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"Friendly, Local and Welcoming" - Evaluation of a Community Mental Health Early Intervention Service.

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Abstract

Purpose

Half of adulthood mental health challenges begin by 14-years-old, making the need for early-intervention clear. The current study aimed to evaluate a new service model that promotes early-intervention through a community based low-intensity Hub.

Methodology

Clinical data from 2,384 young people were analysed through within-group, pre- and post-comparisons, and qualitative survey and interview data was analysed through content analysis.

Findings

Overall, participants reported they were highly satisfied with the Hub and the low-intensity brief interventions met their needs. Participants reported that learning new skills, having a place to talk and positive therapeutic relationships were beneficial. The Hub appeared to be less successful for young people with complex mental health difficulties. As a service, the adoption of the Hub model reduced waiting list times by more than half.

Research Implications

The quantitative data demonstrated that engaging with the Hub reduced symptoms of psychological distress. Qualitative analyses suggest that access to local, community, welcoming and "less clinical" support was beneficial, and the type of brief interventions offered was less important than therapeutic relationships.

Originality

This is the first study of a novel 'Hub' model for low-intensity brief interventions in a socio-economically deprived area of England. Local knowledge, community integrated support, therapeutic relationships, and a welcoming environment were viewed as more beneficial than the type of brief interventions offered. Consequently, community spaces can be created to be therapeutic and beneficial for mental health outside of a traditional conceptualisation of clinical support.

Key words: Community; Hub; Brief Interventions; Mixed Methods Evaluation

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Children and young people are experiencing increasing challenges to their mental health, with services reporting they are "constantly firefighting" to meet demand for support (Health and Social Care Committee, 2022). In 2022, 18.0% of 7-16-year-olds were identified as having a probable mental disorder (NHS Digital, 2023). Child and adolescent mental health difficulties have increased in scale and complexity in recent years, with COVID-19, school closures, and social media-based bullying all cited as aggravating factors (Anderson, Newlove-Delgado, et al., 2022). The COVID-19 pandemic and related disruptions for children and young people has had a profound impact upon young people's mental health, with difficulties increasing by 5.2% (Newlove-Delgado et al., 2021). Epidemiologically, the greatest immediate threat to adolescents from COVID-19 is to their mental health (Sprang & Silman, 2013; Zhou et al., 2021). Prior quarantines during pandemics have shown increases in adolescent anxiety, grief and post-traumatic stress (Loades et al., 2020). Young people at pivotal transitional stages may be at even higher risk of loneliness, socioemotional distress, and economic uncertainty (Bu et al., 2020). Recent history indicates domestic violence, child abuse, neglect, and exploitation are all likely to increase during public health emergencies, although relatively little is known about the long-term mental health effects of global viral outbreaks for adolescents (Lee, 2020). Therefore, it is likely that more young people will need additional help from mental health services, which will need to evolve and adapt to meet growing demand.

In the United Kingdom (UK), the National Institute for Health and Care Research's 2020-2030 health agenda has prioritised innovative and accessible research with children and young people, recognising that the majority of long-term mental health difficulties begin in childhood (National Institute for Health Research, 2020). Youth mental health services in the UK have been cited as lacking in community-based services and preventative, early interventions (Vusio, Thompson, Laughton, & Birchwood, 2021). A recent review has tentatively suggested parent training and early, preventative cognitive behavioural therapy (CBT) interventions could be cost-effective approaches to reduce anxiety related distress for young people (Anna-Kaisa, et al., 2022). Additionally, cross-service collaborations and early intervention models show promise (Tudor, 1996), as children and young people are often particularly vulnerable to environmental factors, such as parental addiction or unemployment (Coates, 2017). As a result, young people who require support frequently engage with multiple agencies, such as schools and mental health services, formal and informal (Cortina et al., 2019). Current research into the prevention and promotion of mental health services for young people recommends integrative, "youth-focused multidisciplinary and trans-diagnostic" services (Colizzi et al., 2020). Therefore, youth-focused, community-based services that offer preventative early therapeutic interventions could be of value to young people, families and communities.

Community-based integrated mental health Hubs offer a joined-up approach and have been identified as valuable resources in improving outcomes in multiple populations around the world, with evidence indicating that they are well received by young people and help improve access, even among 'hard-to-reach' groups (Malachowski et al., 2019). Hubs typically share some key characteristics, such as the use of early intervention and evidence-based tools, environments that are 'youth-friendly', non-stigmatising, and involve family members (Settipani et al., 2019). Effective community mental health provision needs to

provide accessible support that "allows the child to move from being 'somebody else's problem' to working with their family, wider community and environment towards a shared recovery" (Wolpert et al., 2017). This connected approach to integrated care is especially important for young people who may be more susceptible to system fragmentation, particularly those with intersectional vulnerabilities (Settipani et al., 2019).

Brief evidence-based low-intensity interventions for anxiety and depression have been found to be effective for young populations. For example, brief cognitive behavioural therapy (Gallagher & Schlösser, 2015) was determined to have favourable outcomes for children and a brief behavioural activation therapy delivered in children and adolescent mental health services (CAMHS) has also shown good results (Shenton et al., 2021). Additionally, brief guided CBT is as effective as traditional CBT for children with anxiety and is cost-effective. Utilising brief interventions within multi-disciplinary teams can reduce waiting times for patients and quickly improve a person's coping strategies. Additionally, Gallagher and Schlösser (2015) found brief interventions could lead to increases in positive emotions within the family unit and a reduction in distress for young people.

A recent qualitative study found adolescents who had engaged with a brief psychological intervention for depression experienced a positive therapeutic relationship, feeling safe and heard by the clinicians, despite the time constraints inherent in a brief intervention (Shenton et al., 2021). Early brief interventions can also be less disruptive for children as the intervention itself causes minimal disruption to their lives but still yields benefits. As cost-effective tools with generally positive outcomes, brief interventions are well suited for use within low-intensity early intervention community-based integrated mental health Hubs. The current study aimed to evaluate the services offered by a community mental health Hub in one of the most deprived boroughs of England, UK.

Method

Design

The current study sought to establish whether the community based mental health Hub could provide tailored good quality early intervention to support the mental health of children, young people, and families. Through a mixed methods service evaluation, the objectives were to develop an insight into service user experience; establish which elements of the Hub work especially well in terms of integrated service delivery and measures of overall wellbeing; and to draw upon findings to inform recommendations for service development. The study was approved by a National Health Service Research Ethics Committee (REC) and academic REC at the host university. The team worked in two parts throughout the data collection and analysis processes so as not to bias the interpretation of the qualitative data. DD and VS led the quantitative analysis, while SP led the qualitative analysis. The full analysis was then discussed and finalised across the team.

Participants

Routine Outcome Measures from 2,384 young people were analysed to develop an understanding of the characteristics of service users accessing the Hub and to analyse the data related to service provision. Monitoring of survey responses indicated there was no pattern to missed questions, suggesting the questions were generally acceptable.

