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# Mental Health Service Models for Young People

In 2015, the Government committed 5 years of extra funding for Children and Young People's Mental Health Services (CYPMHS). All areas of England were required to submit plans outlining how they will improve their services by 2020. This POSTnote describes some of the new models of CYPMHS and examines the challenges to their effective implementation.

## Overview

- The Office for National Statistics estimates that nearly one in four Children and Young People (CYP) show some evidence of mental ill health.[1]
- It is estimated that between £70-100 billion is lost each year in the UK due to poor mental health.[2]
- New models of CYP mental health services are currently being developed across the country to suit the unique needs of local areas. They include whole-system, schools-based, community-based and other models, and involve integrating services from across the statutory and voluntary sectors.
- Issues with implementing new service models include data monitoring, recruiting and retaining staff and funding.

## Background

Good **mental health (MH)** is a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community.[3] Although a new national prevalence survey on the MH of **Children and Young People (CYP)** is due in 2018,[4] the most recent data available are from a survey in 2004.[5] This survey of CYP in Great Britain estimated that one in ten aged 5-16, and one in six aged over 16 suffered from a clinically diagnosable MH condition. Furthermore, 6% of CYP aged 5-16 suffered from a conduct disorder such as a behavioural disorder, 4% from an emotional disorder such as anxiety, 2% from a hyperkinetic disorder such as ADHD, and 1% from another MH disorder (some CYP suffered from multiple disorders).

Estimates suggest that £70-100 billion (4.5% of GDP) is lost annually in the UK through sickness absence, benefit provision and lost productivity due to poor MH.[2,6] Half of adult mental illnesses start before the age of 14, and three quarters before age 24.[7] However, approximately 7% of the total NHS budget for MH is spent on **Children and Young People's Mental Health Services (CYPMHS)**, and it is estimated that just 25% of CYP with a MH problem access treatment.[8] Therefore, investment in early interventions to tackle MH issues during childhood and adolescence has the potential to alleviate some of the social and economic costs of MH conditions.[9]

**Box 1. The Tiered Model**

Since its development in 1995, the Tiered model of MH care has been the most commonly adopted MH system in the UK. It separates MH services into 4 tiers based on the type of service provision.[10,11]

- **Tier 1**: Includes universal, non-specialist primary-care services, such as school nurses and GPs. These offer general advice and treatment for less severe MH problems.
- **Tier 2**: Involves workers who are more specialised, but still provide a primary care service, such as counselling services.
- **Tier 3**: Comprises specialist multidisciplinary outpatient teams, who deal with more complicated MH problems.
- **Tier 4**: Consists of specialised day and inpatient units, to provide care for patients with the most severe problems.

## Recent Changes in Service Provision

Historically, UK CYPMHS have been structured according to the Tiered model (Box 1). This model effectively requires CYP to fit the specifications of the services available, rather than the services fitting individual needs.[12] CYPMHS have been under-resourced for a number of years. This has led to higher thresholds for access to more specialist services and often means that a patient's condition must get worse before they can get the help they need.[13] NHS England estimates that CYPMHS are facing rising demand, with referrals increasing by 44% in the last 4 years.[8] These issues have prompted the Government to allocate extra funding of £1.25 billion over 5 years for CYPMHS.[14] However, concerns have been raised by service providers about whether this money is being used to maximum effect.[15,16]

The need to improve CYPMHS has prompted a range of policy responses across the UK.[17,18,19] While this note outlines developments in England, Box 2 summarises recent reviews of services in Scotland, Wales and Northern Ireland. In 2014, the Health Select Committee reported that services in England had 'serious and deeply ingrained problems'.[20] The 2015 government-commissioned Future in Mind report addressed some of the issues raised by CYP MH. It aims to move away from the Tiered model (Box 1), to a system built around the changing needs of CYP and their families.[12]

In England, 207 **Clinical Commissioning Groups (CCGs)**, are responsible for planning and distributing funding for local health services for an average 250,000 people in each area.[21] Local CYPMHS are commissioned by CCGs, as well as other funders. These include services provided by **NHS Child and Adolescent Mental Health Services (CAMHS)**, the voluntary sector, schools, local authorities and independent providers. Future in Mind required all CCGs to submit Local Transformation Plans outlining how they will implement changes to CYPMHS to meet the unique needs of their areas. All CCGs submitted a total of 123 plans (some CCGs submitted joint plans), describing a wide range of models, involving many different agencies across the statutory and voluntary sectors.[15]

In 2016, the Five Year Forward View for Mental Health strategy set out 58 recommendations to improve MH services that built upon Future in Mind. It aims to allow an extra 1 million patients (including 70,000 CYP) to access high-quality MH services by 2020/21. This represents 35% of estimated need (25% of need was estimated to have been met in 2016).[22,23] The 2017 Five Year Forward View for Mental Health One Year On report set out further objectives, time-scales and funding.[24]

These national recommendations set out the strategic direction for improving CYPMHS. However, a range of different service models have been developed across the country to deliver these changes. The following sections describe some of the features of these different models, and examine some of the issues raised by implementing them.

