Making a Difference to Young People's Lives Through Personalised care:

Mental Health Inequalities and Social Deprivation

August 2021

NATIONAL CHILDREN'S BUREAU

NATIONAL CHILDREN'S BUREAU

Contents

Executive Summary 2

1. Introduction 7

2. Project Method 8

3. Research Context 11

4. Site Information 13

5. Barriers to accessing mainstream mental health services 22

6. Impact of Personalised Care 25

7. Strengths of Personalised Care for this Group of young people 28

- a) Personalisation 29
- b) Practical support as a Benefit of Social Prescribing 30
- c) Choice and Control 32
- d) Community Based support 33
- e) Holistic and Integrated approach 35

8. Enhancing the Personalised Care offer 36

- a) Support Worker Role 37
- b) Support Groups/Peer Support 40
- c) Different Conversations 41
- d) Responsive Support 42
- e) Flexible and Gradual Entry and Exit Points 43
- f) Self-referrals 44
- g) Whole Family Approach 45
- h) Working with VCS Organisations 46

9. Challenges and Limitations of Personalised Approaches 46

10. Conclusions and Recommendations 49

Appendices 57

Executive Summary

This report aims to understand how personalised care interventions can better support children and young people who experience poor mental health and social deprivation, and to develop evidence regarding what works to enhance the personalised care offer for this cohort. The report makes a series of recommendations aimed at improving the experiences of this group, based on engagement work undertaken across the three sites with 19 young people, 11 parents and 7 site professionals. Among the young people we spoke to, many were care leavers, several had experience of self-harm or attempted suicide. There were several young people with Autism Spectrum Disorder (ASD), and a number of young parents. Many of the families included had low household income or experience of economic disadvantage.

Data methods

Data for this report was gathered from three sites: Bristol, Thurrock and Nottingham via the following methods:

- interviews with key site professionals responsible for commissioning, planning and delivering a personalised mental health offer for young people,
- focus groups and individual interviews with young people who had accessed support.
- focus group with parents/carers of young people who had accessed support
- interviews with parents who had accessed support for their family.

In addition to this data, the recommendations in this report have been informed by a comprehensive literature review and evaluation data from a range of personalised care pilot initiatives, including project surveys and videos from the three sites studied.

The findings from data collected has been grouped under three key themes; impact of personalised approaches for disadvantaged young people, enhancement of the personalised care offer, and challenges of personalised approaches with this cohort.

Overview of findings

Impact of Personalised Approaches on Disadvantaged Young People

While those we interviewed expressed mixed experiences and varying outcomes from clinical mental health support provided by Child and Adolescent Mental Health Services (CAMHS), Emotional Wellbeing & Mental Health Service (EWMHS) or elsewhere, all of the young people and families we spoke to told us how the personalised support they had received had a positive impact on their life, mental health and wellbeing. Considering the nature of the impacts described below, this strongly indicates that personalised support is a highly effective option for young people from backgrounds of social deprivation. Several key impacts emerged across the sites:

<u>Reduced Loneliness and Isolation</u>

Young people aged 16-24 are the age group, particularly from socially deprived backgrounds, who report the highest levels of loneliness and isolation across the UK population (ONS Community Life Survey 2017). Several of the young people we spoke to said that the personalised support they had received had reduced their isolation and loneliness and enabled them to connect with others in their community.

Greater Access to Education, Training and Further Support, Improved Skills and Confidence

Several young people had returned to education and training or were able to access a range of support services they previously did not receive. Young people also explained that the personalised support had improved their skills and confidence, including life skills such as how to cook different meals, and how to budget effectively.

Personalisation

Many of the young people and families we spoke to highly valued the ways the support they received was tailored to their interests and needs, with the offer of choice and flexibility in how they were supported. Many young people explained how the process of receiving person-centred care had made them feel understood and cared for, in a way they hadn't experienced from other forms of support. Many expressed concern about the lack of options for support in mental health services, which several young people described as being a 'one size fits all' approach that was unable to understand and properly meet their needs. Often young people had found talking therapies to be an inaccessible form of support

Practical support

Social prescribing approaches and personal health budgets are accessed with agreement of the relevant NHS clinical team and focus on addressing health outcomes and can provide items and experiences which young people from socially deprived backgrounds would otherwise not be able to afford. In those studied here, it included arts and crafts materials; bus passes; driving lessons; laptops; musical instruments; a cooker; children's toys; sports equipment; gym memberships, and more. Respondents from all sites valued how this practical support helped them address factors in their life that were causing significant stress, or enabled them to access protective activities against poor mental health. For example, several were able to receive bus passes or driving lessons, which reduced their isolation and improved their mental wellbeing.

Choice and control

Young people reported that one of the most important features of the support received was how they were allowed to make decisions. Having choice and control over their support options seems of particular value to young people from socially deprived and other disadvantaged backgrounds, who often have been given little agency in decisions.

Co-production

A significant aspect of this choice and control was that the services had been coproduced having evolved based on the feedback of young people. Young people were also involved in naming the services and, in one area, some had also been trained to volunteer and be part of the delivery of the programme.

Community-based support and Trust

Another particularly valuable aspect for young people from deprived backgrounds is that it is based in the community rather than in clinical settings and is seen as a less formal and more accessible form of support that had put them at ease. Several care leavers expressed low levels of trust in clinical services and reported feeling judged when accessing support. Young parents expressed particular wariness of statutory services because of a fear of having their child taken into care.

Holistic and integrated approach

Young people and one of the site professionals described the benefits of a holistic approach. It was noted that while most mental health care plans focused on mental health needs, and some may also explore access to education, there was a gap in holistic support, particularly around relationships

and social opportunities. Many young people from socially deprived backgrounds have overlapping and complex needs and have had engagement from a range of statutory services. Several of the young people spoke about being in a near-constant process of referral and re-referrals. Many of the young people reported that holistic support had a positive impact on their physical health, confidence, family relationships, loneliness, education, as well as their mental health.

Enhancing the Personalised Care Offer

Our conversations with young people, families and professionals emphasised additional features of the personalised care offer which were key to ensuring the offer worked as well as possible for young people from disadvantaged backgrounds.

Support worker role and ability to build trusted relationships

The aspect of the personalised support which was most valued by the young people and families we spoke to across the three sites was the role of the support worker. Several young people went as far as to say they would not have benefited from a personal health budget if they had not had a support worker to guide them throughout. While the role of a link worker is a key part of most social prescribing approaches, the 'support worker' role across the three sites extended beyond that, as a key trusted point of contact who the young people spoke to regularly, having broader conversations about their wellbeing. The worker acted as a care navigator to ensure they were not lost in the system. This is particularly valuable for young people with mental health needs from socially deprived backgrounds who tend to have poorer knowledge of support systems.

Support groups/peer support

Young people, parents and professionals explained that the peer support groups developed helped young people feel included, increased their confidence, developed social skills and reduced loneliness which was particularly valuable for the young people with autism and learning disabilities, and for young parents, who explained they were particularly isolated. Many valued having a space to talk to others who were also experiencing mental health issues and similar challenges around disadvantage.

Different conversations

The 'different conversations' approach was also found to be of particular value to young people from socially deprived and disadvantaged backgrounds because of its use of accessible, de-medicalised language and its focus on strengths and solutions. Services used videos or drawing during these conversations to explore what young people like and evaluate how things are going, which can be an accessible approach for young people who find it hard to open up in different ways.

Responsive and Rapid Support

For those who did attend CAMHS or other services, the long waiting times decreased their trust in the system and contributing to their feelings that they were not being taken seriously, particularly when they felt they had been left waiting when in crisis. In contrast, the support they received through the personalised care offer had "no long waits" assisting the building of trust and sense that they were being taken seriously.

Flexible And Gradual Entry/ Exit Points

The gradual entry and exit points seemed to be another way the sites we looked at provided support which made the young people we spoke to feel cared for and respected. For example, in one site a gradual hand over process is provided between previous support and the personalised care support to ensure young people do not have to repeat their story, and that their entry into the service is easy.

Self-referrals

it was felt that an option for self-referral would help make accessing the service easier for vulnerable young people. For care leavers, accessing traditional mental health services can feel like 'being processed' through a system in a way that had often felt negative. The need for these young people to retell their stories again in order to meet referral criteria left some feeling retraumatised, as many of them had to do this repeatedly to numerous professionals.

Challenges and Limitations of Personalised Approaches

While many of the young people and their families we spoke to felt that there was **"**nothing", they would change about the support they had received a few young people and professionals identified some challenges and limitations to this way of working.

- Remaining barriers to accessing support

Despite huge efforts to successfully engage young people from socially deprived backgrounds and other hard to reach groups, we know that young people from disadvantaged backgrounds face a range of significant barriers, and all sites felt there was further to go to ensure all disadvantaged young people could access their support.

- Lack of understanding about options available

One of the challenges identified by some young people, particularly those from backgrounds of deprivation, was that they were so used to limited finances, that it was often hard for them to understand what could be possible with a pot of money dedicated to their wellbeing.

- Limitations of virtual working

Most young people understood why the limits were in place and saw it as a temporary restriction on their usual support. However, for some digital poverty meant a greater barrier to accessing personalised care.

- Continuity of offer and of staff

Young people expressed significant frustration and dissatisfaction with previous services or pilot schemes which had closed or changed after a few months. Several were worried about possibility of a threat to the availability of a support worker. Where there had been a consistent offer and the same key professional throughout this was hugely valued

The comments below from participants provide a snapshot of these experiences

> "I was so scared… [I] thought I'd have the children taken away and have no purpose." Instead, "It has changed everything around. I didn't think I had anywhere to go but now we're getting back on our feet and that's thanks to [this support]" [Young parent]

> "It has changed my life, I feel I can cope now." [Young person]

Recommendations

While young people's experiences may be complex, what they need from services is relatively simple**.** Young people valued an approach that was consistent, caring, and which made them feel heard, with the following a priority:

- Developing the support worker role. Although the support worker role will require a well-funded commitment, it was seen to be central to the effectiveness of support underpinned by consistency and continuity of offer.
- Location of social prescribing approaches in local community and trusted services/systems - explore options for additional roles via Primary Care Networks and potentially the Care Coordinator.
- Coproduction, which supports services in adapting to meet CYP priorities, and onboarding young people to volunteer within and promote projects.
- Range of pathways into support: CAMHS, education, self-referral.
- Support for 16-25s with a gradual transition out of services.
- For mainstream services, and areas who do not (yet) have personalised approaches, support for introduction of Different Conversations and training around the needs of complex children and young people across children's health services.
- Establishing Community of Practice or facilitating sharing and learning.

1. Introduction

Context

While any child or young person can experience mental ill health, mental health problems are not evenly distributed across society and some groups of young people are significantly more likely to experience poor mental health.

This project focuses on the experiences of young people who have experienced social deprivation, as well as those from other groups who face similarly high levels of mental health inequality, such as care leavers, young parents, and those with autism and learning disabilities. As well as having disproportionately high rates of mental ill health (e.g. Marmot et al. 2010, Elliot 2016), these populations face increased barriers to accessing care and support (e.g. Chapman et al. 2017, Brown et al. 2016), and report poorer experiences of traditional mental health services if and when they do access support (e.g. Rickwood et al 2007, Beers, Hodgkinson et al 2016).

As well as having a higher incidence of mental health problems, young people experiencing social and economic deprivation also face a "triple barrier" (Commission for Equality in Mental Health, 2020) when it comes to services, facing inequalities in access, experience and outcomes from mental health services.

"Facing wider socio-economic disadvantages may make them more likely to become unwell, whilst at the same time less likely to access or get the care and support they need. Having a vibrant and varied offer of mental health services is critical to ensuring everyone has access to the support and services they need to prevent crisis" – Mental Health Act Review.

Personalised Care

However, while there are numerous studies which explore the increased incidence of poor mental health among children and young people experiencing social deprivation, there is significantly less research on what types of support and treatment are effective for them, and almost no studies have looked at the value of social prescribing, personal health budgets or personalised care approaches for this cohort of young people.

From the existing literature and previous pilots such as the Looked After Children (LAC) with Mental Health Support Needs Demonstrator Project 2016-19; CAMHS Personal Health Budget (PHB) Development Programme 2019-2020, and Street Games Project 2019-2020), it seems likely that personalised approaches may make a difference to CYP from deprived backgrounds. However, there is limited material which unpicks CYP experiences or which explores how to design and deliver support in a way that will be most effective for marginalised CYP.

The CAMHS PHB Development Programme recruited 13 sites from across England who wanted to develop a PHB offer as part of their CAMHS provision. The programme asked sites to identify areas

where a PHB could help to improve their local offer to CYP and their families. Throughout the programme it was apparent that the PHB process and personalised care provides a way of engaging with children, young people and their families who experience social deprivation, enabling them to access local community assets and support to meet their needs.

The LAC Project 2016-19 worked with 7 demonstrator sites to test out personalised care and support planning and personal health budgets for looked after children with mental health support needs. An evaluation into the project indicated that the programme worked well for older children and care leavers with mild or moderate mental health issues, and those reluctant or unable to engage with CAMHS.

The Project

This report seeks to build on those findings to understand how support can be delivered in a way that will be most effective for marginalised children and young people (CYP). We looked at examples of innovative approaches across the country which had followed personalised care models such as those above. We talked to CYP and their families, who have accessed personalised support for mental health, about their experiences, as well as speaking to site staff contacts in three areas about these approaches.

In this report, we will explore the findings from this work, examining the impact of personalised care for young people from socially deprived backgrounds; identifying the key elements of personalised care that work well for young people from socially deprived backgrounds; exploring the limitations and challenges to some personalised care approaches; and highlighting key lessons for further work in this area.

Further detail on our methodology, approach and supporting tools for undertaking the project can be found in Appendices II-VIII.

2. Project Method

This projects aimed to how personalised care interventions can better support children and young people who experience poor mental health and social deprivation, and to develop evidence regarding what works to enhance the personalised care offer for this cohort. Alongside a literature review to examine the existing body of evidence, NCB undertook primary research with sites working in this space. Six local areas were identified with high levels of social deprivation which had developed a personalised mental health offer for young people, including social prescribing approaches and personal health budgets. However, due to the varying levels of development the sites had reached with their offer and the impact of Covid-19 redeployment, we ended up progressing with primary research in three sites: Bristol, Thurrock and Nottingham.

In each of these sites, we held interviews with key members of staff responsible for commissioning, planning and delivering a personalised mental health offer for young people, and with young people who had accessed support. This included a Social Prescribing commissioner, Children and Family Services Commissioner, Youth Facilitator, Social Prescribing Link Worker, and Personal Advisor. The

latter three roles were responsible for day to day delivery working with young people and acted as support workers. Throughout this report we use the word professional to refer to this group of staff.

Work with young people

The core part of our work was engagement with young people from socially deprived and otherwise disadvantaged backgrounds who had accessed personalised mental health support, in order to hear their experiences and perspectives. We held two focus groups for young people, one in Bristol and one in Thurrock. Young people were recruited to these focus groups through their membership of existing youth groups linked to the local personalised care offer and the sessions took place during their existing group meeting schedule. We were keen to ensure all young people were able to fully participate in the session so used access forms to understand their technology, access and support needs; and utilised a range of tools to ensure discussions were varied and accessible, including picture-based activities, surveys, Miro boards, quick fire questions and discussion activities. While we were lucky to have the full backing of support workers in each area who encouraged and helped the young people attend, we also offered alternative ways for young people to participate to ensure any young people who were nervous about a group environment or who could not make the session could still be included. In Nottingham we interviewed one respondent by phone, and in another area a young person provided written responses. The question topics remained the same regardless of the method of engagement.

Work with parents

As mentioned, we were limited by the maturity of projects in some areas which were not yet delivering personalised support to young people or who had recently developed a pilot. As a result, we worked with fewer sites than had been anticipated and were able to hold an additional focus group in Thurrock for seven parents and carers of the young people we had previously interviewed. We also conducted four interviews with parents in Nottinghamshire who had received personalised family support. This provided useful information about the wider value of personalised approaches, including for parents, carers and siblings.