The staff team at the Hub circulated information about the study to encourage young people and parents/carers to participate. Children and young people aged 8-18-years-old and their parents/carers were invited to take part in the online survey or an informal interview. Before any demographic or qualitative data was gathered, parents and participants aged 16-years-old and over were required to offer their consent, and young people under 16-years-old were required to provide their assent through the Qualtrics platform that hosted all participant facing documentation in digital form. All participant facing documents were reviewed and approved by the RECs prior to use. Due to Public Health England guidance in relation to COVID-19 at the time of data collection, Zoom was used for all interviews due to social distancing restrictions at the time of data collection. The online survey for young people and parents/carers was available from October 2020 to February 2021. Interviews also took place during this time. The survey included demographic, Likert, and open-ended questions. Preliminary analyses were undertaken at the mid-point to ensure the Likert Scales and reflective open questions were relevant and suitable. Overall, 35 service users completed the survey, 21 young people and 14 parents and/or carers. Four children (aged 12 and under) and one parent also volunteered to be interviewed.

(Insert Table I: *Survey and Interview Participant Demographics*)

Clinical Records Data

Anonymised data from the service user's clinical records were screened for accuracy of data entry and missing values. Descriptive statistics were analysed in terms of mean and standard deviations, heteroscedasticity was checked using Scatter Plot diagrams and normality assumptions were checked using the Kolmogorov–Smirnoff test. Pre- and post-intervention changes were evaluated using pairwise comparisons (Wilcoxon Signed Rank test for matched-pair data, as the variables considered were not normally distributed) and Cohen's (1988) effect sizes were calculated. Spearman's rank correlations were used to assess presence and direction of the relationships between the initial diagnosis/presenting symptoms, the number of interventions attended, and the improvements obtained by service users. All statistical analyses were performed using SPSS (version 27). A p value of <0.05 was used to identify statistical significance. The data considered were related to the period July 2018 to March 2021 and their analyses allowed us to explore: (1) personal characteristics (e.g., demographics) of the children and young people accessing the Hub; (2) reason (e.g., anxiety) for which they accessed the Hub; (3) services they accessed after leaving the Hub; (4) outcomes for mental health symptoms.

Qualitative Data Collection

Qualitative data, analysed through content analysis, aimed to explore service user experiences of engaging with the Hub. A preliminary literature review and discussions with the Hub team and referring services informed the nature of questions asked in the interviews and survey, which were the same to ensure parity. The topic guides for the interviews were used to facilitate conversation, with participants actively encouraged to reflect on their experiences and expand their answers. Content analysis is commonly used to analyse written data, which formed the majority of the qualitative data collected. An analytic matrix was developed by SP and ZE, deductively from the concept categories from the questions asked, and inductively from the emerging analytical categories from the data

itself. Consequently, six researcher-led predefined concept categories and four analytical categories were identified through the analytic process, which involved the preparation, classification, and coding of data, writing passages for the categories to generate emerging themes, and finally undertaking a synthesis to form the final three themes (Figure 1; Kuckartz, 2019). The synthesis was then agreed by all members of the research team.

Results and Findings

Routine Outcome Measures

Routine Outcome Measures (ROMs) are commonly used in children and young people's services to evaluate change in a young person's difficulties, usually taken before and after an intervention. ROMs typically take the form of questionnaires or surveys, completed by a young people, their parent, teacher or therapist (Waldron, Loades, & Rogers, 2018). Overall, most of the young people accessing the Hub were aged between 13 and 16-years-old. Young females were slightly more likely to be accessing the Hub than young males, with a female to male ratio of 47:39 from available data on gender. A minority of service users (0.1%) self-identified as 'other' and 0.4% chose not to disclose their gender identity ('prefer not to say'). Most of the young people accessing the Hub were White (59.4%) with White British (57.6%) being the most frequent ethnic sub-group, followed by Pakistani (4%) and Bangladeshi (2%). The most common reason for referral to the Hub was anxiety (35.1%) followed by anger (31.5%), low mood (15.1%) and low confidence (4%). Males were most likely to attend for difficulties with anger (20.6%) and females were most likely to seek help for anxiety (23.1%). These gender discrepancies are reflective of the national picture for mental health referrals and likely to be due, at least in part, to social conditioning and gender inequalities in how children develop their individual response to the experience of distress. A minority of young people also presented a diagnosis of autism (7.6%) and learning disabilities (12.4%).

The Young person's CORE (YP-CORE10; Twigg et al., 2009) is one of the ROMs routinely used by the Hub to assess commonly experienced symptoms (e.g., anxiety and depressive symptoms), subjective wellbeing and global functioning (Twigg et al., 2009). YP-CORE10 scores indicated that the majority of young people who accessed the Hub experienced a benefit, with the severity of their reported symptoms reducing from 'moderate' (M = 16.4, SD = 0.2) to 'mild' (M = 11.09, SD = 0.2), according to YPCORE10 categories of distress – Healthy (0–5), low (6–10), mild (11–14), moderate (15–19), moderate-to-severe (20–24), and severe (25 and above; O'Reilly et al., 2016). A Wilcoxon Signed Rank Test revealed a significant reduction in psychological distress following attendance to the Hub (z = -18.419, p = < .001) with a medium effect size (r = .0.62) and a median YPCORE10 score reduction from pre-intervention (16) to post-intervention (9).

The Systemic Clinical Outcome and Routine Evaluation-15 (SCORE15; Stratton et al., 2010) is the outcome measure used by the Hub to assess young people's reported levels of family functioning and the higher the scores obtained on this measure are, the worst the individual rates their family functioning (Stratton et al., 2014). The comparison between the scores obtained by service users when accessing the Hub (M = 43.9, SD = 7.3) and the ones obtained at discharge from the service (M = 31.25, SD = 13.2) indicate an improvement in young people's perception of their family life. The difference between these scores was

statistically significant (z = - 5.405, p = <0.001), meaning that the services offered by the Hub contributed to an improvement in the global family functioning, with a medium effect size (r = 0.67). Neither the type of presenting issue motivating the referral to the Hub (r_s = .005, p = .900; r_s = -.098, p = .854), nor the number of interventions attended (r_s = .037, p = .285; r_s = .059, p = .639) were significantly related to the improvements reported by the service users (assessed via YPCORE10 and SCORE15), indicating that other aspects of the service offered (e.g., quality of the therapeutic support, the relationship between clinicians and service users, the contents of the interventions proposed) may have contributed to the large-scale improvements outlined by the outcome measures used.

Most of the young people accessing the Hub engaged with one intervention. However, some accessed more than one intervention within the Hub, with 10.8% accessing two interventions and 0.6% accessing a third. The majority of those who engaged with more than one intervention engaged with 'Early interventions' (41.8%), followed by 'Counselling' (19.6%) and then a 'Therapeutic group' (15.6%). It is not clear from the data what cumulative benefit accessing multiple services has, although it is representative of the holistic and accessible nature of the Hub.

