Advantage Evaluation Report

Initial Findings — September 2021

Janelle Spira, Assistant Psychologist
Dr Hannah Prytherch, Clinical Psychologist
Dr Nick Isaacs, Consultant Psychiatrist

Table of Contents

Abstract

Despite the dire need for mental health support for young people, many young people lack access to mental health services. The Advantage programme aimed to overcome barriers and increase access to mental health support for young people by providing community-based support through a partnership between the NHS and local football clubs. Demographics were analysed for 23 young people and after 6 months of participating in Advantage, the quantitative outcomes of 8 young people were analysed and semi-structured interviews were completed with 5 young people. Results demonstrate that Advantage successfully overcomes barriers young people face to accessing mental health support, including age, gender, minority ethnicity, and stigma. Six months of participating in Advantage was found to improve young people's life functioning, decrease stress levels, improve wellbeing, and help young people achieve significant progress towards their goals. Qualitative analysis revealed three themes for how Advantage supports young people: accessibility (through ease of accessing Advantage and the flexibility of the intervention), improved wellbeing through relationship (through opening up and growing in confidence), and seeing a change (through progress towards goals and noticing a difference in themselves). In light of these findings, more community-based forms of mental health support like Advantage should be provided for young people, and it is recommended that Advantage should be made available in other geographical areas in the U.K. to provide mental health support for more young people.

Introduction

Young People's Mental Health

Nearly one in four adults in the U.K. experiences a mental health problem (McManus et al., 2009) with seventy-five percent of mental health problems starting before a child reaches his or her eighteenth birthday (Murphy & Fongay, 2012). Hence, providing mental health intervention for young people is essential.

During the unprecedented time of COVID-19, young people's mental health came to the forefront of global conversations as lockdown, fear, uncertainty, and isolation exacerbated mental health difficulties in some young people and triggered new mental health difficulties in others. Studies demonstrated that 17.6% of young people (5-16 years old) and 20% of young adults (17-22 years old) experienced mental health difficulties during the COVID-19 lockdown in July 2020 (Early Intervention Foundation, 2020). Therefore, it is crucial to consider how to meet the mental health needs of young people through pre-existing mental health services and through new approaches designed to fill gaps and overcome barriers that some young people may face in accessing pre-existing mental health services, such as Child and Adolescent Mental Health Services (CAMHS).

CAMHS

Child and Adolescent Mental Health Services (CAMHS) are NHS-funded services that provide specialist support to children and young people experiencing mental health difficulties and their families in the United Kingdom. CAMHS offers children and young people up to the age of 18 specialist mental health assessment, diagnosis, and intervention. Mental health professionals within CAMHS include psychiatrists, psychologists, mental health nurses, and family therapists who collaborate with young people and families to choose the most

appropriate form of support for them. CAMHS provides support for difficulties such as low mood, anxiety, Obsessive Compulsive Disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), learning disabilities, Post-Traumatic Stress Disorder (PTSD), eating disorders, behavioural difficulties, attachment difficulties, and emotion regulation difficulties. Although CAMHS seeks to provide mental health support to all young people, barriers prevent some young people from accessing support from CAMHS.

Barriers to Accessing Mental Health Support

CAMHS services are NHS-funded Tier 3 services, which means that they provide specialist support to young people. Some young people may not meet the threshold for a Tier 3 service, and will, thus, be directed to Tier 2 forms of support, such as mental health support in school with a school counsellor. Some boroughs in the UK have more extensive Tier 2 support than others, and there are some boroughs that have minimal Tier 2 support available (Audit Commission, 1999). This raises the question of how young people's mental health needs can be adequately supported if they do not meet Tier 3 CAMHS thresholds and also lack access to Tier 2 support.

Additional barriers to accessing support from CAMHS include factors such as ethnicity and stigma. Studies have demonstrated that minority ethnic groups are underrepresented among referrals to CAMHS (Stern et al., 1990; Hillier et al., 1994; Skokauskas et al., 2010). Moreover, ethnic minority young people are underrepresented among self-referrals to CAMHS (Messent & Murrell, 2003) and are more likely to be referred to CAMHS through youth justice/social services rather than through primary care in comparison to White British young people (Edbrooke, Child & Patalay, 2019). Low self-referral rates to CAMHS among minority ethnic groups could be explained by factors such as the fear of gossip, stigma about mental health (Bradby et al., 2007), and distrust of mental health professionals (Memon et al., 2016). Past negative experience with services may also discourage some young people and families from seeking support from CAMHS (Memon et al., 2016).