Defining social deprivation and disadvantage

A wide range of definitions of childhood social deprivation are adopted across research and policy, including: measures of relative poverty (households with less than 60% of median income); children in receipt of free school meals; households in receipt of income-related benefits; workless families; low equivalised parental income; and neighbourhood deprivation as measured by the IMD. However, for every metric of childhood deprivation used in research, the rates of childhood mental ill health were disproportionately high. For example, ONS research found that children whose parents were in receipt of welfare benefits were over three times as likely to have a mental health condition than their peers (2019); NHS Digital figures reported that 17% of 11 year olds from households in the bottom fifth of income distribution had severe mental health problems, compared to fewer than 4% of children in the top fifth (2016); and the Marmot Review 2010 reported that children living in relative poverty are "over three times more likely to suffer from mental health problems."

Because the research suggests that young people who fall under any of these criteria of deprivation are disproportionately likely to suffer from mental ill health and because different sites capture varying data, we have not been overly prescriptive about which metrics of deprivation were utilised.

As well as looking at young people who experience social deprivation, this project looks at other disadvantaged groups who experience intersecting mental health inequalities. Appendix I sets out the list of measures of disadvantage we considered in this work. As part of our research with the sites in Bristol, Thurrock and Nottingham, a majority of the young people we spoke to came from these disadvantaged backgrounds, including looked after children; care leavers; those with autism and learning disabilities; young people from households with parental mental illness; excluded young people and those who are not in education, training or employment (NEET); young people with physical health needs; and young parents. Children and young people from any of these backgrounds face significant barriers to accessing mental health services and experience disproportionately high rates of mental ill health, with between three times the incidence for young people from households with parental mental illness (ONS, 2019) to ten times the incidence for excluded young people (IPPR, 2017). We recognise that these categories are overlapping: young people who are in care are more likely to be from socially deprived backgrounds, to have physical and learning disabilities and to face school exclusion, for example, and the young people we spoke to talked about the impact of these complex experiences on their mental health and their experience of support.

Defining 'young people'

While the evidence from existing literature applies to children and young people of all ages, our work with the three sites focused on the experiences of young people aged 14-21, due to the eligibility for personalised support in these sites. All direct quotes from young people therefore refer to young people aged 14-21.

3. Research context

We conducted a literature review to gather the existing evidence on mental health, socioeconomic deprivation and personalised care for young people. The literature review focuses mainly on recent UK-based literature but also draws on relevant international publications where there are key gaps in UK-based material, and was informed by searches of academic databases, journal publications and grey literature, including relevant government and non-statutory reports.

Existing research clearly demonstrates that mental health needs are not equally distributed across the population and children and young people who experience poverty, deprivation and disadvantage are around three times more likely to develop mental health problems than children who do not live in poverty (e.g. Marmot 2010, Ford et al 2005, ONS 2019). Research by the British Academy (2015) suggests that while health services may contribute around 20% to mental health outcomes, and health behaviours account for 30%, "by far the most important influence on mental wellbeing comes from socioeconomic factors." Similarly, the World Health Organisation (2019) acknowledge that "financial inequalities and material deprivation are the major drivers of mental health inequality."

However, while the intersection between mental ill health and social deprivation is widely discussed, it is less commonly known that the income-related gradient in mental health prevalence is much steeper for children and young people than it is for adults (Gutman et al. 2015). As the Marmot Review highlighted, "for children born into poverty, the cumulative impact of poverty intersecting with other inequalities is evident throughout their life course… The effects of poverty on adolescent mental health are severe and cumulative."

The reasons for this relation are complex as poverty and social deprivation intersect with a wide range of social and environmental factors. Social deprivation can cause circumstances which make children more vulnerable to mental health problems: in particular, we know that children who experience deprivation and other forms of disadvantage, are subjected to additional stressors, such as worries about food security. Research by Evans et al (2014) on childhood poverty suggested that "accumulated exposure to multiple physical and psychosocial stressors is a key, unique aspect of the environment of poverty" and suggested this was a key explanation of the link between poverty and mental ill health.

One study which explored barriers and enablers of mental health support for young people from refugee backgrounds emphasised how "addressing practical needs" was an important part of effective support for this cohort (Colucci et al 2015). The study explained how meeting their practical needs had a direct impact on young refugee's mental health; can be seen as "a form of advocacy in itself"; and "can facilitate engagement" with other services, such as education and health services, where there was previously reluctance to engage. Our research did not specifically interview this group, although one of the sites were offering personalised support for them.

In addition, parental mental health and parenting behaviours have a significant impact on the mental health of children and young people and are also closely linked to social deprivation. Another possible reason is that young people's emerging mental health needs can be compounded by poor living conditions related to social deprivation, including poor housing, overcrowding and poorer nutrition.

Children and young people who experience social deprivation also experience fewer protective factors that can facilitate mental wellbeing, such as having secure attachments and trusted relationships with adults, good education, and access to green spaces. Young people who experience social deprivation and other forms of mental health inequality are also the least likely to access high quality mental health services (Beers et al 2016) and face a combination of individual and structural barriers which deter them from accessing support.

Social prescribing schemes, and subsequent evaluations of those schemes, have tended to focus on older people, particularly retired adults at risk of isolation, and nearly all have focused exclusively on adult populations. Although they have focused on adults. some of these evaluations have explored the experiences of people experiencing social deprivation and they are therefore useful for this work. A promising study by Cresswell-Smith et al (2017) concluded that "Activities providing positive social and emotional interactions can offset the negative socioeconomic mental health gradient" (2016). Further research and evaluations of personalised approaches also found that personalised care, particularly approaches which provide social interactions, can be highly effective and linked to improvements in emotional wellbeing, social connectedness, confidence and improved self-

management, and “the benefits have been particularly pronounced for marginalised groups” (Thomson et al. 2015) and ‘complex adults’ (Forder et al 2012). This suggests that personalised care may be effective for young people from these backgrounds as well, although more research is needed.

Research by Singh et al (2019) explored how access to sports, exercise, art and volunteering can improve mental ill health and prevent against worsening mental health problems for young people, however “social problems, such as child poverty can preclude the uptake of such activities.”

While there is limited evidence on the impact of personalised care on the mental health of young people experiencing social deprivation, we examined the existing research which identifies the key barriers and enablers to effective mental health services for young people experiencing deprivation and disadvantage. Studies from the UK and beyond suggest that community-based, informal, flexible approaches which allow young people to be involved in their treatment are likely to be preferred forms of support for young people from deprived backgrounds compared to traditional mental health services and are associated with fewer barriers and higher levels of engagement, which again suggested that personalised care is likely to be a good option for this cohort. One American based study did examine a personalised care offer for young people from deprived backgrounds who were experiencing mental ill health. Laevell et al’s review of nature-based social prescribing for “moms who are minors and economically and linguistically isolated” reported “significant improvements in young people’s wellbeing and reductions in stress and loneliness” (2019).

However, there is currently a lack of evidence across the literature about the lived experiences of young people who have received personalised mental health support, the potential impact of this support, and whether this form of mental health support is more accessible to young people from socially deprived backgrounds and those with overlapping and complex needs; for example, care leavers and those with SEND. We hope this project provides a clearer view of the possible value of personalised care approaches to vulnerable young people, which is suggested but not proved in existing literature; and extends the conversation by focusing in more detail on barriers to support and the interrelation with deprivation.

4. Site information

The sites we looked at used a combination of the following components of the personalised care model:

- **Support planning** - the young person, sometimes alongside their parent or carer, works with a support worker to complete a holistic assessment of their needs and interests, from which a support plan can be produced
- **Different conversations** – an approach to communication and support planning used by support workers in the three sites. Instead of asking young people to talk about their mental ill health, this approach focuses on each young person’s strengths and interests, building on what the young person already knows. It is centred around questions such as

- What do you enjoy doing?
- What does a good day look like to you?
- What could help you have more good days?
- What do you already do? What do you want to do?

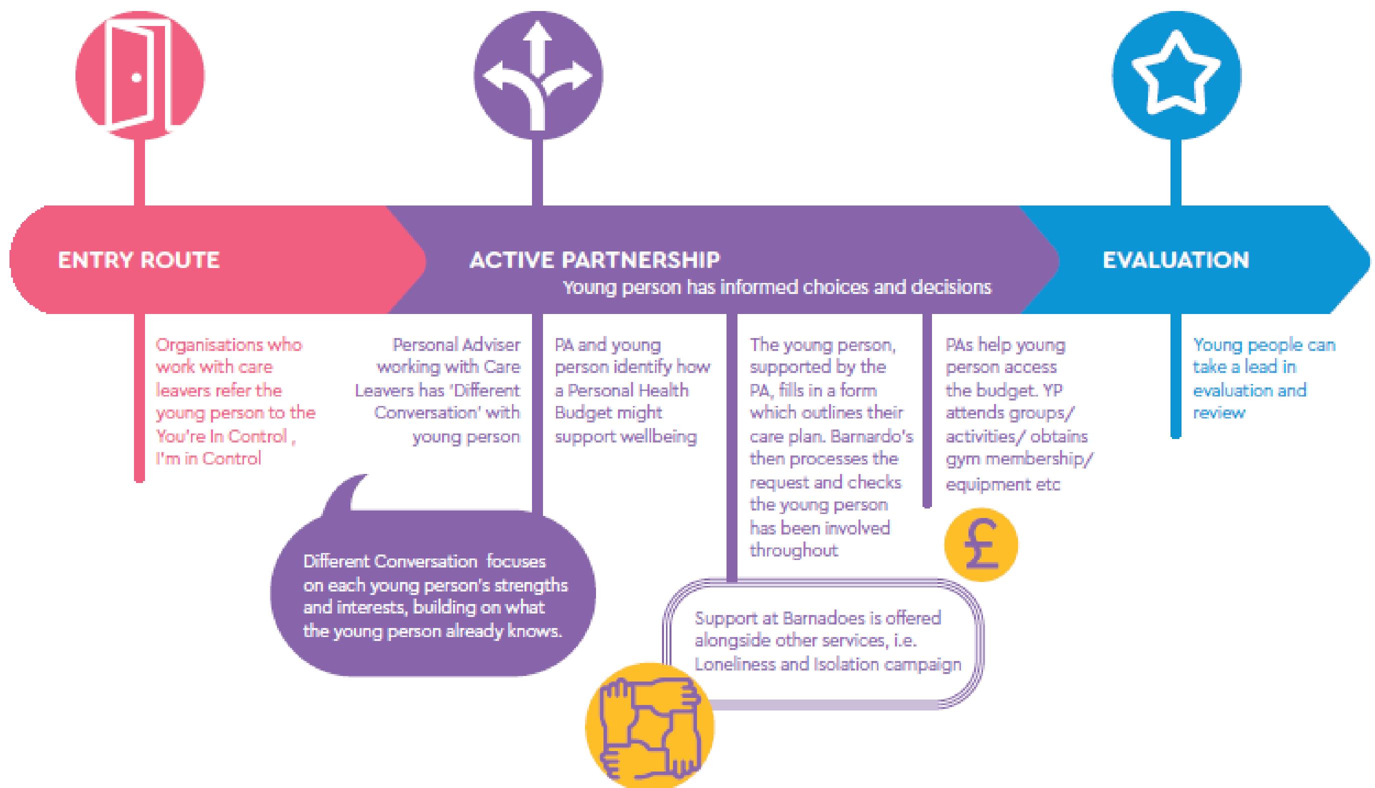
- **Social prescribing**- a system which meets wellbeing needs by referring people to a range of local, non-clinical services which support their holistic wellbeing needs. A support worker will take time to get to know the young person's needs and interests from a holistic perspective, and connect them to a range of community-based support, including social activities, befriending services, art and music groups, learning courses and volunteering opportunities.
- **Personal Health Budget** - a budget which is awarded to an individual to support them in addressing wider issues relating to their mental wellbeing, including loneliness, hobbies, activity level and relationships. Young people are supported to codesign their own packages of support, with oversight from local sites.

Summaries of each project's delivery, incorporating these elements are illustrated below.

Service Name	You're in Control I'm in Control
Area	Bristol
Delivery Organisation	Barnardo's Bristol. NHS Bristol, Bristol City Council
Set up	January 2017
Background	The project began in January 2017, responding to concern about young people who had experienced trauma and were potentially eligible for mental health services but were not engaging with them. It was originally one of the seven demonstrator projects. You're in Control I'm in Control has been delivered through a partnership between NHS Bristol, Bristol City Council and Barnardo's.
Who is it for	Children and young people in care, care leavers, young parents Care leavers, Refugee & Asylum Seekers, age 14-21 in the Bristol area.
Outline of support	Bristol City Council and Barnardo's worked together to offer Personal Health Budgets that promote mental health and wellbeing for Children in Care and Care Leavers in the city, as well as other disadvantaged young people such as young people who are homeless or asylum seeking. Barnardo's administers personal health budgets which are designed to help the young people build skills, gain confidence and knowledge as well as to improve their mental health and combat isolation. Barnardo's formed a coproduction group of young people who helped shape and name the project, and staff were specifically trained up to

	manage the scheme. The dedicated team comprised one full time post and another part time, although this is likely to change. Personal Advisors linked to the project hold a 'Different Conversation' with each young person, after which they populate a form for the suggested purchase(s), which is sent to Barnardo's. Barnardo's check that the young person has been satisfactorily involved in the content of the form and in the process, before allocating the funds. The budgets are typically between £200-300 and young people have chosen to use them on a range of things that help to support their wellbeing, manage emotions, provide a creative outlet or reduce loneliness.

