Meeting the needs of young adults within models of mental health care

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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Introduction

Building on recent reports such as Future in Mind,[1] The Five Year Forward View for Mental Health[2] and From the Pond into the Sea,[3] the NHS Long Term Plan[4] is committed to extending 'current service models to create a comprehensive offer for 0 to 25-year-olds that reaches across mental health services for children, young people and adults' and delivers 'an integrated approach across health, social care, education and the voluntary sector'. This represents a huge opportunity to improve support, care and treatment for young people, particularly those aged between 18 and 25, who have repeatedly reported poor experiences of care within current services, whether provided by statutory or non-statutory bodies. This includes people who are transitioning from children and young people's services into adult services as well as those presenting for the first time.

Over recent years, some services in England have begun experimenting with different ways of providing support, care and treatment for this age group, and we can now start to learn the lessons from this sample to inform the roll-out of new models across the country.

Broadly, services have been more successful where their development has been incremental, co-produced with young people and professionals, rooted in the communities they serve and implemented jointly across different types of providers. Difficulties have arisen where change has been less evolutionary, and specifically where this has led to an overwhelming demand on new services.

This report describes these new models – the challenges, successes and lessons learned – and derives a set of principles and considerations to inform the development of support, care and treatment for young people. While commissioners and providers should consider the needs of all children and young people from 0 to 25, this report focuses on provision for young adults aged 18 to 25.

There are three cohorts within this 18 to 25 age group that commissioners and providers should specifically consider: (1) young people who transition from children and young people's mental health services (CYPMHS) and are accepted by adult mental health services; (2) those who do not meet the criteria for adult mental health services but have continuing needs and require care; (3) people presenting for the first time. This report also considers the needs of those who may have comorbid drug and alcohol problems or neurodevelopmental disorders (although it does not directly address the provision of dedicated services for these problems).

The recommendations in this report were informed by a review of relevant literature (see Appendix 1: Review method), including epidemiological studies, as well as surveying a sample of emerging services and initiatives.

This report defines age ranges as follows:

Children: individuals aged 11 and under

Young people: individuals aged between 12 and 25

Young adults: individuals aged between 18 and 25 (a subset of 'young people')

The scope of the challenge

Prevalence

Epidemiological data suggest that mental health is a significant and potentially increasing health concern for young people.[5] It is now the leading cause of disability in people aged 10 to 24 and is estimated to be responsible for 45% of the overall burden of disease for this age group.[6]

A recent survey of mental health in children and young people in England found that 12.8% of young people aged 5 to 19 had at least one mental health problem,[7] which translates to approximately 2,252 young people per 100,000 all-age population (using 2017 mid-year population estimates).[8] The prevalence increases across childhood and adolescence, from 5.5% of 2 to 4-year-olds to 16.9% of 17 to 19-year-olds.[7] Young women aged 16 to 24 with common mental health problems are particularly overrepresented (26% of women compared with 9.1% of men the same age). Women of this age group also have the highest rates of reported suicidal thoughts, behaviours and self-harm (for example, 25.7% of women aged 16 to 24 reported self-harm, compared with 13.2% of women aged 25 to 34, and 9.7% of men aged 16 to 24).[a]

Current models

In England, community and specialist inpatient mental health services for children and young people below 18 years of age are usually commissioned and provided separately from adult mental health services. This aligns with the current age boundaries across the wider health, education and social care system. However, there is concern that the current age boundaries are not always appropriate, and services are failing to meet the needs of young people, especially young adults aged 18 to 25 and those transitioning between services.[3] Consequently, recent reforms across education and social care are moving towards extending their upper age limit to 25. For example, education, health and care plans now support some children and young people with special educational needs and disabilities (SEND) from birth to 25 years of age, and local authorities are now required to provide support to care leavers up to age 25. Healthcare also needs to introduce reforms if it is to improve service provision to this age group across the system.

The impact of emerging problems

Of adults with mental health problems, up to 75% see the problem emerge before the age of 25.[9] Early intervention may help to prevent problems becoming more severe and enduring; however, for many young people, emerging mental health needs are missed or they do not receive appropriate intervention.[10] For example, in 2014 only 22.7% of 16 to 24-year-olds with symptoms of a common mental health problem were receiving any form of treatment; the all-age average is 39.2%.[11] Young people often go a long time with unmet needs before accessing help[12] and such delays can result in progression to more serious problems with long-term impact on the individual, as well as increased costs for the NHS.

This is a critical period for young people as they develop independence in their social and economic lives, and adolescence and early adulthood are times of major structural and functional change in the brain, with important organisational developments continuing into a person's late 20s.[13–15] Therefore, services that provide care up to 25 may be better equipped to meet the developmental needs of young people and can have significant positive impacts. This issue is partially addressed by the development of services for young people with specific mental health problems that first present in early or late adolescence, such as first episode psychosis (FEP) services that provide age-appropriate interventions that eschew traditional boundaries.

A number of other mental health problems, such as eating disorders, also tend to have an onset before age 25, with needs that continue into adulthood. But often, neither professionals in adult services nor in children and young people's services have the skills or experience to provide effective age-appropriate care across all age ranges. This can stem from a lack of

[a] Appendix 2 outlines the prevalence data by age from the *Children and Young People's Mental Health Survey 2017* and the *Adult Psychiatric Morbidity Survey 2014*.

understanding of the developmental needs of young people, the absence of age-appropriate interventions or a lack of competence to deliver these interventions effectively.[16] This problem is not confined to staff working in mental health services. A recent Care Quality Commission (CQC) review of mental health services for young people found that professionals including GPs, emergency department staff and education professionals did not always have the knowledge, capacity or training to identify or support the mental health needs of young people.[3]

Increased demand and meeting need

It is worth noting that reorganising services to better provide for young people have typically led to a large increase in demand – closer to the actual need that exists. Both the Norfolk Youth Service and Forward Thinking Birmingham have found that referral rates increased beyond what was anticipated before implementation. For example, Norfolk Youth Service reported a 68% increase in referrals, with a threefold increase in 14 to 17-year-olds and an increase of approximately one third in 18 to 24-year-olds.[17] The reasons for this increase could include increased local awareness of services due to publicity,[17] thresholds lowering to accept people with less severe mental health problems, a reduction in services that were previously available, or that the more youth-friendly and non-stigmatising approach made the services more suitable for and acceptable to young people. Additionally, the introduction of a self-referral pathway allowed people to circumvent primary care and community options, leading to an increase in direct referrals to secondary care.[17] Whatever the reason, increased demand without a corresponding increase in resources may have been responsible for falling acceptance rates,[17] longer waiting times and increased caseloads.[18]

Commissioners should expect significantly increased demand for services if the provision of care for 18 to 25-year-olds is improved. It will therefore be important, when designing models of care, to consider local need and epidemiology alongside current service capacity to identify those who currently may not be provided for within existing services, or those who may not have been able to access a service historically. Uncovering levels of unmet need for 18 to 25-year-olds in the local system will require joint working across organisations, both statutory and non-statutory, as there are no national data robust enough to support this at present.

Discontinuity of care and transitions

Discontinuity of care and a poor experience of transitions are common for young people transitioning from CYPMHS to adult mental health services. Young people who reach the age of 18 are often discharged from CYPMHS and, despite needing further care, are not able to access support appropriate to their needs. The TRACK studies, which looked at this transition, found that about a third of people in London who were considered suitable were nevertheless turned away by adult mental health services.[19,20] Those with a history of hospitalisation or who were on medication were more likely to be taken on by adult services, whereas those with neurodevelopmental disorders, emerging personality disorders, or depression and anxiety disorders were not.[20] A recent Europe-wide study of transitions in mental health care reported a lack of connection between CYPMHS and adult mental health services, with the difference in eligibility criteria a frequently cited barrier in the UK.[16] However, the problem is not confined to mental health services; there are similar challenges in meeting the mental health needs of, and managing effective transitions for, children and young people in primary care, paediatrics and tertiary education, further complicating the delivery of effective care.

Recent initiatives

Developing service models

New service models have been informed by several factors that are designed to inform the organisation and development of more effective and accessible services:

1) **Age range**
    a. **0 to 25 years –** services merging to provide for young people aged up to 25.
    b. **Age-specific services –** creating particular services predominantly determined by age. For example, this might include a youth mental health service from 14 to 25 or a young adults' service from 18 to 25.
    c. **Align age ranges** with educational age ranges (0-5, 5-11, 11-18 and 18-25 years).

2) **Flexible transitions**
    a. These models may have a flexible age boundary for entering adult mental health services, depending on need and/or presenting age. For example, a 0 to 25 service may be limited to those who first presented with a mental health problem before the age of 18, or those with additional vulnerabilities, such as care leavers or young people with comorbid neurodevelopmental needs.
    b. Provide additional support to ensure that there are specific services in place to support effective transition.

3) **Complexity of need**
    Services are configured based on low, moderate or high complexity of need, from emotional wellbeing services (low complexity) to specialist interventions for severe and complex needs.

4) **Disorder/problem-specific services**
    This approach focuses on the needs of people with particular disorders or problems and may cut across current age boundaries. Examples include the well-established FEP services, eating disorder services and services for young people who self-harm.

5) **Access and engagement**
    a. Services are built around specific functions such as access, assessment and signposting, or promoting engagement.
    b. Services may operate as a single point of access, providing a triage service followed by appropriate referral and supported transition to a secondary care provider.

6) **Multi-agency service delivery**
    Services for individuals up to the age of 25 can be delivered by statutory providers, non-statutory providers, the voluntary, community and social enterprise (VCSE) sector, or effective combinations of these to meet the broad needs of this age group. These variations in service provision are captured in the service matrix below.

