

Case study: Youth team within the Central Norfolk Early Intervention in Psychosis team

Summary

The youth team is a dedicated team within the Central Norfolk Early Intervention in Psychosis Service (CNEIT) working specifically with 14-18 year olds accessing the Early Intervention in Psychosis (EIP) service.

The youth team has been specially recruited and trained to work with people at the younger end of the age range of people accessing the EIP service. Young people in this age group can receive a five year service rather than a usual three year service in order to reduce the need for unnecessary transition between services and make smoother transfers to Adult Mental Health Services (AMHS) or back into primary care.

How the service works

In 2003 EIP teams were set up across the country as part of the National Service Framework for Mental Health. EIP teams are designed to provide support to young people aged 14-35 experiencing a first episode of psychotic symptoms. Because of working with this age range EIP teams bridge Child and Adolescent Mental Health Services (CAMHS) and AMHS. Their primary aim is to improve the life chances of those affected by psychosis. This includes raising awareness of what it is and how it can affect people, providing practical support to young people in areas such as education and housing, and linking in with appropriate statutory or third sector services.

CNEIT has developed a designated, specialist youth mental health team within the EIP service to support individuals who are 14-18 years old, namely those within the CAMHS age range at point of referral. CNEIT typically offers a three year service. However, participants accepted into the youth team can receive up to a five year service in order to ensure smooth transfer to AMHS or discharge back to primary care.

Typically the youth team will work with the individual, their families and the support system around them (e.g. school or college). Interventions include a combination of cognitive behavioural therapy (CBT), assertive case management, support work and family work. The team focuses on promoting social activity and engagement with existing sources of educational and vocational activity, and peer and family support. The aim is that participants will have their needs sufficiently met to be discharged back to primary care settings. For those who need ongoing support, the team work jointly with adult services to ensure a

smooth transition with adequate support and access to adult services. Between October 2006 and September 2010 the youth team within the EIP service has accepted 88 people to the service.

Background to project

The vast majority of first episodes of psychosis occur between the ages of 14-35 with an average onset age of 22. This coincides with an often critical period in a person's development, during which early treatment is crucial. It is the first few years of psychosis that carry the highest risk of physical, social and legal harm.¹

CNEIT, based within AMHS, was developed to provide an accessible service for this group and reduce the time young people experiencing psychosis went without treatment. CNEIT has been in place since 2003 in line with national developments in EIP services. However, originally CNEIT did not have a permanent and established link to CAMHS in Norfolk making joined up working between the two services difficult. When the EIP service was originally set up, practitioners had mixed case loads both geographically and across the age range of 14-35. For young people aged 18+ at point of referral, medical assessment was provided within CNEIT. For people under 18 at point of referral, medical assessment was provided by CAMHS clinicians who would then need to refer on to CNEIT. Staff felt that the involvement of many different practitioners resulted in difficulties in establishing relationships and maintaining open lines of communication between the two services. Feedback from CAMHS staff showed they were unsure about making referrals into the EIP service and neither CAMHS nor the EIP team felt they were working together satisfactorily.

Following these discussions in 2006 a link-role was established to support more joined up working between CAMHS and CNEIT. The initial idea was that a CAMHS link practitioner would care co-ordinate all CAMHS age referrals within CNEIT. Although this did improve communication and relationships between the services, it was discovered that the demand was too high for a single practitioner. Therefore, 18 months ago a discrete specialist youth team within CNEIT was developed. The team was intended to meet existing need and to further develop aspects of the service outside of CAMHS, for example by developing links with the third sector and education agencies working with young people.

¹ Care Quality Commission. *Commissioning of Early Intervention in Psychosis Services*: <http://www.cqc.org.uk/periodicreview/nationalcommitmentsandpriorities2009/10/primarycaretrusts/nationalcommitments/commissioningofearlyinterventioninpsychosisservices.cfm>

Designing the service

A flexible approach to design and implementation

The design of the EIP service has been developed on an ongoing basis that is responsive to problems and opportunities and how they emerge during implementation. It was discovered that some young people who were already within specialist CAMHS experienced delayed referral and a lot of work was put into clarifying referral pathways - in particular the need to refer early. The youth team within CNEIT was created in response to these pressures by contacting local services to provide information about the EIP service and to clarify issues around referrals. The team also provided a primary care 'check list' and referral guidance from the then National Institute for Mental Health in England.