BRISTOL: YOU'RE IN CONTROL I'M IN CONTROL

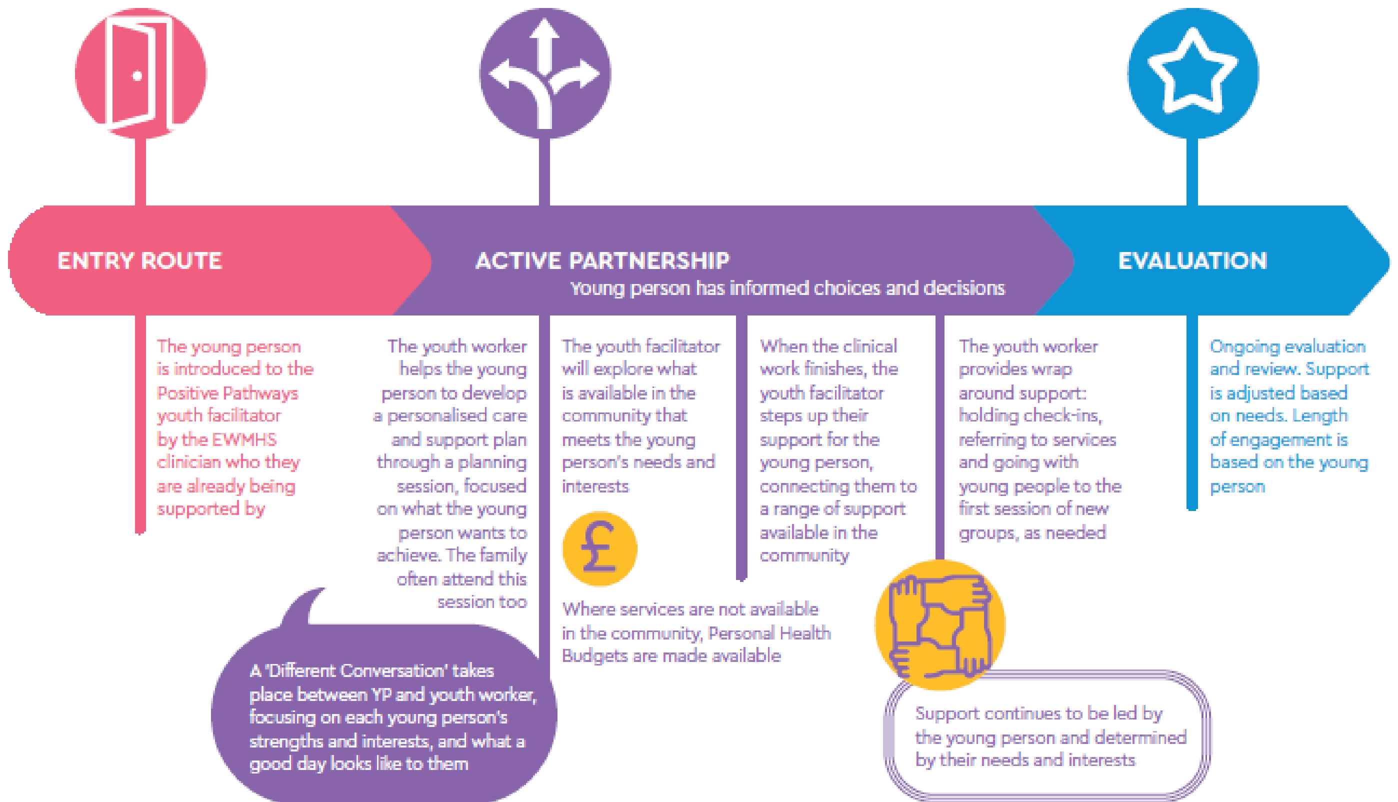


Service Name	Positive Pathways

NATIONAL CHILDREN'S BUREAU

Area	Thurrock, Essex
Delivery Organisation	Thurrock and Brentwood Mind (TB Mind)
Set up	In 2017, TB Mind used a Service Design approach to identify service needs, young people's priorities and co-design the service for Thurrock. Many young people reported that they weren't aware of what resources were available locally, wanted support understanding when they should seek further help, and were lonely, so they became core themes of the project.
Background	Thurrock CCG developed a personalised care approach in response to challenges with their Emotional Wellbeing and Mental Health Service (EWMHS) whereby young people were remaining on therapist caseloads for longer than clinically necessary because of the concerns of clinicians that they were still vulnerable and there was a real lack of follow-up support in the community to meet their needs when they were discharged. The pilot recruited a youth worker through VCS organisation Thurrock & Brentwood Mind, to be based within EWMHS and lead Positive Pathways. The youth worker's role is to develop Personalised Care and Support Plans in conjunction with the young people, their families and EWMHS.
Who is it for	The project is currently open to young people being discharged from EWMHS. Clinicians identify if a young person needs additional community support during their clinical work and can then suggest Positive pathways to the young person and link them into the project. There has been an average of 40 referrals per year.
Outline of support	Positive Pathways currently provides step down support on discharge from EWMHS. The youth worker provides personalised care planning, social prescribing and access to a personal health budget as needed where provision is not available in the community. Support is planned between the youth worker, the clinician, the young person and their family, with the youth worker taking a key role to explore what is available in the community that meets the young person's needs and interests. When the clinical work finishes, the youth worker for Positive Pathways carries on supporting the young person with support available in the communities and will introduce them to other organisations in Thurrock, for example sports, mentoring or a music school. Where services are not available or where young people are unable to access them due to a lack of technology, Personal Health Budgets are made available. In response to the needs of young people, the service co-developed a young people's group as the young people who had engaged with Positive Pathways wanted to be with likeminded individuals.

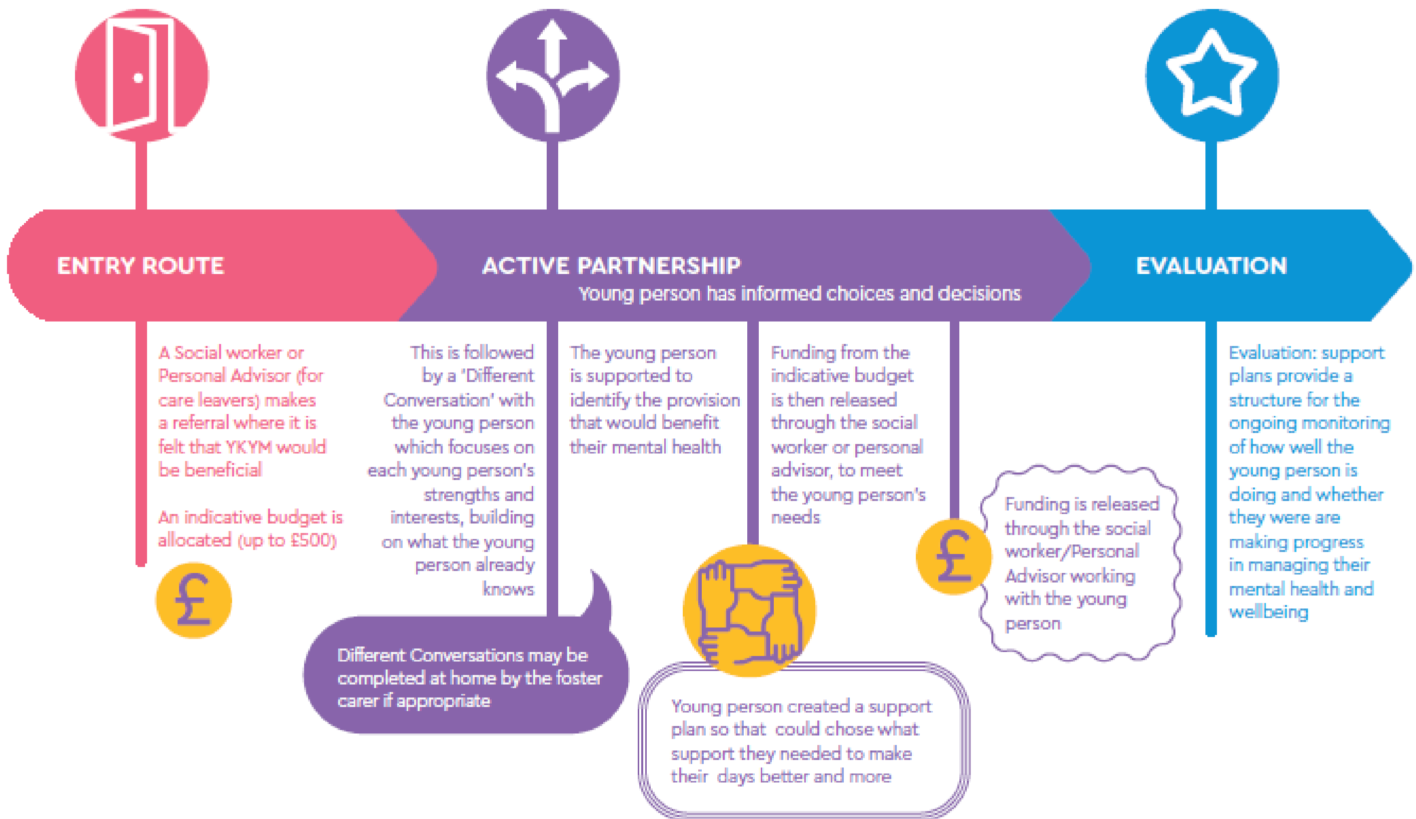
THURROCK: POSITIVE PATHWAYS



Service Name	You Know Your Mind (YKYM)
Area	Nottingham City and Nottinghamshire

Delivery Organisation	Nottingham City Council, Nottinghamshire County Council, NHS Nottinghamshire CCG
Set up	The project was initially set up in 2018 as part of a group of demonstrator sites testing personalised care approached for looked after children.
Background	YKYM project is designed to support young people with mental health needs in the Looked After Care System in Nottingham City and Nottinghamshire County Council. It is delivered through Nottingham City Council, Nottinghamshire County Council, NHS Nottinghamshire CCG, NHS Nottingham City CCG and NHS Bassetlaw CCG.
Who is it for	The project has been targeted at Looked After young people ages 0-25. YKYM does not require a mental health diagnosis as the aim is to reach young people who could have unmet mental health needs. Therefore, it is the social worker or personal advisor who suggest a young person they think would benefit.
Brief outline of support	The project provides personalised care, including social prescribing and personal health budgets in Nottingham City and across Nottinghamshire. The YKYM project uses a range of codesigned templates for each stage of the process from referral to development of a support plan. A Social worker or personal advisor (for care leavers) makes a referral and an indicative budget is allocated (up to £500). This is followed by a 'different conversation' with the young person who is supported to identify the provision that would support their mental health. Funding from the indicative budget is then released through the social worker or personal advisor, to meet the young person's needs., for what the young person requires, through the social worker/Personal Advisor working with them.

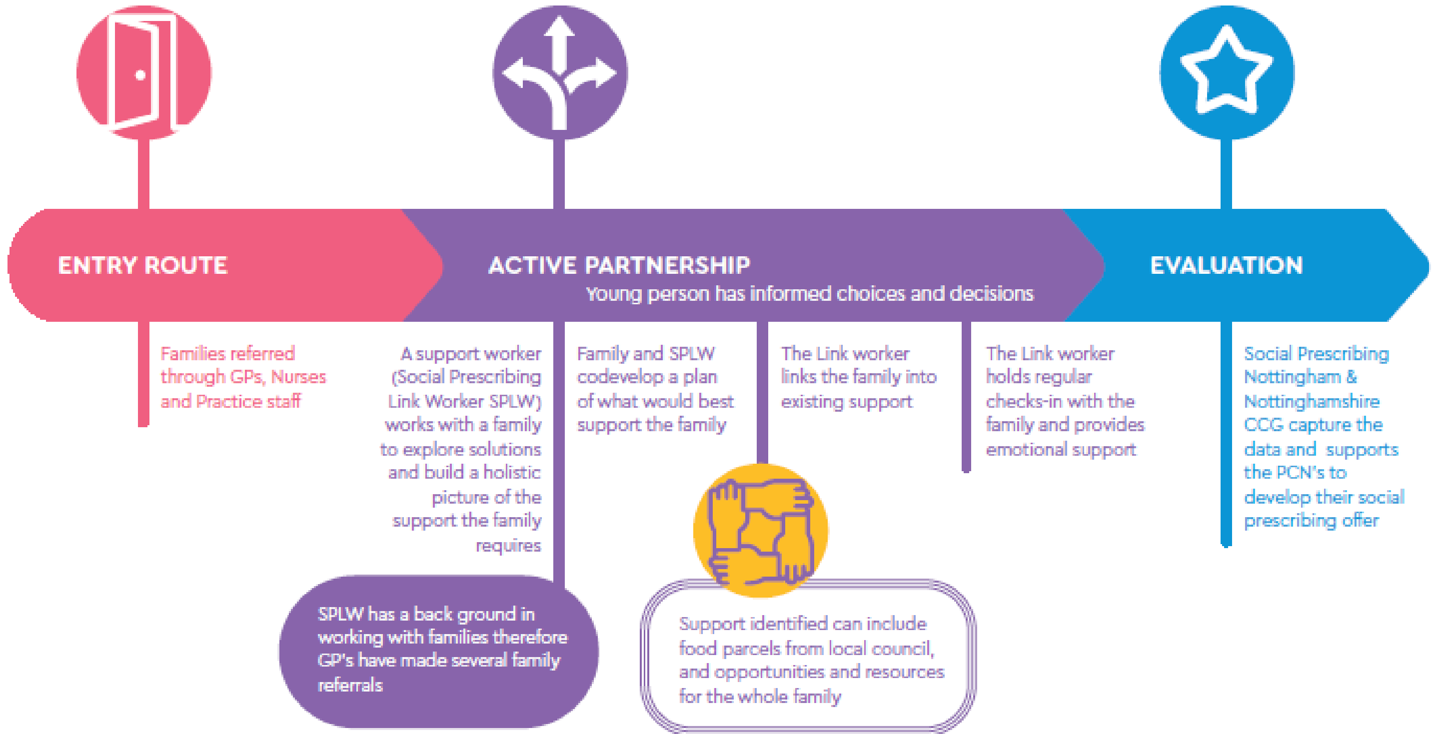
NOTTINGHAM: YOU KNOW YOUR MIND (YKYM)



Service Name	Social Prescribing through PICS Primary Integrated Community Services
Area	Nottinghamshire

Delivery Organisation	PICS Primary Integrated Community Services
Set up	The service was set up in November 2019
Background	The Social Prescribing Link Workers are funded as part of the Direct Enhanced Service – additional re-imbursement roles. The social prescribing link worker in the Nottingham service is employed by Primary Integrated Community Services (PICS). The service delivers Social Prescribing across the Mid Notts Primary Care networks in Nottinghamshire. The Social Prescribing roll out was part of an ICS wide Personalised Care Programme. Each of the 3 CCG's (prior to the amalgamation) were initially supported by a Project Manager to roll out Social Prescribing.
Who is it for	The service supports families with complex social needs affecting their wellbeing who need additional support to live comfortably, including those who experience social deprivation. A range of patients are referred through GPs, Nurses and Practice staff.
Outline of support	A Social Prescribing Link Worker works with a family to explore solutions and build a holistic picture of the support the family requires, and they codevelop a plan. The worker can link the family into existing support e.g. food parcels from local council, and opportunities and resources for the whole family. The support worker holds regular checks-in with the family and provides emotional support.

NOTTINGHAM: FAMILY SOCIAL PRESCRIBING



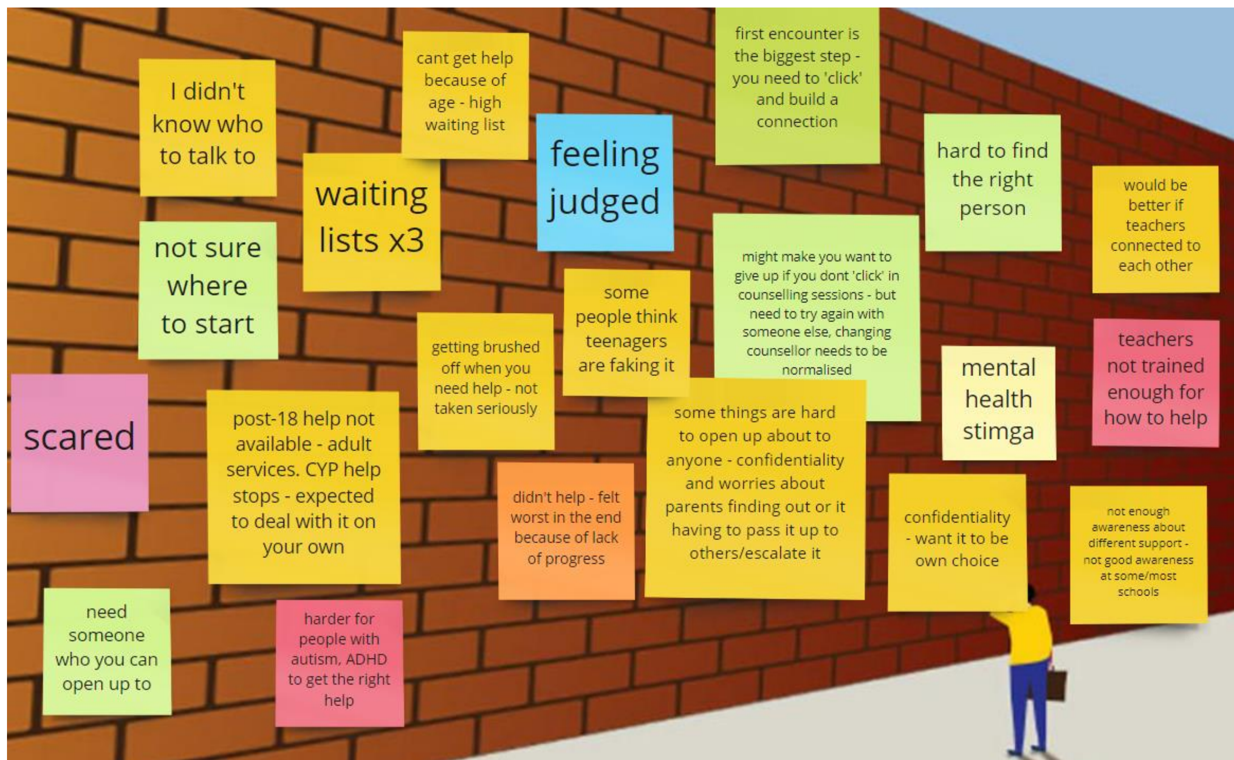
5. Barriers to accessing mainstream mental health services

Before exploring the impact of personalised care on young people from socially deprived backgrounds and examining why personalised approaches are seemingly very effective for this cohort, it is important to understand the challenges these young people have faced when accessing mental health support, and how personalised approaches may mitigate some of the barriers young people report. Existing research identifies a number of key barriers to accessing mental health services for young people who experience deprivation and disadvantage:

Existing research findings	Our findings
Lack of awareness of where to seek help	Not knowing where to seek help
Stigma – perceived and real	Mental health stigma
Shame and embarrassment	Feeling judged
Sociocultural factors, that lead to a preference for self-reliance and informal support	Not knowing who to talk to
Lack of trust in healthcare settings	Lack of trust, fear, Negative past experiences
Complex routes to treatment (which are harder to navigate with language barriers, low literacy or no support)	Service support changes after 18th birthday, Trouble understanding support offered
Poor mental health literacy	Not being taken seriously/seen as 'faking it',
Inaccessibility of services, e.g. clinic times, location, type of support available (i.e. talking therapies)	High waiting times and thresholds Finding it hard to open up
Poor prior experiences, including experiences of discrimination in health settings	Finding the right person
Lack of choice and inflexibility of services	Inflexible services
	Barriers for YP with ADHD and autism
	Lack of teacher communication
	Lack of teacher mental health training
	Lack of MH awareness in schools

Barriers from primary research

The young people we spoke to told us about the range of barriers they experienced which made it harder for them to access mental health support, many of which were similar to the barriers identified in the literature review. These included a lack of options for support, which several young people described as being a 'one size fits all' approach that was unable to understand and properly meet their needs.