Service matrix – sample of pilots and services

This matrix provides an overview of existing services by key features. Please note that these features may represent the initial aims of the service, rather than achieved goals. Additional details of some of these models, including their successes and limitations, are provided in the appendices.

Service examples (grouped by age boundary type)	**Extent of service reorganisation**		**Focus of service**						**Improvement focus**		**Who is involved**					
	Replaces existing service (system-wide)	Additional or partial replacement of service	Prevention and emotional wellbeing	All needs	Problem-specific	Low complexity	Moderate to severe complexity	Vulnerable or at risk	Transitions-focused	Access	Partnership approach	Primary care	Secondary mental health services <18	Secondary mental health services >18	Local authority	VCSE sector
Children and young people's 0 to 25 services – extending cut-off age from 18 to 25																
Forward Thinking Birmingham	An ambitious 0 to 25 mental health service established in 2015 with the aim of delivering whole-system change across all mental health services for children and young people.															
	✓			✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓
Liverpool and Sefton Youth Service	The Liverpool and Sefton Youth Mental Health Model provides early intervention and help from three hubs in Liverpool and one in South Sefton. It is delivered by the Young People's Advisory Service in Liverpool – a third sector organisation – in line with Youth Information Access and Counselling. In Sefton the service is delivered by Venus.															
Youth Information Advice and Counselling Service		✓				✓				✓	✓		✓	✓		✓
Out-of-hours, street triage and transition		✓					Crisis		Transition team		✓		✓	✓		
Young people's services – Lower age limit within adolescence, upper age limit of 24/25 to align better with developmental and social transitions																
Shropshire Access and emotional wellbeing service	Provides access route for all aged under 25, delivered in partnership with VCSEs. Triage children and young people to the appropriate service, including VCSE providers, NHS CYPMHS and adult mental health services															
		✓				✓				✓	✓		✓			✓

Service examples (grouped by age boundary type)	Extent of service reorganisation		Focus of service						Improvement focus		Who is involved					
	Replaces existing service (system-wide)	Additional or partial replacement of service	Prevention and emotional wellbeing	All needs	Problem-specific	Low complexity	Moderate to severe complexity	Vulnerable or at risk	Transitions-focused	Access	Partnership approach	Primary care	Secondary mental health services <18	Secondary mental health services >18	Local authority	VCSE sector
Norfolk Youth Service	Norfolk Youth Service provides mental health care for young people aged 14 to 25 years old. Following an initial pilot focusing on those with severe and complex needs, the service was expanded to meet the needs of all those requiring specialist or secondary care interventions aged 14 to 25, replacing the existing CYPMHS-adult mental health service model. A child and family service provides care for those under 14, and an adult service for those aged 26 and above. The child and family and youth teams form part of a wider 0-25 service line with shared management and processes.															
• Norfolk Youth Service (14-25)	✓						✓	✓	✓		✓		✓	✓		✓
• First episode psychosis (14+)					✓								✓			
Minding the Gap (Camden)	Minding the Gap has three main elements: 1) a multidisciplinary team delivered by Catch 22 from the Hive, a youth-based co-designed hub, offering holistic support for a range of needs including substance misuse, sexual health, employment and leisure; 2) a transitions team including outreach support from the personality disorder service delivered by Camden and Islington NHS Foundation Trust; and 3) counselling and psychotherapy delivered by The Brandon Centre. The service does not replace the existing model of specialist mental health services for children and young people (pre-18) and adults (18+) but is an additional service aiming to meet the needs of the most vulnerable young people between the ages of 16 and 25.															
		✓				✓		✓	✓		✓		✓	✓	✓	✓
First Episode Psychosis/Early Intervention in Psychosis programmes	FEP services were initially established for an age range of 14 to 35 years (with the upper age limit now removed) and typically have an organisational base located within adult mental health services. They have had considerable success[21] in both implementation, uptake of services and outcomes and have developed a strong and separate ethos within mental health services.															
		✓					✓							✓		

Service examples (grouped by age boundary type)	Extent of service reorganisation		Focus of service						Improvement focus		Who is involved					
	Replaces existing service (system-	Additional or partial replacement of	Prevention and emotional	All needs	Problem-specific	Low complexity	Moderate to severe complexity	Vulnerable or at risk	Transitions-focused	Access	Partnership approach	Primary care	Secondary mental health services	Local authority	VCSE sector	
i-Rock Youth Mental Health Service	A 'one stop shop' service offering timely support for mental health issues, wellbeing, education, employment and housing for young people aged 14 to 25.															
		✓		✓		✓	✓	✓		✓	✓		✓	✓	✓	✓
MAC-UK INTEGRATE	An approach developed and adopted by VCSE projects specifically aimed at engaging excluded young people aged 16 to 25, such as young offenders.															
		✓				✓		✓		✓	✓					✓
42nd Street	42nd Street is an example of a Youth Information Access and Counselling model, providing emotional wellbeing and mental health support to young people in Greater Manchester aged 11 to 25. Individual and group-based services are delivered through community venues, arts and cultural centres, and schools and colleges, as well as their city centre base. The charity promotes choice and creativity championing young person-centred approaches that demonstrate local impact and have national significance.															
		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓
Jigsaw (Ireland)	A mental health service exclusively for 12 to 25-year-olds that provides early intervention mental health support from 13 hubs across Ireland.															
		✓				✓		✓		✓		✓				
Flexible transitions																
Shropshire CYPMHS	Young people already in CYPMHS can remain in CYPMHS up to age 25 as determined by their needs and readiness to transition to adult services. Young people referred into the service after 18 go into adult service unless they have additional needs such as comorbid neurodevelopmental disorders or are care leavers.															
				✓				✓			✓		✓	✓		

Principles underlying mental health care for young adults

This section outlines the principles that should be considered when developing mental health services for 18 to 25-year-olds. These principles are informed by an analysis of a sample of service models, discussions with experts and people with experience in commissioning and delivering services, as well as a literature search.

These principles should be considered when commissioning or developing services aiming to:

- meet the needs of 18 to 25-year-olds
- manage the transition points
- meet the full range of complexity of need.

Local areas should consider these principles alongside their local context, needs and challenges.

The principles also largely apply to all services provided for 0-25 year olds.

Co-produced with young people

Services should be designed, developed and evaluated in partnership with young people. This was a central feature of all service initiatives sampled for this report.

Co-production should occur at all stages, including design, delivery and evaluation of services. For example, INTEGRATE projects recruited young people to key positions such as 'community consultant' in their development teams, to provide insight into the needs of young people in the community and how the service may best meet those needs. In Minding the Gap, young people helped develop transition protocols, deliver workshops, provide peer support and sit on a young people's board. In Norfolk, 'youth commissioners' from the Norwich Youth Advisory Board contributed to an examination of the effectiveness of services, and co-produced recommendations to inform future service development.

Meaningful engagement with young people was an integral part of the process from the beginning. This included in-depth interviews with over 500 young people prior to service specification and then the establishment of a young people's board who worked on the design of the young hub and service model. Young people have continued to be included and influence the developing provision. This has been a genuine example of real co-production with service users.

Jennie Mackeith
Strategic Commissioning Manager,
London Borough of Camden

The co-production principle sits above all others as it creates the right context for the remaining principles to be appropriately realised.

Age-appropriate care

Mental health needs change significantly across the 0 to 25 age range, as does the approach and professional competences required to meet these needs. Commissioners and providers should ensure that services have the right skills, competence and knowledge to provide age-appropriate care from birth to 25. For example, interventions for childhood mental health needs are typically targeted at families and parents or carers, while

interventions for adults are often directed at the individual. Mental health care for young people should also include families and peer groups[22] and should be tailored to the specific challenges and demands of emerging adulthood, such as employment, education, housing and social demands associated with growing independence.

Need and complexity-based care

Information on population-level needs are often based on diagnosis, as is advice on the most effective interventions or treatments. This information can guide service planning and workforce development and training, but it may lack the precision or flexibility to account for personal and social factors, or coexisting problems with physical health, mental health, drug and alcohol misuse, or neurodevelopmental disorders, which add considerably to the complexity of a person's needs. Understanding an individual's needs may be a better guide to service provision; for example, services for mild to moderate complexity of needs may be provided at a local level while more complex needs may be met by services commissioned across several local populations.

Need and complexity-based approaches, such as the THRIVE Framework, have been adopted by a number of children and young people's services. This framework describes five areas related to complexity in which a child or young person will have service-related needs:

1. thriving (prevention and promotion)
2. getting advice (signposting, self-management and one-off contact)
3. getting help (goals-focused, evidence-informed and outcomes-focused interventions)
4. getting more help (intensive treatment)
5. getting risk support (risk management and crisis responses).

Complex needs

Minding the Gap sought to provide a service for a cohort of young people with complex needs, but for whom traditional service models were failing. This included young people who did not fit diagnostic categories but presented with multiple needs associated with mood disorder, substance misuse, interpersonal difficulties, emotional dis-regulation and history of trauma, or young people presenting in distress through anti-social behaviour, violence or gang involvement. These young people often failed to meet the high thresholds for adult secondary care, were hard to engage or dropped out of services that failed to outreach or work flexibly to meet their needs. Minding the Gap has been a great resource for these young people – enabling engagement and support that has given them the trust to later engage with treatment services when required…or to move on with their lives without services.