**Box 2. Mental Health Reviews in Scotland, Wales and N. Ireland**

- The 2017 Scottish Government's 10-year Mental Health Strategy focuses on prevention and early intervention services for CYP. It suggests improving support at Tiers 1 and 2 to stem the flow of referrals to Tiers 3 and 4, as well as improving progress monitoring in all MH services.[25]
- The Welsh Government's 10-year Together for Mental Health plan was released in 2012, and further updated for the 2016-19 Delivery Plan. For CYP, the plans aim to improve the accessibility and timeliness of CYPMHS, and focus on supporting the transition to adult MH services, and the development of emotional wellbeing and resilience.[26,18]
- In Northern Ireland, an Independent Review of Child and Adolescent Mental Health Services (CAMHS) was published in 2011. It suggests improvements to CAMHS structure and organisation, access and availability of services, and methods of measuring outcomes and monitoring demographic information.[19]

## Different Service Models

CYP suffer from a wide range of MH problems, and each individual and their family is unique. There is thus a clear consensus on the need to provide a variety of CYPMHS, across a wide range of settings to meet local needs. Many plans aim to integrate services across the statutory and voluntary sectors, through whole-system, schools-based, community-based and other models.

### Whole-System Models

Many areas are developing whole-system models to integrate all locally available CYPMHS; from NHS CAMHS to voluntary services. These models aim to provide flexible MH support that takes into account the preferences and needs of CYP and their families, to find the most appropriate service for them. Many of these models have been developed around the THRIVE framework (Box 3), which ensures that CYP and their families take an active part in choosing the right approach for them, by grouping CYP based on their choices and the support they need.[27] Another example of a whole-system model is Liverpool's Integrated Comprehensive CAMHS Pathway (Box 3).[28] This, and many similar models, includes a single point of access to assist CYP in negotiating the variety of services available.

### Schools-Based Models

MH services provided in schools are some of the most accessible for CYP. This is because most CYP attend school, access to schools-based services does not require a clinical diagnosis, and schools are often the first point of contact for CYP and their families when they begin to experience MH problems. A 2017 joint report by the Health and Education Select Committees emphasised the importance of a whole-school approach to MH, MH training for teachers, and co-ordinating schools and CYPMHS.[29]

A key part of schools' MH work across the entire education system is preventative; for example, building resilience, promoting wellbeing, and destigmatising MH issues through Personal, Social, Health and Economic education (PSHE).[30] In addition, school counselling is provided in 70% of secondary schools and 52% of primary schools in Great Britain, providing an opportunity for early intervention to tackle some MH problems before they get worse.[31] The voluntary service Place2Be (Box 4) provides schools-based MH services, including counselling, training and support for teachers, and working with parents.[32] NHS Child and Adolescent Mental Health Services (CAMHS) are also placed in some schools to improve the accessibility of their services. For example, the Mental Health Services and Schools Links Pilots (Box 4) led to improved communication between schools and NHS CAMHS.[33] However, schools-based CYPMHS provide little support outside of school hours and may not be accessible to all CYP, such as those who do not attend school. Therefore, schools-based services typically form part of an integrated whole-system model which includes other types of CYPMHS.

### Community-Based Models

A major criticism of CYPMHS has been their inaccessibility for CYP and their families.[12] Vulnerable young people, such

**Box 3. Whole-System Models**

**The THRIVE framework** was developed as a conceptual model for CYPMHS in 2014.[11] It takes a person-centred, needs-based approach to CYP MH, by grouping CYP into five categories of increasing need; Thriving, Getting Advice and Signposting, Getting Help, Getting More Help, and Getting Risk Support.[34] I-THRIVE is an evidence-based approach to implementing the THRIVE framework[35] that is potentially accessible to 47% of CYP in England. It aims to help local areas to improve their services and provides training and a community of practice where all members can learn from each other.[36]

**The Integrated Comprehensive CAMHS Pathway** is made up of a range of MH services in Liverpool, including NHS CAMHS and voluntary services, as well as other specialist services. These services form an inter-linking pathway that can be accessed at any stage, dependant on the user's MH needs. A single point of access can handle both self-referrals and referrals from a professional, to assist CYP in finding the most suitable service along the pathway. This approach has led to reduced referrals to more specialist services, and improved patient outcomes and satisfaction.[28,37]

as children in care, those in contact with the youth justice system, and homeless young people have higher rates of MH disorders and may face barriers to accessing CYPMHS.[38,39,40] Making early intervention services more accessible for all users, particularly those most at risk of MH issues, can prevent the escalation of MH problems. Many community MH services reach out to at-risk CYP. For example, the INTEGRATE model (Box 5) engages with vulnerable young people such as those involved in gangs.[41]

