BeeU Service (0-25 Emotional Health & Well-being)

Our Journey

The I-Thrive Model & Partners (One Service)

Bee U Service Stepped Care Framework

Bee U
Emotional Health and Wellbeing

Integrated Risk Support

Working with our most vulnerable children across all agencies

e.g. Looked after children, Children in Need, Children with Special Educational Needs, Children who are at risk of or have offended, Children requiring safeguarding

Poly-Pharmacy

- **Physical Health clinic** set up every Monday at the Redwoods and further development of physical health ongoing in service.
- **Repeat prescribing SOP created**
- • All caseloads have ben reviewed and within these all children prescribed antipsychotic medications have been reviewed. Where continued prescribing of antipsychotics is indicated all NICE CG is complete and physical health monitoring including ECG and bloods have been undertaken, with a plan to continue this monitoring every 6 months.
- • Over past 18 months Within the BeeU service there has been a particular focus on medicines optimisation with clinicians supporting patients to improve their quality of life and outcomes from medicines.
- The aim has to been to offer evidence based choice of medicines and therefore where appropriate we have pursued a de-prescribing approach with a particular focus on antipsychotics inline with the STOMP-STAMP agenda.
- In line with the medicines optimisation principles, we are ensuring medicine use is as safe as possible, with regular reviews, performing regular physical health monitoring and creating a culture which allows patients to feel comfortable to ask questions about their medication, discuss side effects which gives CYP more confidence in taking their medicine.
- **Circadin/ Melatonin**
- • All cases have been reviewed. Melatonin in forms other than Circadin tablets have been changed to Circadin where clinically appropriate. There is also improved emphasis on improved sleep hygiene.
- • This is providing cost effective practice and ensuring that a holistic approach to sleep is being considered and planned for.
- We are also starting to introduce sleep hygiene groups within service to support young people stopping sleep medication and this is also happening in the early help sector with sleep hygiene being offered by Early help, school nurses etc so medication is no longer the only option
- We have now made links with 2 pharmacies- Rowlands and Lloyds Pharmacy Dawley so families can collect straight from there rather than increased footfall in bases. WE don't have Electonic presecribing to these were pharmacies in walking distance to main sites that we can take prescriptions to
- Sharing side effects leaflets with parents and carers an discussing these as well as schools through letters and the school panel

Case Study

13yr old known with diagnosis of ADHD, anxiety, ODD. Complex case known with above comorbidities. On inheriting the case he was prescribed atomoxetine, circadin and risperidone.Risperidone was mainly used for behavioural issues. Family were psychoeducated regarding the longterm side effects of its use. Emphasised on holistic approach and behavioural support with partner agency BEAM was offered instead. Risperidone was gradually reduced and ultimately discontinued. Circadin was switched to promethazine that helped both as sleeping aid and taking the edge of anxiety away. Again this was short term trial was discontinued once sleep pattern concerns were addressed.Currently on monotherapy- Atomoxetine only and he seem to be doing well and is settled.

Neuro-developmental

- ADHD
- **The service**
- Our Attention Deficit Hyperactivity Disorder (ADHD) pathway is made up of a small team of experienced professionals. The service provides diagnostic, treatment and consultation services for children and young people with ADHD who have complex needs from the age of 6. It is supported by a dedicated consultant and non-medical prescriber and who can support the psychiatric team around diagnosis and treatment management.
- There is multi-disciplinary Team who consider the implementation of decisions and interventions around referrals coming into the service. These are in line with NICE guidance as well as the development of service need.
- There are local procedures in place for shared care arrangements with primary care providers. These support and ensure that clear lines of communication between primary and secondary care are maintained.
- There are clear links and transition arrangements with the Adult ADHD service.
- Guidance drawn up is in line with NICE guidance on ADHD – NICE NG87 Attention deficit hyperactivity disorder: diagnosis and management (www.nice.org.uk/guidance/NG87