Within CAMHS, some practitioners were particularly positive about having a part of CNEIT dedicated to what they saw as the unique needs of CAMHS age clients. Staff sought to join up the geographical focus of the youth team EIP service with CAMHS services to facilitate smoother communication and joint working across the two services. In addition, EIP staff involved with 14-18 year olds have been given additional training around Common Assessment Framework (CAF), safeguarding, confidentiality, competency and consent to ensure the youth team within the EIP service had the right skills and knowledge to work with this younger age group.

Ethos of the service²

CNEIT offers an intensive outreach model of treatment that does not depend on clients' attendance at clinic or office-based appointments. Instead individuals are seen in a variety of settings including in the home, at school and at GP surgeries. The focus of this model of the service is on engagement and working on the young person's agenda using problem solving and self-management skills to reduce distress and develop emotional resilience.

Much effort has been put into making the service accessible and youth oriented. For example, appointments are offered at times that suit the needs of younger people, such as outside school and working hours. Appointments are driven by the interest of the young person, which in many instances can mean a focus on employment, education, family and peer relationships or housing, rather than the psychosis itself.

² This description has largely been drawn from: Central Norfolk Early Intervention Team, Norfolk and Waveney Mental Health NHS Foundation Trust and University of East Anglia: *Evaluating an intensive outreach approach for 'high-risk' 14-18 year olds*

The service adopts a normalising, non-pathologising approach to psychosis. As with most EIP teams, they are able to offer more relaxed assessment criteria than other statutory services and so embrace diagnostic uncertainty. This allows the team to accept many young people where presentation of psychosis is unclear, as is the case with most young people that they work with. The team accepts referrals from all agencies (third and statutory), as well as self-referrals and referrals from family members. They aim to see people within two weeks of referral but will prioritise any young person at risk of admission to a care/hospital setting.

In addition to client work, the youth team within the EIP team have also linked-in with other local services such as Connexions and Young Person's Drugs Service to provide more joined-up support for young people and referral routes between different youth services. The youth team have also begun providing a monthly drop-in session for young people and counselling staff in a local one-stop shop for young people and providers of young people's services.

Intended outcomes

Staff within CNEIT and CAMHS were aware that they weren't working together as effectively as possible. Through creating a CAMHS link role and later a youth team within CNEIT, staff aimed to:

- Reduce the stigma associated with psychosis, increase access to the service and improve professional and lay awareness of the symptoms of psychosis and the need for early intervention. The youth team has built links with non-statutory services, particularly the local third sector who operate a number of well-used, non-stigmatising services that a high number of young people access. In addition, they have established links with universal services, such as Connexions, presented at training events and have also forged links with the local further education college, providing free training for all learning support assistants and pastoral workers. This was done to promote the service's referral criteria to reduce delays in young people accessing support and to challenge stigma about what psychosis is and is not. It was also important in order to build stronger bridges with other agencies working with young people that reported feeling that their work was not valued by specialist mental health services.
- Reduce the length of time young people with psychosis remain undiagnosed and untreated. In addition to increasing others' ability to identify possible psychosis, the youth team's less stringent eligibility criteria means that young people are able to access services faster than with other services.
- Develop more of an assertive outreach service that did not disadvantage young people for non-attendance. A significant difference between CAMHS and CNEIT at the point of the youth team's development was that

CAMHS were operating a policy to discharge the young person back to the referrer after three unattended appointments. Within CNEIT it is recognised that some of the most vulnerable and difficult to engage young people that most need the service may take some time to establish a relationship with CNEIT, and therefore non-engagement does not lead to discharge.