Some popular services are also delivered outside of the interventions measured through ROMs, such as the arts and crafts groups, which means their benefit is essentially not recorded through the ROMs. The staff team can work across interventions when needed to provide tailored individualised care for young people with complex needs, which is also not accounted for in the ROMs but an important key performance indicator of child-centred needs-focused care and therefore important to document nonetheless. The staff team recognised the need for ROMs collection but also accepted that this process was time consuming and could reduce the amount of therapeutic time they had with children and young people. In terms of *what* was being measured and *how*, the traditional methods of ROMs collection were not particularly well suited to the holistic and responsive nature of the Hub. Consideration should be given as to how measures may need to be adapted to suit this novel integrated holistic model of community-based services. In terms of the other key performance indicators of the Hub, waiting lists have reduced through the implementation of the Hub model from an average of eight weeks from referral to initial appointment to three weeks as of March 2021.

Survey and Interview Data

The survey data indicated that 86% of parents stated their child received a good quality service from the Hub and received help when they needed it. Additionally, 79% said their child's needs had been met and the Hub provided family-friendly support. Finally, 71% of respondents said their child felt positive about the care they had received, and that the Hub had manged COVID-19 well.

Theme 1: Therapeutic Space and Relationships

The Hub was described as a place, a helping non-judgemental and welcoming space, as well as somewhere that could offer therapeutic relationships and scope for collaboration: "somewhere to get help" (child); "a useful service" (parent); "kind, welcoming, caring and supportive" (parent); "Thank you for making this lovely place". The purpose of the Hub is to provide low-intensity early brief intervention, which young people reported was helpful: "Its brilliant and it helps through regular support… Um, given me a bit of confidence" (child).

Two emerging themes developed in relation to therapeutic relationships and collaboration, which was described in terms of personal qualities of the staff and how clients felt: "very helpful and kind and will listen" (child); "Open, welcoming, peaceful, warm, relaxed" (parent); "very talkative and fresh, made me feel welcome and comfortable" (child). The emerging theme of 'collaboration' was distinct from 'therapeutic relationships' as it suggested that feeling heard and validated led to the action of proactively working for improved mental health with a practitioner: "Amazing people who really understand young people…he didn't expect me to change instantly and accepted it was hard" (child); "easy to start working with, very helpful, approachable" (parent).

Theme 2: Experience of the Hub Model

Although the Hub provides low-intensity brief interventions through a relatively junior mental health team, service users were complimentary about their skills and knowledge; "They are clearly knowledgeable and well connected in the [X] area" (parent); "Full of people who understand children and know how to help" (parent). The experience of the Hub was also described as 'less clinical' than other mental health services, which meant it was more accessible and acceptable as a service, for example, "experience with other services has put [daughter] off, and she was reluctant to try for fear of being rejected or her issues minimised – this did not happen at the [X] Hub" (parent); "Doesn't feel like you're attending an appointment in a clinical way" (child). In terms of reaching their community, the staff team also used mediums that many statutory services do not, with good effect: "[Hub] also has social media which is like a mini [Hub] service for us at home. I can also always get through to someone on the phone" (parent). Finally, the Hub aims to become fully integrated into the community and with other services, such as schools, which was appreciated by service users s, "a variety of services including transfer to adult services" (staff).

Theme 3: Limits and Expectations

The qualitative data was collected during one of the UK lockdowns, which meant that many appointments were undertaken through Zoom. This aspect of service delivery was met with mixed responses; "I would have preferred not to be online" (child); "Coronavirus meant we waited a long time but that's not anyone's fault" (parent); "it's not quite the same over the phone" (parent); "I think Zoom, it works quite well. Um especially in the winter, when it's, you know, darker outside and its bad weather and you can still sort of get on with it especially if you've got more than one child" (parent). Additionally, the brief nature of the interventions offered flexibility and shorter waiting lists, although some young people and parents did not feel it was enough, "They only offered 4 sessions" (parent), and could prevent family participation: "family didn't participate" (child), "my family wasn't a massive part of it" (child), "Not long enough to speak to parents in the initial meeting" (staff). Finally, The Hub had begun to offer a small range of additional sessions from volunteers that were focused on creativity for wellbeing. These were appreciated by many of the children, although there was also a recognition that these interventions were not suitable for young people with more complex difficulties and high levels of distress: "some volunteers are not equipped to be dealing with the level of problems" (parent).

Discussion

Evaluations of Hub models have highlighted five key areas of focus for service development: (1) Communication; (2) Hub 'Nuances'; (3) Leadership; (4) Staff; and (5) Challenges (Colizzi et al., 2020). Within our evaluation, communication was favourably viewed, with service users able to contact the Hub easily through a range of platforms. The nuances of the Hub were explored through the qualitative data. The Hub was viewed as a welcoming and less clinical access point for brief mental health support. Worryingly, recent research indicates practitioners in mental health services are less likely to have friendly conversations with people from ethnic minority communities and are less likely to involve them in decision making (Khan, 2014). There were no indications of this behaviour at the Hub. The Hub promotes a child-focused approach that empowers young people to make decisions about their health and wellbeing and also promotes a friendly inclusive environment.

The 'simple strategies and tools' provided by the Hub were valued by service users and their goal focussed compassionate support was viewed as beneficial and 'refreshing'. An additional nuance that emerged was that practitioners were tailoring the brief interventions for each service user by drawing on the overall resources of the Hub. For example, if a child was receiving a brief intervention for low self-esteem but was also experiencing anxiety and low mood, the practitioner would include resources and techniques from other pathways to provide individualised holistic care. If this evaluation were to be conducted again, without COVID-19 restrictions, it would have strengthened the evaluation to observe the flexible approach of the Hub in person, perhaps developing an ethnographic account of their holistic approach. Observations would offer helpful information about how the flexibility described is offered and received. It would also have been helpful to speak with a greater number of young people and parents about their experiences to benefit from a broader array of perspectives. Research teams conducting evaluations in the future may wish to consider options for creating additional safe sharing spaces for young people and families to reflect on the impact of such services in their unique setting, perhaps through realist methods, which are increasingly showing benefits for exploring what is working well for young people's mental health services, and why (e.g., Lane, et al., 2021). Young people of Black, Asian and minoritised ethnic communities in the UK are reported to experience higher levels of psychological distress due to a range of intersectional inequalities (Ollendick, 2014) but are less likely than White peers to be able access youth mental health services (Dixon et al., 2016). The COVID-19 pandemic disproportionately affected young people from ethnic minority groups, with the true impact for individuals only now becoming clear in terms of the individual, relational and practical support that young people want (e.g., Lenoir & Wong, 2023). A recent study of how young people from ethnic minorities access CAMHS demonstrated the important role of school referrals for children of Black African and Black Caribbean heritage in particular (Edbrook-Childs & Patalay, 2019). Schools can provide an environment to engage children and young people with mental health support (Coates, 2017; Settipani et al., 2019) and teachers are often the first adults that children disclose mental health concerns to (Coates, 2017; Ford et al., 2007). Successful holistic integration between schools and community mental health services particularly supports timely mental health access for children and young people from low-income urban areas (Atkins et al., 2015). Recent research into the inequalities of referral pathways for Black, Asian, and ethnic minority communities has also highlighted that young people of Black African and Black Caribbean heritage are significantly more likely to be referred to inpatient and crisis services, which is perhaps indicative of referral

inequalities and a lack of access to early intervention (Chui et al., 2021). Potentially, integrated community mental health Hubs could play a significant and vital role in disrupting these harmful referral processes and remove some of the barriers and health inequalities to accessing timely early intervention.