Case Studies

- Case of misdiagnosis/ RH

Revolving door presentation to CAMHS during early childhood. At the age of 9/10, was diagnosed with Anxiety disorder and treated with SSRI by my predecessors. Some improvement in anxiety symptoms however behavioural problems persisted leading to numerous exclusions, educational placement breakdowns and subsequently academic underachievement. I took over this yp care in 2019 and revisited his diagnosis. Presented with longstanding difficulties such as inattention, mixture of boredom, restlessness, impulsivity, and behavioural outbursts as main concerns. Thorough neurodevelopmental assessment was carried out, collateral information including structured questionnaires were requested. Diagnosis of ADHD was made. Family were psychoeducated and explained that frequent interruptions, blurting out, restlessness and being forgetful, may increase the stress levels and can cause additional anxieties hence its paramount to treat the primary symptoms first. Fluoxetine was no longer effective anyways therefore I had weaned him off it and had commenced him on first line stimulants for treatment of ADHD.Core symptoms of ADHD improved when stimulants were introduced and so did his social functioning and academic abilities. Anxiety and behaviour had subsequently improved. Currently, he is doing well and is on stable medication dosage hence been discharged to ADHD f/u clinic.

Neuro-developmental

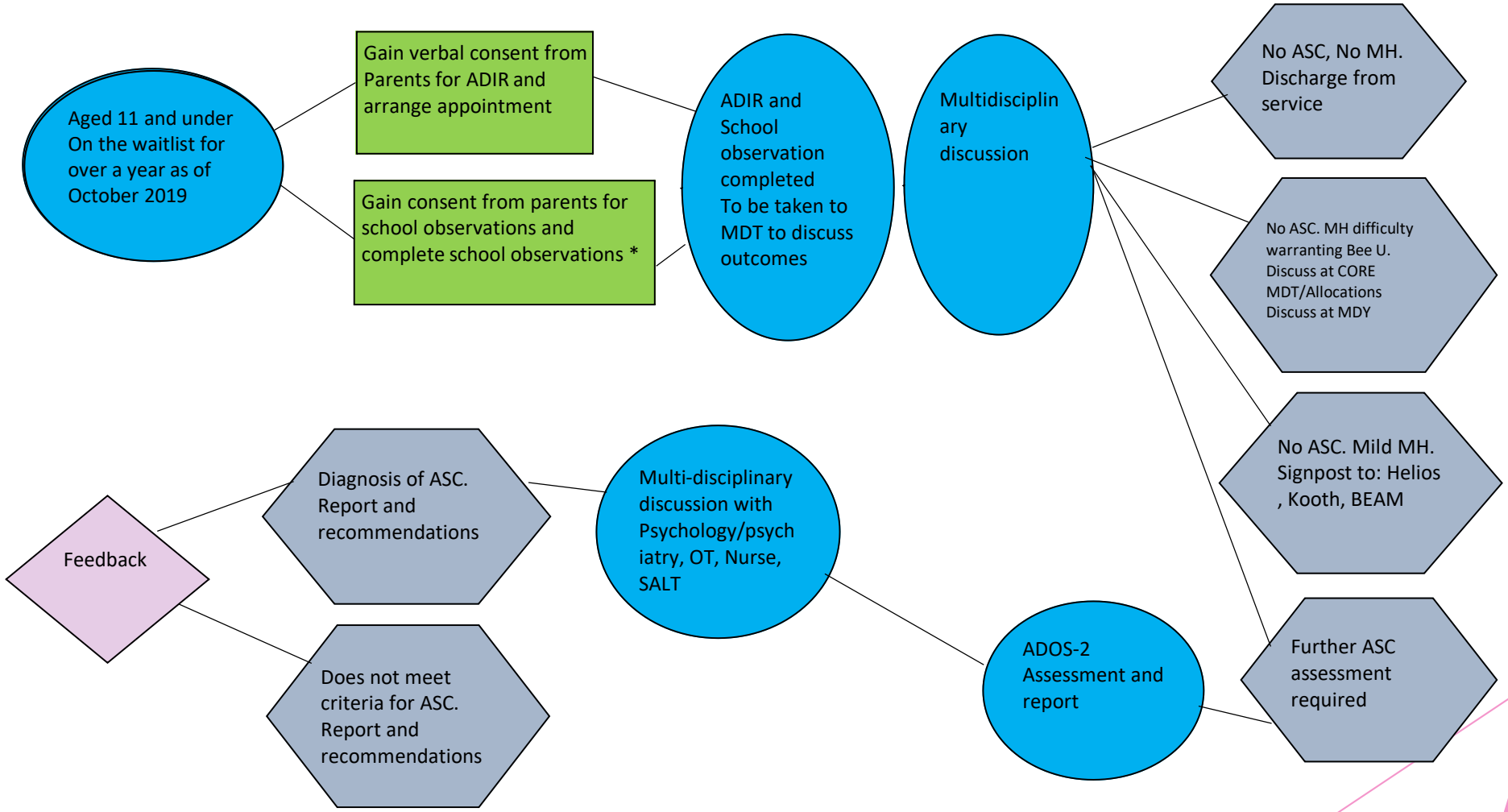
ASD

Have now been provided with the funding for a ASD team which we have staffed and are working on the cases outside of the Waiting list initiative fro 2019

