

Reaching out through innovation

A group of academics explain how they developed a project to consider the feasibility of identifying, treating and improving outcomes in 'hard to reach' young people with multiple complex mental health disorders in Newcastle

All young people negotiate a number of transitions during adolescence and early adulthood. These transitions increase vulnerability to risks including homelessness, lack of training or education and poor health (in particular sexual and mental health). So we should not be surprised that around 75% of mental disorders develop before the age of 25 years. Importantly, young people (aged 15-25) developing mental disorders around this time in life have high rates of long-term morbidity and mortality.

The problem is that for a number of reasons, (including down playing of issues, tolerance of behaviour, stigma or poor past experiences with mental health services) only a small proportion of young people suffering from mental ill health are successfully accessing mental health services. Therefore meaningful access to mental health services for at risk young people is a public health priority.

The term 'hard to reach' has no universal definition and different communities or groups of people are felt to be 'hard to reach' in different contexts. In our health service context, young people who are disadvantaged, marginalised, disconnected with welfare/ education/health systems, unwilling to engage with service providers, or burdened with multiple and complex needs are considered hard to reach by conventional health service provision.

The aims of the Innovations Project were firstly to establish whether it is possible to identify young people (aged 15-25) with multiple, complex, mental disorders, who were not in contact with mental health services. Secondly to determine the outcomes

of offering them an innovative, specialist, community-based mental health service specifically set up for hard to reach young people.

The innovative service

The new service was set up in an inner city Darzi Centre, a new GP practice with a walk-in service in Newcastle upon Tyne, which it was felt likely to be used by this group of young people. It ran between January and December 2011 and was funded by a service development grant from the North East Strategic Health Authority. It was delivered by an assistant psychologist (the outreach worker) and a senior trainee working in child and adolescent psychiatry.

It provided both an assessment and also flexible therapeutic interventions. The team was supervised weekly by a consultant child and adolescent psychiatrist.

Information about the service was made available to all staff at the host health centre and also a second Darzi health centre in a neighbouring area. Local mental health services, youth offending teams, voluntary sector organisations and services for young people who were or had been in local authority accommodation were also notified. This involved explaining referral criteria, while the team offered referring professionals the opportunity to carry out joint initial assessments,

Case studies

Simon, aged 18, received a diagnosis and management including individualised intensive tailored therapy for autism spectrum disorder, emotionally unstable personality disorder, harmful use of cannabis, alcohol and recurrent self-harm. He had a long history of previous, unsatisfactory experiences from mental health and education services. He had spent many years out of school and was housebound. When he did go out, he would get into trouble with others and often get arrested. Simon and his mother said the diagnosis made him feel understood for the first time, opened doors to other services and improved his daily function.

Lisa is another person who was referred to this service. She was 25 years old. She had a longstanding history of physical and emotional abuse from her mother. She recalled being given insulin-induced hypoglycaemic episodes when her mother deemed Lisa was not behaving well. When

Lisa was first reviewed by this service she suffered from very low moods with suicidal ideation and was self-harming on a regular basis. Lisa talked of an unrewarding experience from CAMHS where she had had psychotherapy and CBT and had been tried on four types of antidepressants without any success. We found that she suffered from Bipolar disorder, with a current episode of severe depression, emotionally unstable personality disorder and reactive attachment disorder. She attended around 30 sessions of individualised intensive tailored therapy and was managed in a bio-psycho-social way.

When we subsequently arranged her transition to adult mental health services, her moods had been good for a few weeks, the relationship with her partner was stable, she was back at university continuing her nursing degree, whilst holding down a part time job and was making positive contact with her family members.

**All names have been changed*

Top tips we learnt

Face to face collaborative working with NHS colleagues in the health centres and other agencies results in successful identification of these hard to reach young people.

A young person-oriented, flexible approach makes a difference.

This included not demanding initial commitments, offering young people face to face meetings with professionals in as flexible a way as possible using a variety of types of appointment reminder, and flexibility about venue (home visits or meetings offered to take

so as to facilitate a discussion and further understanding about the young person and their situation.

After referral, engagement with the young people began with the outreach worker making contact by telephone and attempting to agree attendance at a service that they sometimes did not feel they required. Considerable resources were devoted to this, the main role of the outreach worker.

The assessment phase consisted of an in-depth clinical assessment substantiated by a structured diagnostic questionnaire. Several assessments provided outcome data and were completed at initial assessment and on discharge.

Of the 36 young people who were eligible, 31 (86%) successfully entered the assessment phase and fell into three distinct groups:

1. Those who after a few months remained only partially assessed, with numerous missed appointments. The outreach worker would make many attempts to contact the young person over this period, including sending reminders about sessions via phone calls and letters.

2. The second group consisted of seven (19%) young people who were suffering from less severe mental health disorders, which the team felt would be more appropriately managed by a generic community mental health service so they were referred on.

3. There were 15 (48%) in the

place somewhere where the young person felt more comfortable).

The emotional intelligence practiced by the outreach worker. This started off initial engagement, showing interest and being flexible with time, date and place for appointment, and persevered with despite the clients' multiple non-attendances.

An empathetic style of consultation, ensuring the young person feels accepted and understood.

The high staff-to-young-person-ratio, with an outreach capability

third group, who were found to be suffering from multiple, complex, mental disorders. These young people were offered weekly, individually tailored therapy. The intervention was not manualised in advance. The therapy offered by the senior trainee followed an evidence-based approach. The delivery of the therapy differed in that what was offered was

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intensive, weekly 60-90 minute sessions with the main focus being on appropriate attunement with the young person's affect (emotional state) and psychological development. The therapy followed a bio-psycho-social approach, following NICE recommendations for medication and implementing various techniques from a variety of psychological therapies, focusing on the improvement of the young person's mental health, social and emotional needs. For social problems therapy focussed on interpersonal relationships and affective regulation.

and protected caseload, enabled individualised intensive treatment to be delivered at a pace and timing attuned to the young person's developmental stage and cognitive ability.

The use of accurate empathy, consistency and a combination of aspects from different psychological therapies, rather than using a manualised approach, facilitated the more individualised work tailored to the young people.

Other publications are forthcoming.

Results

This service was successful in helping colleagues in the health centres and in other agencies to identify and refer a particularly vulnerable group of young people. Almost half were living in unstable accommodation, three-quarters were not in employment or education and had experienced unsatisfactory previous contact with CAMHS and all had multiple, complex mental disorders.

With the right effort these young people can be engaged in treatment – 86% of the group received a personalised assessment; and 15 (48%) received individualised intensive tailored therapy – with improvements in their mental health and social functioning. In comparison to other CAMHS services who used the same assessment tools, we found that our young people had more severe mental disorders than reported for other specialty community CAMHS. The mental and social improvements observed after therapy was greater than that reported by other mainstream CAMHS.

A patients' satisfaction questionnaire was completed by 18 (58%) young people and 82% reported a positive experience. ■

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