Participants described both positive therapeutic relationships and aspects of collaboration with the staff of the Hub, which indicates an absence of a hierarchy often present within traditional mental health service structures. Collaboration was also one of the fundamental ingredients for a Hub as set out in Settipani's (2019) review, which the current study supports.

Within this evaluation, the clinical records data was interrogated and checked carefully. However, there were a number of limitations in the dataset, which prevented further interpretation. Hubs could enhance the quality and accuracy of data collection for evaluation purposes by training staff on the purpose and importance of routine data collection, to check p service users' understanding prior to completion of self-report measures and using appropriate and recognisable terms to collect demographic information. Within child and adolescent mental health services, it is also helpful to employ commonly used measures, such as the Strengths and Difficulties Questionnaire (SDQ; e.g., Vugteveen, de Bildt, & Timmerman, 2022) to facilitate comparing one's own data set to wider research in the field. Additionally, a more integrated approach among different services would improve data sharing and record keeping, allowing services such as the Hub to store more complete information on service users *before* they accessed the Hub and *after*. This would aid the implementation of a more integrated care approach, in which different care providers and settings have access to shared service users data to improve their services and the quality of care they offer, in line with the action plan set by the NHS (2021).

There is growing consensus that integrated and collaborative service provisions are a more effective way of delivering mental health and wellbeing support to children and young people (Settipani et al., 2019), compared to more traditional clinic-based provisions. However, relatively little is currently known as to *how* to establish these integrated community mental health services and *how* to help them be as effective as possible for the communities they serve. Therefore, despite common limitations of field-based research, this study offers novel insights that could support the development and evaluation of future mental health community Hubs.

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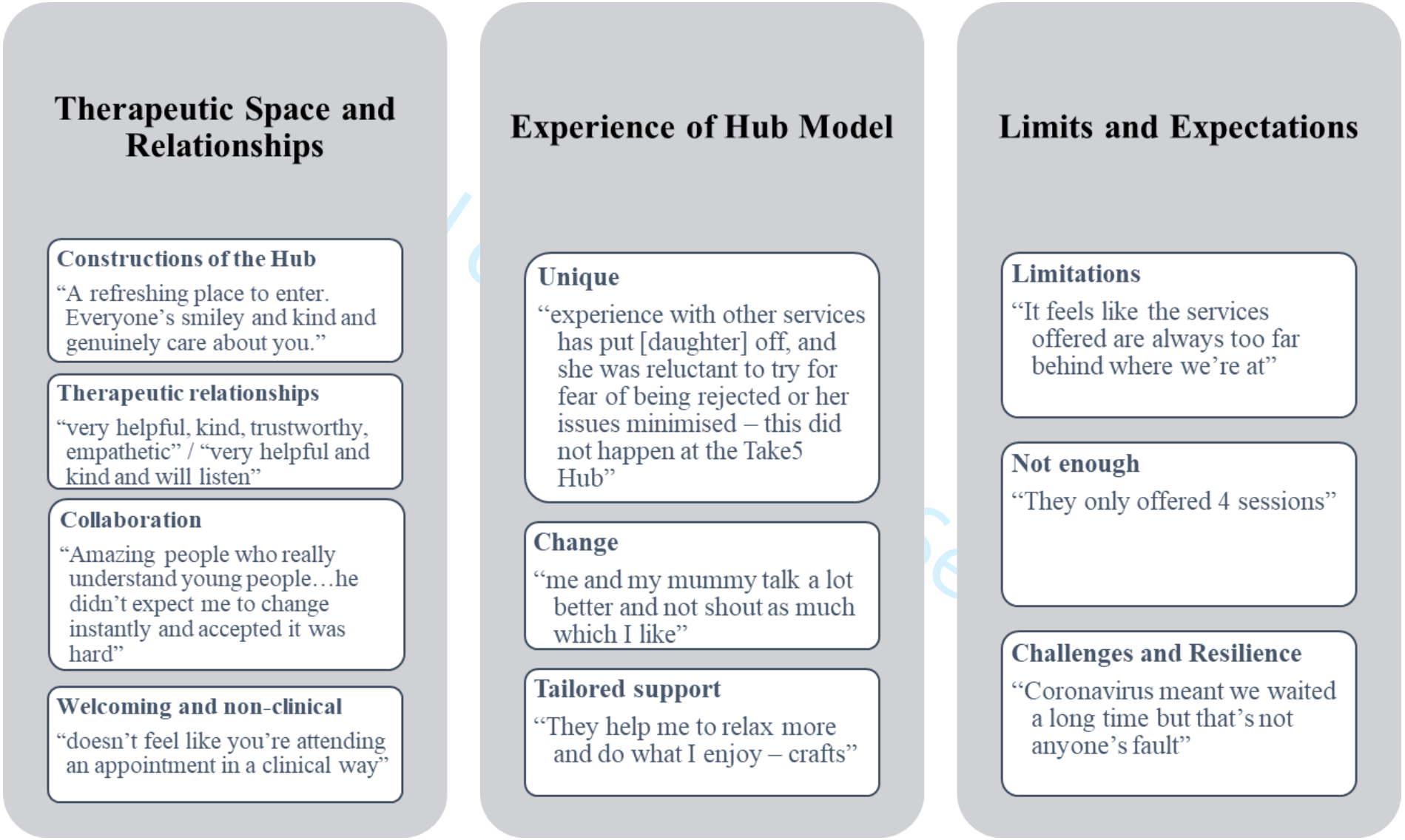
Table 1: *Demographics of participants for qualitative data*

Characteristic	Frequency (%)
Gender (n=40)	
Female	27 (68%)
Male	10 (25%)
Non-Binary	3 (8%)
Age (n=40)	
12 and under years	13 (33%)
13-15 years	7 (18%)
16-18 years	5 (13%)
18 years and above	15 (38%)
Ethnic Origin (n=36)	
White British	31 (86%)
Pakistani	3 (8%)
Asian	1 (3%)
Black British	1 (3%)
Have your Expectations been met? (n=39)	
Yes	33 (85%)
Partially	3 (8%)
No	3 (8%)
Which services have you used? (n=43)*	
Early Intervention	26 (60%)
Drop Ins	7 (16%)
Counselling	3 (7%)
CYP Therapeutic Courses	2 (5%)
Wellbeing Activities	2 (5%)
Solution Focused Interventions	1 (2%)
Family Solutions	1 (2%)
Children and Young People Together	1 (2%)
*Service users can access more than 1 service	

Figure 1: *Content Analysis Synthesis*



Abstract

Purpose

Half of adulthood mental health challenges begin by 14-years-old, making the need for early-intervention clear. The current study aimed to evaluate a new service model that promotes early-intervention through a community based low-intensity Hub.

