Developing an outreach service in adolescent mental health to improve engagement

An adolescent mental health team set up an outreach role as a way of engaging vulnerable young people with mental health services and interventions

INTRODUCTION
The Barnes Unit in Sunderland is a tier 3 adolescent mental health team that provides a community-based treatment service for 16–18-year-olds with complex mental health difficulties. It follows the recommendations in Together We Stand (Health Advisory Service, 1995), which recommended a four-tiered approach in child and adolescent mental health services (CAMHS).

Our aim is to identify, assess and treat young people with complex mental health problems and provide a consultancy and training resource for professionals working with young people. Therapeutic interventions available include family therapy, cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR).

Part of my role as a mental health practitioner is to provide outreach services to the adolescent population to improve access to tier 3 mental health provision.

There is a huge amount of discussion about ensuring that people receive the appropriate therapeutic intervention (Project Match Research Group, 1997).

However, there is also a wealth of research showing that engagement and the therapeutic relationship can create change in clients (for example, Ritter et al, 2002).

Within the adolescent mental health outreach role, I also considered the cycle of change (see Prochaska and DiClemente, 1982).

Assessment and conversations with young people showed that some were not ready to enter services. It therefore seems appropriate to consider what interventions could be implemented to help straight away and move clients to the stage of considering service involvement.

SETTINGS
In Sunderland, there are a number of accommodation services for young people including for the following groups: young women aged 16–18 who have experienced domestic violence; 16–23-year-olds who are homeless; and single parents. All offer supportive key-worker packages.

Apart from accommodation services, areas supporting young people include education, training, drug and alcohol services, non-statutory mental health services, housing agencies and young parent groups.

All these services have one thing in common – that is, young people attend them – so they provide a setting where interventions can potentially be offered. They also provide a way of improving information-sharing with young people and access to services while addressing inequalities (Department of Health, 1999).

ENGAGEMENT
I believed that engagement with young people and staff needed to be the foundation of anything that was to follow.

First, I introduced myself to unit managers and key workers, asking what they would like from my role. This allowed me to attend previously arranged drop-ins to meet young people.

The aim was to support staff and ensure accessibility to a service for young people offering evidence-based interventions, as recommended in the CAMHS Review (Department for Children, Schools and Families, 2009).

However, mental health intervention was not the agenda with the young people concerned; being accepted into their community was my main aim initially.

I gave young people advice and information on benefits, harm minimisation, drug use, sexual practices and physical health problems, allowing them to set their own agenda. This approach helped me to become accepted and to begin to introduce mental health messages in a non-imposing manner.

After some time, informal conversations arose on the young people’s concerns about their mental health. This led to setting up appointments to see me at the drop-in venues.

I carried out informal assessments and made suggestions about the best way to help them deal with their concerns. Since clients were at different stages of change, making referrals was appropriate and helpful for some, while, for others, continuing with drop-in appointments when they wanted them was as much as they would accept. One issue was how we could meet the needs of those young people who would not accept any support from me.
Staff support
One way forward appeared to be to support staff at these venues as much as possible. Increasing their awareness of mental health issues would further improve the service for young people, while I waited for clients to take the next step to talk to me. Training was provided to increase staff understanding of various mental health conditions.

I was able to identify where regular drop-ins would be needed and occasional ‘pop-ins’ helpful, while always providing brief intervention appointments when requested.

The agencies I worked with were aware of the Barnes Unit’s flexible approach to meeting individual needs. They would contact me at any time to request an appointment for an assessment outside of drop-in and pop-in times.

The hope is that, if the right interventions can be given at the appropriate time, it may prevent young people presenting in crisis. 11 Million (2008) discussed the need to avoid inappropriate admission of young people to hospital, especially onto adult wards.

OUTCOMES
I believe that useful interventions have taken place, whether in the form of structured therapeutic sessions or brief intervention and engagement. The brief format was a maximum of six sessions offering a therapeutic intervention influenced by a cognitive approach and supported by other styles of work such as narrative techniques, advice and education.

This created the opportunity for clients to make sense of and ‘normalise’ some of the unpleasant thoughts and feelings they were experiencing. This helped them to understand that mental health services were not frightening and can be accessible.

BACKGROUND
- The Department for Communities and Local Government (2008) discussed the prevalence of mental health problems among young homeless people.
- Over half of all respondents in the DCLG survey (52%) had experienced depression, anxiety or other mental health problems, and 33% had current mental health difficulties (a rate of around three times higher than that of young people in the general population).
- Current mental health problems were more common among young women (40%) than men (24%) (DCLG, 2008).

For some young people considering treatment, this engaging process has facilitated a move to the action stage of change (see Prochaska and DiClemente, 1982), resulting in them requesting a referral to our service.

I feel I have built up good relationships with clients and staff, resulting in improved access to services and availability of support.

In the first 12 months of the outreach work, 126 face-to-face brief interventions were given, of which 15 were for males aged 16–18, 91 were for females aged 16–18 and 20 were for people over 19. Those over 19 were assessed and referred to appropriate agencies. The conditions/diagnoses presented in the 126 face-to-face contacts are shown in Fig 1.

CLIENT INVOLVEMENT
Throughout this process, young people have been encouraged to express their opinion on the service we offer, influence training packages and any resources developed.

When recently designing the new service leaflet, we sought advice from clients about content, wording and graphics.

Recently, interviews were held for a community nurse post. Questions from clients were incorporated into the process and a representative from our client group was part of the interview panel.

All these activities will continue and, hopefully, new ones will be developed, to ensure clients’ voices are integral to service development.

REFLECTION
There have been some obstacles in developing the outreach role. There were times when I felt my presence in the venues was being questioned and I often felt like an unwanted student. However, after expressing my feelings in supervision, I realised that I could not expect everyone to see me automatically as a resource. It was up to me to prove that I could be of value to them.

This was validated through anonymous evaluation questionnaires which clients completed. Some comments included:
‘It’s good people think I’m hard but I need someone to talk to.’
‘It’s good ’cause it comes to where we are.’
‘Two people should come so you don’t have to wait to see somebody.’

PLANS
I will continue with this process by listening to young people, taking their views back to the team and sharing their opinions on what they would like to be different. I intend to engage with any new services opening in our area, constantly reflecting on the questions of engagement or therapeutic intervention.

Data shows that a number of people over 18 have also accessed the outreach services and it appears there is a gap in service provision for this client group. We need to discuss how to meet their needs with adult services.

REFERENCES