Dr Jeff Halperin, Consultant Clinical Psychologist, Head of Psychology and Psychotherapy Services, Camden and Islington NHS Foundation Trust

A needs-based approach should also consider the importance of the person's functioning and social recovery. Social factors, meaningful activities and providing or signposting to supportive interventions are an important part of meeting a young person's needs. Services can support children and young people to engage with resources and activities in the community to help them build their own internal resources and resilience, and to develop the skills to look after their own health and wellbeing in the long term.

Youth-friendly and non-stigmatising

Many models emphasise youth-friendly approaches and non-stigmatising environments to increase the suitability and acceptability of services for young people. Minding the Gap and i-Rock both worked with young people to design the space in which services were delivered, recognising the importance of welcoming spaces that look 'less like an NHS service'.

Early identification

Given that many mental health needs emerge across adolescence and early adulthood, early identification and intervention are particularly pertinent for this age group. There is growing evidence that effective support and interventions may reduce the risk of developing severe and enduring mental health problems, as well as reducing crisis presentations and the need for costly inpatient care. The service models identified by this review often approached these objectives by building on the guidelines and principles of FEP services. These include early detection and access to comprehensive evidence-based interventions and services, understanding the importance of personal, social, educational and employment outcomes, and actively working with young people, their families and support networks, to ensure they receive age-appropriate, person-centred care that is sensitive to phase of illness, gender, sexuality and cultural background.[23] Working together with primary care, emergency departments, crisis services, youth or criminal justice, education providers such as schools, colleges and universities, as well as VCSE organisations is central to ensuring that needs are identified and interventions are delivered as early as possible. Additional training and support may be required to ensure professionals across services are able to identify emerging mental health problems and can provide appropriate care to children and young people.

Early access, flexibility and choice

Mental health services should be easily accessible for all ages, with clear pathways into care from multiple points of entry, including primary care, social care, educational settings, communities, VCSE organisations, the youth or criminal justice system and through self-referral. Some areas have invested in a single point of access as a way of trying to ensure that referrals from all of these places are directed at a central first point of contact into mental health services. Services should consider the needs of their local context to ensure the appropriate mechanisms are in place to enable easy access for all people. Other areas seek to ensure that they are accessible by locating themselves within people's communities.

Services should also be flexible enough to meet the needs of children and young people, and their families and carers, so that they can choose how they access and receive support, care and treatment in a way that fits around their lives. This should apply to opening hours, methods of communication (such as face to face, text messages, emails or video chat) and settings where care is delivered. Young adults over the age of 18 who present for the first time with a mental health problem

Service example: i-Rock Access and Engagement

i-Rock services have placed significant emphasis on minimising barriers to accessing their service – young people do not need an appointment, referral or minimum level of difficulty to receive support.

In order to foster engagement, i-Rock services actively support the transition when they refer young people to secondary services and follow up with these services to improve continuity of care.

For more information on i-Rock, see Appendix 3B.

should be given the choice, where possible, of receiving care from a CYPMHS (or youth service that goes up to 25) or an adult mental health service. For this to be in place, CYPMHS would need to be commissioned and resourced to offer support to 18 to 25s. This choice should aim to match the individual's needs to the most appropriate service. Local areas will need to have clear referral processes and funding agreements in place across CYPMHS and adult mental health services in order to manage resources and staff capacity while ensuring people receive care from the appropriate service. This might require joint referral meetings, case discussions and training, which would also improve any subsequent transitions across services that may be required. For instance, a 19-year-old who presents with a mental health problem for the first time may prefer to be seen by the local CYPMHS as they may have an initial need for family-focused interventions. However, over time the person may require dialectical behaviour therapy, delivered by the local adult mental health service. It is important to note that funding agreements will need to be put in place for those CYPMHSs not currently funded to see young people over the age of 18. Having had an initial joint referral meeting between CYPMHS and adult mental health services, with subsequent joint case meetings, will ensure a smoother and more effective transition (see Effective management of transitions).

Partnerships and integrated working

Delivering a comprehensive offer for 0 to 25-year-olds will require partnerships and integrated working across a range of organisations, including primary care, physical health care, youth and criminal justice, education providers, social care, adult mental health services and the VCSE sector. Services will also need to work with organisations providing care for people with neurodevelopmental disorders or drug and alcohol problems.

Minding the Gap: reflection on leadership and commissioning processes

Providers from across the voluntary sector and the NHS have worked collaboratively, rather than in competition, and this is reflected in the strength of the ongoing strategic management board which provides oversight of the model. The initial approach from senior leaders across the council and CCG to be innovative and work together with a shared vision and outcomes was the driver which has enabled the model to thrive and succeed for some of Camden's most vulnerable young people.

Jennie Mackeith, Strategic Commissioning Manager, London Borough of Camden

In my experience, the development of this service was unique. There was exceptional collaboration between commissioners (who were superb in being creative and solution focussed) and a range of providers – Tavistock CAMHS, Camden and Islington Adult Services, Anna Freud Clinic, Brandon Centre and Catch 22. Senior clinicians (perhaps, critically, very senior clinicians) from each organisation worked together to develop a strategy and an operational management structure that worked. It has been an excellent example of collaborative working across agencies – dare I say that the fact it was so strongly clinician-led made a huge difference and helped to reduce inter-agency rivalries (…) we united around meeting the needs of young people. We set up a lively and effective strategic management board, an operational management group and supervision structure that really held the project together and kept things connected. A young people's advisory group, with the support of a participation officer, created a great social enterprise that captured people's imagination. The usual tension and caution between commissioner and provider have not been a feature here. We have really worked as one with a common goal. If I sound a little evangelical it may be because I am so delighted to have been working on something that really seems to have been a success (knowing how many initiatives don't seem to quite deliver as we hoped).

Dr Jeff Halperin, Consultant Clinical Psychologist, Head of Psychology and Psychotherapy Services, Camden and Islington NHS Foundation Trust

A key component of effective partnerships is a leadership team composed of senior clinicians and managers, responsible for developing and overseeing the implementation of locally determined integrated working agreements that take into account available resources and support. Integrated working should be based on clear local governance and protocols that specify information-sharing protocols across organisations, how services will provide joint care, as well as how services will assess risk and safeguarding. An integrated approach to care should include joint meetings, training and education opportunities, as well as the development and use of a coordinated care plan.

All models identify partnerships and integrated working as part of their service design. VCSE services in particular were frequent partners. There was variation in the degree of shared leadership and the roles of different partners, but these integrated models were generally pursued with the common aim of considering young people's mental health within the context of their wider needs, providing a holistic service, and ensuring coordinated care and smoother transitions. For instance, Minding the Gap co-located services within the Hive and ran multidisciplinary and multi-agency teams.

While some services reported links with primary care – such as Liverpool, which has a GP drop-in service – other services may need to explicitly consider including primary care in their working agreements, as GPs are often a first point of contact and a key part of providing follow-up.

Leaders in Norfolk sought to foster effective partnership across organisations by actively engaging in 'systemic conversations', to align the disparate services on an improved pathway through the recognition of each other's strengths across the system.[24]

Working with the VCSE sector – Reflections from Forward Thinking Birmingham

Partnership working with VCSEs was a key feature in the Forward Thinking Birmingham model, however, they experienced a number of challenges to achieving this. Their final evaluation of Forward Thinking Birmingham made the following recommendations to improve integration:

- Include VCSE partners in development of the service's access and assessment process to promote better management of demand across the network.
- Establish a clear protocol for sharing information about young people across the network of partners.
- There should be a manager responsible for referrals across the service and VCSE partners; this person should be contacted for information on the support offered (or to be offered in the future) to a young person.
- VCSE partners need to remain fully informed about the overall structure of the 18 to 25 service and the roles of staff within it.
- Where possible, the service should aim to commission VCSE partners for more than a year at a time to foster long-term sustainability.
- The VCSE sector should be regarded as equal partners in the provision of mental health support for young people up to the age of 25, rather than as a lesser entity. They must be allowed to retain the flexible, responsive and young-person-centred methods of operation that make their support valuable to this demographic.

Impact and Process Evaluation of Forward Thinking Birmingham (2018)

Effective management of transitions

Transitions are a common are of focus in supporting young adults. Well-managed transitions between teams and services can improve engagement and long-term outcomes. This may be achieved by establishing transitions teams responsible for proactively identifying young people who require continued support and providing case management to support the transition process. Another example is appointing dedicated transitions/pathways coordinators and transitions champions to ensure the transitional needs of young adults are considered in both children's and adults services. NICE guidelines on transition and an NHS England transitions CQUIN (Commissioning for Quality and Innovation) have also been published to support effective transition.

Creating a 0 to 25 offer may improve continuity of care, or it may simply delay transition to a later stage. Further, introducing a separate service for young people will create an additional transition point on the path from children's to adults' services.[25] Therefore, joint working between the extended model and adult services will remain an important consideration to ensure effective transitions, regardless of the service model used.

Key challenges and considerations

Place-based delivery of services

Mental health support, care and treatment should be place-based, in line with recommendations in the forthcoming *Framework for Community Mental Health Support, Care and Treatment for Adults and Older Adults*. This means that it is rooted in communities and designed with and for the people in those communities. Place-based delivery of care promotes close and effective links with primary care (on which the localities should be based) and thereby establishes a base for a fully integrated model of mental health care for children and young people.

'Community' has several definitions: it can mean the geographical space in which people live or the groups in which people find or place themselves due to their ethnicity, gender, sexual orientation, socioeconomic status or occupation. Increasingly, people also develop bonds through online communities.

Whatever the definition, a healthy community can provide social support, employment, education and the means to build relationships. It can also be a component of good mental health care, but it relies on people's ability to utilise what a community has to offer. When communities function well, they can transform lives. When they don't, people face adversity.