Methodology

Clinical data from 2,384 young people were analysed through within-group, pre- and post-comparisons, and qualitative survey and interview data was analysed through content analysis.

Findings

Overall, participants reported they were highly satisfied with the Hub and the low-intensity brief interventions met their needs. Participants reported that learning new skills, having a place to talk and positive therapeutic relationships were beneficial. The Hub appeared to be less successful for young people with complex mental health difficulties. As a service, the adoption of the Hub model reduced waiting list times by more than half.

Research Implications

The quantitative data demonstrated that engaging with the Hub reduced symptoms of psychological distress. Qualitative analyses suggest that access to local, community, welcoming and "less clinical" support was beneficial, and the type of brief interventions offered was less important than therapeutic relationships.

Originality

This is the first study of a novel 'Hub' model for low-intensity brief interventions in a socio-economically deprived area of England. Local knowledge, community integrated support, therapeutic relationships, and a welcoming environment were viewed as more beneficial than the type of brief interventions offered. Consequently, community spaces can be created to be therapeutic and beneficial for mental health outside of a traditional conceptualisation of clinical support.

Key words: Community; Hub; Brief Interventions; Mixed Methods Evaluation

"Friendly, Local and Welcoming" - Evaluation of a Community Mental Health Early Intervention Service.

Children and young people are experiencing increasing challenges to their mental health, with services reporting they are "constantly firefighting" to meet demand for support (Health and Social Care Committee, 2022). In 2022, 18.0% of 7-16-year-olds were identified as having a probable mental disorder (NHS Digital, 2023). Child and adolescent mental health difficulties have increased in scale and complexity in recent years, with COVID-19, school closures, and social media-based bullying all cited as aggravating factors (Anderson, Newlove-Delgado, et al., 2022). The COVID-19 pandemic and related disruptions for children and young people has had a profound impact upon young people's mental health, with difficulties increasing by 5.2% (Newlove-Delgado et al., 2021). Epidemiologically, the greatest immediate threat to adolescents from COVID-19 is to their mental health (Sprang & Silman, 2013; Zhou et al., 2021). Prior quarantines during pandemics have shown increases in adolescent anxiety, grief and post-traumatic stress (Loades et al., 2020). Young people at pivotal transitional stages may be at even higher risk of loneliness, socioemotional distress, and economic uncertainty (Bu et al., 2020). Recent history indicates domestic violence, child abuse, neglect, and exploitation are all likely to increase during public health emergencies, although relatively little is known about the long-term mental health effects of global viral outbreaks for adolescents (Lee, 2020). Therefore, it is likely that more young people will need additional help from mental health services, which will need to evolve and adapt to meet growing demand.

In the United Kingdom (UK), the National Institute for Health and Care Research's 2020-2030 health agenda has prioritised innovative and accessible research with children and young people, recognising that the majority of long-term mental health difficulties begin in childhood (National Institute for Health Research, 2020). Youth mental health services in the UK have been cited as lacking in community-based services and preventative, early interventions (Vusio, Thompson, Laughton, & Birchwood, 2021). A recent review has tentatively suggested parent training and early, preventative cognitive behavioural therapy (CBT) interventions could be cost-effective approaches to reduce anxiety related distress for young people (Anna-Kaisa, et al., 2022). Additionally, cross-service collaborations and early intervention models show promise (Tudor, 1996), as children and young people are often particularly vulnerable to environmental factors, such as parental addiction or unemployment (Coates, 2017). As a result, young people who require support frequently engage with multiple agencies, such as schools and mental health services, formal and informal (Cortina et al., 2019). Current research into the prevention and promotion of mental health services for young people recommends integrative, "youth-focused multidisciplinary and trans-diagnostic" services (Colizzi et al., 2020). Therefore, youth-focused, community-based services that offer preventative early therapeutic interventions could be of value to young people, families and communities.

Community-based integrated mental health Hubs offer a joined-up approach and have been identified as valuable resources in improving outcomes in multiple populations around the world, with evidence indicating that they are well received by young people and help improve access, even among 'hard-to-reach' groups (Malachowski et al., 2019). Hubs typically share some key characteristics, such as the use of early intervention and evidence-based tools, environments that are 'youth-friendly', non-stigmatising, and involve family members (Settipani et al., 2019). Effective community mental health provision needs to

provide accessible support that "allows the child to move from being 'somebody else's problem' to working with their family, wider community and environment towards a shared recovery" (Wolpert et al., 2017). This connected approach to integrated care is especially important for young people who may be more susceptible to system fragmentation, particularly those with intersectional vulnerabilities (Settipani et al., 2019).

Brief evidence-based low-intensity interventions for anxiety and depression have been found to be effective for young populations. For example, brief cognitive behavioural therapy (Gallagher & Schlösser, 2015) was determined to have favourable outcomes for children and a brief behavioural activation therapy delivered in children and adolescent mental health services (CAMHS) has also shown good results (Shenton et al., 2021). Additionally, brief guided CBT is as effective as traditional CBT for children with anxiety and is cost-effective. Utilising brief interventions within multi-disciplinary teams can reduce waiting times for patients and quickly improve a person's coping strategies. Additionally, Gallagher and Schlösser (2015) found brief interventions could lead to increases in positive emotions within the family unit and a reduction in distress for young people.

A recent qualitative study found adolescents who had engaged with a brief psychological intervention for depression experienced a positive therapeutic relationship, feeling safe and heard by the clinicians, despite the time constraints inherent in a brief intervention (Shenton et al., 2021). Early brief interventions can also be less disruptive for children as the intervention itself causes minimal disruption to their lives but still yields benefits. As cost-effective tools with generally positive outcomes, brief interventions are well suited for use within low-intensity early intervention community-based integrated mental health Hubs. The current study aimed to evaluate the services offered by a community mental health Hub in one of the most deprived boroughs of England, UK.

Method

Design

The current study sought to establish whether the community based mental health Hub could provide tailored good quality early intervention to support the mental health of children, young people, and families. Through a mixed methods service evaluation, the objectives were to develop an insight into service user experience; establish which elements of the Hub work especially well in terms of integrated service delivery and measures of overall wellbeing; and to draw upon findings to inform recommendations for service development. The study was approved by a National Health Service Research Ethics Committee (REC) and academic REC at the host university. The team worked in two parts throughout the data collection and analysis processes so as not to bias the interpretation of the qualitative data. DD and VS led the quantitative analysis, while SP led the qualitative analysis. The full analysis was then discussed and finalised across the team.

