Abstract

Aims: Young people attempting to access mental health services in the United Kingdom often find traditional models of care outdated, rigid, inaccessible and unappealing. Policy recommendations, research and service user opinion suggest that reform is needed to reflect the changing needs of young people. There is significant motivation in the UK to transform mental health services for young people and this paper aims to describe the rationale, development and implementation of a novel youth mental health service in the UK, the Norfolk Youth Service.

Methods: The Norfolk Youth Service model is described as a service model case study. The service rationale, national and local drivers, principles, aims, model, research priorities and future directions are reported.

Results: The Norfolk Youth Service is an innovative example of mental health transformation in the United Kingdom, comprising a pragmatic, assertive and ‘youth friendly’ service for young people aged 14-25 that transcends traditional service boundaries. The service was developed in collaboration with young people and partnership agencies and is based upon an engaging and inclusive ethos. The service is social recovery oriented, evidence based and aims to satisfy recent policy guidance.

Conclusions: The redesign and transformation of youth mental health services in the United Kingdom is long overdue. The Norfolk Youth Service represents an example of reform that aims to meet the developmental and transitional needs of young people, while remaining youth oriented.

Keywords:
Adolescent; Child Health; Community Mental Health Services; Mental Health; Young Adult

Introduction

Since 2009, lead clinicians and managers from Norfolk and Suffolk Foundation Trust (NSFT) have paid particular attention to service provision for young people with complex mental health difficulties. Young people and their advocates have been calling nationally for the redesign of services and, since most
severe and enduring mental illnesses emerge before the age of 25, there are strong economic and social justifications for targeting emerging mental health difficulties through appropriately designed services. Recent evidence suggests that whilst rates of transition to psychosis from At Risk Mental States (ARMS) are relatively low, outcomes are poor and often associated with complex clinical and social co-morbidity. In addition, traditional services available to young people with severe and complex mental health conditions are often rigid and outdated, under-funded, inaccessible and unappealing to those needing to access them. Furthermore, the transition between CAMHS (Child & Adolescent Mental Health Services) and AMHS (Adult Mental Health Services) with pre-defined acceptance criteria can create systemic barriers that are often negatively experienced and are developmentally or socially inappropriate. Therefore, the UK government and Department of Health (DoH) have called for novel improvements in mental health care and declared an urgent need for change.

In collaboration with local young people, and building on the pioneering work of ORYGEN (National Centre of Excellence in Youth Mental Health, Australia), our team of local academics, clinicians, service users, third sector organisations and NHS managers set out to redesign mental health services for young people. It was apparent that a new philosophy across the whole system was indicated, requiring scrutiny and improvement of existing clinical systems.

In order to initiate this change, we worked closely with the National Institute for Health Research (NIHR) East of England Collaborations for Leadership in Applied Health Research (CLAHRC) programme to conduct a systematic review of young people’s views of UK mental health services and investigate local provision in Norfolk. This propelled a vision for a new service structure that was created in partnership with a panel of young people with lived-experience of using services (the Norfolk Youth Council). The rationale, vision and service structure are further described below.

**Background**

**National Context**
National surveys, policy recommendations and studies repeatedly call for changes to the way mental health services are delivered to young people with mental health difficulties\(^2,13-15\). This need is also a priority on the UK government agenda, supported by the recommendations of the Children and Young People’s Mental Health and Wellbeing Taskforce\(^5\), and the NHS five yearforward view for mental health report\(^11\), recommending mental health services to consider innovative models of care in line with young people’s needs. Such recommendations urge for service providers to break from tradition and develop dynamic services that fit the changing needs of young people, rather than young people being expected to fit services\(^2\).

The reform of youth mental health services is not a new suggestion; previous children and young people’s mental health policy and guidance has also reflected the need for change\(^16\). These include, but are not limited to, Every Child Matters\(^17\), The National Service Framework for Children, Young People and Maternity Services\(^18\), Foresight Mental Capacity and Wellbeing report\(^19\), Children and Young People in Mind: The final report of the National CAMHS Review\(^20\), New Horizons: a shared vision for mental health\(^21\), No Health without Mental Health\(^22\), and Children’s and adolescents’ mental health and CAMHS\(^23\). Additionally, a systematic review of young persons’ requirements from mental health services\(^12\) suggested that the premise upon which many CAMHS and AMHS were commissioned does not match with how young people conceptualised their distress, nor were they delivered in a manner seen as appealing or irrelevant.