A key aspect of effective mental health is maximising the support communities can provide to people who need it, whereas social determinants and a paucity of services, assets and other resources in a community can lead to poorer mental health for the people who live there. Close working between professionals in local communities can eliminate exclusions, unnecessary repeat assessments and multiple referrals.

The service coverage required to meet most community mental health care needs of children and young people (aged 0 to 25) is one service per 100,000 all-age population, depending on natural geographies and/or communities (not including acute and specialist inpatient care). This would translate to 2.5 teams per CCG (Care Commissioning Group) on average, with approximately 550 teams across the country. Each specialist service (for young people with complex needs, such as FEP services) would provide for a community of around 250,000 people (of all ages).

Ideally, services should be embedded within local communities, with strong links to the broad range of services and assets they offer. Community resources such as housing, debt advice and employment services can and should make a significant contribution to providing support to young people with mental health needs.

Leadership

Multi-sectoral and clinical leadership is essential to delivering change. Leadership should focus on co-production, getting the right interventions in place and partnering across organisations. It should also ensure that staff are engaged, supported and effectively supervised.

An effective way of emphasising co-production is the recruitment of young people, or those with lived experience, to leadership positions. For example, projects adopting the INTEGRATE approach employ young people as 'community consultants' during service development to provide insight into the needs of young people within the community. An impact evaluation of Forward Thinking Birmingham highlighted limitations in staff support such as insufficient trust induction for locum staff and lack of supervision that may have contributed to high staff turnover and poor continuity of care.[18]

Learning from Norfolk and Waveney Children and Young People's Mental Health Commission

Change must be supported by evidence and national policy recommendations. Importantly, the whole system, provider organisations and commissioners, need to come together in a fully integrated way to deliver services that are easy to access, simple to navigate and offer excellent quality care.

Local 'systemic conversations' have developed strong connections, recognising strengths across the system, and senior representatives have acknowledged that such conversations have improved integration.

There is a requirement to improve transparency across the system and further open conversations are required about how resources are allocated. A review is needed to examine what changes may be required to meet the changing needs of children and young people. The strengths of the current but small local workforce must be recognised and used appropriately to enrich the system. Any potential changes in how resources are distributed and used must be based on an assessment of what children and young people need, in line with clinical guidelines, directives and models. Commissioning models must be well planned, managed and done over a reasonable period to allow for shifts.

There must be clearer accountability in the leadership and commissioning of the system. Any changes in commissioning must not destabilise the system. The system may consider making the most of local evaluation and external consultation….

It is clear that we must genuinely listen to children and young people, and their parent/carers who access the local system. We should rally behind young people that seek change and facilitate them to lobby local system leaders and CCGs to demand change in line with national policy recommendations and funding allocations. Improving transparency with children and young people, stakeholders and the wider community is important, and we must consider how they can help hold the providers and commissioners to account.

Extracts from A Better Future Together: The report of the Norfolk and Waveney Children and Young People's Mental Health Commission (2019) pages 16-19

Organisational challenges

The challenge of whole-system commissioning is apparent in most of the service examples, and additional organisational barriers between and within agencies add to the complexity of providing a service up to the age of 25. For instance, where adult services and CYPMHS are delivered by different providers, there will be differences between board and service-level agendas. Other organisational challenges include a lack of ownership and buy-in across all partners.

Organisational change typically takes longer than expected and causes significant disruption to service delivery and staff. Commissioners and providers need to be realistic about timelines, double running and implementation costs. They should use a quality improvement (QI) approach where possible, rather than relying on service reconfiguration to improve care (see section on Quality improvement methods for more information).

Providers should also anticipate a degree of organisational challenge arising from the misalignment between services for 0 to 25-year-olds and the age ranges of other organisational bodies and services (such as schools and paediatrics). Services will have to establish clear access pathways across both adult services and children and young people's services, which will require significant relationship building, strong communication and collaborative working.

Underestimated demand

The lack of prevalence data has meant that in some cases, providing a service for young people up to the age of 25 has led to an unanticipated and overwhelming increase in demand. Services have not had the capacity to satisfy demand, resulting in increased waiting times, staff burnout and significant strain on services.

This increased demand indicates that a 0 to 25 service configuration does meet a previously unmet need, and it is critical not to underestimate the magnitude of this need during service development. Therefore, demand should not be estimated based on the current statutory service data, but should incorporate data from local VCSE and non-statutory providers to better capture the prospective need. Building a nuanced understanding of the local population through engagement with local communities, driven by strong leadership and management, will support services to better manage increased demand. Services will need to be flexible in managing unmet need, as early implementation experience may highlight a need to adjust their estimates of demand and review their workforce plan or reallocate resources accordingly.

Funding

Because of the demand issues outlined above, it is unlikely that simply adding funds currently allocated to 18 to 25-year-olds to existing CYPMHS budgets will be sufficient. Commissioners will therefore need to consider the appropriate funding model to meet the needs and demand that exist for this age group. The following table discusses the funding models and experiences of sites that have developed services to date.

	Funding model			
	Redistribution of existing funds	**Additional investment (grants etc.)**	**Investment via charity and third sector sources**	**Other, e.g. non-health**
Services	**Forward Thinking Birmingham** (see Appendix 3A). **Norfolk Youth Service** (see Appendix 3B).	**Liverpool and Sefton** were granted additional funding, but it was withdrawn within 12 months (see Appendix 3B).	**Jigsaw** progressed from dependence on philanthropic funds to receiving funding from government agencies (see Appendix 3C).	**i-Rock** has been granted £100,000 per year by the Department for Education as a part of a social mobility initiative (see Appendix 3B).
Overview	Service is not commissioned separately but funded through the redistribution and combination of existing budgets.	Service is commissioned separately and funded by additional investment from an existing source.	Funds are provided through philanthropic or charitable organisations.	Broadening the scope of the service may open up new funding streams (e.g. through Department for Education).
Advantages	Funding source is reliable and secure, supporting the longevity of the service. No additional funding required.	If ringfenced, additional investment does not require redistribution of funding from existing services.	Can serve as a proof-of-concept which may lead to subsequent funding from government sources. Utilises community assets.	Potential sources of funding are not specifically limited to mental health stakeholders. May foster increased integrated working between agencies.
Disadvantages	Redistribution of funds and, by extension, responsibilities across trusts carries a substantial administrative burden which can impede the development of the service. Reallocating adult funding for 18 to 25-year-olds to CYPMHS may have a small negative impact on provision for adults. It may also be insufficient to meet the costs of redesign and implementation, and the increased demand associated with previously unmet needs.	Additional funding may be less secure over the longer term. Money not ringfenced for children's and young people services may be used to redress existing budget deficits.	Services funded via this means may have to undertake frequent fundraising initiatives and face little security in their funding stream. VCSE sector services may have different protocols and requirements e.g. differing financial governance, staff pay bands and competences.	The provision of services that cover more than health care will necessarily require higher levels of funding. As with the VCSE sector, non-health funding may also require consideration of differing protocols and requirements e.g. multiple metrics and reporting requirements.
Considerations	May be easier where both adult and children and young people's services are provided for by the same provider. Effective leadership and realistic timeframes to implement change may mitigate the negative impact of redistributing funds. Transparency and open conversations will be essential.	Services established via this means should seek longer-term security by diversifying funding streams.	Commissioners will need to consider tendering processes carefully to ensure sustainability and stability.	Strong leadership, effective approaches to integrated working, clear accountability and governance will be important.

Quality improvement methods

QI has been shown to help deliver excellent mental health care when adopted at an organisational level. QI is made up of a number of different methods and approaches, but they all systematically use the knowledge, skills and experience of people who use and provide care to test and implement change. Organisations should have a QI strategy and should use it to improve their services. For more information about QI approaches and how they have been used please see Institute of Healthcare Improvement, The ELFT QI method and The Kings Fund report Making the Case for Quality Improvement.

Mental health inequalities

Mental health services must seek to deliver a more equitable service across all age ranges, eliminating the current limitations experienced by young adults in terms of prevention, access, experience and outcomes. Inequities within the young people's cohort also need to be addressed, informed by knowledge of the local context and needs as well as specific individual attributes:

- Protected characteristics as defined by the Equality Act including young people from Black, Asian and Minority Ethnic populations and young people who have a minority sexual orientation or are transgender
- Socioeconomic characteristics including those associated within urban and rural localities
- Young people with additional vulnerabilities, including:
    - young carers
    - looked-after children, care leavers and young people on the edge of care
    - youth in contact, or at risk of involvement, with the youth or criminal justice system including those affiliated with gangs
    - refugees and asylum seekers
    - victims of abuse
    - those who are homeless or in temporary accommodation
    - children and young people of armed forces families
- Young people with comorbid needs including:
    - intellectual disabilities
    - neurodevelopmental needs including autistic spectrum disorders
    - long-term physical health conditions such as diabetes and rheumatoid arthritis
    - drug and alcohol problems.

Governance

Commissioners, providers and services will need to consider governance at a number of different levels:

- **at a system level:** governance should be shared by all partners, including young people and their family or carers. Services should be owned at a system level, and it is critical that all partners sign up to the same aims and outcomes, with services evaluated against these outcomes, which should be monitored at this level
- **at an organisational level:** all organisations within the partnership should ensure that their own strategies and key performance indicators (KPIs) are aligned with and serve the system level aims
- **at the team/individual service user level:** organisations should ensure that governance processes are shared across partners so that teams can access all

information required, and so that young people do not experience vastly different cultures and approaches to governance as they receive support, care and treatment from different organisations.