Participants

Routine Outcome Measures from 2,384 young people were analysed to develop an understanding of the characteristics of service users accessing the Hub and to analyse the data related to service provision. Monitoring of survey responses indicated there was no pattern to missed questions, suggesting the questions were generally acceptable.

The staff team at the Hub circulated information about the study to encourage young people and parents/carers to participate. Children and young people aged 8-18-years-old and their parents/carers were invited to take part in the online survey or an informal interview. Before any demographic or qualitative data was gathered, parents and participants aged 16-years-old and over were required to offer their consent, and young people under 16-years-old were required to provide their assent through the Qualtrics platform that hosted all participant facing documentation in digital form. All participant facing documents were reviewed and approved by the RECs prior to use. Due to Public Health England guidance in relation to COVID-19 at the time of data collection, ~~teleconferencing software~~Zoom was used for all interviews due to social distancing restrictions at the time of data collection. The online survey for young people and parents/carers was available from October 2020 to February 2021. Interviews also took place during this time. The survey included demographic, Likert, and open-ended questions. Preliminary analyses were undertaken at the mid-point to ensure the Likert Scales and reflective open questions were relevant and suitable. Overall, 35 service users completed the survey, 21 young people and 14 parents and/or carers. Four children (aged 12 and under) and one parent also volunteered to be interviewed.

(Insert Table I: *Survey and Interview Participant Demographics*)

Clinical Records Data

Anonymised data from the service user's clinical records were screened for accuracy of data entry and missing values. Descriptive statistics were analysed in terms of mean and standard deviations, heteroscedasticity was checked using Scatter Plot diagrams and normality assumptions were checked using the Kolmogorov–Smirnoff test. Pre- and post-intervention changes were evaluated using pairwise comparisons (Wilcoxon Signed Rank test for matched-pair data, as the variables considered were not normally distributed) and Cohen's (1988) effect sizes were calculated. Spearman's rank correlations were used to assess presence and direction of the relationships between the initial diagnosis/presenting symptoms, the number of interventions attended, and the improvements obtained by service users. All statistical analyses were performed using SPSS (version 27). A p value of <0.05 was used to identify statistical significance. The data considered were related to the period July 2018 to March 2021 and their analyses allowed us to explore: (1) personal characteristics (e.g., demographics) of the children and young people accessing the Hub; (2) reason (e.g., anxiety) for which they accessed the Hub; (3) services they accessed after leaving the Hub; (4) outcomes for mental health symptoms.

Qualitative Data Collection

Qualitative data, analysed through content analysis, aimed to explore service user experiences of engaging with the Hub. A preliminary literature review and discussions with the Hub team and referring services informed the nature of questions asked in the interviews and survey, which were the same to ensure parity. The topic guides for the interviews were used to facilitate conversation, with participants actively encouraged to reflect on their experiences and expand their answers. Content analysis is commonly used to analyse written data, which formed the majority of the qualitative data collected. An analytic matrix was developed by SP and ZE, deductively from the concept categories from the questions asked, and inductively from the emerging analytical categories from the data

itself. Consequently, six researcher-led predefined concept categories and four analytical categories were identified through the analytic process, which involved the preparation, classification, and coding of data, writing passages for the categories to generate emerging themes, and finally undertaking a synthesis to form the final three themes (Figure 1; Kuckartz, 2019). The synthesis was then agreed by all members of the research team.

Results and Findings

Routine Outcome Measures

Routine Outcome Measures (ROMs) are commonly used in children and young people's services to evaluate change in a young person's difficulties, usually taken before and after an intervention. ROMs typically take the form of questionnaires or surveys, completed by a young people, their parent, teacher or therapist (Waldron, Loades, & Rogers, 2018). Overall, most of the young people accessing the Hub were aged between 13 and 16-years-old. Young females were slightly more likely to be accessing the Hub than young males, with a female to male ratio of 47:39 from available data on gender. A minority of service users (0.1%) self-identified as 'other' and 0.4% chose not to disclose their gender identity ('prefer not to say'). Most of the young people accessing the Hub were White (59.4%) with White British (57.6%) being the most frequent ethnic sub-group, followed by Pakistani (4%) and Bangladeshi (2%). The most common reason for referral to the Hub was anxiety (35.1%) followed by anger (31.5%), low mood (15.1%) and low confidence (4%). Males were most likely to attend for difficulties with anger (20.6%) and females were most likely to seek help for anxiety (23.1%). These gender discrepancies are reflective of the national picture for mental health referrals and likely to be due, at least in part, to social conditioning and gender inequalities in how children develop their individual response to the experience of distress. A minority of young people also presented a diagnosis of autism (7.6%) and learning disabilities (12.4%).

The Young person's CORE (YP-CORE10; Twigg et al., 2009) is one of the ROMs routinely used by the Hub to assess commonly experienced symptoms (e.g., anxiety and depressive symptoms), subjective wellbeing and global functioning (Twigg et al., 2009). YP-CORE10 scores indicated that the majority of young people who accessed the Hub experienced a benefit, with the severity of their reported symptoms reducing from 'moderate' (M = 16.4, SD = 0.2) to 'mild' (M = 11.09, SD = 0.2), according to YPCORE10 categories of distress – Healthy (0–5), low (6–10), mild (11–14), moderate (15–19), moderate-to-severe (20–24), and severe (25 and above; O'Reilly et al., 2016). A Wilcoxon Signed Rank Test revealed a significant reduction in psychological distress following attendance to the Hub (z = -18.419, p = < .001) with a medium effect size (r = .0.62) and a median YPCORE10 score reduction from pre-intervention (16) to post-intervention (9).

The Systemic Clinical Outcome and Routine Evaluation-15 (SCORE15; Stratton et al., 2010) is the outcome measure used by the Hub to assess young people's reported levels of family functioning and the higher the scores obtained on this measure are, the worst the individual rates their family functioning (Stratton et al., 2014). The comparison between the scores obtained by service users when accessing the Hub (M = 43.9, SD = 7.3) and the ones obtained at discharge from the service (M = 31.25, SD = 13.2) indicate an improvement in young people's perception of their family life. The difference between these scores was

statistically significant (z = - 5.405, p = <0.001), meaning that the services offered by the Hub contributed to an improvement in the global family functioning, with a medium effect size (r = 0.67). Neither the type of presenting issue motivating the referral to the Hub (r_s = .005, p = .900; r_s = -.098, p = .854), nor the number of interventions attended (r_s = .037, p = .285; r_s = .059, p = .639) were significantly related to the improvements reported by the service users (assessed via YPCORE10 and SCORE15), indicating that other aspects of the service offered (e.g., quality of the therapeutic support, the relationship between clinicians and service users, the contents of the interventions proposed) may have contributed to the large-scale improvements outlined by the outcome measures used.