This is now forming BAU for that pathway

Autism spectrum condition (ASC) waitlist initiative (4-6 months)

For children on the ASC waitlist whom are 11 years and under and been waiting longer than a year from date of referral.
NB: a substantive ASC pathway is being devised from point of referral please refer to that for future referrals to ASC team.



ASD Waiting list Feedback

- We have with the help of the involvement team created a ASD feedback form which is given to families to complete following ASD assessment process
- We are currently rated by families and SU's as 4/5 Stars some examples of feedback :
- *"Once we finally received contact after 3 years of waiting and constant let down and promises, the specialists that we saw were very good, kept in contact and explained the process at length."*
- *"Explanations were very thorough. Contact was also on point. Very polite staff and very approachable. Didn't make me feel like i was an overprotective mother but really took my concerns on board"*
- *"Very friendly, made sure they listened to what my son was saying and made us feel at ease"*
- *2Happy to receive a diagnosis. The verbal feedback from Kirsty was brilliant."*
- *"Just thank you for the help to help me get what I needed for my son to have more help at school2*
- *School referral panel – signposting and problem solving without diagnosis*

Schools

Following proposals within the CYP MH Green Paper (2017) the NHS Long Term Plan (2019) re-confirmed commitments to fund Mental Health Support Teams to provide specific capacity for early intervention and ongoing help within a school and college setting.

MHSTs will have three core functions:

- Delivering evidence based interventions for mild to moderate mental health issues. The new teams will carry out interventions alongside established provision such as counselling, educational psychologists, and school nurses building on the menu of support already available and not replacing it;
- Supporting the designated senior mental health lead in each education setting to introduce or develop their whole school or college approach;
- Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education. Work as part of an integrated referral system with community services to ensure that children and young people who need it receive appropriate support as quickly as possible.

The Offer

Education Mental Health Practitioners (EMHPs) are part of the government's Mental Health Support Team's (MHST) plans for schools to provide early intervention mental health support. Currently in the Trailblazer stage, we have a number of schools who are part of the trailblazer wave of this national project. Our team will be working closely with the designated Mental Health Lead in our schools. Schools will be referring pupils directly to the Team following consultation, if appropriate for intervention. The team will also delivery training/groups within schools and supporting whole school approaches in additional to one to one work.

- The offer is for those CYP with low-level common mental health problems. They cannot work with serious and enduring mental health problems and forms part of the Early help offer as outlined in the I Thirve Framework
- There will be thorough assessments, evidence based (proven to work) individual & group pupil work, shared decision making with pupils, parenting work, onward signposting to more specialist teams and whole school approaches.

REFERRAL GUIDANCE

EMHP's WILL DO	EMHP's MAY DO	EMPH's WILL NOT DO
Behavioural difficulties		Conduct disorder, anger management Full parenting programmes
Training parents and teachers to support interventions		Treatment of parents depression and anxiety
Low Mood	Irritability as a symptom of depression	Treatment for moderate depression
Worry Management	Low Confidence, assertiveness or interpersonal challenges e.g with peers.	Low self-esteem, social anxiety disorder
Anxiety /Avoidance e.g simple phobias, separation anxiety	Some short-term phobia exposure	Extensive phobias e.g blood, needles or vomit phobia
Panic Management		
Assess self-harm and support alternative coping strategies to self -harm. Pupils with history of self-harm but not active	Thoughts of self-harm, superficial self-harm. Basic harm reductions techniques	Severe, active, high risk self-harm.
Sleep Hygiene	Insomnia	PTSD, trauma, nightmares
Thought Challenging- negative automatic thoughts		
Problem Solving	Assessment and understand complex interpersonal changes	Relationship problems- counselling for issues such as relationship problems may be better suited to school counsellors
	Mild/Early onset Obsessive Compulsive Disorder	Obsessive compulsive disorder moderate
		Moderate to severe attachment disorders.