It will take time to develop all of these aspects of governance and align them between partners, and they will likely be iterative and emergent.

Infrastructure and information systems

Infrastructure, environment and information systems are key considerations for services. Services will need to:

- find suitable, age-appropriate spaces from which to deliver services
- upgrade information and data management systems to ensure consistent collection of data over time, and appropriate sharing of data across services
- use real-time data to update prevalence estimates of need and demand and adjust service resources and capacity accordingly.

Evaluation

Routine data collection should feed into a robust evaluation of the service's processes, aims and outcomes. Evaluations must include a critical external assessment and a robust research approach, as they are key to objectively demonstrating a service's success. Commissioners and providers should ensure that routine evaluations are included in their service specifications.

Implications for existing mental health services and needs groups

Adult Improving Access to Psychological Therapies (IAPT) services

Most of the common mental health problems, especially anxiety disorders, have their origins in early or late adolescence. By the time people seek help (which may be in their mid-20s or later) these problems have often been long established and may require longer and/or more extensive treatment than if they had been identified sooner. IAPT services see significantly higher numbers of young people than other age bands, with somewhat higher attrition rates, but above average outcomes for those who engage with treatment. So IAPT services may wish to look at ways to help young people better engage with services. The IAPT manual includes recommendations for IAPT services working with children or young people; these should be considered for services working with 18-25 year olds. This would also mean that the data, outcomes and standards should link with core IAPT services.

Eating disorders

Given that the age of onset of eating disorders is broadly in the 14 to 25 age range, some specialist eating disorder services are moving to bridge the CYPMHS /adult services divide. This integration is based on the need for continuing care, particularly for young people who have a more severe eating disorder, and a need to coordinate care effectively between community and inpatient services (including acute medical admissions). Although early intervention aims to minimise the number of young people who transition, a number of people with eating disorders, particularly those with anorexia, may require long-term mental health care and will inevitably experience a transition to adult services at some point.

Alcohol and drug misuse

As with other mental health problems, drug and alcohol problems often start in mid to late adolescence and commonly coexist with a range of other mental health problems. However, there is a lack of drug and alcohol services for this age group. An integrated approach across mental health and substance use services is likely to offer the most effective route to recovery. This could be in the form of a shared care plan, case management from both services or a drug and alcohol care coordinator based within the mental health services. Another approach could be establishing a non-age-limited substance misuse service containing various strands for different age groups and according to the substance used.

Intensive community-based intervention and crisis services

The provision of urgent and emergency mental health services differs across localities. Adults tend to have better crisis and intensive home treatment service provision than children and young people. Changing the age boundaries of community mental health services would require a review of urgent and emergency mental health services for both adults and children and young people, both in terms of referral pathways and structures, and in terms of resources and capacity.

Specialist adult community mental health services

Creating a service for 0 to 25-year-olds across CYPMHS and adult mental health services, or the creation of young-people-specific services, will have implications for adult mental health services, particularly in terms of resources, capacity and funding. Commissioners and providers across CYPMHS and adult services should work together to minimise the impact and disruption any potential changes may have on staff or service delivery.

Inpatient mental health services

Any changes to the age range of community mental health services will have to account for interactions with inpatient services. As with community services, there has been a call for acute care to deliver developmentally and age-appropriate services for young people. *The Five Year Forward View for Mental Health* also recommended trialling new care models for acute inpatient care for young adults aged 16 to 25.[3] For some young people, locally based intensive community mental health services may provide a more clinically and cost-effective service than inpatient care.

The safeguarding and legal implications of inpatient care for young people up to the age of 25 must also be considered.

Perinatal mental health services

Services for 0 to 25-year-olds will need to work with perinatal services to ensure young women receive appropriate mental health care. This may be done through integrated working across services and perinatal liaison workers within community mental health services. There will also need to be clear processes around managing referrals and joint working. Commissioners and providers should refer to The Perinatal Mental Health Care Pathways and NICE guidance.

Implications for the wider system

A modern CYPMHS should be commissioned, managed and delivered with a range of key partners. This principle also applies to services aimed at 18 to 25-year-olds.

Education

The 2017 Green Paper *Transforming Children and Young People's Mental Health Provision* set out the case for the provision of mental health care in schools and colleges.[25] This includes designated school leads, mental health support teams and a 4-week maximum waiting time for NHS specialist mental health services. The mental health support teams will work closely with CYPMHS, across groups of schools and colleges, to offer evidence-based interventions to children and young people up to the age of 18, with needs of low to moderate complexity.

The NHS Long Term Plan also emphasises the need to improve access to mental health care for young people in higher education. While many universities have established their own mental health and wellbeing services, this education-based model of mental health teams working across settings, with links to statutory services, could be adapted across higher education providers. Some areas such as Liverpool are working with universities and higher education colleges to scope out the city's student mental health needs. Local areas should consider the higher education population and how a model of 0 to 25 mental health services can be developed in partnership with education providers. Services will need to consider how to meet the needs of young people relocating to attend university, or those who may be in higher education or training programs.

NHS Long Term Plan – mental health in higher education

NHS England is working closely with Universities UK via the Mental Health in Higher Education programme to build the capability and capacity of universities to improve student welfare services and improve access to mental health services for the student population, including focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities.

NHS Long Term Plan, 2019

Commissioners and providers should also consider how a 0 to 25 service may provide care to young people not in education, employment or training, who may not have the same social structures or community supports in place as young people attending university.

Employment

Mental health services that expand provision up to 25 should also consider the person's employment needs, and the impact their mental health may have on their ability to work. As young people may need additional support to remain in, or return to, employment, services should offer proactive arrangements with local employers or organisations to provide placements or volunteering opportunities if someone would like to engage in these, and they should continue to provide support while the person is in employment. Services should offer this advice and support to people as well as to potential employers, particularly around employment rights and responsibilities. This might mean that current CYPMHS staff will require additional training around employment or financial advice, or will need to develop links with agencies that already provide this support, as the age limit extends to 25.

Social care and the VCSE sector

Social care and the VCSE sector are key partners in improving the delivery of mental health care to children and young people and both should be part of integrated working arrangements under the new configuration. Services need to work closely with VCSE organisations to deliver effective care, and social workers should be embedded within CYPMHS to ensure the wider social needs of the child or young person, or their families or carers, are met.

Physical health

As with social care, a 0 to 25 team should include staff with the skills to meet the physical and sexual health needs of young people. This is particularly pertinent for services aimed at meeting more complex, serious mental health needs associated with physical health issues (such as eating disorders) and risky sexual behaviour.

Primary care

Primary care services should be integral to the development of mental health services for young people. While primary care service development is not a major feature of the examples within this report, it should be a key feature of new models. This should include partnerships between primary care, the VCSE sector, education and CYP mental health and social care services to ensure that care is integrated and built around all of the young person's needs.

The Well Centre – Lambeth

The Well Centre is a youth health centre provided by Herne Hill Group Practice and Redthread, where young people aged 11 to 20 can see a youth worker, counsellor or GP to discuss their physical and mental health needs. By bringing together a range of services under one roof, and working in an integrated way with local organisations including VCSEs, the local authority and the NHS, they are able provide an accessible, youth-centred comprehensive service.

Find out more at: https://www.thewellcentre.org

Youth and criminal justice system

Children and young people in the youth justice system (if under 18), or criminal justice system (18 to 25) often have a complex presentation of mental health needs, learning disabilities, alcohol and drug use problems and/or social vulnerabilities. Mental health services for young people – including young adults – should work closely with youth justice and criminal justice systems to ensure that appropriate care and support is available. NHS England's Liaison and Diversion (L&D) service operates an all-age model that aims to identify the needs of individuals when they first come into contact with the youth or criminal justice system. Where needs are identified, a referral is made to treatment or support services and an appropriate package of care and/or support is initiated. L&D services are currently being rolled out across the country, with the aim of 100% coverage by March 2021. For further information on mental health and the justice system, see https://www.england.nhs.uk/commissioning/health-just/children-and-young-people/.

NHS Long Term Plan – Health and the justice system

We will invest in additional support for the most vulnerable children and young people in, or at risk of being in, contact with the youth justice system. *The development of a high harm, high risk, high vulnerability trauma-informed service will provide consultation, advice, assessment, treatment and transition into integrated services. This will provide support to, and help to address the complex and challenging needs of vulnerable children and young people.*

NHS Long Term Plan, 2019

Useful tools and resources

The NHS England Children and Young People's Mental Health and Wellbeing Commissioning Hub brings together information, tools and resources to help support the development and commissioning process.

The CYPMH Strategic Modelling Tool was commissioned by NHS England and developed by South, Central and West Commissioning Support unit in partnership with Healthcare Decisions Ltd and Oxford Health NHS Foundation Trust. Its scope includes health, education, third sector and local authority services.

Appendix 1: Review method

Research question

Which models exist for delivering community mental health care for young adults (aged 18 to 25 years of age)?

Method

This research question was approached using a rapid scoping review. Scoping reviews aim for a preliminary assessment of the available evidence to identify the nature and extent of research available on a given topic.[27] In this case, the aim was to identify models of community mental health services for young people (aged 18 to 25 years of age) and to identify strengths, successes, limitations and challenges as identified by stakeholders.