Most of the young people accessing the Hub engaged with one intervention. However, some accessed more than one intervention within the Hub, with 10.8% accessing two interventions and 0.6% accessing a third. The majority of those who engaged with more than one intervention engaged with 'Early interventions' (41.8%), followed by 'Counselling' (19.6%) and then a 'Therapeutic group' (15.6%). It is not clear from the data what cumulative benefit accessing multiple services has, although it is representative of the holistic and accessible nature of the Hub.

Some popular services are also delivered outside of the interventions measured through ROMs, such as the arts and crafts groups, which means their benefit is essentially not recorded through the ROMs. The staff team can work across interventions when needed to provide tailored individualised care for young people with complex needs, which is also not accounted for in the ROMs but an important key performance indicator of child-centred needs-focused care and therefore important to document ~~none-the-less~~nonetheless. The staff team recognised the need for ROMs collection but also accepted that this process was time consuming and could reduce the amount of therapeutic time they had with children and young people. In terms of *what* was being measured and *how*, the traditional methods of ROMs collection ~~was~~were not particularly well suited to the holistic and responsive nature of the Hub. Consideration should be given as to how measures may need to be adapted to suit this novel integrated holistic model of community-based services. In terms of the other key performance indicators of the Hub, waiting lists have reduced through the implementation of the Hub model from an average of eight weeks from referral to initial appointment to three weeks as of March 2021.

Survey and Interview Data

The survey data indicated that 86% of parents stated their child received a good quality service from the Hub and received help when they needed it. Additionally, 79% said their child's needs had been met and the Hub provided family-friendly support. Finally, 71% of respondents said their child felt positive about the care they had received, and that the Hub had manged COVID-19 well.

Theme 1: Therapeutic Space and Relationships

The Hub was described as a place, a helping non-judgemental and welcoming space, as well as somewhere that could offer therapeutic relationships and scope for collaboration: "somewhere to get help" (child); "a useful service" (parent); "kind, welcoming, caring and supportive" (parent); "Thank you for making this lovely place". The purpose of the Hub is to provide low-intensity early brief intervention, which young people reported was helpful: "Its brilliant and it helps through regular support… Um, given me a bit of confidence" (child).

Two emerging themes developed in relation to therapeutic relationships and collaboration, which was described in terms of personal qualities of the staff and how clients felt: "very helpful and kind and will listen" (child); "Open, welcoming, peaceful, warm, relaxed" (parent); "very talkative and fresh, made me feel welcome and comfortable" (child). The emerging theme of 'collaboration' was distinct from 'therapeutic relationships' as it suggested that feeling heard and validated led to the action of proactively working for improved mental health with a practitioner: "Amazing people who really understand young people…he didn't expect me to change instantly and accepted it was hard" (child); "easy to start working with, very helpful, approachable" (parent).

Theme 2: Experience of the Hub Model

Although the Hub provides low-intensity brief interventions through a relatively junior mental health team, service users were complimentary about their skills and knowledge; "They are clearly knowledgeable and well connected in the [X] area" (parent); "Full of people who understand children and know how to help" (parent). The experience of the Hub was also described as 'less clinical' than other mental health services, which meant it was more accessible and acceptable as a service, for example, "experience with other services has put [daughter] off, and she was reluctant to try for fear of being rejected or her issues minimised – this did not happen at the [X] Hub" (parent); "Doesn't feel like you're attending an appointment in a clinical way" (child). In terms of reaching their community, the staff team also used mediums that many statutory services do not, with good effect: "[Hub] also has social media which is like a mini [Hub] service for us at home. I can also always get through to someone on the phone" (parent). Finally, the Hub aims to become fully integrated into the community and with other services, such as schools, which was appreciated by service users s, "a variety of services including transfer to adult services" (staff).

Theme 3: Limits and Expectations

The qualitative data was collected during one of the UK lockdowns, which meant that many appointments were undertaken through ~~teleconferencing software~~Zoom. This aspect of service delivery was met with mixed responses; "I would have preferred not to be online" (child); "Coronavirus meant we waited a long time but that's not anyone's fault" (parent); "it's not quite the same over the phone" (parent); "I think Zoom, it works quite well. Um especially in the winter, when it's, you know, darker outside and its bad weather and you can still sort of get on with it especially if you've got more than one child" (parent). Additionally, the brief nature of the interventions offered flexibility and shorter waiting lists, although some young people and parents did not feel it was enough, "They only offered 4 sessions" (parent), and could prevent family participation: "family didn't participate" (child), "my family wasn't a massive part of it" (child), "Not long enough to speak to parents in the initial meeting" (staff). Finally, The Hub had begun to offer a small range of additional sessions from volunteers that were focused on creativity for wellbeing. These were appreciated by many of the children, although there was also a recognition that these interventions were not suitable for young people with more complex difficulties and high levels of distress: "some volunteers are not equipped to be dealing with the level of problems" (parent).

Discussion

Evaluations of Hub models have highlighted five key areas of focus for service development: (1) Communication; (2) Hub 'Nuances'; (3) Leadership; (4) Staff; and (5) Challenges (Colizzi et al., 2020). Within our evaluation, communication was favourably viewed, with service users able to contact the Hub easily through a range of platforms. The nuances of the Hub were explored through the qualitative data. The Hub was viewed as a welcoming and less clinical access point for brief mental health support. Worryingly, recent research indicates practitioners in mental health services are less likely to have friendly conversations with people from ethnic minority communities and are less likely to involve them in decision making (Khan, 2014). There were no indications of this behaviour at the Hub. The Hub promotes a child-focused approach that empowers young people to make decisions about their health and wellbeing and also promotes a friendly inclusive environment.

The 'simple strategies and tools' provided by the Hub were valued by service users and their goal focussed compassionate support was viewed as beneficial and 'refreshing'. An additional nuance that emerged was that practitioners were tailoring the brief interventions for each service user by drawing on the overall resources of the Hub. For example, if a child was receiving a brief intervention for low self-esteem but was also experiencing anxiety and low mood, the practitioner would include resources and techniques from other pathways to provide individualised holistic care. If this evaluation were to be conducted again, without COVID-19 restrictions, it would have strengthened the evaluation to observe the flexible approach of the Hub in person, perhaps developing an ethnographic account of their holistic approach. Observations would offer helpful information about how the flexibility described is offered and received. It would also have been helpful to speak with a greater number of young people and parents about their experiences to benefit from a broader array of perspectives. Research teams conducting evaluations in the future may wish to consider options for creating additional safe sharing spaces for young people and families to reflect on the impact of such services in their unique setting, perhaps through realist methods, which are increasingly showing benefits for exploring what is working well for young people's mental health services, and why (~~e.g.~~e.g., Lane, et al., 2021). Young people of Black, Asian and minoritised ethnic communities~~Black and Asian young people~~ in the UK are reported to experience higher levels of psychological distress due to a range of intersectional ~~risk factors~~inequalities (Ollendick, 2014) but are less likely than White peers to be able access youth mental health services (Dixon et al., 2016). The COVID-19 pandemic disproportionately affected young people from ethnic minority groups, with the true impact for individuals only now becoming clear in terms of the individual, relational and practical support that young people want (e.g., Lenoir & Wong, 2023). A recent study of how young people from ethnic minorities access CAMHS demonstrated the important role of school referrals for children of Black African and Black Caribbean heritage ~~young Black people and children~~ in particular (Edbrook-Childs & Patalay, 2019). Schools can provide an environment to engage children and young people with mental health support (Coates, 2017; Settipani et al., 2019) and teachers are often the first adults that children disclose mental health concerns to (Coates, 2017; Ford et al., 2007). Successful holistic integration between schools and community mental health services particularly supports timely mental health access for children and young people from low-income urban areas (Atkins et al., 2015). Recent research into the inequalities of referral pathways for Black, ~~Asian~~Asian, and ethnic minority ~~Ethnic Minority~~ communities has also highlighted that young people of Black African and Black Caribbean