Barriers Miro Board from Bristol focus group

One young person explained the CAMHS service they had accessed "didn't understand me and my ADHD," while a young person from a different site explained how it was "harder for people with autism [and] ADHD to get the right help."

A key part of this 'one size fits all' system was how talking therapies tended to be the first, or only, option made available to young people. While several young people continued to be seen by CAMHS and some of them spoke of the positive difference this had made, other disadvantaged young people had found talking therapies to be an inaccessible form of support which had not improved their mental wellbeing, and they criticised the lack of alternative options within CAMHS or EWMHS. One young person explained that it was "hard to tell people how you feel and not just say 'I'm okay,'" while another said their experience of CBT "didn't help" and they "felt wors[e] in the end because of lack of progress." Several young people also explained how the practical set-up of services could act as a barrier for those experiencing disadvantage:

> "Us parents find it really hard to access mental health services because of the [in]flexibility of appointments and childcare and not having that support there to get help." (Young parent and care leaver)

A site professional in Bristol added that, in their experience, young people from deprived backgrounds tended to "find [that] the rigid scheduling of mental health services doesn't work well and they won't turn up at the right place at the right time," pointing out that these young people often had more "chaotic" lives which made attending appointments to a strict schedule difficult, as well as having additional responsibilities compared to others their age, including being young parents or undertaking shift-work.

As in the literature review, several young people explained that their lack of awareness of where and how to seek help was a key barrier to accessing support. One said "I didn't know who to talk to," while another said they were "not sure where to start." This was particularly the case for young people who did not have parental support. A third young person explained there was "not enough awareness of different support" options among their peers, and "not good awareness at most/some schools" which could have helped them.

Two young people mentioned feeling stigma and fear around accessing mental health support: one young person wrote "MH stigma" and another simply wrote "scared" when they were explaining their barriers to accessing help. While these comments are important, feeling of stigma, shame or fear only came up twice across our discussions and was a less prevalent concern among the young people we spoke to than the research suggested.

While much of the existing literature is focused on what prevents young people from disadvantaged barriers from seeking support, several young people told us that the main barrier they faced was not been taken seriously when they tried to access mental health support. Different young people explained their experiences:

> "They said I wasn't unwell enough"

> "[The main barrier] was getting brushed off when you need help – not taken seriously."

> "Some people think teenagers are faking it."

Similarly, several young people told us how they experienced long waiting lists into services when they tried to access support. Three young people from Thurrock and one young person from Bristol all wrote "waiting lists" on the Miro board when identifying barriers, and another added "people not getting back to you within the time that you need." Linked to this, high or restricted thresholds into services meant some young people were unable to get help when they tried. One young person identified "thresholds for services" as a significant barrier, while another explained:

> "You have to get to crisis before someone actually listens."

One young person in Nottingham explained his experiences of being 'bounced' different services where he was told he didn't meet the criteria, leaving him without support despite facing a mental health crisis.

> "They always say young people should ask for help and not bottle things up, but then when you ask for help, they say "not yet". And then they wonder why teenage suicide rates are going up."

Several of the young people we spoke to, including care leavers and young people with autism, were over 18 and no longer had access to appropriate clinical mental health support but instead described a "black hole between children and adults' services." One young person explained:

> "I can't get help because of [my] age". Post-18 help [is] not available – only adult services. Once children and young people's help stops, you're expected to deal with it on your own."

An additional barrier was feeling they couldn't relate or 'click' with mental health practitioners which made it harder to open up. One young person explained it is "hard to find the right person", while another said:

> "The first encounter is the biggest step – you need to click and build a connection… [it] might make you want to give up if you don't 'click' in counselling sessions."

Finally, several young parents told us they were put off of accessing support because of confidentiality concerns and fears they would be judged. One young person explained:

> "It is difficult for care leavers who are parents, to first of all admit, really, that they are struggling and they need the support, because you're constantly feeling like you're being judged."

Another young parent told us they had "confidentiality worries about [services] having to pass it up others/escalate it".

Young people and their families explained how many of these barriers, including inflexible services, trouble understanding and navigating support, lack of trust and high waiting times and thresholds, had been overcome by the personalised mental health support they received, and this is explored in more details in the sections below.

6. Impact of personalised care

While those we interviewed expressed mixed experiences and varying outcomes from clinical mental health support provided by CAMHS, EWMHS or elsewhere, all of the young people and families we spoke to told us how the personalised support they had received had a positive impact on their life and wellbeing, which indicates that personalised support is a highly effective option for young people from socially deprived and disadvantaged backgrounds.

Young people and their families spoke with real enthusiasm about the positive differences in their lives since receiving personalised support through Positive Pathways, You're In Control or You Know Your Mind, and many explained that the reason they wanted to take part in our focus groups was because they were keen to share just how much their lives had changed as a result of this support:

> "It has completely changed our lives. It meant my children could have a Christmas, it helped with their education, with their happiness, with my happiness… it stopped [my daughter] harming herself and it stopped me harming myself because I was also cutting." [Parent]

> "[It] saved my life… I wouldn't be here without R* helping me to see it differently." [Parent]

> "I was so scared… [I] thought I'd have the children taken away and have no purpose." Instead, "It has changed everything around. I didn't think I had anywhere to go but now we're getting back on our feet at that's thanks to [this support]" [Young parent]

> "I feel less stressed, less anxious, I feel able to join in with social activities." [Young person]

> "It has changed my life, I feel I can cope now." [Young person]

Mental health and emotional wellbeing

All 12 of the young people who filled in our impact survey said their mental health had improved, and all 12 said they now felt more positive and happier in their daily life since accessing personalised support. Young people told us they had experienced reduced anxiety levels, reduced compulsive behaviour, reduced feelings of depression, more stable moods, reduction in or cessation of self-harm, reduced suicidal feelings, as well as more general improvements to their emotional wellbeing and mood compared to how they felt before accessing personalised care.

Several young people commented on the changes to their emotional wellbeing via our impact survey, including to say:

> "It [has] had a good impact on my mental health, whilst I've been caring for a little one during the lockdowns too"

> "Yes [the support has made a difference]. I am more content in myself and I understand my emotions A LOT more."

Alongside improvements to mental health and to young people's lives more generally, several key impacts emerged across the sites:

Loneliness and isolation

Young people aged 16-24 are the age group who report the highest levels of loneliness and isolation across the UK population (ONS Community Life Survey 2017), and young people from socially deprived backgrounds seem to experience even higher rates of loneliness, partly due to the ways low socioeconomic status prevents young people from accessing the same opportunities as others, such as attending groups and other socialising opportunities, and makes it harder for them to relate to their peers (Siva 2020). Loneliness and isolation are also closely linked to poorer physical and mental health, with the relationship between mental health and isolation being described as a vicious cycle (Siva 2020). Several of the young people we spoke to from disadvantaged backgrounds shared that the personalised support they had received had reduced their isolation and loneliness and enabled them to connect with others in their community. As one young person from Bristol explained:

> "[It] gave me a chance to slowly reintegrate with society and help tackle the isolation and loneliness I was struggling with. Having had an unstable childhood and then leaving care with mental health difficulties, I had barely any friends and no family network before this."

Another young person told us "it has taught me that I'm not alone even when I feel like I am"

9 out of the 12 young people who filled out our impact survey said they felt less lonely since accessing personalised support, with half reporting that they now felt a lot less lonely.

Access to education, training and further support

Another key impact of personalised support was that several young people had ended up back in education and training and many young people and families were supported to access a range of support services they previously did not receive. Young people and families went on to access education support, carers grants, housing benefits, food parcels, ASD referrals, parent support groups, free school meals and technology grants, which they saw as a result of the personalised support they had received. One young person explained they had been "referred into different services, support agencies and groups" as a result of their involvement with one of the sites.

Another young person told us how the support had "opened up opportunities like college" and another said that without this support "I wouldn't be at college, I wouldn't be doing my volunteering". Young people from deprived and disadvantaged backgrounds are disproportionately likely to be NEET and face significant barriers in accessing support, so it is notable that this form of support enabled several young people to re-enter education, training or employment and to access support when they had previously felt unable to do so.

Skills and confidence

Several young people also explained that the support had improved their skills and confidence. 11 out of the 12 young people who completed our impact survey said they felt more confident after accessing support. The young people we spoke to also felt they had developed a range of life skills since receiving support. One young person explained "I have learnt new skills like how to cook different meals", while another highlighted how accessing a PHB had "helped with my budgeting".

Other impacts

Many young people had developed positive coping strategies, including breathing exercises, mindfulness, crafting activities and exercise, and felt more able to manage their own conditions as a result of the support they received. 10 out of 12 young people said they felt more able to make good decisions about their health and wellbeing after receiving personalised support.

Finally, young people told us they had experienced a sense of hope since receiving this support, some of them for the first time. One young person explained "it has given me the determination to carry on", and 11 out of 12 young people said they now felt more positive and hopeful about the future.

Overall, it seems clear that personalised care, both social prescribing approaches and PHBs, had a significant and positive impact on the lives, mental health and wellbeing of the young people we spoke to. In the rest of this report, we will examine what it is about personalised care approaches in general and about these three sites specifically that made them so effective at improving the lives of young people from socially deprived and disadvantaged backgrounds, and which led to them being so highly regarded by the young people we spoke to when other forms of mental health support were referred to in mixed or negative terms.

7. Strengths of personalised approaches for disadvantaged young people

There are many aspects of personalised mental health approaches which were valued by the young people and families we spoke to, and which explain why personalised care approaches seem particularly effective for young people from disadvantaged backgrounds. Among these strengths, which are explored below, personalised care approaches were seen as more flexible, informal and less boundaried than clinical work, which seemed to be particularly valuable for young people with complex experiences whose life patterns did not fit with mainstream services.

Young people also valued the holistic nature of support, which some did not see as a form of mental health help, but as a way of them becoming more involved in their local community. Crucially of course, social prescribing approaches and personal health budgets (PHBs) helped young people to access things that benefited their wellbeing which they would not otherwise have been able to access or afford, and in that way helped to address some of the mental health inequalities faced by young people from socially deprived and disadvantaged backgrounds.

a) Personalisation

The young people and families we spoke to valued the way the support they received was tailored to their interests and needs. When asked what the best part about the support they had received was, many young people across the three sites focused on how personalised it was, commenting:

> "we all get our own individual needs met, because my needs aren't the same as [others]"
>
> "the best thing is… it is able to fit to your needs and be unique to you."

This flexibility was in contrast to other forms of support which were described as 'one size fits all' and as approaching young people as if they were cases in a textbook, rather than as individuals with individual needs and experiences. One young person explained how the experience of being treated as an individual had made him feel valued, including through person-centred planning conversations with a support worker, and receiving provisions from a PHB that was tailored to him, in contrast to previous experiences where he felt "just lumped together with others who were similar to you on paper, just because you are all adopted" and was offered unsuitable support.

A young person in Bristol emphasising how crucial a personalised approach was for them, and explained that:

> "they took the time to research my ideas and activities and came back telling me all my options. This is why I think the personal health budget was used in the most efficient way. Had they not been so person centred and took in my needs and wishes, I think the personal health budget would not have made any positive impact on me."

Similarly, a young person in Nottingham explained that the best thing about the support was how "R* [support worker] actually listened and could adapt the support to us", which was in stark contrast to support he had received from other services which were inflexible and had not taken his needs or preferences into account.

Young people talked about the importance of personalisation in relation to their interests and preferences, for example being able to choose to do music lessons and pick which instrument they

wanted to learn rather than having a particular support group prescribed to them. However, the critical importance of a personalised form of support was highlighted by young people when they explained how they felt mainstream services could fail to understand and appropriately meet their needs, particularly for young people with ASD and ADHD, for young carers or young parents, and for those who had experienced the care system or abuse. One young person felt CAMHS "didn't understand me and my ADHD", whereas the support worker they had accessed as part of a personalised approach had taken the time to truly understand how their ADHD related to other parts of their identity, and to plan support accordingly. Similarly, one parent explained:

> "one approach just isn't suitable. In the children's service, with the therapists, there needs to be a recognition of their differences… it's very different for each of them."

In contrast to their previous experiences of the inflexibility of CAMHS, the support their child had received through Positive Pathways "does recognise every child as an individual. It's just amazing."

Personalisation can improve experiences of mental health support for young people from a range of backgrounds, and research by Gondek et al found that "inflexible treatment provision [is] a major barrier in child and young people['s] mental health services" (2017). However, it seems to be of particular value to young people from deprived and disadvantaged backgrounds who experience poorer outcomes from mainstream services and who often have complex and intersecting needs which fall outside the thresholds of other services.

Research into the experience of adults from BAME and low-income backgrounds concluded that non-personalised mental health services are "not equipped to understand [their] needs, beliefs, [and] backgrounds to be able to provide appropriate care and support" (Memon 2016). Research into mental health support for young people from refugee backgrounds similarly concluded that in order for mental health support to be effective for this cohort, "it cannot use a one size fits all approach" (Colucci, 2015). Our research with young people suggests this is likely to be equally true for young people who experience social deprivation and multiple disadvantage, as well as for refugee and asylum-seeking young people.

Receiving personalised support also had more indirect benefits, and several young people explained how the process of receiving person-centred care had made them feel understood and cared for, in a way they hadn't experienced from other forms of support:

> "to know that somebody cared so much to understand me and to help me how I needed… it broke me."

b) Practical support as a Benefit of Social Prescribing and PHBs

Social prescribing approaches and PHBs budgets provide items and experiences that meet health outcomes, agreed and signed off by the relevant NHS clinical team, and which young people from socially deprived backgrounds would otherwise not be able to access / afford. Across the three sites this included arts and crafts materials; bus passes; driving lessons; laptops; musical instruments; a cooker and children's toys for a young parent; sports equipment; gym memberships, and more.

Sometimes funding is used for items which directly address specific mental health symptoms, such as a 'Mindful Colouring' activity book to reduce anxiety, a fidget cube to help a young person with ADHD, and a distraction box to reduce self-harming. More commonly however, things are provided which meet the broader, practical needs of young people in other areas of their life.

