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Young people attempting to access mental health services in the United Kingdom often find traditional models of care outdated, rigid, inaccessible and unappealing.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 useropinion suggest that reform is needed to reflect the changing needs of young people. There is significant motivation in the UK to transform mental health serviceforyoung people and this paper aims to describe the rationale, development and implementation of anovel youth mental health service in the UK, the Norfolk Youth Service.

Methods: The Norfolk Youth Service model is described as aservice 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 exampleof mental health transformation in the United Kingdom, comprising apragmatic, assertive and 'youth friendly' service foryoung 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 inclusiveethos. 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 Servicerepresents an example of reform that aims to meet the developmental and transitional needs of young people, whileremaining 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 foryoung peoplewith complex mental health difficulties. Young people and theiradvocates have been calling nationally forthe redesign of services[1, 2] and, since most

severe and enduring mental illnesses emerge before the age of 25[3, 4] ,there are strong economicand social justifications fortargeting emerging mentalhealth difficulties through appropriately designed services[5]. Recent evidence suggests that whilst rates of transition to psychosis from At Risk Mental States (ARMS) are relatively low, outcomes are poorand often associated with complex clinical and social co-morbidity[6]. In addition, traditional services available to young peoplewith severe and complexmental health conditions are often rigid and outdated[7], under-funded[2], inaccessibleand unappealing to those needing to access them[1]. Furthermore, the transition between CAMHS (Child & Adolescent Mental Health Services) and AMHS (Adult Mental Health Services) with pre-defined acceptance criteria can create systemicbarriers that are often negatively experienced and are developmentally orsocially inappropriate[8-10]. Therefore, the UK government and Department of Health (DoH) have called fornovel improvements in mental health care[11] and declared an urgent need forchange[2].

In collaboration with local young people, and building on the pioneering work of ORYGEN (National Centre of Excellence in Youth Mental Health, Australia), ourteam of local academics, clinicians, service users, third sectororganisations and NHS managers set out to redesign mental health services foryoung 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 systematicreview of young people's views of UK mental health services[12] and investigate local provision in Norfolk. This propelled avision foranew service structure that was created in partnership with apanel of young people with lived-experience of using services (the Norfolk Youth Council). The rationale, vision and service structure are furtherdescribed below.

Background

National Context

National surveys, policy recommendations and studies repeatedly call forchanges to the way mental health services are delivered to young people with mental health difficulties[2, 13-15]. This need is also apriority on the UK government agenda, supported by the recommendations of the Children and Young People's Mental Health and Wellbeing Taskforce[2], and the NHS five yearforward view formental health report[11], recommending mental health services to consider innovativemodels of care in line with young people’s needs. Such recommendations urge forservice providers to break from tradition and develop dynamic services that fit the changing needs of young people, ratherthan young peoplebeing 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 forchange[16]. Theseinclude, but are not limited to, Every Child Matters[17], The National Service Framework for Children, Young Peopleand Maternity Services[18], Foresight Mental Capacity and Wellbeing report[19], Children and Young Peoplein Mind: The final report of the National CAMHS Review[20],New Horizons: ashared vision formental health[21], No Health without Mental Health[22], and Children’s and adolescents’ mental health and CAMHS[23]. Additionally, a systematicreviewof 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 theirdistress, norwere they delivered in amanner seen as appealing orrelevant.

Traditionally,CAMHS and AMHS services are commissioned separately in the UK, resulting in a transition between services at 18 years (or 16) foryoung people. CAMHS and AMHS services have different ways of working with young people and criteria forwho they work with. A recent study looking at young people making this transition found that, forthe majority, it was poorly planned and experienced[9]. It has also been argued that emerging adulthood is aprolonged 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 foryoung people catering forthose up to the age of 25 in order to betterrepresent societal changes in the developmental transition from childhood to adulthood[2]. Further,

the need foryouth services to be preventative in nature, with agoal to reduce the need for transition into adult services is emphasised.

This drive forreform 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 aservice transformation initiative that supports services to satisfy national policy, provide evidence based interventions, adhere to nationally agreed outcomeframeworks and maximise partnership work (www.england.nhs.uk/mentalhealth/cyp). Such ambition reflects achange 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 reconfiguremental health services foryoung people, but also in response to locally identified concerns regarding young peoplewith 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 widergroup 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 asmall sub-team focussing on young people at risk of developing long term severe and complex mentalhealth difficulties who did not meet the criteria for EIP involvement, norlocal 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 apragmaticmanner, using an intensiveoutreach and partnership model with identified young people. This included engaging young people through offering joint appointments with partner agencies in a flexibleand timely manner. Significant changes were observed after 12 months for social and symptomaticoutcomes, including improvements in psychoticsymptomatology and co-

morbid anxiety and depression.[24]. Following the implementation of this model, the team was cited as an example of good practice for improving the accessibility of mental health services foryoung people[25], forming the basis of a youth service model.

Relevant local historic CAMHS and AMHS service datawere 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 adiscrepancy 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 peoplewere not successfully engaging at a time of clearperceived 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 anew service in 2012 foryoung people not eligibleforthe Early Intervention Servicebut still offering an EIP type social recovery model with an emphasis on functional recovery[26] 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 alongsidelocal partner agencies already supporting young peoplewhich included mental health services, voluntary sectoragencies, 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, systematicbarriers, 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 aresult, the pilot service adopted a philosophy of diagnosticuncertainty, ratherthan labelling serviceusers through a lens of mental illness, while explicitlyaddressing specificpsychological and social needs with good effect[27]. Datafrom the young people engaged with this servicedemonstrated that they were presenting with amultitudeof complex problems including health, social, financial and occupational difficulties. Many presented with psychotic-like experiences[28], as well as having other significant psycho-pathology (depression and social anxiety), and frequently asignificant history of trauma[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[29].

