16: *'I have to keep checking that I have done things right'* (like the switch is off, or the door is locked)'. Jake said that he checks the front door and back door of his house, the kitchen lights and the living room lamp. "I check the door handles twice."; Jake said he feels "happy once he's checked." Jake said he checks for safety reasons. Jake went onto say that his anxiety was "really bad" approx. 1 year ago. When asked why, he said that his grandad passed away when he was 9/10 years old, his aunty passed away when he was 11/12, and his uncle passed away when he was 12. He also said that his best friend had cancer when they were 10 years old.

Another example, Item 10: *'I am bothered by bad or silly thoughts or pictures in my mind'.* Jake said if he sees people arguing, it can trigger images of those people being in a physical fight. He said these images can be more severe if people are especially confrontational I.e. getting very close to each other, squaring up to each other. He said that those situations can trigger images of fighting, injury and bloodshed.

A third example, Item 11: '*I have trouble sleeping'.* Jake said, "I can't get to sleep until 1am." When asked why, he said he hears "noises", "banging", "gates slamming", "a male shouting". Jake said he sometimes "goes to check to ease myself", but "nothing is there".

In his second appointment, Jake without prompting mentioned the traumatic event that his mother referred to in her assessment appointment – the attack against his neighbour's house. He believed the noises he sometimes hears at night ("noises", "banging", "gates slamming" etc.) are "mostly from next door", where the traumatic event took place. He then said he was not sure if these noises "are actually being made or if it's my anxiety." This suggested that Jake had some understanding that ongoing anxiety related to a traumatic event could be affecting his perception of threat from his neighbour's house.

The practitioner asked Jake about the traumatic event: "does it still effect you?" Jake said over the past two months, he has been "coping better". I asked him how, he said, "I take my mind off it", and "do things until I am tired". He said he doesn't think about the traumatic event at all, and when the thought of it is sometimes triggered by noises at night, he distracts himself – "I get on with my day now."

The assessment and formulation showed discrepancies between the parent and the young person's idea about the extent to which traumatic events (namely, the attack 16 months ago, numerous family bereavements, best friend being diagnosed with cancer) were underpinning the current anxiety and worry.

The practitioner felt that they had established a good therapeutic relationship with Jake following the two appointments. The practitioner again discussed this case in clinical supervision, and expressed they felt confident low-intensity evidence-based interventions could potentially be used to treat this young person. The supervisor and practitioner agreed to try low-intensity evidence-based intervention, but to refer the young person on for further support afterwards if their symptoms had not improved post-intervention.

Treatment

After the assessment, the practitioner worked with Jake to devise goals for intervention. The goals were as follows:

Goal 1) “By the end of support I would like to go out for 3-4 hours.”

Goal 2) “By the end of support, I would like to get my ‘daily anger rating’ from 8/10 to 4/10.”

In the first treatment appointment following assessment, Jake and the practitioner drew a thoughts/feelings/behaviour formulation around a recent situation where Jake felt anxious. Jake appeared to understand the link between thoughts, feelings and behaviours and how safety behaviours can reduce anxiety in the short-term but perpetuate it in the long-term.

The practitioner related this formulation back to Jake’s goals, and they agreed on a task for Jake to attempt before the following appointment: Jake said that when he is at home, he sometimes checks the safety/well-being of his family by going downstairs from his room and asking them if they are okay. Jake said that on Saturday 01/05, he would like to try and do activities in his room for 6 hours without going down the stairs to check on his family by asking them if they are okay – not including times he may go downstairs for other reasons. E.g. to get a drink/something to eat. This homework was a “graded exposure” task designed to encourage Jake to reduce or drop safety behaviours.

In the following appointment, Jake explained that he managed to stay in his room for the full 6 hours. He said at first, he found it difficult but that after a while his anxiety/worry around the safety of his family had reduced. This was a significant learning point from the homework – Jake was now able to see, from practice at home, that “facing your fears” and not turning to safety behaviours to reduce anxiety will mean that it reduces over time.

Jake was set another small homework – to try and go out either by himself or with his friends for 2 hours. Practitioner stressed to Jake that if he felt uncomfortable about the task, then he shouldn’t pressure himself to do it. Jake understood, but felt confident that he could attempt this task.

In the following appointment, Jake said he had not yet attempted to go outside either by himself or with his friends for 2 hours. Jake said the reason for this was the restrictions at the time related to Covid-19. Jake said that when restrictions lifted on 17/05, he would try and complete this task. Practitioner asked Jake how he is felt about this. Jake said that he is “looking forward to going out.”

The practitioner and Jake then covered psychoeducation around the fight/flight/freeze response, and the difference between real and perceived threat.