We spoke to one young person who was a care leaver and young parent, who had no means of cooking after her cooker had broken and she could not afford to replace it. This was contributing significantly to feelings of stress and low mood, particularly as she was looking after very young children without being able to cook or heat food. She was provided with a cooker and some simple cooking equipment through her personal budget, and felt this had a significant impact on her wellbeing.

A parent in Nottingham used their personal budget to access electric top ups for their home and a bed for their teenage daughter who had severe mental health needs. This allowed them to heat their home in their winter and improved their daughter's sleep, and they explained this improved the mood of the whole family and 'helped loads' with their feelings of despair and worry. They had also been supported to complete a referral to a fuel poverty service, which illustrates how short term, practical support can be particularly effective alongside support to connect young people and their families to wider, ongoing services. In these cases and others we heard about, young people's practical needs were caused by the material deprivation they faced, which highlights why personalised support can be particularly impactful for young people experiencing disadvantage.

Respondents from all sites valued how this practical support helped them address factors in their life that were causing significant stress. Evans et al research (2014) cited above highlights why it is so important for personalised support to mitigate against the multiple stressors young people in poverty experience in order to reduce mental health inequalities for this cohort.

As well as meeting areas of need and reducing stressors, social prescribing approaches and personal health budgets (PHBs) provide practical items and experiences which act as protective factors against poor mental health. Research by Singh et al (2019) cited above concluded that approaches which facilitate engagement in those activities "can help to "address child health inequalities." The young people we spoke to had similarly benefited from being able to access these protective activities, which they otherwise would not have had the opportunity to undertake due to their socioeconomic background:

> "[T]he personal health budget helped me a lot because at first I wanted to go to the gym [but] being on benefits, I couldn't afford £30-something a month to be able to go. [Accessing a gym through social prescribing] helped me control a lot of my anger and a lot of my emotion"

> "I used the personal health budget to purchase art and craft supplies, I could express myself through drawings and paintings. It helped keep me in a good mindset whenever I was struggling,"

Young people were also given support around transport, such as bus passes or driving lessons, which reduced their isolation and improved their mental wellbeing. Young people experiencing deprivation often struggle to afford any form of transport and often can't rely on parental support to access activities, in a way that other children and young people might take for granted. As a result, being given access to a bus pass or driving lessons had a significant impact on their wellbeing, and young people told us:

> "I can go on any bus I want now. How life changing is that?"

> "It [has] given me something to look forward to and something to keep me focused… I feel like freedom is so close and I'll be able to go and see my family and actually be able to do things with my daughter." (Young person describing their driving lessons)

Many of the forms of support provided, including crafts supplies and bus passes, were low cost investments yet they had a significant impact on the emotional wellbeing of the young people we spoke to.

c) Choice and control

Young people reported that one of the most important aspects of the support received was how they were allowed to make decisions. Two aspects of choice and control were important across the sites we looked at: firstly, the ability to shape and choose the support that was meaningful to them through a PHB or social prescribing conversations, and secondly, the chance to coproduce and have some control over the service itself in Bristol and Thurrock.

The young people we spoke to said they wanted to be involved in the care they received and have a choice in the way it was delivered but had not had the option to do this in other forms of mental health support. Having choice and control over their support options seems of particular value to young people from socially deprived and other disadvantaged backgrounds, who often have been given little agency in decisions about their own life and who told us of times they felt disregarded by the other support services they received. Existing research also shows that "lack of personal control over their treatment and future plans" can be a key barrier to accessing support for young people living in poverty (e.g. Darbyshire et al 2006) for 'at risk' young people, including homeless young people and care leavers (Brown et al 2015), and for young people with special educational needs, where it was reported that almost a third were discouraged from continuing to access mental health support due to a lack of choice and joint decision making (Anderson et al 2017).

The importance of choice was also emphasised in our focus groups. When asked what they would change about mental health services in England, responses included:

> "Where you don't get just chucked into CBT therapy, or you don't just get dashed into the trauma therapy, or counselling, or anything like that. I feel like you should sit down with the young person and be like: what do you think works better for you? Is it a physical activity? Is it a talking therapy?"

A parent similarly explained that they were "just offered drugs" for her son who was dealing with mental ill health and ADHD; her son wanted to learn "different ways of coping" and didn't want to take medication but "was refused it and told that it was bah humbug, basically, and that the only thing that would help him would be to have the drugs." Instead, they had eventually found Positive Pathways support in Thurrock and her son had been able to have a say over the support he wanted to receive, based on his interests, needs and preferences; he was now "thriving."

In Bristol and Thurrock, the personalised care services were coproduced and had evolved based on the feedback of young people. When the project was initially being developed in Thurrock, the service design project worked with 76 young people in order to gather their priorities and test ideas for support, to ensure young people had a say and a choice over the project. In another area, the site coordinator brought groups of young people together to ask whether the materials they used for care planning were accessible and asked the right questions. They were then redesigned based on young people's feedback, for example using a cartoon to communicate the young person's journey. Similarly,

a youth group that was developed in Thurrock was not part of the original proposal, but had been developed in response to feedback from young people who wanted to speak to others who had experienced the same support.

Young people in Bristol expressed that they didn't want the care leavers service to decide what the support looked like and they chose to name their service "You're in Control", which helped them feel a sense of "ownership" and control over the support they received. Young people were also involved in naming the services in Thurrock. In Bristol, some young people had also been trained to volunteer and be part of the delivery of the programme, offering peer support to others, while continuing to be supported themselves. In these ways, the idea of choice and control over their treatment was extended beyond their own support options, to having a role in shaping the service itself.

d) Community-based support

Another aspect of personalised care which can make it particularly valuable for young people from deprived backgrounds is that it is based in the community rather than in clinical settings, and is often seen as a less formal and more accessible form of support as a result.

While young people had a range of experiences of other forms of mental health support, even the young people who said they had hugely benefited from CAMHS/EWMHS explained that accessing support in clinical settings had been "a bit scary," and they had found it "hard to open up" in that environment. In contrast, young people described the support they had received from the three sites as being "informal and light hearted," "supportive, really 'normal', just great" and one said it had felt "like a family" in that it felt caring and put them at ease.

Many young people from socially deprived backgrounds have particularly low levels of trust in mainstream mental health services due to prior bad experiences, concerns over being judged and disrupted provision (Collins 2009), and for those who feel that way, the way personalised approaches are centred on community provision and sit outside of clinical services is particularly valuable. Several parents from disadvantaged backgrounds told us they felt judged and blamed by CAMHS, EWMHS, schools and other statutory services, with one saying that they had been told "It's your fault. You're not doing this. You're not being strict enough. You're coddling him too much" when trying to seek help for their child's mental ill health. Another parent told us "I strongly believe that we were hugely let down by services and by schools" and a third told us about "the blame game" she had experienced. Parents told us how their children had also lost trust in statutory and other services due to long waiting times, broken promises and the same feeling of judgement and blame:

> "the children feel let down by adults [in education and mental health settings] … once that child is let down, the trust is gone"

Several care leavers also expressed low levels of trust in clinical services and reported feeling judged when accessing support, and some young parents expressed particular wariness of statutory services because "[I] thought I'd have the children taken away". The experiences of the young people we spoke to chime with the existing literature which highlights how young parents, refugee and asylum-seeking young people, LGBT young people, homeless young people and some other young people from deprived backgrounds do face more frequent incidents of discrimination when accessing health services, and report higher levels of distrust in services than other young people (e.g. Collins and Barker, 2009, Yardley 2008, Bachman and Gooch 2018).

Young people across all three sites tended to see the support worker and the support they had received as coming from "outside" of the system, and it therefore did not have the same negative associations as clinical and statutory services. There are a number of reasons the sites were seen as sitting outside of "the system", one of which was because support was delivered by voluntary sector organisations rather than just statutory services. The informal approach of the support workers also helped to set the projects apart from clinical interventions, with support being described as "informal", "genuine" and less "boundaried" than clinical work.

A key reason why these projects were set apart from other forms of mental health provision was because of the social prescribing approach which connects young people to a range of non-statutory support in the community. In Thurrock in particular, the young people did not really see the scheme as a form of mental health support, but as a more holistic project which was about being active in the community, and several of them did not see themselves as service users but as a part of the project. By framing the support offered as a way for young people to be involved in, and even to give back to, their communities, these approaches helped destigmatise receiving mental health support and turned receipt into a positive, empowering thing.

One young person highlighted the importance of support seeming to be outside of the education, social care and health systems, explaining:

> "Before I joined this group, I had been through so many different counselling organisations and the amount of services and people that have [referred me to] this group thing or that group. I turned down every single one."

When asked what the difference was this time, he replied:

> "she [support worker] isn't forcing us. It's about my own choices… It is thoughtful and kind… It's not like school [where] I've been brushed off so many times."

It is for that reason that research by Beers, Hodgkinson et al. concluded that moving mental health care out of statutory and specialised mental health settings and into the community "is the most promising means of increasing access to mental health care, particularly for children from low income families" (2017) and a review of ten studies into mental health provision similarly found that "providing mental health services in easily accessible…non-clinical settings… is an effective strategy to increase access and engagement for users from hard to reach groups" (Anderson et al. 2017).

e) Holistic and integrated approach

Another strength of personalised mental health approaches for this cohort is that they offer holistic support, with person-centred conversations exploring all aspects of a young person's life and needs. One young person explained that the best thing about the support they had received was that it:

> "thinks about all the different things that can affect the young person's life and not just our clinical mental health."

One site coordinator explained that they started the process of support by helping each young person complete a wide-ranging survey, which includes sections on how the care plan could address their social life and relationships. They were concerned by the high levels of isolation experienced by young people from disadvantaged backgrounds due to the combination of mental ill-health and income-related barriers to engagement with existing activities. The site coordinator noted that while most mental health care plans focused on mental health needs, and some may also explore access

to education, there was a gap in holistic support, and support around relationships and social opportunities, which can have a profound impact on mental health outcomes.

Young people explained that other services tended to have strict dividing lines between what they could and could not talk about and help with, with some services only supporting their social care needs, others only supporting their mental health needs, or on their experience of being care leavers etc. The support received from each of the three sites had an integrated approach, and, as highlighted below, young people talked about the way in which holistic support had an impact on their physical health, confidence, family relationships, loneliness, education, as well as their mental health.

Many young people from socially deprived backgrounds have overlapping and complex needs and have had engagement from a range of statutory services. Several of the young people spoke about being in a near-constant process of referral and re-referrals to various specialist services, none of which were able to support them across the breadth of their experiences. One young person explained:

> "other services see problems as if they are in a textbook, and when they can't help you, they pass you onto new services and you have to begin all over again."

A parent in Thurrock similarly explained "you just go round and round as parents, round and round."

Another young person spoke in some depth about his experience of being "bounced" between services, where he had to explain his background and "retraumatise" himself repeatedly, before being told he didn't meet the service criteria or was "too complicated" for a particular service. For example, Tom[1] was referred to a counselling service which said they were not able to deal with issues arising from his experience of adoption and care, and then referred to a care leavers therapy service which said they were not trained to deal with conversations around childhood sexual abuse, and then to an adoption specialist service who referred him back to mental health support. Until receiving a personalised approach and PHB, he felt services saw aspects of his past experience as separate issues requiring separate treatment, rather than looking at him and his experiences holistically:

> "It makes no sense to say I can talk about my day-to-day mood but not my adoption, or adoption but not the abuse. I think about all these things every day – but they all specialise in these different parts. It needs to be joined up."

This experience of falling between the gaps of services was mitigated by a personalised approach to mental health, which starts with holistic conversations about all aspects of a young person's life. In Tom's case, although his experiences were complex, the approach which helped him was not: what he wanted was to be able to talk about all aspects of his life and wellbeing. The support he benefited from was not complex either: he was given a gym membership to help him be active, was able to access transport and was supported to volunteer with younger people where he intended "to be the person I never had myself". A young person from a different site explained that being able to talk about their mental health, their experiences as a care leaver, and their needs as a young parent in one space made them "feel fully accepted".

[1] Not his real name

8. Enhancing the personalised care offer

As well as highlighting the aspects of personalised care which are particularly valuable for young people experiencing social deprivation, our conversations with young people, families and professionals emphasised additional features of the personalised care offer which are not necessarily part of every personalised care approach but which were key to ensuring the offer worked as well as possible for young people from disadvantaged backgrounds across the three sites. We have therefore pulled out the key characteristics of the sites which enabled the personalised care offer to work as well as possible for young people, which hopefully can inform the development of personalised care approaches for this cohort in other areas. The personalised care offer was enhanced through the role of a support worker; peer support groups; flexible entry and exit points; self-referral options; a whole family approach; and the use of VCS organisations, all of which are explored below.

a) Support worker role and ability to build trusted relationships

By far the most valued aspect of the personalised support received was the role of the support worker. Several young people went as far as to say they would not have benefited from a PHB if they had not had a support worker to guide them throughout. One young person in Nottingham explained having weekly one-on-one time with a support worker had been significantly more useful than the provision he had received from his personal budget. Due to cuts in the programme, his access to a support worker had been cut and he had struggled to cope as a result. He asked:

> "Why is there money for these… material things, [but] not to pay for a support worker? Surely some of that money would pay for someone who could actually give us some 1-to-1 support."

Likewise, the project in Bristol had reduced the hours a support worker was available to the project and one young person explained that this worried her because she had particularly valued "doing the intense work and the holistic work with [the support worker]" and thought "it's not effective if it doesn't have a worker".

Young people told us about the qualities they valued in the support workers in each of the sites, repeatedly highlighting that they were "non-judgemental", "warm", "informal", "encouraging but not forceful", "consistent", "friendly" and "authentic". One participant explained that that they valued how the support worker was "real", not "textbook" in the way they related to each young person, and how she was able to develop a positive relationship with the young people she supported:

> "She relate[s] to me as a real person, she saw me as Mark,[2] as a person, not as a number."

[2] Not his real name

The importance of using 'paraprofessionals' such as youth workers or family navigators to improve the reach of mental health support for young people from low income and "at risk" backgrounds has previously been established (e.g. Hodkinson et al. 2017) and research by Carmill et al. (2009) highlighted how youth and support workers were able to connect with young people who were otherwise disconnected from mainstream services "by being highly accessible", "befriending" them, "and acting as advocates." The young people we spoke to also highlighted these characteristics as being key to building the trust needed for young people to open up.

While the role of a link worker is a key part of most social prescribing approaches, the Support Worker role across the three sites we looked at extended beyond that. In this context, support workers are a key, trusted point of contact who the young people spoke to regularly, not only to help them develop a care plan and access social prescribing or a personal budget, but to have broader conversations about their wellbeing. They hold informal check-ins; remind young people about their appointments or send them encouragements via text when they know the young person is struggling; attend sessions with young people where needed; facilitate group activities; and help them to think through and access a wide range of support across the area.

Support Workers were seen to help young people to understand and get the most out of the personalised support offer and wider system, both of which can be inaccessible for young people experiencing social deprivation and complex for those who do not have other forms of support. One young person explained:

> "Can help you access a lot of different things that you need professionals to access."

Others valued the "wrap around" support the support worker offered throughout their journey of accessing support. A professional in Bristol explained that many of the young people who accessed a personal budget for their mental health required a significant amount of support to fully benefit from the provision. For example, if a young person chose a gym membership, they may need support to sign up, to find or acquire the right identity documents, to arrange an induction, encouragement to go and a check-in afterwards to see if anything needed to be adjusted.

Support workers also adopted a care navigator role, following up on individual young people's cases to ensure they were not lost in the system. This is particularly valuable for young people with mental health needs from socially deprived backgrounds who tend to have poorer knowledge of support systems and lower mental health literacy, as well as for those without parental support. One young person from Thurrock explained:

> "There is no one else like [the support worker] … she's always there for you. When I got discharged from [a service], she made sure that I was still with the system, if that makes sense, so I wasn't really forgotten about."

Another young person in Thurrock explained that the difference of having a support worker attached to the project was:

> "Not having to fight for everything and then having to do it yourself, because no one else will bother helping you."