- Increase stability in the lives of people who use services, facilitate development and provide opportunities for personal fulfilment. The youth team have adopted a holistic approach to psychosis driven by factors that are important to the young person. To promote full social recovery their approach uses the Social and Occupational Functioning Scale (SOFAS) which includes rates of peer group/social functioning, levels of isolation and access to/participation in meaningful activity (as defined by the young person).
- Reduce the need for unnecessary service transitions and provide a seamless service available for those from age 14-35 that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services. By providing a single point of contact for participants (through a case manager) young people who use service experience minimal transition between services. Upon reaching the age of 18, this can mean as little as changing from a CAMHS to AMHS psychiatrist. At the same time, 16-17 year olds have a choice over whether they are treated within CAMHS or move over fully into CNEIT. Young people accepted into the youth team within CNEIT can receive up to a five year service (rather than the typical three year service in EIP) in order to ensure smooth transfer to AMHS or discharge back to primary care, reducing the need for unnecessary transitions.
- To support more effective transitions for young people at the end of the treatment period by ensuring that the care is transferred thoughtfully and effectively. The aim of the youth team is for participants to move back to primary care, or to AMHS if continued specialist mental health support is necessary at this level. If a young person was going back to primary care, clear signposting would be provided by the youth team to ensure young people knew what universal services were available or where to go if they had concerns about their mental health. This would take the form of conversations about other services, the provision of leaflets, relevant websites or actual visits to primary care services. Every young person discharged from the youth team would also be provided with a 'staying well' plan. This would include signposting and guided self-help support to help young people manage their mental health and wellbeing. If the young person made a transition to AMHS, the youth team would make the referral and there would be the identification of a care coordinator in AMHS. Following on from this there is a period of joint working for at least three months, allowing time for the young person to establish a relationship with their new care coordinator.

Measuring impact

CNEIT have collected data both formally and informally to measure the impact of the youth team as well as the wider EIP service. Data against outcomes and other factors presented here are for the youth team specifically and include:

- Analysis of missed appointments. The service achieves very low rates of non-attendance with an only nine per cent 'did not attend' (DNA) rate for 13 month period May 2009-June 2010. Seventy-four per cent of these missed appointments are accounted for by four, all of whom are now showing good engagement with the team. These clients would have been excluded by CAMHS after three missed appointments.
- Analysis of in-patient bed days pre- and post-referral to the youth team.
- Analysis of services that young people were discharged into at the end of their contact with CNEIT. Over two-thirds of young people were discharged back to the care of their GP at the end of contact with the team, which indicates that the team successfully manage to reduce the complexity of the needs and difficulties associated with this group.
- A range of clinical outcomes for patients measured through:
 - a semi-structured interview (the Positive and Negative Syndrome Scale)
 - clinician rated measures (including Duration of Untreated Psychosis, Global Assessment of Symptoms Scale, Global Assessment of Social and Occupational Functioning Scale, Camberwell Assessment of Needs)
 - self-report measures (including Beck Anxiety Inventory, Beck Depression Inventory, Schizotypal Symptoms Inventory, Brief Core Schema Scale, Social Interactions Assessment Scale, Psychotic Attachment Measure).

Outcomes are gathered in three main areas:

- Social recovery - treatment outcomes after 12 months of service show an improvement in social and occupational functioning as assessed by the Social and Occupational Functioning Assessment Scale (SOFAS) and hours engaged in education, employment and voluntary work.
- Symptomatic recovery - the number of clients experiencing one or more psychotic symptoms, of at least moderate severity (a score of four or above on the PANSS), decreased from 64 per cent at baseline to 40 per cent at 12 months.
- Beliefs about self and others - in addition to social and symptomatic recovery, outcome data at one year into the service shows an increase in positive self images and decreases in negative self and negative other ideas, as assessed by the Brief Core Schema Scales (BCSS). This is shown in Figure 4.

The assessments are aimed at evaluating a range of symptoms and areas of need including psychotic symptoms, anxiety, depression, self-harm, drug and alcohol use etc. Baseline assessments are carried out when clients join the service, then repeated at 12 months, 24 months and discharge (or sooner if before three years). The outcome data has shown that intervention from the team

has resulted in reductions in not only psychotic symptoms, but also co-morbid anxiety and depression, as well as improvements in social recovery.