Literature search

Rapid scoping reviews are concise and pragmatic and are not an exhaustive review of the evidence.[26] In this rapid scoping review, the literature search was composed of two phases:

Phase one: identifying potential models

Models were identified through the following non-database search methods:

- Contacting experts: The purpose of this method was to identify potential models through dialogue with experts. This is an efficient and targeted method since it was possible to explain the context of the research question and the purpose of this rapid review.[27]
- Web search: The aim of this search was to identify models from websites and unpublished evaluation reports. An initial Google search was undertaken to a depth of two pages. A second search, limited by region to the United Kingdom, was undertaken to a depth of two pages.

Phase 2: identifying evaluations of the models identified in phase one

Having identified potential models in phase one, the following search methods were used to identify evaluations, or strengths and limitations of models, as identified by stakeholders.

- Bibliographic database search: keyword searches in ten bibliographic databases, using the primary name of the model. These databases represented:
    - mental health (e.g. MEDLINE, PsycINFO)
    - social science and social care (e.g. Social Policy and Practice, Social Services Abstracts)
    - educational databases (to identify models focused on the 0 to 25 population) (e.g. British Education Index, Education Resources Information Centre [ERIC])
- Web search: A search was conducted through Google ‘advanced’ as well as the meta-search engine Dogpile, to identify any unpublished reports and evaluations. Where specific websites existed for an identified model, these were also searched for evaluations
- Author/stakeholder contact: named stakeholders were contacted to identify evaluations of their respective models, where possible.

Further details on the second phase of the search is available upon request.

Sifting

Models identified in phase one were reviewed by two researchers. Models that aligned with the research question were prioritised for a phase 2 search. Evaluations, published studies and evidence of strengths or limitations were reviewed by one researcher.

Extraction

Characteristics of the models – such as age range (e.g. 14 to 25) and location – together with stakeholder evaluations were extracted by one researcher. Data were extracted into the Service matrix – sample of pilots and services. Once completed, data for each model were sent to relevant stakeholders for verification and to identify any additional data.

Results

The literature search identified 38 potential models which were reviewed for relevance to the research question. Ten models were included in this review. An overview of the characteristics of these models can be found on pages 5-8.

The phase 2 search identified a variety of studies and data. Where available and identified by stakeholders, information concerning the strengths, successes, limitations and challenges of these models was extracted and summarised. These summaries can be found in Appendix 3. The major themes identified regarding strengths and weaknesses across the models have been discussed throughout this report. There was limited consistency on what constituted strengths and limitations across the models.

Limitations

Since a rapid scoping review is intended as a preliminary assessment, the work reported here is not a systematic review. This review should therefore be viewed with some potential limitations in mind.

The literature search, while undertaken systematically and to a high methodological standard, was not necessarily comprehensive. It is possible that relevant models, as well as published and unpublished evidence, may have been overlooked. We consider this a minor risk, however, as the review was undertaken by leading researchers, working closely with experts and stakeholders in the field.

In addition, we acknowledge that data for this review was extracted by a single researcher, without being double-checked.

Appendix 2: Prevalence data

Prevalence of mental health needs in children and young people aged 5-19*

Mental health needs by disorder type	**Percentage prevalence by age**			
	5-10	**11-16**	**17-19**	**All**
Emotional disorders	4.1	9.0	14.9	8.1
Anxiety disorders	3.9	7.9	13.1	7.2
Depressive disorders	0.3	2.7	4.8	2.1
Bipolar affective disorder	-	0.0	0.1	0.0
Behavioural disorders (conduct disorders, oppositional defiant disorder)	5.0	6.2	0.8	4.6
Hyperactivity disorders	1.7	2.0	0.8	1.6
Other less common disorders	2.2	2.2	1.8	2.1
Pervasive developmental disorder/ autism spectrum disorder	1.5	1.2	0.5	1.2
Eating disorders	0.1	0.6	0.8	0.4
Tics/other less common disorders	1.1	0.6	0.6	0.8
Any disorder	**9.5**	**14.4**	**16.9**	**12.8**

*Data from NHS Digital (2018)[7]

Prevalence data from the adult psychiatric morbidity survey (2016)*

Mental health needs	Percentage prevalence by age							
	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Common mental health disorder								
Symptoms in past week using CIS-R score 12 and over	17.3	17.2	17.9	18.0	17.1	10.2	8.1	15.7
Psychotic disorder								
In the past year	0.4	0.6	1.0	0.5	0.7	0.2	0.1	0.5
Probable psychotic disorder	0.5	1.0	1.1	0.8	0.8	0.3	0.2	0.7
Bipolar disorder								
7+ MDQ characteristics with several experienced at the same time and causing problems	**3.4**	**3.1**	**2.4**	**1.6**	**1.5**	**0.4**	**-**	**2.0**
Personality disorders								
*Positive screen for **antisocial personality disorder** (SCID-II)*	4.9	4.6	2.4	2.2	No data	No data		3.3
*Positive screen for **borderline personality disorder** (SCID-II) (18 years old+)*	5.7	2.3	1.5	1.0	No data	No data		2.4
*SAPAS **personality disorder** screen (4+ rating)*	22.4	17.0	12.8	9.4	8.0			13.7
Self-harm and suicide								
Suicidal thoughts	26.8	22.6	21.9	23.7	22.7	11.8	8.1	20.6
Suicidal attempts	9.0	8.5	8.0	6.8	7.0	3.6	1.7	6.7
Self-harm	17.5	12.1	7.9	4.1	4.1	1.9	0.3	7.3
Neurodevelopmental disorders								
***ADHD** characteristics present in the past 6 months (4+ ASRS score)*	14.6	12.2	10.5	10.7	9.0	4.2	3.4	9.7
***Autism** (2 phase screen and 10+ ADOS score)*	1.5		0.1	0.6		-		0.7
Alcohol and drug misuse								
Harmful and dependent drinking in the past year (8+ AUDIT score)	28.9	23.5	20.9	19.1	21.5	12.0	4.7	19.7
Harmful and dependent drinking in the past year – 16+ AUDIT score)	4.2	4.4	4.3	2.8	2.8	1.1	0.3	3.1
Any drug dependence	8.3	5.0	3.2	1.6	1.0	0.3	0.1	3.1

*Data from NHS digital[11] – please see full report and data for more details and breakdown of data by gender and ethnicity.

CIS-R – Clinical Interview Schedule Revised
MDQ – Mood Disorder Questionnaire
SCID-II – Structured Clinical Interview for DSM-IV Personality Disorders
SAPAS – Standardised Assessment of Personality: Abbreviated Scale
ASRS – The Adult Self Report Scale
ADOS – Autism Diagnostic Observation Schedule

Appendix 3: Summary of emerging services and initiatives

This section provides further details of some of the services identified in the initial stage of this scoping review. The following descriptions are based solely on information provided by the services themselves – NCCMH have not evaluated or verified the strengths, successes, limitations or challenges reported.

Appendix 3A: Children and young people's (0 to 25) services

Forward Thinking Birmingham

Forward Thinking Birmingham is a 0 to 25 mental health service. It was established in 2015 with the aim of delivering whole-system change across all mental health care services for children and young people.

Birmingham's population profile

- 420,938 children and young people under 25 (2015 data)
- Ethnically diverse

Strengths and successes

- There has been strong support for the model's key aims of extending CYPMHS to age 25 and integrating practitioners from both adults' and children and young people's services
- The Pause (a drop-in service provided by VCSE partner, The Children's Society) and the Access centre (referral and triage team) elements of the model are seen as successful in increasing access to mental health services
- It has achieved radical system change in a relatively short space of time.

Limitations and challenges

A final evaluation of the implementation of Forward Thinking Birmingham reported the following issues:

- **Workforce –** The main concerns were low staff morale, staffing shortages, suboptimal skills mix, issues with recruitment, retention and a high use of locums in evaluation, compromising the continuity and experience of care for children and young people.
- **Capacity and demand –** While the updated structure improved access for those with unmet need, the scale of this new demand had not been anticipated and quickly overwhelmed capacity, leading to long waiting times, delays after referral and unmanageable caseloads.
- **Flawed partnerships with VCSEs –** Excess demand for the service was met by signposting service users to VCSEs without follow-up, and many VCSE partners were not adequately funded. As a result, the intention of working in co-ordination with the VCSE sector was not fully realised.
- **Limited co-production with young people –** Failure to make full use of the skills and experience of young people.
- **Inadequate and incompatible data management systems** across the model made information-sharing difficult between the service and VCSE and NHS partners.
- **Limited infrastructure** including available space, equipment and age-appropriate environments.
- **Competitive tendering** of services led to fragmentation of mental health services in Birmingham, as 25+ is provided by a different trust. The resultant Transfer of Undertakings (Protection of Employment) of staff from the former adult provider to the new 0 to 25 service impeded the mobilisation of the new service.

Funding

Forward Thinking Birmingham was funded by redistributing the 18 to 25 aspects of the adult mental health services budget and combining it with the existing CYPMHS budget.

Find out more

An Impact and Process Evaluation of Forward Thinking Birmingham[18] is available via the University of Warwick open access service WRAP.

Liverpool and Sefton Youth Mental Health Model

Liverpool and Sefton's population profile

- 49,944 young people aged 18-25 (2015 data)

Liverpool has an established framework of commissioning 0 to 25 services from NHS and VCSE providers as part of CYPMHS partnership. The Liverpool and Sefton Youth Mental Health Model provides early intervention and help from three hubs in Liverpool and one in South Sefton. It is delivered by the Young People's Advisory Service in Liverpool (a third sector organisation) in line with Youth Information Access and Counselling. In Sefton the service is delivered by VCSE partner, Venus. A range of services are provided from the hubs, such as:

- Access and assessment
  - multi-agency single point of access and triage
  - drop-in
  - GP drop-in
  - an early help assessment tool
  - signposting through 'information, advice and guidance' workers.
- Holistic support and interventions including:
  - psychosocial education programmes
  - group work
  - peer support
  - online counselling
  - cognitive behavioural therapy.