Young people explained how the consistency of support from the support worker encouraged them to keep accessing help, even at times when they wanted to give up. While some young people had dropped out of other forms of support, refused to attend, or been discharged after not attending, the support workers across all three sites offered persistent encouragement, and did not discharge young people from the service if they missed appointments. One parent explained:

> "[The support worker] has just been a lifeline. She helps remind Sam[3] [about classes and support] because… he forgets everything. Without her carrying it on, Sam would have just been chucked back into the fishpond again."

One young person explained how the support worker's regular check-ins and ongoing support "helped me get on the right path and stay on it". Another spoke about how the constant, gentle encouragement from the support worker had made the difference in encouraging him to access support:

> "It opened up more doors to things... [The support worker] starts off by easing me into something… I never liked one-on-one sessions until she kept telling me to do it… The only reason I agreed to do [the youth group and a music group] was because she's just so encouraging"

The role of a support worker helps to enhance a truly personalised approach, as they have the space and time to get to know a young person holistically and develop a trusting relationship with them in a way that is difficult to do if conversations are focused narrowly on their mental health needs, contained within strict time limits or will end after an 8-week intervention, as in some clinical settings. As a result, the young people felt truly understood by the support worker and explained that they were able to access more appropriate support, based on how they truly felt:

> "When [support worker] sees things that make her think you'll particularly like it, she can share that with you because she knows you and what interests you"
>
> "If someone knows you properly, they know how you really feel and can really help"
>
> "She knows when we're down as well. She can just tell straightaway."
>
> "It's literally just having that bond with someone, knowing you can actually trust them to tell them… everything. If you just tell them little bits of something, they're not going to understand."

Some young people we spoke to from socially deprived backgrounds explained they had not previously experienced an adult in their life who took the time to understand them and think about what might help them thrive, and as a result, they had never really opened up fully.

Finally, the support offered by support workers was more flexible and less prescriptive than other forms of support they had experienced, and in some sites support included check-ins via text and

[3] Not his real name

email, informal drop in sessions, and responsive support. As a result, one young person felt the support worker "is always there for you", while another explained:

> "I know that even if I feel like I have no one to go to, I can go to [support worker] … Even if you felt your struggle was the most stupid thing in the world and you went to [her], she would be there and she would help you with it"

This was in contrast to their experiences of other forms of mental health support which had often been characterised by feelings of disappointment, mistrust and frustration.

b) Support groups/peer support

Young people, parents and coordinators in Thurrock and Bristol emphasised the huge value of the peer support groups which had been set up for the young people who were accessing social prescribing or PHB support. The peer support groups were opportunities for young people to access support from the support worker in a group setting, but also to share challenges and successes with each other, meet other young people their age, and have fun together. Young people, parents and the site professionals explained that the groups helped young people feel included, increased their confidence, developed social skills and reduced loneliness which was particularly valuable for the young people with autism and learning disabilities, and for young parents, who explained they were particularly isolated.

One young person in Bristol explained that the peer support group:

> "gave me a chance to slowly reintegrate with society and help tackle the isolation/loneliness I was struggling with. Having had an unstable childhood and then leaving care with mental health difficulties, I had barely any friends and no family network."

One young person in Thurrock shared that the group had helped them to 'come out of my shell' and feel confident talking to others, adding:

> "That's kind of why I started [going to] the group… to have the few hours of social interaction that I didn't give myself outside of this"

Another added:

> "I love meeting every month… The group has given me a wider opportunity of things to do, outings, meeting up with an individual worker or zoom calls where we bake or do quizzes"

In Bristol, the scheme also includes befrienders, who help other young people to engage fully in the support and develop their socialising and interpersonal skills.

As well as reducing loneliness and improving social skills, young people valued having a space to talk to others who were also experiencing mental health issues and similar challenges around deprivation and disadvantage. They were able to relate to each other, and the groups were felt to be safe, supportive spaces:

> "Even if you're completely different to the person on the other side of this screen, we're all together as a family. I think that's what makes us unique. It doesn't matter what you

> look like, what you enjoy, what your favourite food is, everyone here will love each other the same. It's so accepting"

One parent of a young person in the Thurrock group explained:

> "He absolutely loves the groups. He can really relate to everyone in there, because they all have similar problems. I love the fact that they all back each other up. They all support each other. "

Whilst peer support groups are not part of every personalised care offer, they were highly valued by everyone we spoke to and were felt to play a key role in the effectiveness of the support young people had received.

c) Different conversations

The "different conversations" approach explained in section 5 was also seen to be of particular value to young people from socially deprived and disadvantaged backgrounds because of its use of accessible, de-medicalised language and its focus on strengths and solutions.

Several young people we spoke to shared that they had trouble opening up to professionals during standard assessments and treatment, and several also explained that they often didn't fully know or understand how they were feeling when asked. One parent also explained:

> "Even when we were going through the counselling, they really weren't much help. Where they don't understand their feelings, they can't talk. They can't express it. With counselling, it's a lot about the talking… Even if there was a problem, every week it would be, 'How are things?' He'd say 'fine', but they're not fine. It was never fine…"

Starting with questions such as 'what do you enjoy doing' and 'what does a good day look like to you?' helps to develop a personalised support plan that meets their needs and interests, without putting young people on the spot. Several young people in the Bristol group highlighted the benefit of this approach, some referencing 'different conversations' specifically:

> "It's called a different conversation because you're not asking, what would make your mental health good? It's not such a direct question, it's a question like, what would you see as a good day?... I think the whole process worked really well, the different conversations"

> "It's almost enlightening, the questions that they ask you, because you're just like, why have I not been asked something like this before?... Instead of asking what problems, they're asking what could the solution for this be"

Site professionals in Thurrock and Bristol explained that they use videos or drawing during these conversations to explore what young people like and evaluate how things are going, which illustrates how accessible an approach this can be for young people who find it hard to open up in different ways.

d) Responsive support

The sites were set up in a way that enabled them to provide support and respond to young people's needs quickly. This contrasted with young people's previous experiences of long waiting times, which could also increase the risk of young people not attending services at all because by the time the appointment came around, they no longer felt desperate enough to take up the support:

> "You might feel what you feel today, that I'm really sad, then when the person finally contacts you, you might not feel that feeling anymore"

For those who did attend CAMHS or other services, the long waiting times decreased their trust in the system and contributed to their feelings that they were not being taken seriously, particularly when they felt they had been left waiting when in crisis.

In contrast, the support they received through the personalised care offer had "no long waits" and one parent felt that the difference was:

> "You haven't got to go banging on a load of doors to say, 'Can someone please help me?' Now, the [support worker will] do it right away"

The responsiveness of support across the sites was facilitated by strong relationships with other services and teams across the area, and strong buy-in from commissioners which meant that support could be quickly provided when needs were first identified. The site professional in Thurrock explained how the commitment of the commissioning team, including their finance team, and their flexibility and availability to the project had been central to the effectiveness of this work. The commissioning team and Positive Pathways team had codesigned a wellbeing plan template which allowed commissioners to quickly consider funding things on an individual basis. Senior level buy-in from the project and regular contact between commissioners and those involved in the project helped continue this relationship and allow the service to respond quickly. However, we would need to consider whether this responsiveness can be preserved if the social prescribing and PHB scheme became more established and widely marketed.

Good relationships with other services, and the dedicated support worker role, also helped the service respond quickly. As one example, during lockdown the young people had really wanted to meet in person and the team were able to quickly conduct risk assessments, work with other services to provide transport and with commissioners to fund individual transport arrangements, and work with the Parks team to find space so they could set up in-person meetings quickly. This was very positively regarded by the young people, who enjoyed meeting together but also valued how they were listened to in the process.

e) Flexible and gradual entry and exit points

Another aspect of the personalised care approaches we looked at which enabled effective care was the flexible entry and exit points for services. In terms of entry points, young people described the project as "super quick to get into", with "no long waiting lists". Many young people explained how their previous experience of mental health services had involved complex routes into treatment and long waiting times, and staff in each of the three sites we looked at explained they wanted their personalised care projects to feel like a different experience for young people.

Several young people also talked about the problem of having "a blank page" every time they were referred to a new worker or new mental health service, where they would have to explain their history, circumstances and needs all over again. The Positive Pathways project developed a gradual hand over process between the support provided by EWMHS and the personalised care support they

provide to ensure young people do not have to repeat their story, and that their entry into the service is easy. The Positive Pathways support worker will attend initial conversations with the young person and the clinician during EWMHS sessions so the transitions feels smooth. The support worker explained:

> "the gradual handover process between EWMHS and positive pathways is a real strength."

As Positive Pathways expands beyond the focus on young people who have previously accessed EWMHS, as it plans to do, the intention is still to ensure the support worker understands the young person's background and tries to link in to previous support.
In terms of exit points, site professionals in all areas explained how young people can come back into the service if they want to after they have left. The sites also did not have a strict cut-off point for age or length of intervention in the way other services did, and continued to be needs led. One young person explained that what they liked best about the support they received was that:

> "There's not a time limit on it, [I'm] not getting kicked out a certain point"

Another young person agreed:

"That's what I was afraid of; that this was a limited thing, but then [the support worker] says you can do it just for however long we want it."

Parents were also relieved by the flexible and gradual exit points, with one explaining that they initially were worried:

> "Do they get to a certain age and the plug is pulled and people were on their own again? Is this potentially an ongoing thing or is it you've have… your quota, you can't have it any more?"

The services were also seen as "bridging the gap between child and adult services" which one young person had described as "a black hole" and others had talked about having their support suddenly taken away from them at 16 or 18. In contrast, many of the young people involved in the three sites were between 16-19 age range, and one young person was 21. The support worker in Thurrock explained that when the project was first set up, it was intended just to provide personalised care for young people through the transition period out of EWMHS and into adult services. However:

> "There was this grey area with these young people that are struggling… and were very scared of going into adult mental health services. I took that to the commissioners that they're struggling…. [and] we just decided that [they could access support through Positive Pathways] …. I've got some 19-year-olds in the group, as well which, for them, the social group is just really powerful…. We're not going to say to them, as soon they reach 18, 'Right, off you go. There's the door!"

The gradual entry and exit points seemed to be another way the sites we looked at provided support which made the young people we spoke to feel cared for and respected. Young people

did successfully leave the services when they were ready to do so and, in both Bristol and Thurrock, some of them took on peer support roles and encouraged others.

f) Self-referrals

When setting up the project in Bristol, it was felt that an option for self-referral would help make accessing the service easier for vulnerable young people. The Bristol site professional explained that for care leavers, accessing traditional mental health services can feel like 'being processed' through a system in a way that had often felt negative to them in the care system.

Several young people also told us that they struggled to be honest about their struggles, including at the point of assessment, due to worries they would be judged and these worries could put vulnerable young people off accessing support:

> "It's quite difficult for care leavers who are parents, to first of all admit, really, that they are struggling and they need the support, because you're constantly feeling like you're being judged."

Parents similarly expressed high levels of frustration and distrust with what they described as a 'cycle of assessment and referrals' for their children and a continuous "ladder where you go a few steps. Then, you go down. Then, you go up. Then you go back down again."

While only one site currently had the option for self-referral, a young person in another area suggested this would be a valuable change to mental health support services generally, saying:

> "surely whatever service it is, if they want to access it, let them access it."

Existing research backs up this view, with previous studies suggesting that enabling young people to directly access mental health services through self-referral "proved to effectively facilitate access for young people who were unlikely to connect with services through traditional access routes" (Anderson et al. 2017)

g) Whole family approach

Support often took a whole family approach, looking at the needs of the young person but also of their parents and carers, wider family, and any children they had. The whole family approach was seen as a key strength of the support received in Thurrock and Nottingham, and was also highly valued by young parents in Bristol.

In Nottingham, the support worker focused on joining up the wider system of support to ensure it worked well for a family experiencing hardship, linking them to a range of practical and emotional support for different family members of all ages. We spoke to one family where there was a young person with significant mental health needs, who was regularly self-harming and had attempted suicide. Their parent had significant ill health and they also had siblings with complex medical needs which meant they had to shield during the Covid-19 pandemic, and the young person also acted as a young carer. They were isolated due to shielding, and had been unable to access the school support, including free lunches and laptop provision, which they should have been eligible for. Their parent was unable to work due to their illness, had recently been impacted by a bereavement and they were struggling financially and facing food and fuel poverty. The parent was also struggling with mental ill

health, feelings of low worth and was also self-harming. In this case, it is clear why only addressing the young person's mental health needs, and not their broader home and family situation, would have been a very partial solution. Whilst a whole family approach may benefit many young people, the often multiple and overlapping challenges experienced by those from backgrounds of social deprivation or low income exacerbate the need for a holistic form of support, as is illustrated here.

Young people and families in other areas also valued the family-centred approach they received:

> "[Services] can't just work with one member of a family, need a collective approach and to think about the parent and the children together, just looking at one part of it wouldn't make as much of a difference"

> "I'm so grateful that Positive Pathways was there. [Support worker] is amazing not only for the support for the young people but for the support of the parents, as well. She's just referred me to Carers [support] and I'm now in a support group [and] counselling, as well."

In a young person's focus group, the importance of thinking about the whole family was highlighted by a young parent who explained how her personal budget had been used to get some toys for her child, which helped keep her child entertainment and helped her stay calmer during the lockdown period:

> "So it helped [my] mental health but it also helped my son's [wellbeing] as everything has an impact on him too."

h) Working with VCS organisations

As mentioned earlier in the report, young people and parents saw the personalised support they had received as being substantially different from other forms of mental health help, and perceived it sitting outside of that system. This meant that it didn't have the same negative associations as statutory support and mental health services for some young people from disadvantaged backgrounds and for some families, which facilitated trust and reduced barriers.

A key part of this sense that the support was different from other services was down to how the project was delivered by VCS organisations: TB Mind in Thurrock and Barnardo's in Bristol. The existing literature also emphasised the importance of mental health support services being "provided in non-stigmatising settings… in collaboration with third-sector or other agencies" in order to increase its success for young people from disadvantaged backgrounds. Whilst this isn't a necessary part of the set-up of personalised approaches, it was certainly a key enabler of effective support for the young people and families we talked to.

9. Challenges and limitations of personalised approaches

The personalised support offered across the sites was highly valued by young people and their families, and the most common response to what they would change about the project was "nothing", with several young people telling us "it's perfect". Nevertheless, a few young people and site professionals identified some challenges and limitations to this way of working.

a) Remaining barriers to accessing support

While the sites worked hard in the ways outlined above to successfully engage young people from socially deprived backgrounds and other hard to reach groups, we know that young people from disadvantaged backgrounds find it particularly hard to access support and face a range of significant barriers, and all sites felt there was further to go to ensure all disadvantaged young people could access their support. For example, in Thurrock, all young people came into Positive Pathways when they were discharged from EWMHS, which means the scheme does not reach young people who feel unable or unwilling to engage in clinical mental health support, which we know is disproportionately true of young people from particularly disadvantaged backgrounds. However, the site professional explained that they were hoping to expand the reach of the service and support young people who had not accessed EWMHS in the next phase of the pilot.

Likewise, in Bristol, site professionals felt there was more to do to ensure the service was fully accessible to those who were most disadvantaged. While You're in Control had reached many of the most disadvantaged groups of young people in the city, including care leavers, young parents, homeless young people and unaccompanied asylum seekers, they had struggled to reach African Caribbean young men. The site was planning to undertake an evaluation of how a wider range of ethnic groups could be supported by their service.

b) Lack of understanding about options available

One of the challenges identified by some young people, particularly those from backgrounds of deprivation, was that they were so used to sticking with a really strict budget and experiencing limited finances, that it was often was hard to understand what could be possible with a PHB. In areas of social deprivation and for other groups such as care leavers, many young people will not previously have had an opportunity to use a dedicated pot of money for their wellbeing, and they found it difficult to consider the full range of options and choose what would benefit them most.

One young person told us:

> "I didn't know my options. So instead of getting a gym membership … I would have done my driving lessons so then I could get supported a bit more and had a bit more freedom as I can't get on buses at all [because] my anxiety's way too high … So, I would have had actually [picked] driving lessons if I knew that that was an option, but I didn't know I could."