- Qualitative feedback from other agencies through informal discussions and collaborative working.
- Qualitative feedback from people using the service regarding their time with the team and the care that they are receiving. The information collected during these assessments are fed back to the clinical team and used to identify areas of need for the individual and to improve the care that is being delivered to young people more generally. The data that has been collected during these assessments is also currently being analysed to evaluate the outcomes of the youth team. The results of this analysis will be submitted for publication in the *Early intervention in psychiatry* journal in spring 2011 and were presented at the 7th International Conference on Early Psychosis in November 2010. Informal feedback from young people is that:
 - they find the service friendly and accessible
 - staff listen to their views without being patronising, give clear information and can be trusted
 - they can be seen at a location that they chose
 - the service will help to tackle bullying in school
 - the service provides additional support around exam time (i.e. extra writing time, sitting exams in private room)
 - the service offers the chance to meet other young people during groups, provides fun social activities and gives ideas on how to cope.
 - The following are some examples of feedback gathered from young people using the service:

'Appointments always fit in around school so I don't have to take time off and answer awkward questions from friends about where I'm going'

'[Staff] didn't just ask me about my mental health and all the weird stuff, but helped me sort out all the things that were stressing me out; college, getting a safe place to live, helping smooth out arguments in my family.'

Feedback from families and carers is also positive. Outlined below is an example of feedback given from a carer whose daughter received support from a four year service with previous contact with a local CAMHS service and post discharge from CNEIT with a community mental health team:

'As parents we have felt supported and included by the Early Intervention team - it is sometimes unbelievably isolating to care for a person with a mental health problem and we found the case manager was always open to hearing our concerns and never dismissive of our opinions. This was possible because she was accessible and willing to take time to listen. By engaging with the whole

family I am sure she built up a more accurate view of our daughter's whole life, and could capitalise on strengths and allow for weakness.'

Sustainability and transfer to other settings

CNEIT did not carry out a formal cost-benefit analysis prior to setting up the youth team. Based on external research on the cost benefits of EIP, they have however been able to make a case that the youth team is an efficient use of resources. Effective EIP has been shown in this external research to be a cost-effective approach rather than more costly interventions when an individual's condition has the risk of becoming more severe. Anecdotal evidence has also shown resources to be effectively used. For example, staff found that missed appointments were clustered around three young people. They have since been able to engage these young people before their psychosis and associated social isolation/deprivation escalated. This can mean economic benefits not only for the young person using the service (i.e. able to engage in paid employment) but also a long-term economic gain for local services as clients are less likely to require more intensive, costly services later down the line. In addition, staff have also been surprised about the amount of cost-neutral change that was possible by forging links with other services. For example, staff in the youth team delivered some training to learning support staff at the local further education college, which helped to build links and meant the youth team had an identified point of contact within the college inclusion team. Strong links were also forged with the under 18s substance misuse service. Both services delivered training to one another and shared skills to support better joint working. Better relationships between services meant the youth team could use venues in establishments such as colleges and the youth counselling service which saved costs.

The youth team are planning to undertake a more detailed analysis of the effectiveness of an outreach model of case management, and are currently designing a pilot study to evaluate case management vs 'treatment as usual' for young people presenting with complex mental health needs and significant distress.

Resources involved

Existing CNEIT practitioners who had expressed an interest in developing work with 14-18 year olds were recruited into the team. External recruitment was also carried out to develop the team further. The focus was placed on employing practitioners that could demonstrate enthusiasm for working with this client group, and show excellent, creative engagement skills and innovative ideas for service development.

When the team was at full complement it consisted of:

- Band 7 Clinical Lead/Care Co-ordinator 0.8 WTE
- Band 6 Care Co-ordinators 1.6 WTE

- Band 5 Nurse 1 WTE
- Band 5 Occupational Therapist 1 WTE
- Band 8a Clinical Psychologist 0.5 WTE
- Support Worker 0.5 WTE
- Band 5 Assistant Psychologist 0.5 WTE

Medical responsibility continued to be provided by the CAMHS consultant psychiatrist covering the appropriate geographical area.

Due to research funding ending for some fixed term posts and the need to meet cost improvement targets for the whole CNEIT they currently have a reduced resource within the youth team affecting some of the posts.

Contact details

Emma Corlett - CAMHS Lead for Central Norfolk Early Intervention Team

emma.corlett@nwmhp.nhs.uk

tel:01603 201552 / 07825 061047