Traditionally, CAMHS and AMHS services are commissioned separately in the UK, resulting in a transition between services at 18 years (or 16) for young people. CAMHS and AMHS services have different ways of working with young people and criteria for whom they work with. A recent study looking at young people making this transition found that, for the majority, it was poorly planned and experienced\(^9\). It has also been argued that emerging adulthood is a prolonged and unstable developmental stage, not best represented by rigid age thresholds that transfer young people from CAMHS to AMHS\(^13\). Recommendations have been made to redefine service structures for young people catering for those up to the age of 25 in order to better represent societal changes in the developmental transition from childhood to adulthood\(^2\). Further,
the need for youth services to be preventative in nature, with a goal to reduce the need for transition into adult services is emphasised.

This drive for reform from national policy recommendation and literature, as discussed above, is also reflected within the NHS funded Children and Young People’s Improving Access to Psychological Therapies (CYP-IAPT) programme. CYP-IAPT reflects a service transformation initiative that supports services to satisfy national policy, provide evidence based interventions, adhere to nationally agreed outcome frameworks and maximise partnership work (www.england.nhs.uk/mentalhealth/cyp). Such ambition reflects a change in the way child and young people’s mental health services have traditionally been delivered.

**Local Context**

The Norfolk youth mental health team was developed, not only as a response to national policy and research recommendations to rethink and reconfigure mental health services for young people, but also in response to locally identified concerns regarding young people with complex mental health needs who were otherwise excluded from local service structures. The transformation of services leading to the development of the Norfolk youth mental health team developed from well-established local Early Intervention in Psychosis services but aimed to expand this to a much wider group of young people who found themselves not eligible to enter this service. This work initially started within the EIP team. In 2008 the Norfolk Early Intervention in Psychosis (EIP) team began to pilot a small sub-team focussing on young people at risk of developing long term severe and complex mental health difficulties who did not meet the criteria for EIP involvement, nor local CAMHS provision. Young people accessing this pilot service had a broad range of complex needs, including high levels of psychological distress, attenuated psychotic symptoms and social and occupational functioning difficulties. The pilot team, as part of the Early Intervention service, worked in a pragmatic manner, using an intensive outreach and partnership model with identified young people. This included engaging young people through offering joint appointments with partner agencies in a flexible and timely manner. Significant changes were observed after 12 months for social and symptomatic outcomes, including improvements in psychotic symptomatology and co-
morbid anxiety and depression. Following the implementation of this model, the team was cited as an example of good practice for improving the accessibility of mental health services for young people, forming the basis of a youth service model.

Relevant local historic CAMHS and AMHS service data were interrogated with support from the NIHR CLAHRC. This involved examining rates of referral and comparing them with contact rates (using contacts as a proxy for intervention). This revealed a discrepancy between need and access to and/or engagement with secondary services. Referrals peaked at 18 years, while contact rates almost halved between 17y and 18y (see Figure 1). This implied that, whilst demand remained high, young people were not successfully engaging at a time of clear perceived need and further implied that such a "cliff edge" needed addressing through a modified service model.

[Insert Figure 1]

Following this, we began to pilot a new service in 2012 for young people not eligible for the Early Intervention Service, but still offering an EIP type social recovery model with an emphasis on functional recovery to those young people aged 14 to 25 with the most complex emerging mental health difficulties across Norfolk. The pilot teams offered social recovery and pragmatically focused interventions to these young people. Interventions included: assertive case management, team case formulation, systemic interventions, access to evidence based therapies such as CBT and DBT, and timely medication reviews. DBT skills, training and supervision were specifically added during the course of the pilot due to the nature and complexity of the clinical presentations, e.g. emotional dysregulation and self-harm. The team also explicitly focused on working alongside local partner agencies already supporting young people which included mental health services, voluntary sector agencies, education, housing and social care teams. The pilot ensured that young people had timely access to support by actively trying to transcend the traditional complex care system, systematic barriers, and commissioning constraints. This was achieved in part by allowing direct referrals, offering consultation and signposting.
Working closely alongside third sector agencies, which demonstrate excellent principles of non-stigmatising engagement, positively influenced the new service model. As a result, the pilot service adopted a philosophy of diagnostic uncertainty, rather than labelling service users through a lens of mental illness, while explicitly addressing specific psychological and social needs with good effect.\(^\text{27}\) Data from the young people engaged with this service demonstrated that they were presenting with an multitude of complex problems including health, social, financial and occupational difficulties. Many presented with psychotic-like experiences,\(^\text{28}\) as well as having other significant psycho-pathology (depression and social anxiety), and frequently a significant history of trauma.\(^\text{27}\) Additionally, it was observed that young people did not always access mental health services in a timely manner, often leading to long and multiple help-seeking pathways.\(^\text{29}\)

Following positive initial outcomes in service engagement, global and social functioning,\(^\text{27}\) the pilot model was used as the basis for developing a service for a broader range of young people requiring mental health input, rather than just those with the most complex presentations, leading to the design of the Norfolk Youth Service.