They explained:

> "It takes quite a bit of support to [understand] the options… because I've never done this before, I thought I was quite restricted."

Another young person shared:

> "If you don't know what the options are you don't know how far you could go. I think because we're so used to sticking with a really strict budget and really tight finances, just

> don't really know what is possible… Care leavers are so used to be confined [that] it's quite hard to think long-term."

To combat this, they suggested "having some examples of things, like case studies or stories" to help young people understand the breadth of what was available, and not just pick something they thought would be easier and cheaper, and therefore they would be likely to get. It was also crucial that they had access to a support worker who could guide them through the process, help them explore what was possible, and encourage them to have the confidence to ask for what they needed, rather than to pick something they felt was less demanding.

c) Limitations of virtual working

While young people and families told us they were very glad that personalised care support had continued during the Covid-19 pandemic, when many services had stopped, one of the few negatives which was mentioned by several young people was the limitation of virtual working. Several young people told us they missed meeting up in person with their support worker, peer support group and for some of the clubs and activities they had been referred to:

> "I just wish we could meet, like meet more and do more"

> "I hate that online thing. I really don't like it very much."

> "The downside is literally just Covid… I want to meet up more, I still want to meet face-to-face."

Most young people understood why the limits were in place and saw it as a temporary restriction on their usual support. However, there had been more significant impacts of the move to virtual working. Without face-to-face support, digital poverty became a greater barrier to accessing personalised care. The sites had support options in place for young people who needed help accessing the internet or getting an appropriate device, but digital poverty sometimes prevented people from making contact with sites in the first place. One area explained that a young person had been referred to them but they were couch surfing with a friend and did not have a phone, any equipment or access to Wi-Fi. They had applied for a PHB but unfortunately had lost contact before support could be arranged.

The impact of digital poverty and virtual working on ongoing support, as well as on the ability to access support in the first place, needs to be carefully considered for all services which want to reach young people experiencing deprivation and disadvantage.

d) Consistency of offer and of staff

The final challenge we heard was the importance of maintaining a consistent offer, with consistent support staff. Young people expressed significant frustration and dissatisfaction with previous services or pilot schemes which had closed or changed after a few months, "after getting [their] hopes up."

One young person, James[4], had received patchy and changing provision where he was referred into a new scheme, went through the process of opening up and beginning to trust a new worker, only for the service to be cut after a few months and his support withdrawn. He explained that this had stopped him trusting new services, and had significantly impacted both his mental health and his physical health, as he had a form of epilepsy which was triggered by stress. He told us about his frustration of support offers regularly changing, in name, funding and the support they offered:

> "They often cut a good service and then bring it back in a new shiny way but they may as well have bought it off Wish [a knock-off website] because it now looks shiny on the outside, but it has been so cut down and reduced that it is useless in reality"

Likewise, while the young people valued the support they had received in Bristol, several of them explained they were worried about the recent changes which would reduce the availability of a support worker linked to the personal budget service.

Other young people emphasised that the continuity of their relationship with the support worker was key to developing trust. They explained the importance of "having a regular face" and "not having a blank page every time you get a new worker." One young person told us that every time there was staff turnover:

> "You have to start from the beginning about 'I've got a family and blah blah blah'… It's just that feeling of dread about starting afresh with someone after you've got to know a worker really well."

In contrast, where there had been a consistent offer and the same key professional throughout this was hugely valued. One parent told us the best thing about the support their child had received was:

> "The consistency of it. [The support worker] is consistent. No matter if it's holidays, snowing, raining, COVID, or if there is a falling rocket, she will still get in touch with us and make sure that we've not dropped off the radar."

10. Conclusion

Existing literature and previous pilots indicated the likelihood that personalised approaches may make a difference to CYP from deprived backgrounds. This report has attempted to add further detail with regards to their experiences and explores further how to design and deliver support in a way that will be most effective for marginalised CYP. We have taken note of research such as by the British Academy (2015) which suggests that "by far the most important influence on mental wellbeing comes from socioeconomic factors" and that of the World Health Organisation (2019) which acknowledges that "financial inequalities and material deprivation are the major drivers of mental health inequality."

Many of the young people we spoke to had complex experiences and multiple disadvantages, for example a young woman who had ADHD, was NEET, a care leaver, a young parent and had mental

[4] Not his real name

health needs, one young man who had previously attempted suicide, had experienced sexual abuse, had physical health needs, had spent time in care and grown up around parental mental illness. However**,** a key message from our work is that while young people's experiences may be complex, what they need from services is relatively simple. What they valued was an approach which was consistent, caring, and which made them feel heard. Whilst these are inherently part of a personalised approach to mental health support, they are also key principles that can be embedded across other services.

We have highlighted that such uncomplicated service needs include practical support, choice and control and a holistic and integrated approach which can address overlapping issues. There was also evident value in a whole-family approach.

We have also attempted to build more detail on what was suggested in existing literature about changes required to improve such young people's experience, in particular in relation to minimising barriers to services. These barriers includes the onerous thresholds and waiting times, and the lack of flexible entry and exit points into services. 'De-medicalising' the experience and giving attention to the importance of trusted relationships, such as those with support workers, can help to increase accessibility and effectiveness of services. Use of the "different conversations" approach played an important part in this de-medicalisation. Indeed, many of the young people we spoke to did not see the support they had received as a form of mental health help.

These latter elements constituted an enhancement to the personalised care offer. Other features which contributed to enhanced offer included support groups or peer support, and a system of self-referrals. The development of peer support groups had been empowering and allowed for co-production, while self-referral would help to address the difficulties faced in meeting referral criteria which left some feeling retraumatised as they went round and round the system

Despite huge efforts made by the sites to successfully engage young people from socially deprived backgrounds and other hard to reach groups, we know that young people from disadvantaged backgrounds face a range of significant barriers. All sites felt there was further to go to ensure all disadvantaged young people could access their support. We also recognise there are a few important challenges to be addressed to ensure young people maximised support received. For example, clarity about options available is needed, ensuring Continuity of offer and of staff and providing the opportunity for face-to-face support as digital poverty persists.

Recommendations

Our recommendations outline the priorities to take forward and acknowledge that the key issues identified may apply to many young people but are more acute for those experiencing social deprivation, in particular:

- Give priority to developing the support worker role. Although the support worker role will require a well-funded commitment, it was seen to be central to the effectiveness of support for the young people we spoke to. Where there was a positive support worker relationship, low cost budgets (for example, to provide art supplies) nevertheless had a significant and positive impact.

This is particularly valuable for young people experiencing social deprivation who may not have had previous opportunities to use a dedicated budget for their wellbeing and may therefore struggle to identify how it could be spent. Systems should explore options for additional roles via Primary Care Networks and potentially the Care Coordinator.

- Recognise the value in having a range of pathways into support including CAMHS, education settings, as well as self-referral to ensure that young people are not excluded from services as a result of referral routes which they find inhospitable

- Greater support is needed for 16-25s and gradual transition out of services for this age range

- Consider location of social prescribing approaches in the local community and 'trusted' services, and the value of working with VCSs for young people from socially deprived communities (in contrast to social prescribing approaches for adults, many of which are facilitated by GPs)

- Priority to be given to coproduction of services. This will also enable services to adapt to meet CYP's priorities, as well as supporting the skills and confidence of CYP in communities experiencing social deprivation

- Onboarding of young people to volunteer within and to promote projects - which will similarly help to achieve this

- Establishing a Community of Practice (COP) or facilitating sharing and learning. Interviews with site professionals in other areas indicated this would be a welcome development. Such learning would benefit from the active inclusion of CYP's voices, with a COP being co-produced with CYP.

We would also recommend that some of the approaches and learning discussed here could be used by mainstream services (e.g. CAMHS) and areas who do not (yet) have personalised approaches, based on some key principles of what young people from socially deprived backgrounds told us are the key barriers or enablers to effective mental support across all services:

- Use of the "different conversation" approach to engage service users

- Greater understanding of and training around the needs of complex children and young people across children's health services. Moving away from a one size fits all approach to have more specialisms and flexibility within all support services.

- Prioritise continuity of offer and approach used when any form of personalised care is made available for young people

And finally, the following contributions from young people regarding their priorities strongly illustrate need for the above recommendations

- "More funding, more training, and stop giving people false hope"

- "Longer-term funding is needed, ensuring any support it is continuous and consistent. They should not just set up new projects up without thinking about this, they need a long-term plan in Government and locally – it is hard to trust new schemes when they will be taken away from you again."
- "Treat us as individuals, be personalised"
- "Give us a choice over who you speak to,"
- "One thing I would change is sort the waiting list because the waiting list is always long. I'd just make the waiting list instant"
- "I feel like there should be priority for care leavers on accessing mental health services, like there is with housing and stuff like that."
- "... one thing that I would definitely change is young people have more of a choice [of treatment options] … give them the option, because it is their mental health, it's the way they deal with things. Not every young person deals with things the same, we're all different and what works for someone might not work for the other person."

References

Allen, J., Boyce, T., Goldblatt, P., Marmot, M., Morrison, J. (2020). Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity. Https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Allen, J., Boyce, T., Geddes, I., Goldblatt, P., Grady, M., Marmot, M., McNeish, D. (2010). Fair Society, Healthy Lives – The Marmot Review: Strategic review of health inequalities in England post-2010. UK: The Marmot Review. Https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Anderson, J. K., Howarth, E., Humphrey, A., Jones, P.B., Vainre, M. (2017). A scoping literature review of service-level barriers for access and engagement with mental health

services for children and young people. Children and Youth Services Review, 77, 164-176. Https://doi.org/10.1016/j.childyouth.2017.04.017

Bachman, C., Gooch, B. (2018). LGBT in Britain: Health Report. London: Stonewall. Https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

Bambra, C., Chandola, T., Dorling, D., Jenkins, A., Kendig, H., Maynard, A., Melhuish, E., McKenzie, K., Nazroo, J., Phillipson, C., Pickett, K. (2014). "If You Could Do One Thing…": Nine local actions to reduce health inequalities. London: British Academy. https://www.thebritishacademy.ac.uk/publications/cohesive-societies-local-actions-reduce-health-inequalities/

Barker, C., Collins, P. (2009). Psychological help-seeking in homeless adolescents. International Journal of Social Psychiatry, 55(4), 374-384. Https://doi.org/10.1177/0020764008094430

Baxter, K., Caiels, J., Davidson, J., Dolan, Glendinning, C., P., Forder, J., Irvine, A., Jones K., King, D., Welch E., Windle, K. (2012) Evaluation of the personal health budget pilot programme. London: Department of Health and PSSRU. Https://www.york.ac.uk/inst/spru/research/pdf/phbe.pdf

Beers, L.S., Godoy, L., Hodgkinson, S., Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. Paediatrics, 139(1).

Braddick, F., Gascon, M., Gonzalez, J., Leavell, M., Leiferman, J., Litt, J. (2019). Nature-based social prescribing in urban settings to improve social connectedness and mental well-being: a review. Current Environmental Health Reports, 6(4), 297-308. Https://doi.org/10.1007/s40572-019-00251-7

Brown, A., Parker, A., Rice, S.M., Rickwood, D.J. (2016). Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. Asia-Pacific Psychiatry, 8(1), 3-22. Https://doi.org/10.1111/appy.12199

Camic, P., Chatterjee, H., Thomson, L. (2015). Social Prescribing: A review of community referral schemes. London: University College London. Https://artsandminds.org.uk/wp-content/uploads/2015/10/Social_Prescribing_Review_2015.pdf

Cassells, R., Evans, G. (2016), Childhood Poverty, Cumulative Risk Exposure, and Mental Health in Emerging Adults. Clinical Psychological Science, 2(3): 287-296. Https://doi.org/10.1017/S0954579420001947

Chapman, L., Edbrooke-Childs, J., Gondek, D., Hayes, D., Saunders, F., Velikonja, T., Wolpert, M. (2017). Facilitators and barriers to person-centred care in child and young people mental health services: a systematic review. Clinical Psychology & Psychotherapy, 24(4), 870-886. Https://dx.doi.org/10.1002/cpp.2052

Colucci, E., Guerra, C., Minas, H., Paxton, G., Szwarc, J. (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services. Transcultural Psychiatry, 52(6), 766-790. Https://doi.org/10.1177/1363461515571624

Commission for Equality in Mental Health (2020). Mental health for all? The final report of the Commission for Equality in Mental Health. London: Centre for Mental Health. Https://www.centreformentalhealth.org.uk/publications/mental-health-for-all

Cresswell-Smith, J., Haaramo, P., Parkkonen, J., Wahlbeck, K. (2017). Interventions to mitigate the effects of poverty and inequality on mental health. Social Psychiatry and Psychiatric Epidemiology, 52(5), 505-514. Https://doi.org/10.1007/s00127-017-1370-4

Cribb, A., O, J., Singh, G. (2018). Practicing 'social paediatrics': what do the social determinants of child health mean for professionalism and practice? Paediatrics and Child Health, 28(3), 107-113. Https://doi.org/10.1016/j.paed.2017.12.033

Deane, F., Rickwood, D., Wilson, C. (2007). When and how do young people seek professional help for mental health problems? Medical Journal of Australia, 187(S7). Https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.2007.tb01334.x

Elliott, I. (June 2016) Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy. London: Mental Health Foundation. Https://www.mentalhealth.org.uk/sites/default/files/Poverty%20and%20Mental%20Health.pdf

Ford, T., Goodman, R., Green, H., McGinnity, A., Meltzer, H. (2005). Mental health of children and young people in Great Britain. London: Office for National Statistics. Https://www.northlanmindset.org.uk/documents/Mental%20Health%20of%2Children%20and%20Young%20People%20in%20Great%20Britain_2004

Gill, K., Quilter-Pinter, H., Swift, D. (2017). Making the Difference: Breaking the Link Between School Exclusion and Social Exclusion. London: IPPR. Https://www.ippr.org/publications/making-the-difference

Gutman, M.L., Joshi, H., Parsonage, M., Schoon, I. (2015). Children of the New Century: mental health findings from the Millennium Cohort Study. London: Institute of Education, UCL and Centre for Mental Health. Retrieved from https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/newcentury.pdf

Memon, A., Taylor, K., Mohebati, L., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic communities: a qualitative study in southeast England. The Lancet, 388, S76.

Office for National Statistics (2018, July). Community Life Survey 2017-18. Retrieved from: https://www.gov.uk/government/statistics/community-life-survey-2017-18

Office for National Statistics (2019, March). Children whose families struggle to get on are more likely to have mental health disorders. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/childhealth/articles/childrenwhosefamiliesstruggletogetonaremorelikelytohavementaldisorders/2019-03-26

Siva, N. (2020). Loneliness in children and young people in the UK. The Lancet Child & Adolescent Health, 4(8), 567-568. Https://doi.org/10.1016/S2352-4642(20)30213-3

World Health Organisation (2019). Healthy, prosperous lives for all: the European Health Equity Status Report. Copenhagen: World Health Organisation. Https://www.euro.who.int/en/publications/abstracts/health-equity-status-report-2019

Appendix I

Defining disadvantage:

Defining disadvantage
Households in relative poverty i.e. with less than 60% of median income
Households in persistent poverty i.e. who have experienced relative poverty in the current year and at least two out of the three preceding years
Children and young people living in households in the lowest one fifth or two fifths of household income
Children and young people who receive free school meals
Children and young people in households that receive income or disability-related benefits or young adults who receive these benefits themselves
Low equivalised parental income (income adjusted for number of children)
Food insecurity and food bank referrals
Households with overcrowded living conditions
Children and young people in households with an income of less than £17,500
Children and young people living in households where no parent or carer works
If needed: Neighbourhood deprivation via IMD[5]

[5]While the IMD is useful for building up a comparative picture of a neighbourhood's level of deprivation, research by NHS Digital published in 2017 found that it is the measure of deprivation which correlates least closely to mental health inequalities for young people, compared to family income, income-related benefits and relative poverty. Likewise, the 'Marmot Review: 10 Years On' found that socioeconomically deprived children living in poor areas had better mental health outcomes than socioeconomically deprived children in more affluent areas, suggesting IMD measures of a neighbourhood's level of deprivation may not be as useful for understanding the most disadvantaged young people experience mental health and mental health services. Other metrics of disadvantage may therefore give a better indication of the risk of mental health need. However, if the IMD is the only data available to a service, it will still provide some picture of disadvantage.