One-stop shops are an alternative community-based approach. These offer numerous services under one roof, to support CYP on a wide range of health and social issues, including MH. YIACS (Box 5) is one such approach which has been implemented in many areas.[42] This model, which has a 50-year history in the UK, shares many similarities with 'Head Space', which has been successful in improving outcomes for vulnerable young people in Australia.[43]

Community-based services are well-placed to provide MH support for vulnerable young people, and to direct them to targeted MH services if required. Effective communication between community MH services and other CYPMHS is therefore a vital part of an integrated whole-system model.

### Other Models

Schools- and community-based services are just two key elements involved in the system-wide transformation of CYPMHS. Online services, such as Kooth (Box 6), are another area of focus. Kooth provides online counselling and well-being support for CYP and points them towards other local MH services, as part of an integrated MH system.[44] Other models focus on improving specialist services for more severe MH problems. For example, the New Care Models in Mental Health Services Programme (Box 6) aims to include local MH providers in commissioning inpatient services, to reduce the length of inpatient stays and avoid inappropriate admissions to services far from the patient's home or in adult beds.[45] MH crisis care has also been a recent focus, for example through Crisis and Liaison Teams (Box 6).[46]

**Box 4. Schools-Based Models**

**Place2Be** is a children's MH charity, which provides an integrated, whole-school approach to CYP MH.[32] The whole-school approach aims to promote the social and emotional wellbeing of CYP, moving beyond learning and teaching, into all aspects of school life.[47] In 2016/17, Place2Be worked directly with 282 schools and provided training to a further 100 schools. Place2Be focuses on early intervention, providing a variety of MH support to help CYP deal with life challenges and build resilience. Place2Be has enlisted over 1000 volunteers on placement, most of whom are college/university students working towards a MH qualification. Volunteers of placement deliver counselling sessions for children in schools supervised by a Place2Be manager who oversees group counselling sessions and self-referral sessions for pupils along with support for teachers and parents.[32] These managers use tablets to collect data and feedback from teachers quickly and easily, and to assess changes in CYP behavioural, emotional and social wellbeing. This anonymised data can then be easily shared for monitoring and evaluation.[48]

**The Mental Health Services and Schools Links Pilots** were launched in 255 schools in 2015 by the Department for Education and NHS England. They aimed to establish points of contact in schools and in NHS CAMHS to improve the clarity of local pathways to NHS CAMHS from a school perspective and to reduce inappropriate referrals and to support efficient use of local resources.[33] Representatives from CCGs, NHS CAMHS workers, schools' MH leaders, and other local area organisations came together in a series of workshops to develop a better understanding of local CYPMHS.[49] An evaluation of the pilots in 2017 found that they strengthened communication and joint-working between schools and NHS CAMHS, and contributed to faster and more appropriate referrals. The report noted concerns about the cost and sustainability of providing the required support, and the lack of resources available to deliver the scheme across all schools.[33] However, some CCGs have extended the model to additional schools in their area.[50]

## Challenges to Effective Implementation

Although recent anti-stigma campaigns have helped to change the public perception of MH, there is a widespread consensus that the stigma surrounding MH can still delay or discourage people from accessing MH services.[51,52] Even those who do seek help can still struggle to access services. The following sections examine some of the other challenges to implementing effective CYPMHS.

### Outcomes Monitoring and Service Transparency

A lack of data about the success of CYPMHS is a central problem for the development of needs-focused MH services. This is primarily due to the challenges involved in collecting and using data such as child- and parent-reported outcomes data.[53] The CYP IAPT (Improving Access to Psychological Therapies) initiative covers 90% of CYP in England, supporting practitioners to collect child- and parent-outcomes and experience data, to help inform shared decision making in clinical practice. NHS England suggests that it has significantly improved practitioner training and the delivery of evidence-based therapies.[8] In 2016, the Child Outcomes Research Consortium (CORC) released a report which analysed 75 CYP IAPT services from 2011-15.[53] Difficulties with IT systems led to missing data, and CORC described the dataset as "flawed, uncertain, proximate and sparse." However, it suggested that analysis of imperfect datasets could still be useful to establish benchmarks to improve service quality.