**Service Design**

Informed by the above, and in close collaboration with local young people and third sector agencies, we designed a vision for secondary mental health services with a focus on how best to engage young people. This included the adoption of core principles which we monitor ourselves against, that complement EIP guidelines,\(^\text{30}\) CYP IAPT principles and are in line with the Youth Mental Health Declaration.\(^\text{31-32}\) These include:

- Being youth orientated and non-stigmatising to ensure positive early engagement
- An assertive outreach and pragmatic approach
- Working with diagnostic uncertainty
• Being recovery focused to minimise functional/social disability
• Promoting self-management and self-directed treatment
• To offer risk management with a service user involved approach
• Aiming to reduce inpatient admissions
• Optimising partnership with other support agencies and working with systems e.g. families
• Using evidence-based interventions and seeking to develop this evidence base
• Incorporating and embedding monitoring, evaluation and research into everyday practice

The service aims to be different in vision and culture from traditional mental health services, maintaining an ethos of ‘youth and family focus whilst prioritising functional and social improvement, rather than only diagnosis, pathology or symptom reduction.

The interventions offered by the service include a combination of Cognitive Behavioural Therapy (CBT), assertive case management, medication management, Dialectical Behavioural Therapy (DBT), Systemic Therapy and family work, Occupational Therapy, support work, group work and consultation. Peer support workers are also employed and embedded within the various teams at the suggestion of the Norfolk Youth Council. Their role is to use their lived experience to co-facilitate groups, enhance engagement in services and with treatment and to help in the development of the services. The clinical interventions are delivered using a clinical staging model i.e. focusing the interventions on where an individual exists on a continuum of disorder progression. The teams aim to support the system around the young person in line with the Adolescent Mentalization-Based Integrative Treatment model (AMBIT), with a distinct focus on social activity and engagement with community services. Specifically, use of the AMBIT model has supported a shift away from the conventional ‘team around the young person’ towards a ‘team around the worker’ model. This has promoted individual therapeutic attachment relationships for the young person with a key worker, regardless of profession or agency. This combined way of working reflects a genuine biopsychosocial and social recovery-focused service.
Figure 2 depicts the service model and Figure 3 illustrates the re-designed service landscape. Key components include an overt remit to work with and consult with external services, and aid detection of individuals at high risk of developing pervasively mental health difficulties. The function of a wellbeing service for young people (with mild to moderate difficulties) is incorporated and aids in the development of an accessible whole youth mental health pathway.

[Insert Figure 2]

The aim is to offer a staged youth mental health service dependent on the needs of the individual. This encompasses:

1. Detection, Engagement and Assessment: actively in-reaching into community and other local services in order to identify and engage young people in most need of specialist mental health services. A youth focused, embedded and accessible assessment team signpost to sub-teams and treatment based on clinical need.

2. Norfolk Youth Wellbeing Team (16-25 years): the front door of mental health and wellbeing services offering youth-friendly evidence-based stepped care interventions, at a youth oriented venue, in collaboration with non-statutory agencies, using a variety of interventions including peersupport workers and social interventions. This embedded service allows for the appropriate stepping up and down of service users based on need. This incorporates the principles of CYP IAPT and is forming a part of the local CYP IAPT provision.

3. Youth Mental Health Team: building on the pilot service we aimed to liaise with both outside agencies and the wellbeing team to coordinate care in a therapeutic manner, advise/consult on complex cases and offer specific interventions to those with severe and complex mental health difficulties.

4. Intensive Support Team: in collaboration with other teams and outside agencies, this team assists those young people presenting with significant risk with an aim to prevent admission to hospital and to retain young people within their families and communities.
The youth service serves all young people between the ages of 14 to 25 years old in Norfolk and Waveney, UK. There is no time limit for the service’s involvement with an individual, however there is an emphasis on not retaining people in service for longer than is required, but allowing for flexible re-referral into the service. Referrals can come from any source including self-referral which are then all triaged and diverted to the appropriate service within the serviceline for assessment and interventions.

Alongside the development of the Norfolk Youth Service there remains a Child and Family Team (C&F) with close links to the Youth Service. This team focuses on young people below the age of 14 and specialises in early, family-orientated treatment of developmental and attachment problems, incorporating a Perinatal and Infant Mental Health Service (PIMHS). This team similarly aims to work with other agencies such as health visitors and children’s centres. The aims are for genuine flexibility around the age ranges between teams, smooth transitions and joint working based on the needs of young people. The C&F and Youth teams have shared management and team members integrated in both services to maintain links and across-boundary working. This single management structure also incorporates Neuro-Developmental Disorder (NDD), EIP (historically ages 14-35 but with plans, subject to commissioning, to expand this to all ages in line with UK EIP national standards), in-patient and Eating Disorder (ED, currently commissioned for ages 0-18 within NSFT with a separate Trust commissioned for services over 18 years) teams (see Figure 3). It is anticipated that this will improve the experience of transitions, engagement, communication and joint working.