Workforce & Service Offers

- ***Change in Workforce & Skill-mix- a changing landscape with more variety and specilism***
- Increase in psychology, CRHT 24hr funding for young people, 4 OTs in service. SALT , social workers, family therapists, CBT, PWPS, recruiting band 3s
- NMPs
- Substantive psychiatrists
- Had trainee Dr
- Increase in student nurses
- Medical students
- ***Change in Therapies on Offer***
- Beam , kooth, Healios
- Trailblazers – delivering therapy in early help in schools
- Change in Therapies on Offer CBT, EMDR, Complex Trauma, Systemic Family Therapy
- Looking at recruiting a play therapist
- Setting up groups- sleep hygiene to reduce use of Melatoin, First steps, parent lead support group

Access – all age 24/7

- Targets
- Full compliment of access which has merged with the adult SPA
- Helps with safety and robustness of referrals, cross cover, enhanced workforce with greater knowledge. Equipped to deal with all inequalities and protective characteristics . Whole family approach. Introducing of urgent/ crisis helpline
- CYP Specialists sit within and share knowledge
- Referrals can be made via phone on 0808 196 4501 BeeU option – 1 or 0300 124 0365 option 1 (urgent)
- Email : 025spa@mpft.nhs.uk (Routine)

Successes

- Parents an GPS reliance of sleep medication – we have trained staff in sleep hygiene and setting up groups as well are trained with schools and school nurses to offer sleep hygiene in community at early help
- Share sleep hygiene leaflets with parents
- No waiting lists for core, psychiatry,
- MDT working improved
- Staff lead change
- Adult transition meeting
- Regular case records audits quality improvement focus
- Huddles
- Looking at lessons learnt
- Bronze Quality award
- OT in service got Trust mission excellence aware
- LAC- do have 2 LAC workers that work with LA and placements . WE provide space for conversation and consultation

Successes

- Now got ASD monies we can start on those waiting over 12mths
- Increased psychological service
- More responsive
- Substantive staff and reduced reliance on agency
- Developing 24/7 CYP service
- Improving links with liaison MH
- Part of the Anna Freud centre school links project in Telford and Shropshire
- Improved response rates
- Clear pathway
- MHSTs
- Improved moral
- Staff ownership of service and model

What's Getting in the Way

- Lack of funding 0-25 service has staffing below what is recommended for a 0-18 service
- System approach and agenda varies between Shropshire and Telford which creates differences in how we work ie school panel In Telford and Not in Shropshire
- Culture of escalation
- No Autism West Midlands in Telford
- Expectations – being expected to fill gaps in the system – what is mental health
- Mental health deemed as only Bee u responsibility
- Likely to be increased demands due to covid
- Gaps in treatment provision for attachment disorder in the service and wider system which has consequences for family but no one in the system that can provide that support as needs funding – example from Sadia around 5yr old
- Expectation by system that medicine is first line treatment and only psychiatry will do – this is improving
- No funding or commissioning for ARFID (Avoidant Restricted Food Intake Disorder) which puts huge resource implications on the Core team. Now have part time agency dietician in CEDS service but need full time dietician and family therapist
- Challenges are the amount of OOA LAC in county and demands that causes. They arrive with minimal information but in distress as not wanting to be in that placement. Placements usually paid to provide a package but often they cant provide what they have initially offered. Young person moves and we aren't informed
- Gaps in provision for particular diagnoses e.g. Tourette's Syndrome and Gender Identity Disorder and Post Diagnostic Interventions and support for ASD
- As GPs refuse to do shared care in a lot of circumstances this creates an extra pressure and bottle neck in the medical pathway

Next Steps

- Stronger parent voice
- Joint partnership with Stafford CAMHS sharing good practice
- We want to develop a rollercoaster parent group but this will require funding for a lead parent to be employed
- Good relationship with PACCs in Telford would like to improve relations with PODS in Shropshire
- Ongoing growth and development of offer e.g. CYP CRHT and ASD and BEAM
- Gap in system around Tier 4 beds and Specialist provision
- Transition review and policy development - ongoing audit and review
- Looking at a safe place for young people in crisis to reduce admissions to 136 suite or presentation to A&E
- 3mth pilot with Children's society to provide crisis drop in and support 4 nights a week referral based starting in January