In the following appointment, Jake reported that he had completed Goal 1. Moreover, Jake explained that he went out with his friends for longer than the 2-3 hours agreed as part of this goal. He agreed he had completed it, and that we no longer needed to rate the goal as part of intervention.

Jake also said that he had made significant progress with Goal 2 “By the end of support, I would like to get my ‘daily anger rating’ from 8/10 to 4/10.” He explained that his anger has been “really good”; “I don’t think I’ve had a spike (of anger)”. The practitioner theorised that Jake’s anger may have been underpinned by the extent to which his anxiety was having an impact on his sleep, mood and functionality. Up to this point in his intervention, he had completed two tasks in which he had challenged his anxiety by facing a situation (e.g. going out with friends) that pre-intervention most likely would have caused him high amounts of anxiety. This in tern may have helped Jake to feel less angry and frustrated about the extent to which his difficulties were impacting on his life.

At the end of this appointment, Jake and the practitioner devised another task around staying away from home overnight. Jake agreed that the practitioner could liaise with his mum and older sister if necessary, to encourage them to arrange for Jake to stay round his older sister’s house at some point over the next couple of weeks. The practitioner would explain about how this challenge fits in with his treatment for anxiety. Jake went on to complete this task as well.

The practitioner reviewed Jake’s progress following intervention in a follow-up appointment with him and in a separate appointment with his mother. Jake’s mother reported that he is now going out “all the time” with his friends, that he is now sleeping in his own room, and that he is rarely angry at home. The table below shows the scores on the RCADS for both parent and young person, pre- and post-intervention.

| RCADS Subscale | Parent Score | | Young Person Score | |
|---|---|---|---|---|
| | Pre-intervention | Post-intervention | Pre-intervention | Post-intervention |
| Social Phobia | 14 | 1 | 1 | 0 |
| Panic | 9 | 3 | 3 | 2 |
| Major Depression | 15 | 4 | 5 | 1 |
| Separation Anxiety | 13 | 7 | 4 | 1 |
| Generalised Anxiety Disorder | 14 | 6 | 3 | 1 |
| Obsessive Compulsive Disorder | 8 | 3 | 7 | 1 |
| Total Anxiety Score | 58 | 20 | 18 | 5 |
| Total Anxiety and Depression Score | 73 | 24 | 23 | 6 |

Key:

| | |
|---|---|
| Below clinical threshold | |
| Borderline clinical threshold | |
| Above clinical threshold | |

The scores, particularly on the parent-completed version of the RCADS, had reduced significantly. Following advice from their clinical supervisor, the practitioner also asked mum to fill in the parent version of the Children’s Revised Impact of Event Scale (CRIES-

13), a brief measure designed to screen children at risk for Post-Traumatic Stress Disorder.

The subscale for Separation Anxiety post-intervention and the results of the CRIES-13 suggested that Jake may still be experiencing some anxiety that may be related to the traumatic experiences identified at assessment (the attack of 16 months ago, numerous family bereavements, best friend being diagnosed with cancer). However, the practitioner, young person and parent in this case all agreed that the symptoms had reduced sufficiently to suggest that Jake may be able to keep reducing his anxiety using the skills and knowledge acquired in treatment independent of a therapist.

In their follow-up appointment, the practitioner shared and discussed these skills with Jake's mother and provided her with resources so that she could support Jake to continue using them at home. The practitioner assured Jake and his mother, both in an appointment and subsequently in a letter, that should Jake relapse to the point where his anxiety and worry again begin to have a severe impact on his ability to function in his day-to-day life, then they can approach the service/school regarding another referral for support.

This case study provides evidence for the efficacy of low-intensity evidence-based interventions, with appropriate supervision, in treating young people who present with quite complex and severe mental health difficulties.

## SUMMARY

The team have worked incredibly hard in the first 12 months of the project to be proactive, flexible, resilient and above all young person focused, having continued to offer a clinical service throughout lockdown, 52 weeks of the year.

The new term in September 2021, already feels a challenging one as young people struggle to adapt yet again to new environments, services become increasingly stretched and resilient staff are faced with yet more challenges.

The team continues to develop the physical activity and groupwork element of the offer for which there has been much commitment and enthusiasm. We will also be reviewing the 7 Day Schools follow up this term and piloting a consultation model with the OJC schools and 2 Pupil Referral Units to explore how the TiE model can support the more complex needs of vulnerable pupils. Recruitment for the year 6-7 transition project will commence in January 2022 and as always, the team will be exploring new ways to develop their skills, improve their knowledge and provide a high-quality service for young people, families and schools.