Appendix II

Method

Establishing scope of analysis

Scope of the research was set by identifying existing analysis on personalised care, then agreeing definitions for deprivation, and the sample to be included. We undertook a comprehensive Literature Review to identify what existing research says about supporting the mental health needs of young people experiencing social deprivation and disadvantage.

Our initial scoping meeting confirmed the data gathering process as outlined below. Six areas were approached where there were high levels of social deprivation and where they had an existing personalised care offer for CYP's mental health. This included a mixture of urban and rural settings, and the sites selected were at different levels of maturity with their offers. Three areas were able to proceed in participating in the research – Bristol, Thurrock, and Nottingham.

Overview of Fieldwork

A comprehensive local picture was developed in relation to personal care and social deprivation in our selected areas. We used the methods below to understand the experiences of areas which are delivering personalised mental health care for young people experiencing social deprivation and disadvantage and to understand the experiences of and impact on the young people and families who have received personalised approaches.

- Obtaining relevant local area information including relevant evaluation data from all sites.
- telephone interviews with our selected pilot site professionals comprising those who had either commissioned, set up or delivered the projects
- Holding virtual focus groups with young people
- Holding virtual focus groups with parents of these young people
- Telephone interviews with young people
- Telephone interviews with the parents of those young people
- Written surveys of parents of young people in our sample
- Written feedback from young person

Background information from local areas included evaluation reports, videos from young people and co-ordinators, local surveys and future funding bids. A full list of these and the materials used for recruitment, interviews and focus groups are contained in Appendices III, IV, V, VI and VII

Telephone Interviews with Site professionals

We carried out interviews with site professionals across all three sites comprising:

- Children's Services Manager
- Social Prescribing commissioner
- C&F services commissioner
- Youth Facilitator
- Social Prescribing Link Worker

- Personal Advisor

We used predominantly open questions with an opportunity for those we interviewed to add any further reflections. A topic guide was sent in advance to allow for gathering of any historic detail and for general preparation. The interviews were conducted on Microsoft Teams, recorded and transcribed

Questions covered background to their initiative, course of a 'usual' intervention, key enablers which have led to the project working well, the challenges and how have these been addressed, outcomes and impact.

Focus Groups

We held two for young people, one in Bristol and one in Thurrock. Recruitment was led by site staff contacts. The site professionals were able to incorporate the focus group session within their young peoples' group meeting schedule, so that we would be able to gather views from the range of project participants.

To facilitate as interactive and accessible a focus group session as possible we assessed needs through our consent forms and adopted a mix of tools. Appendix IV provides an illustration of how these tools were used.

Given the sensitive topics that could potentially be raised in relation to young participant mental health, and taking into account their challenges, we carried out thorough risk assessments for our focus groups and interviews with young people. This covered areas such as how we would respond to distress caused by topics, the management of digital and other access issues and wellbeing follow-up support. Clear ground rules were established for focus groups to encourage participants to listen to each other, respect differences and secure confidentiality within limits. We introduced each group by explaining the value of all participants' contributions, the context for the research and use of the findings. The presence of site staff contacts was secured, who know participants well, either throughout call or at the start and on hand if needed. These staff were able to offer follow up support for participants after the focus group discussion.

Individual Interviews

In the case of individual participants who had not been part of a project group we offered individual interviews using the same question themes as outlined in the focus group materials..

We found it necessary to offer an alternative option for giving feedback due to difficulties in scheduling interviews for some participants, this was especially so for parents with caring responsibilities. Therefore, a small number of respondents were able to provide responses through their support worker who transcribed these for NCB.

Appendix III

Changing young people's lives through personalised care

Interviews with Local Site Staff

December 2020 - January 2021

Thank-you for agreeing to take part in this research interview. As you know, we are hopingto develop a body of evidence regarding what works to enhance the personalised care offer within CAMHS and / or wider children's services that provide mental health support, whilst also demonstrating a reduction in health inequalities.

The purpose of this interview is to help us understand in more detail the current experience of personalised care from your perspective, (in particular PHB and Social Prescribing) in your area, how this works and what you have learnt from the process.

We will use the information you provide to inform further discussions with children and young people who experience poor mental health and social deprivation or mental health inequalities and to produce a report with key learning and recommendations on implementing personalised approaches to support the mental health of young people from socially deprived and harder to reach backgrounds. A report of the interview findings will be produced by NCB.

We will be looking to share good practice examples, with your permission, but apart from these, the report and anything that is shared or published will be anonymised.

The key point is that this is not a test of you or your service. There are no right or wrong answers, and if there are any questions you are unable then just let me know and we can move on.

The interview will last approximately 30 minutes.

- It will be conducted using Microsoft Teams and with your permission this will be recorded digitally and then transcribed. This is so we have an accurate record of what you said and do not have to ask you to repeat yourself. The recording will not be shared with anyone outside the National Children's Bureau. A report of the interview findings will be produced by NCB.
- Responses may be attributed to a named individual unless requested otherwise.
- Please let us know if you have any questions by contacting Deborah McLean-Thorne at NCB, dmclean-thorne@ncb.org.uk

We would be grateful if you would confirm that you are happy to take part in this interview by contacting us on the above email. Further details on the interview are below.

The questions will be focused on the background to the work you have been doing, a description of the intervention(s) and your perspective on impact, and will include:

1. What was the background to this work? When did it start

2. What has the uptake been like?
3. What is the referral process?
4. What happens in the course of a 'usual' intervention, what are the stages?
5. What do you think are the key enablers which have led to the project working well?
6. What have been some of the challenges and how have these been addressed?
7. What do you think the process of accessing the service is like for young people? How does this compare to traditional mental health services? Is this different for disadvantaged young people?
8. What do you think the experience of receiving personalised support is like for young people? How does this compare to traditional MH services? Is this different for disadvantaged young people?
9. How well do you think the service is suited to CYP from deprived or hard to reach backgrounds? How do you think it help to address mental health inequalities?
10. You may also wish to advise us of the next steps for your project?

It would be helpful if you could identify (for the interview or afterwards):

11. **Any data you have on numbers and demographics of young people who have accessed your service**. If available, it would be helpful to know numbers of young people accessing the service that come from BAME backgrounds, who are excluded, in care or care leavers, or young people from deprived backgrounds.* Is there any local data about how this compares to other forms of mental health support for young people in your area e.g. CAMHS or school-based interventions

- **Any data you collect on the outcomes or impact of your service**, including for the young people receiving personalised support and/or their families. Is there any local data on how this compared to other forms of mental health support for young people in your area? Is there any information on whether the outcomes/impact is different for disadvantaged young people?

* This could include young people in receipt of free school meals, young people living in relative or persistent poverty, young people whose household receive income-related benefits or who are in workless households, or other metrics of childhood deprivation used by your service.
Research into mental health inequalities for disadvantaged young people use a wide range of measures and definitions of socioeconomic deprivation and poverty, including each of the metrics mentioned above. However, regardless of which metric of deprivation is chosen, the rates of mental health need among children and young people are far higher (between 3 to 4 times higher) than for their peers. We therefore do not want to be prescriptive about which metric or definition of social deprivation you use, as the research suggests children and young people who fall under any of these criteria are disproportionately likely to suffer from mental ill health and to experience poorer access to mental health services.

Appendix IV

Young People's Focus Group- Example Session Plan

Activity	Notes
Introduction and ground rules Introduce selves. We are really grateful for your time and for letting us into your group – your feedback will help make a difference to other young people and we also	

NATIONAL CHILDREN'S BUREAU

<table>
<tr><td>have vouchers for each of you to thank you for your time which we will share with [site professional] to give to you.

Explain about recording the session to make notes.

Ground rules:
There are no right or wrong answers, so tell us what you really think
Because no right or wrong answers, may think differently, so respect each other's opinions, listen and don't talk over each other
Anonymity – we will not record your names or use identifying information, we will just feedback the points you make without it being linked to you
Don't need to share anything you don't feel comfortable with, or feel you need to share anything really sensitive
Let us know if something doesn't make sense, you need help or want to take a break. You can also let me know if you would like [site professional] to come back in at any time.
Can everyone find the chat, knows how to mute/unmute and use the hands-up button?
Any questions?</td><td></td></tr>
<tr><td><u>Quick name Icebreaker</u>
Name and superpower</td><td></td></tr>
<tr><td><u>Quick discussion</u>

'Does anyone want to tell us, in a few sentences, what support they received and what they thought about it'</td><td></td></tr>
<tr><td><u>Activity 1: Best and Worst Miro board</u>

We want to know the best and worst things about the support you received from [site professional]

Explain about Miro board, post link in chat, show how to add post-it notes and explain they can also tell us and we will add their comments to the board.
5 mins on positives, 5 mins on negatives
Conversation can dig deeper around facilitators and challenges of good support</td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td>Check in – See if people would like a short break, get a drink etc.</td><td></td></tr>
<tr><td><u>Activity 2: Barriers Miro Board</u>
We want to think about how easy or difficult it was to access support for your mental health, and think about anything which might put people off getting support or which makes it harder.</td><td></td></tr>
</table>

We want you to think of any barriers to accessing support, and write these on a 'barrier wall' on Miro. Barriers are anything that can make it harder to seek help, for example being too embarrassed to tell anyone you are struggling, or things that might put you off about getting help for example the referral process being complicated. It can be things that made it harder for you or that you think might put friends or other young people off mental health support. **Share Miro board link.** Are there certain groups of young people who you think might face more barriers? Which young people, which barriers? If time, think about solutions/what would help for each of those barriers. E.g. 'What might make you less embarrassed?	
Activity 3: Comparison • 2-5 minute - Discussion of what they found more helpful: CAMHS/EWMHS, [the project] or any other type of support they received and why – to unmute or use the chat box • 2-5 minute - Mindmap of any words they associated with CAMHS/EWMHS. (All young people asked how helpful it was 0-10) • 2-5 minute - Mindmap of any words they associate with [the project]. (All young people asked how helpful it was 0-10)	Zoom Whiteboard if possible option of Miro board
Activity 4: Impact discussion Thinking about how you were doing before you got support from[the project]. compared to how you are doing now. Share link to visual poll and go through the questions together e.g. are you more confident, less confident or the same now https://www.questionpro.com/t/ASDQTZk2Gb	
If you were Prime Minister/if you had a magic wand, and you could make sure that services did one thing to support young people better, what would it be?	

Appendix V

Changing young people's lives through personalised care

Interviews with Local Families

January – April 2021

Thank-you for agreeing to take part in this research interview. We are hoping o develop a body of evidence regarding what works to enhance the personalised care offer within CAMHS and / or wider children's & family services that provide support, whilst also demonstrating a reduction in health inequalities.

The purpose of this interview is to help us understand in more detail the current experience of personalised care from your perspective, (in particular Social Prescribing) in your area, how this works and what you have learnt from the process.

We will use the information you provide to inform further discussions with children, young people and families who experience mental health inequalities and to produce a report with key learning and recommendations on implementing personalised approaches to support the mental health of young people. A report of the interview findings will be produced by NCB the report and anything that is shared or published will be anonymised.

There are no right or wrong answers, and if there are any questions you are unable to answer or would prefer not to answer then just let me know and we can move on.

The interview will last approximately 30 minutes.

- It will be conducted using Zoom or telephone and with your permission this will be recorded digitally and then transcribed. This is so we have an accurate record of what you said and do not have to ask you to repeat yourself. The recording will not be shared with anyone outside the National Children's Bureau. A report of the interview findings will be produced by NCB.
- Please let us know if you have any questions by contacting Deborah McLean-Thorne at NCB, dmclean-thorne@ncb.org.uk

We would be grateful if you would confirm that you are happy to take part in this interview by contacting us on the above email. Further details on the interview are below.

There will be no more than five questions which will be focused on the description of the support you received and on its impact.

Appendix VI

NOTTINGHAM PICS (PRIMARY INTEGRATED COMMUNITY SERVICES)

Your experiences of social prescribing support

Thank you so much for sharing your experience and your family's experience of receiving social prescribing support from PICS (Primary Integrated Community Services).Your answers will be fully anonymous and will be used as part of a project o understand and improve mental health and wellbeing support for other young people and their families.

1. What support did you or your child receive from the PICS (Primary Integrated Community Services) social prescribing project?

2. What did you like most about this type of support? Which aspects of it do you think are most valuable?

3. What did you like less about the support you received? What would you change about it?

4. How easy or difficult was it to initially find/get help from PICS and through Rose? What would have made it easier to access support?

5. How does this support compare to any other mental health and wellbeing support your child has received (e.g. CAMHS)

6. Has this support made a difference to you or your family, and if so how?
(Things to consider include changes to confidence, loneliness, good decision making about health and wellbeing, optimism about the future, mental health, physical health, happiness in daily life, socialising, access to services, and any other impacts)

7. If you could make some key changes to the mental health support young people and families receive across the country, what do you think should be changed?

8. Is there anything else you want to say?

If you have any queries about any of these questions, please contact Deborah Mclean-Thorne at Dmclean-Thorne@ncb.org.uk

Appendix VII

Nottingham Social Prescribing Support

Parent Interview Questions

1. What did you like most about the Social Prescribing support you received through [link worker]?

2. What did you like least about the support you received? What would you change about it?

3. How does it compare to other forms of support you or your child has accessed (e.g. CAMHS, support in school)?

4. How difficult or easy was it to accessing support?

5. Impact – What difference did the social prescribing support make to your child and family?

6. If services which support young people's mental health and family wellbeing could do one thing differently in the future, what would it be?

Appendix VIII

NOTTINGHAM ADVICE AND GUIDANCE 21+ AND CARE-LEAVER SERVICE, AND SOCIAL PRESCRIBING PROJECT

Questions For Young Person Interview

- What do you like most about support received/what you valued most about support

- What did you dislike about the support you have received

- What has been the main Impact on you of the support you received

- If you could make any changes to wider mental health services and other support for young people, what would they be?

We would be grateful if you would confirm that you are happy to take part in this interview by contacting us on the above email. Further details on the interview are below.

There will be no more than five questions which will be focused on the description of the support you received and on its impact.

NATIONAL CHILDREN'S BUREAU

Appendix IX

Breakdown of participants

4 parents (Nottingham)

1 Young Person (Nottingham)

7 Young People (Bristol)

11 Young People (Thurrock)

7 parents (Thurrock)

= 19 young people and

11 parents

YP we talked to included:

- *care leavers*
- *several young parents*
- *several YP with ASD*
- *YP who had experience self-harm and attempted suicide*
- *families with low household income /experience of economic disadvantage*

NB The local sites were unable to facilitate detailed demographic breakdown or systematic information due to worries about asking CYP to systematically disclose e.g. economic status

Site staff we talked to included *those who had either commissioned, set up or delivered the projects:*

- *Children's Services Manager*
- *Social Prescribing commissioner*
- *C&F services commissioner*
- *Youth Facilitator*
- *Social Prescribing Link Worker*
- *Personal Advisor*

NATIONAL CHILDREN'S BUREAU

United for a better childhood

The National Children's Bureau brings people and organisations together to drive change in society and deliver a better childhood for the UK. We interrogate policy, uncover evidence and develop better ways of supporting children and families.

Let's work together: 020 7843 6000 | info@ncb.org.uk

London: 23 Mentmore Terrace, London, E8 3PN

Belfast: The NICVA Building, 61 Duncairn Gardens, BT15 2GB

Part of the family
NATIONAL CHILDREN'S BUREAU

National Children's Bureau is registered charity number 258825 and a company limited by guarantee number 00952717. Registered office: 23 Mentmore Terrace, London E8 3PN.