The hubs also act as a base for delivering services from a variety of agencies.

At present, specialist CYPMHS and adult mental health services maintain the traditional age boundary of the 18th birthday, so a team has been developed to assist with transitions from CYPMHS to adult mental health services. The model also provides street triage for 12 to 25-year-olds, in partnership with the police.

Strengths and successes

- **Co-production –** The model was developed in collaboration with a range of services and co-produced with young people from the start. For example, the initial proposal was developed by running workshops with a range of stakeholders including the two NHS providers responsible for children and young people's mental health care and adult mental health services, a range of multidisciplinary team professionals, youth offending teams, youth or criminal justice liaison teams, the local authority, public health and children and families teams, as well as service users across all levels of need in CYPMHS and transition years (16 to 25).
- **Young-person-friendly environment –** The hubs provide an age-appropriate space to support emerging mental health problems. Consultation has been developed with secondary care services to provide support, supervision and transition as required.

- **Developing integrated services –** To facilitate integrated working, all GPs, children's centres, and schools and further education institutions have a named specialist CYPMHS or primary mental health worker to provide consultation and training, brief intervention and to facilitate navigation to additional help.
- **The COUIN payment framework –** A proportion of funding was dependent on the service demonstrating improved quality and innovation in mental health care for young people.
- **Needs-based support –** The service's holistic approach allowed resources to be allocated appropriately and efficiently.
- **Reduced waiting times –** When operating with sufficient funding, the time from referral to treatment was 2 weeks.

Limitations and challenges

- **Loss of funding –** The bolstered investment from the CCG to operate this model was withdrawn within 12 months. This drastically limited the service's capacity to continue meeting demand, as it meant the loss of 40 staff members across the three hubs. Consequently, the time from referral to treatment increased from 2 weeks to 22 weeks.
    - The model was initially much more expansive and included comprehensive changes to secondary care services, such as a specialised CYPMHS for ages 0 to 13 and CYPMHS/adult mental health services for ages 14 to 25, to address challenges around transition for engaged service users when turning 18. However, this transformative proposal never received funding.
- **Organisational resistance to hub working –** Existing CYPMHS services expressed reluctance to shift their triage services into a hub location.
- **Commissioning** across both child and adult frameworks and managing differing commissioning frameworks and priorities.

Funding

The implementation of hub services and staff was initially funded through an additional grant investment of approximately £800,000 from the CCG. However, this funding was withdrawn within 12 months of operation.

All three hubs have maintained services despite this, albeit significantly scaled down. This has been achieved through the receipt of Trailblazer funds, the Big Lottery Fund and original funds from the CCG.

The street triage service for 18 to 25-year-olds remains fully operational as this is funded by NHS England rather than the CCG.

Other considerations

- Liverpool has recently announced its intention to commission a 0 to 25 service and will spend the next financial year scoping the need.
- A Joint Strategic Needs Assessment has just been completed in four universities and two higher education colleges around the specifics of the city's student mental health needs.

Further information

For more information on the Youth Information, Advice and Counselling Services model, visit:

http://www.youthaccess.org.uk/about-us/the-yiacs-model

http://www.youthaccess.org.uk/downloads/yiacsanintegratedhealthandwellbeingmodel.pdf

Appendix 3B: Young people's mental health service models

Norfolk Youth Service – Norfolk and Suffolk Foundation Trust

Norfolk Youth Service provides mental health care for young people aged 14 to 25. Following an initial pilot focused on those with severe and complex needs, the service was expanded to meet the needs of all those aged 14 to 25 requiring specialist or secondary care interventions, replacing the existing CYPMHS/adult mental health service model. A child and family service provides care for those under 14, and an adult service for those aged 26 and above. The child and family and youth teams form part of a wider 0 to 25 service line with shared management and processes. Transition between these teams is based on need. A virtual single point of access is operated for all services.

Norfolk population profile

- 271,698 children and young people under 25 (2015 data)
- Predominantly rural
- 86% of population identify as white British
- Higher rates of looked-after children and children in need compared with the England average

Providers

- Norfolk and Suffolk Foundation Trust

The services' core principles were informed by the early intervention in psychosis (EIP) guidelines,[23] CYP-IAPT principles and the Youth Mental Health Declaration.[29]

Strengths and successes

- **Partnership with the VCSE sector** from the start (though not integrated services).
- **Co-production** with young people working with Norfolk Youth Council and wider public consultations.
- **Youth-friendly service –** with high satisfaction scores on the Experience of Service Questionnaire.
- **A shared management structure and cross boundary working** with the children and families, EIP and neurodevelopmental services has helped support smoother transitions and better communication between teams.
- **Balanced** clinical leadership and operational management.
- **Increased service use in 18 to 25 age range –** The average number of service contacts per referral increased from 5.3 to 7 for 18 to 25-year-olds resulting in a more equitable service across the age range. Increased number of 15 to 18-year-olds using the service reflect unmet need.[17]
- **Development of a hybrid 'youth' clinical model and philosophy** merging aspects of child and adult clinical models.

Limitations and challenges

- **Increased demand –** Referral rates increased by 68% with the biggest increase in those aged 14 to 17.[17] This has led to significant pressures on waiting lists, caseloads and the ability of the service to work in line with their core principles.
- **Falling acceptance rates –** The proportion of referrals accepted fell by 27 percentage points.[17]
- **Workforce development** is an issue. The youth clinical model needs to be continually refreshed and delivered to all new staff.
- The service is currently working to improve partnerships with other agencies such as education, the VCSE sector, employment and social services.
- Aligning with other health and local authority services that do not have corresponding age boundaries.

Other considerations

- This service model may also have experienced reduced organisational challenges as Norfolk and Suffolk Foundation Trust are responsible for delivering both adult and child mental health services.
- Service redesign has been provider-led rather than commissioner-led.

Funding

- The 0 to 25 service was funded by redistributing adult mental health service funds and merging them with the existing CYPMHS budget.

Find out more

http://www.nsft.nhs.uk/Our-services/Pages/Community-Youth-Mental-Health-Team.aspx

Minding the Gap

Minding the Gap is delivered by a consortium of partners. It has three main elements:

- a multidisciplinary team delivered by Catch 22 from the Hive, a youth-based co-designed hub in Camden offering holistic support for a range of needs including substance misuse, sexual health, employment and leisure
- a transitions team, including outreach support from the personality disorder service delivered by Camden and Islington NHS Foundation Trust
- counselling and psychotherapy delivered by The Brandon Centre.

A wider network of stakeholders includes the Tavistock and Portman NHS Foundation Trust, the Anna Freud Centre and The Winch Youth Centre.

The service does not replace the existing model of specialist mental health services for children and young people (pre-18) and adults (18+) but is an additional service aiming to meet the needs of the most vulnerable young people between the ages of 16 and 25.

Strengths and successes

- **Access and engagement –** The core objective of a number of the services is to increase access and engagement by delivering a youth-oriented approach, facilitated through co-production with young people. The service was designed to be less stigmatising and clinical, but rather a place where young people could go and access a wide range of support. This was seen as particularly important for young people who might have quite complex needs but who are not ready to engage with statutory services. The Minding the Gap model allows support workers to help meet the needs of young people in a flexible way.
- **Reducing crisis presentation –** Another core aim was to reduce crisis presentation by intervening earlier.
- **Integrated working –** Able to offer a more holistic and joined-up approach to care.
- **Improved transition between CYPMHS and adult services** for some of the most vulnerable young people – 81% of Minding the Gap staff agreed that the model was an effective way to support transitions.
- **Co-production** was involved at all stages from design of the service to delivery and governance. For example, young people helped design the environment and building, helped develop transition protocols, delivered workshops, sat on a young people's board and were involved in establishing the social enterprise at the Hive.

- **Positive outcomes for young people –** The Hive reported that 70% of young people showed improved scores on the Resilience and Social Engagement Scale**.** Young people also reported positive experiences with Minding the Gap – 88% said that 'if a friend needed help, I would suggest for them to come here' and 94% said that 'overall the help I received here is good'.
- **Cost-effective –** the social return on investment is calculated to be a £3.40 social and economic benefit for every £1 invested.

Limitations and challenges

- This is a smaller scale project – the wider system does not extend to age 25.
- It is difficult to demonstrate longer-term impact (e.g. prevention of serious mental illness for at-risk youth) within shorter funding cycles.

Other considerations

- Minding the Gap was aligned with Camden's i-THRIVE plan.

Find out more

http://www.implementingthrive.org/case-studies-2/minding-the-gap-transitions-service-in-camden/

INTEGRATE

London's population profile

- 885,593 young people aged 18–25 (2017 statistics)
- 36,000 offenders under 25 in 2016/17, 86% being male.

The INTEGRATE model was developed by MAC-UK with a focus on engaging excluded young people – particularly young offenders – as one third of this group experience mental health difficulties. A number of projects across London, led by both statutory and third sector organisations, have adopted the INTEGRATE model with the aim of addressing inequalities in access to mental health support. At the core of INTEGRATE is 'Adolescent Mentalisation Based Integrative Therapy' (AMBIT), delivered by teams of workers trained in mental health or with lived experience of mental health difficulties, and led by mental health professionals. The staff's holistic 'Streetherapy' approach involves developing an understanding of each young person's needs and bridging the gap to the appropriate existing services.