[Insert Figure 3]

The workforce within the Youth Service has been drawn from pre-existing CAMHS and AMHS services within NSFT. This has allowed the merger of existing ideas and treatment philosophies that have evolved as part of the culture of the two services. However, the Youth Service also sets out to develop innovative and novel solutions to mental health difficulties and associated complexities. As such, the Norfolk Youth Service
was designed to be research and data orientated, drawing from the best available evidence to drive improved service design. Service evaluation, research and compliance with CYP-IAPT principles is key to inform continual servicedevelopment as well as influencing local commissioning.

**Research Priorities**

Due to the novel approach of the Norfolk Youth Service in the UK, we are keen to develop our learning and continually improve service quality for young people through conducting research. Research conducted is planned to satisfy national policy guidance and recommendations (e.g. Future in Mind\(^2\)). In addition to currently participating in national research projects, the research development team plans to engage clinicians, managers and young people in research through:

1. Evaluating the service in relation to impact on social and symptomatic recovery, cost-effectiveness and from the perspective of young people and families.
2. Exploring young people’s experience and quality of transition between teams with a view of developing user-led transition protocols.
3. Evaluating and exploring psychological factors and predictors of mental health difficulties, with a view to reducing impact on wider-population public mental health.
4. Developing and testing clinical models, novel interventions and effectiveness of peer support.
5. Exploring factors associated with pathways to care, access and service engagement.
6. Exploring factors associated with the meaning of recovery and interventions aimed at social recovery.

**Future Directions**

Plans are being implemented to further develop a better co-ordinated wider Youth Mental Health pathway, which will include Social Care, Education and other statutory and non-statutory organisations - in line with recommendations from the Children and Young People's Mental Health and Wellbeing Taskforce\(^2\) and a local mental health transformation plan. Discussions and joint forums with key stakeholders, including NHS
commissioners, are established and service transformations developing. The Norfolk Youth Service aspires to act as an exemplar for other areas wishing to develop similar models.

The Norfolk Youth Council will remain central to any further developments to ensure we continue to keep the views and wishes of young people central to future transformation. They are keen to continue to develop this Norfolk "Headspace" inspired service in the UK - a one-stop-shop approach avoiding the need to navigate themselves through a complex maze of overlapping organisations, before they reach the appropriate service. The Norfolk youth model aims to continue to offer genuinely integrated services for young people in conjunction with partner agencies across all tiers whereby it is difficult for young people to fall through service provision gaps. We aim to continue developing a one-stop shop approach whereby all agencies offer coordinated support and consultation to one another.

In addition, the Youth Service wishes to continue development of further community initiatives through employment of peer support workers and social intervention programmes, delivered together with other non-statutory partners. There are also plans to radically develop outreach services to deliver interventions in youth relevant ways, particularly through innovative IT and virtual platforms. The UK government is watching the Norfolk Youth Service model with interest and we will feedback to the taskforce with the hope that aspects of our service implementation can be translated to the wider mental healthcare system.

**Summary and Conclusions**

Redesigning mental health services for young people is long overdue. Calls from organisations across varied domains, together with growing dissatisfaction from users of, and referrers into, current services suggest the need for a new approach for child, family and young people’s mental health services. By intervening early in a comprehensive and youth orientated manner for individuals with a range of mental health difficulties and those at risk of long term problems, it is likely that enormous benefits can be gained both for individuals and society. The Norfolk Youth Service has been designed to do this, having been developed alongside young people and stakeholders, and is different to traditional CAMHS and AMHS. The
aim is to achieve such significant service transformation in an evidence-informed way, by working together across the wider system, being youth focused, engaging and offering evidence based interventions to improve social and psychological outcomes. It is therefore hoped that the developments already set in motion can continue to be fully embedded in line with young people’s wishes.

Reflections

Upon reflection, the model developed has increased awareness and accessibility for young people in to mental health services. Young people have been consulted and listened to, meaning the service delivery model feels genuine. As a result of improving access the service must constantly review service demand, capacity and patient flow. At times, this has resulted in high volume referrals, waitlists and overwhelming caseloads meaning that maintaining our principles consistently has been a challenge. However, in conjunction with young people, expanded clinical pathways that fit with our ethos have been developed to optimise flow through the system. Additionally, the challenges of commissioning and culture change across the system for a service model such as this, has at times been difficult. Despite this, developing such a model has maximised integrated working between teams and improved access for young people through joined up working across tiers and agencies. We have developed a learning environment which draws from CAMHS and AMHS and reflect regularly to continue to evolve our services to meet the needs of young people.

References


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