**Box 5. Community-Based Models**

**INTEGRATE** was developed by the charity MAC-UK and partners in 2008 to engage vulnerable young people, who often experience multiple risk factors for poor MH. INTEGRATE partnerships are underpinned by evidence-based psychological approaches, and delivered in an adaptive and flexible way through 'streetherapy'.[41] Clinical and youth-work professionals act alongside 'community gatekeepers', reaching out to meet young people where they are at, to establish trusting relationships. Young people can ask for help with a variety of issues, from housing or jobs, to MH, and are supported to take up leadership roles in their community by delivering projects they are interested in. An independent evaluation of three INTEGRATE projects concluded that they had successfully engaged marginalised groups of young people who were involved in, or at risk of, offending. Young people reported an improvement in their mental wellbeing, which was confirmed by clinician-rated measures. However, they were still found to be reluctant to use mainstream MH services.[54]

**YIACS** (Youth Information Advice and Counselling Services) are a voluntary sector service for young people aged 13-25. YIACS provide a variety of MH services in 170 centres across the UK.[42] which are easily accessible through self-referral or referral from a GP, including in evenings and on weekends. The YIACS model uses one-stop shops, which allow young people to walk in the door and immediately see a professional who will listen to their needs.[55] They provide support for young people's emotional, social and health needs; offering a range of advice services including MH, sexual health, employment and money. A close link has been established between social welfare and MH, suggesting that social welfare advice may have a significant impact on young people's MH.[56] Evidence suggests YIACS services are attended more regularly than NHS CAMHS.[57]

The Future in Mind report identified the need for greater transparency of providers and commissioners of CYPMHS, in order to promote service improvement.[12] It suggested that local CYPMHS providers and commissioners should release regular information about CYPMHS performance, including prevalence, access, thresholds and waiting times. This data will help to determine if the new models are successful and cost-effective at improving service provision.

In 2016, CYP MH data were added to the Mental Health Services Dataset, including rates of access, bed days of CYP on adult wards, and number of appointments attended.[58] Since 2016, NHS England has published a Mental Health Dashboard, which is updated quarterly.[59] The Dashboard includes 52 indicators mapped against recommendations from the Five Year Forward View for Mental Health strategy, to support monitoring of progress and allow national and local bodies to be accountable for implementing the recommendations. Both of these datasets are experimental, and not yet complete, due, for example, to a lack of available data and IT system problems.[8] However, an analysis of the data from the 2016 and 2017 Dashboards found a wide variation in performance across the country, with 73.2% of local CCGs failing to meet NHS England's aims for improving services.[60]

In 2017, an evaluation of CYP Community Eating Disorder services was published. [61] Although the dataset had data quality issues, it found that referral-to-treatment waiting times had improved so that 69% of CYP had started urgent treatment within 1 week, and 79% within 4 weeks.

**Box 6. Other Models**

**Kooth** employs certified counsellors and MH workers to provide online counselling and psychotherapy services, as well as moderated peer support forums and self-help materials, 7 days a week until 10pm.[44] Online services are easily accessible for CYP, as they provide a quick response and use a media platform that CYP are comfortable with.[62] Kooth is commissioned by 42 CCGs, where it works in partnership with other local organisations to provide an integrated early intervention and prevention strategy, primarily for 11-18 year olds.[63]

**The New Care Models in Mental Health Services Programme** aims to enable CYP with severe MH problems to access an inpatient bed close to their home; decreasing the length of inpatient stays, avoiding inappropriate admissions, and reducing stress for CYP and their families. The model supports local MH service providers to manage budgets for these services in their local areas, through joint-commissioning with NHS England. This model was first implemented in April 2017 in West London and North East and North Yorkshire.[45]

**Crisis and Liaison Teams** in Durham & Darlington provide an urgent MH response for CYP who are experiencing a MH crisis, including out of hours. An evaluation of this service in 2015 showed it had reduced waiting times for CYP and their families from 26 hours to an average of 1 hour 38 minutes. It had also significantly decreased admissions to overnight paediatric beds, and reduced attendance at A&E.[46]

## Staff Recruitment and Retention

The 2017 Mental Health Workforce Plan for England identified a total of 214,100 NHS (clinical, support and administrative) posts to care for people who need MH services. [64] Of these, 20,100 are currently vacant. The report announced plans to employ 19,000 additional MH staff by 2020 to fill most of the vacancies. However, it is uncertain what impact Brexit will have on the recruitment and retention of MH staff in the NHS, and the Royal College of Nursing has questioned whether enough new staff can be trained within the required timeframe.[16]

## Funding the Rising Demand

An investment in CYPMHS of £1.25 billion over 5 years was announced in 2015, in addition to £150 million allocated in 2014 for under-18s with eating disorders.[14] However, there is wide variation in CCGs' reported planned spending for CYPMHS, ranging from less than £23 to over £52 per person.[13] The NHS Dashboard reports an increase in the number of new CYP receiving treatment in NHS-funded community services, [59] and studies suggest that services are struggling to cope with an increase in demand of at least 11% per year,[53] on average turning away 23% of CYP referred to them.[13] Many MH charities have welcomed the increased investment in CYPMHS, but have also expressed concerns that some funding is being diverted to meet other local priorities and noted a need for further investment.[65]

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