Strengths and successes

- **Access and engagement via assertive outreach –** 'Meeting young people where they're at' is a central principle of the INTEGRATE approach, meaning staff actively approach young people who may need support in order to circumvent the typical barriers to services faced by this age group. Once established, engagement is maintained through daily outreach via youth-friendly technology. INTEGRATE projects have successfully engaged hundreds of young people and have even reversed disengagement for some.
- **Co-production** is viewed as vital to achieving successful engagement across INTEGRATE projects, by ensuring that young people *want* the service to be made available. The input of young people is actively sought throughout all stages of project development, with young people even taking on explicit leadership roles and short-term employment within a project.[28]

- **Harnessing peers and community experts –** Peer workers and referrals have also played a role in successful engagement across INTEGRATE projects. INTEGRATE services do not accept professional referrals but nevertheless succeed in reaching excluded young people by developing meaningful partnerships with trusted figures and existing resources in the local community.
- **Positive outcomes for young people –** On a range of measures, both service users and service staff reported that young people's mental wellbeing had increased throughout engagement with various projects employing the INTEGRATE approach.

Limitations and challenges

- **Measuring impact –** As many core aims of the INTEGRATE approach focus on prevention and reaching those who would not otherwise access a service, it has been challenging to accurately assess the impact of INTEGRATE projects in these domains.
- **Co-production as commissioning limitation –** Commissioners often requested that concrete outcomes and goals be specified before providing funding for INTEGRATE projects, but they could not be completely defined until young people had been consulted.

Find out more

https://www.mac-uk.org/our-approach

i-Rock

i-Rock is a hub based drop-in service for young people aged 14 to 25. All young people accessing i-Rock services are triaged to assess their specific needs and subsequently provided with appropriate information about further support. This information is intended to aid young people in deciding between three clearly defined exit routes: (1) referral to a non-statutory provider for counselling, peer support, or similar; (2) referral to a statutory provider for psychosocial intervention (with the transition supported by i-Rock); or (3) a brief psychosocial intervention delivered by i-Rock.

Strengths and Successes

- **No barriers to access –** Young people do not need to make an appointment, receive a referral or meet minimum threshold criteria to access i-Rock services.
- **Immediate support –** In 2 years of operation, no service user has waited more than 30 minutes between arriving and accessing support from i-Rock staff.
- **Staff knowledge of service network –** Staff are well connected to local services, and their knowledge of minimum threshold criteria for those services prevents young people being misdirected.
- **Capacity to support those with high need –** Figures from recent years suggest that nearly half of young people accessing i-Rock's service present with high to very high complexity and risk. Since i-Rock opened, the local accident and emergency department has seen a decrease in the number of young people attending with mental health problems.

Limitations and challenges

- **Integrated working –** offering i-Rock services within existing systems and across multiple agencies has been challenging due to a lack of clarity over governance structures, reporting structures and data protection concerns. This has necessitated the development of an organisational policy.

Funding

The Department for Education has pledged £100,000 per annum to support and expand i-Rock's services as part of a wider plan to improve social mobility.

42nd Street

42nd Street is an example of a Youth Information Access and Counselling model, providing emotional wellbeing and mental health support to young people in Greater Manchester aged 11 to 25. Individual and group-based services are delivered through community venues, arts and cultural centres, and schools and colleges, as well as their city centre base. The charity promotes choice and creativity, championing young person-centred approaches that demonstrate local impact and have national significance.

Strengths and successes

- *General*
    - Increased commissioning as a result of strengthening partnerships with CCGs and local authorities across Greater Manchester.
    - The pilot Integrated Community Response Service provides rapid de-escalation and short-term support for young people experiencing high levels of distress. Co-developed and delivered across the health, social care, VCSE and education sectors, it is showing significant clinical impacts and financial savings across the whole system, as well as cultural change across sectors and within teams.
- *Manchester Arena Attack, 2017*
    - The attack impacted many children, young people, parents and carers who attended the event, or knew someone who did. 42nd Street supported the initial response and the development and delivery of the Resilience Hub.
    - Through bespoke funding from the Co-op Foundation and Big Lottery, the charity have supported over 30 of the young people directly affected by the attack.
- *Peer research*
    - The *'We Tell You'* manifesto and report is a result of a 3-year peer-led research programme exploring and seeking solutions to the barriers faced by young Black men in accessing mental health care.
    - Peer researchers co-developed 'Missing', an immersive theatre piece, and toured the UK to hear first-hand experiences and insights of young people from a variety of communities. This resulted in the 'Loneliness Unites Us' report, informing future practice at 42nd Street and drawing attention to youth loneliness issues.
- *Other initiatives*
    - *The Horsfall* creative venue has been in operation since February 2017, with exhibitions, projects and events across the year. For example, the 'Dress' project explored fashion and identity with young women from Wythenshawe.
    - *Q42* have developed an online platform for lesbian, gay, bisexual, transgender, queer and 'other' (LGBTQ+) young people, bringing together different

communication channels and opportunities for young people to support one another and link with organisations and professionals for information and support.
    - *TC42* uses the principles of democratic therapeutic communities to help young people take more control over their lives and better understand how their feelings and emotions impact on their lives. Outcomes for young people have been outstanding, with many reporting significant improvements, securing jobs for the first time, cutting down on drug and alcohol use and establishing positive supportive relationships.

- *Outcomes*
    - 42nd Street has Do Not Attend (DNA) rates of between 5–13% and consistently high 'reliable change' and 'reliable recovery' rates for individual therapeutic work: 67.5% in Manchester, 63% in Trafford and 56% in Salford. For group approaches, 42nd Street saw an average 78% reduction in YP-CORE scores and qualitative measures, and over 95% of young people consistently report they would recommend the charity to friends and family.

Limitations and challenges

- *Resources*
    - There is a risk that increased competition forces 42nd Street to lose capacity. To manage these risks, the charity have diversified funding sources and programmes to better reflect the needs of young people.
    - Resourcing has not kept pace with demand over the years, leading to increased waiting times for some elements of the service. This carries risks for young people and risks reputational damage for the organisation. The charity has made some improvements to internal systems, has introduced more group work and creative alternatives, and will be piloting a waiting times initiative in Trafford. The charity is also developing bespoke work with key cohorts and stakeholders to avoid the traditional referral-assessment-appointment model.
    - Changes in funding streams for young people's mental health, the devolution of health and social care in Greater Manchester and other external factors impact on the charity's work – this has led to investing time in local, regional and national networking, involving 42nd Street service users and ambassadors in key forums to ensure young people's voices are represented in shaping policy and practice.

- *Serious incidents*
    - 42nd Street has seen an increase in complexity and high-level risk including trauma, self-harm, suicide ideation, suicide attempts and completed suicides. 42nd Street has robust, NHS audited safeguarding/child protection/Serious Untoward Incident policies and protocols in place and all staff are fully inducted and trained in these. The Duty Team now operates each day to support difficult cases as they arise.
    - Escalation processes for more serious incidents go right through the organisation to the Executive and the Board. Robust risk assessments are built into all levels of delivery and all staff receive the appropriate internal and external training.
    - All mental health practitioners have regular practice-led meetings and one-to-one internal and external supervision to support and scrutinise practice. All new staff are subject to detailed induction and probationary periods.

Appendix 3C: International models of young people's mental health services

IRELAND

Jigsaw – The National Centre for Youth Mental Health

Jigsaw provides brief and early intervention services for young people with mild to moderate mental health difficulties across 13 hubs in Ireland.

Ireland's population profile

- 331,208 young people aged 19-24 (2016 statistics)
- The catchment populations of Jigsaw sites range from 150,000-250,000.

Jigsaw services are embedded in their local communities in order to complement existing services, accepting referrals from a broad range of sources including self, families or carers, schools, GPs and other mental health services.

Strengths and Successes

- **Co-production –** Young people have been actively involved in the design, implementation and review of Jigsaw services.[29]
- **Access and engagement –** The successful co-production of a service that is accessible and non-stigmatising for young people is reflected by the high number of self-referrals to Jigsaw.[30] Jigsaw services have also been effective at engaging young people who are typically regarded as less help-seeking; almost half of young people receiving support from Jigsaw are male.[33]
- **Positive outcomes for young people –** Young people have experienced a significant reduction in psychological distress after receiving an intervention through Jigsaw. These positive effects apply to all ages and genders across the 18 to 25 demographic.[33]
- **Data systems –** Detailed information including demographic data, presenting issues, support offered, referral pathways and outcomes data is recorded for all young people who engage with Jigsaw, facilitating evaluation of the service.[31]
- **Diverse staff skills and competence –** Young people engaging with Jigsaw often present with very different problems but experience similar improvements in psychological distress following Jigsaw interventions.[31] Overall, Jigsaw appears to be equally effective at addressing a wide range of issues.
- **Effective referral pathways in an integrated network –** Jigsaw staff, and those within the broader network of services, are able to recognise their own and others' capacities to support young people, and actively make referrals to each other to ensure young people receive appropriate care and that resources are allocated to areas of greatest need. For example, mental health services refer young people of lesser need to Jigsaw, whereas Jigsaw will refer young people to mental health services after an act of self-harm – their greater need is recognised and they are referred to the service that can better accommodate them.

Funding

- Jigsaw (originally called Headstrong) was established using a new philanthropic funding stream from the One Foundation. This funding continued from 2006 to 2013.
- There was a €1million grant from the Dormant Accounts Fund in 2007.
- Grant funding was allocated from Atlantic Philanthropies from 2010 to 2014.
- Innovation Funding was received from the former Department of Health and Children from 2011, until mainstream funding was secured in 2014 from the Irish Health Service Executive.

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