Following positive initialoutcomes in service engagement, globaland social functioning[27], the pilot model was used as the basis fordeveloping aservice fora broader range of young people requiring mental health input, ratherthan just forthose 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 avision forsecondary mental health services with afocus on how best to engage young people. This included the adoption of core principles which we monitorourselves against, that complement EIP guidelines[30], CYP IAPTprinciples and are in line with the Youth Mental Health Declaration[31-32]. These include:

- Being youth orientated and non-stigmatising to ensure positive earlyengagement
- An assertive outreach and pragmaticapproach
- Working with diagnosticuncertainty

- Being recovery focused to minimise functional/socialdisability
- Promoting self-management and self-directed treatment
- To offer risk management with aservice userinvolved approach
- Aiming to reduce inpatient admissions
- Optimising partnership with othersupport 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 traditionalmental health services, maintaining an ethos of 'youth and family focus whilst prioritising functional and social improvement, ratherthan only diagnosis, pathology orsymptom reduction.

The interventions offered by the service includeacombination 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. Peersupport workers are also employed and embedded within the various teams at the suggestion of the Norfolk Youth Council. Theirrole is to use their lived experience to co-facilitate groups, enhanceengagement 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 acontinuum of disorder progression [33]. The teams aim to support the system around the young person in line with the Adolescent Mentalization-Based Integrative Treatment model (AMBIT)[34], with adistinct focus on social activity and engagement with community services. Specifically, use of the AMBITmodel has supported a shift away from the conventional'team around the young person' towards a 'team around the worker' model. This has promoted individual therapeuticattachment relationships forthe young person with a keyworker, regardless of profession oragency. This combined way of working reflects agenuine 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 pervasivemental health difficulties. The function of awellbeing service foryoung people (with mild to moderate difficulties) is incorporated and aids in the development of an accessible wholeyouth 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 otherlocal 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 ayouth oriented venue, in collaboration with non-statutory agencies, using avariety of interventions including peersupport workers and social interventions. This embedded service allows forthe appropriate stepping up and down of service users based on need. This incorporates the principles of CYP IAPTand is forming a part of the local CYP IAPTprovision.
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 therapeuticmanner, advise/consult on complex cases and offer specific interventions to those with severe and complexmental health difficulties.
4. Intensive Support Team: in collaboration with otherteams 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 peoplebetween the ages of 14 to 25 years old in Norfolk and Waveney, UK. There is no time limit forthe 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 servicelineforassessment and interventions.

Alongside the development of the Norfolk Youth Service thereremains a Child and Family Team (C&F) with close links to the Youth Service. This team focusses 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 forgenuine flexibilityaround 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 NSFTwith a separate Trust commissioned forservices 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 innovativeand 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 compliancewith 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 ourlearning and continually improve service quality foryoung peoplethrough 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 peoplein research through:

1. Evaluating the service in relation to impact on social and symptomaticrecovery, cost-effectiveness and from the perspectiveof young peopleand families.
2. Exploring young people's experience and quality of transition between teams with aview of developing user-led transition protocols.
3. Evaluating and exploring psychological factors and predictors of mental health difficulties, with aview to reducing impact on wider-population publicmental 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 abetter 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 keystakeholders, including NHS

commissioners, are established and service transformations developing. The Norfolk Youth Service aspires to act as an exemplar forotherareas wishing to develop similarmodels.

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"[13] inspired service in the UK - a one-stop-shop approach avoiding the need to navigate themselves through acomplex maze of overlapping organisations, before they reach the appropriate service. The Norfolk youth model aims to continue to offer genuinelyintegrated services for young people in conjunction with partner agencies across all tiers whereby it is difficult foryoung people to fall through service provision gaps. We aim to continue developing aone-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 peersupport 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 ITand virtual platforms. The UK government is watching the Norfolk Youth Service modelwith interest[2] and we willfeedback to the taskforce with the hope that aspects of our service implementation can be translated to the widermental healthcare system.

Summary and Conclusions

Redesigning mental health services foryoung 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 fora new approach for child, family and young people's mental health services. By intervening early in a comprehensiveand youth orientated mannerforindividuals with arange of mental health difficulties and those at risk of long term problems, it is likely that enormous benefits can be gained both for individuals[2] and society[5]. The Norfolk Youth Service has been designed to do this, having been developed alongsideyoung people and stakeholders, and is different to traditional CAMHS and AMHS. The

aim is to achieve such significant servicetransformation 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 psychologicaloutcomes. It is therefore hoped that the developments already set in motion can continue to be fully embedded in linewith young people's wishes.

Reflections

Upon reflection, the model developed has increased awareness and accessibility foryoung peoplein to mental health services. Young people have been consulted and listened to, meaning the service delivery model feels genuine. As aresult 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 ourprinciples consistently has been achallenge. However, in conjunction with young people, expanded clinical pathways that fit with ourethos have been developed to optimise flow through the system. Additionally, the challenges of commissioning and culture change across the system fora service model such as this, has at times been difficult. Despitethis, developing such a model has maximised integrated working between teams and improved access foryoung 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 ourservices to meet the needs of young people.

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