heritage ~~Black people~~ are significantly more likely to be referred to inpatient and crisis services, which is perhaps indicative of referral inequalities and a lack of access to early intervention (Chui et al., 2021). Potentially, integrated community mental health Hubs could play a significant and vital role in disrupting these harmful referral processes and remove some of the barriers and health inequalities to accessing timely early intervention.

Participants described both positive therapeutic relationships and aspects of collaboration with the staff of the Hub, which indicates an absence of a hierarchy often present within traditional mental health service structures. Collaboration was also one of the fundamental ingredients for a Hub as set out in Settipani's (2019) review, which the current ~~review~~ study supports.

Within this evaluation, the clinical records data was interrogated and checked carefully. However, there were a number of limitations in the dataset, which prevented further interpretation. Hubs could enhance the quality and accuracy of data collection for evaluation purposes by training staff on the purpose and importance of routine data collection, to check p service users' understanding prior to completion of self-report measures and using appropriate and recognisable terms to collect demographic information. Within child and adolescent mental health services, it is also helpful to employ commonly used measures, such as the Strengths and Difficulties Questionnaire (SDQ; e.g., Vugteveen, de Bildt, & Timmerman, 2022) to facilitate comparing one's own data set to wider research in the field. Additionally, a more integrated approach among different services would improve data sharing and record keeping, allowing services such as the Hub to store more complete information on service users *before* they accessed the Hub and *after*. This would aid the implementation of a more integrated care approach, in which different care providers and settings have access to shared service users data to improve their services and the quality of care they offer, in line with the action plan set by the NHS (2021).

There is growing consensus that integrated and collaborative service provisions are a more effective way of delivering mental health and wellbeing support to children and young people (Settipani et al., 2019), compared to more traditional clinic-based provisions. However, relatively little is currently known as to *how* to establish these integrated community mental health services and *how* to help them be as effective as possible for the communities they serve. Therefore, despite common limitations of field-based research, this study offers novel insights that could support the development and evaluation of future mental health community Hubs.

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We thank the reviewer for these observations and recommendations, and have addressed each point below to improve the final manuscript.

Reviewer(s)' and Associate Editor Comments to Author:

Reviewer: 1

Recommendation: Minor Revision

Comments:
See comments. I appreciate the efforts the authors have made to respond to the points raised in the previous review.

Additional Questions:
1. Originality: Does the paper contain new and significant information adequate to justify publication?: See previous comments: there is sufficient information to justify publication.

2. Relationship to Literature: Does the paper demonstrate an adequate understanding of the relevant literature in the field and cite an appropriate range of literature sources? Is any significant work ignored?: For me, this is satisfactory. I appreciate there can be demands with fitting a lot in with w/c, but useful work relating to the challenges with online-based care delivery are overlooked.

The evaluation explored the experience of engaging with a community based mental health Hub, so online mental health support was not a focus or aim of the current study.

3. Methodology: Is the paper's argument built on an appropriate base of theory, concepts, or other ideas? Has the research or equivalent intellectual work on which the paper is based been well designed? Are the methods employed appropriate?: Generally speaking, yes. There are more obvious limitations as a service evaluation, but for a more modest study, the methods are appropriate.

We appreciate the flexibility in relation to what methods are available to use in service-based research, without the controls and resources that may be available for a trial, for example.

4. Results: Are results presented clearly and analysed appropriately? Do the conclusions adequately tie together the other elements of the paper?: As previously, I think the quotes from the participants should include some indication of who the participant was,

i.e. if it was parent, carer, young person and age and gender where possible. This is usual practice for the presentation of qualitative findings and helps to evidence that the material used represents different participants (and were not just quotes that simply support any claims made). On this point, there is less of a sense of a critical synthesis in the development of the themes - more the grouping of comments deemed to address similar topics.
We have attributed quotes to children, parents, or staff. The quotes presented are based on the quotes that formed each theme from the concept categories.

5. Practicality and/or Research implications: Does the paper identify clearly any implications for practice and/or further research? Are these implications consistent with the findings and conclusions of the paper?: Implications are discussed.

6. Quality of Communication: Does the paper clearly express its case, measured against the technical language of the field and the expected knowledge of the journal's readership? Has attention been paid to the clarity of expression and readability, such as sentence structure, jargon use, acronyms, etc.: Generally speaking. I would respectfully disagree with the authors re their response regarding the inclusion of the quote in the title, although I appreciate it is their prerogative.

We would prefer to leave the title as it is, although we are happy to leave the final decision to the editor.

Reading through, I noticed the following:

p.14 in PDF: COVID – is colloquial changed to COVID-19
Have mental health difficulties 'increased in complexity' in recent years? Are the authors' implying they weren't complex before? We would agree that complexity has always been a feature of mental health difficulties for some people. However, the multifaceted impact of the pandemic upon young people's day-to-day lives and the availability of support does seem to have led to a situation in which young people faced additional stressors, often needed to wait longer for mental health support, and as a consequence, are often experiencing more severe and complex challenges by the time they are able to access support (e.g. Anderson, Newlove-Delgado, et al., 2022).

National Institute for Health Research is now the National Institute for Health and Care Research This has now been amended.

p. 17: Please clarify if it was written informed consent or if a protocol was used if it was only verbal consent. Ethical practice would dictate this. Written assent/consent was gained via Qualtrics. A sentence has been added to explain this.

p. 19: 'none-the-less': nonetheless Amended
'large-scale improvement'? Amended
Can the Hub be 'holistic' itself? Is it not the approach that is holistic? We have discussed a 'holistic approach' and 'holistic care'
p. 20: teleconferencing software? Amended to 'Zoom'.
p.22: 'current review supports'? Do you mean 'findings of the current study support'?
one's own data? The services' data... Amended to 'current study'.