Additionally, gender and age are potential barriers to accessing services. Studies show that females are more likely to seek support from mental health services (WHO, 2002) and are more likely than males to report signs of common psychological difficulties (National Statistics, 2003). This could be explained by increased stigma among males around accessing mental health support or admitting to experiencing psychological difficulties. Age also plays a key role in accessing support from mental health services. CAMHS supports young people up to the age of 18, after which they can seek support from Adult Mental Health Services (AMHS). Whereas CAMHS emphasizes managing developmental and emotional difficulties (Lamb & Murphy, 2013), AMHS are often more focused on addressing serious and long-term psychiatric disorders, which can mean that young adults with less serious, but still significant mental health difficulties are less likely to receive support from adult services (Birchwood & Singh, 2013).

In light of the impact of COVID-19 on young people's mental health and the numerous barriers that prevent young people from accessing mental health support from CAMHS, it is important to consider what other forms of mental health support are available for young people.

Advantage

Advantage is a new mentoring programme designed to support young people aged 14-21. Advantage was launched in response to the COVID-19 pandemic to provide support to young people whose mental health and wellbeing was affected by the pandemic. Advantage is a partnership between West Ham United Foundation (Newham), Arsenal in the Community (Hackney), Leyton Orient Trust (Waltham Forest), East London NHS Foundation Trust and North East London NHS Foundation Trust. Advantage focuses on improving education, employment options, and physical activity and helps young people to re-establish aspirations and a sense of connection. Advantage participants receive ongoing individual mentoring support from a trained youth worker, who is in turn supported by CAMHS practitioners.

As a community-based form of support, Advantage may be well placed to overcome some of the barriers young people face to accessing other sources of mental health support. Basing support in local football clubs may decrease stigma for young people and may encourage young people who are less likely to access traditional mental health services like CAMHS to engage with Advantage. Additionally, Advantage does not have a high threshold to entry like CAMHS, so it is able to provide mental health support to young people who otherwise might lack access to support.

As a pilot project, Advantage looked to offer and demonstrate impact in the following areas:

1. Coaching and Connecting - Offering a relationally-informed coaching intervention to help young people rebuild their self-esteem and sense of connection with their communities and get themselves back on track to achieve and aspire for the future.

2. Achieving Goals - To support young people to reach self-directed goals and to utilise this goal setting skillset for the future.

3. Addressing Wellbeing - To support the physical and emotional wellbeing of young people through a trusted relationship with their mentor, as well as through an individually tailored and bespoke offer of activities that provide a focus on education, employment, and physical activity.

4. Working within an age of uncertainty - To support young people transitioning from lockdown to ‘new normal’ and facing the world of uncertainty, and acknowledging the stresses and anxieties that may accompany this uncertainty.

5. Building on learning and ensuring sustainability - To rigorously (qualitatively and quantitatively) evaluate the impact of this work so that all learning can inform the development of a new, best practice model for community-based support for young people’s mental health, offering scalability and sustainability as future aspirations for this approach.

Aim of Evaluation

The aim of the present evaluation was to report on the initial findings of Advantage. The Advantage pilot was designed to last 12 months with outcome measures being collected at

the start of the project (T1), at 6 months into the project (T2), at the point of exit from the project (T3), and at follow-up 6 months post involvement in the project (T4). Currently some young people have reached 6 months into the project (T2), so this evaluation compares T2 to T1 to give an indication of the initial findings and impact of Advantage on young people's lives.

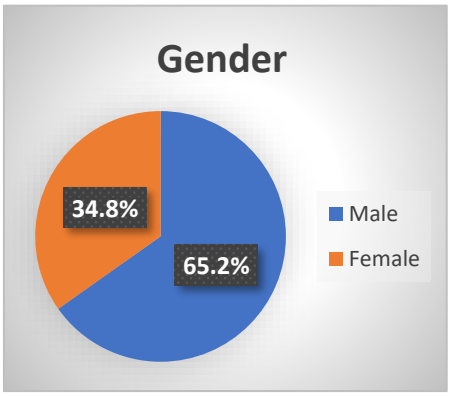
Method

Participants – Inclusion Criteria

The inclusion criteria for Advantage was 14-21 year olds for whom transitioning to adulthood / education was interrupted due to COVID-19. These young people were identified by professionals, such as school teachers, social workers, police officers, and CAMHS practitioners as having emerging mental health and emotional needs that were brought on as a result of the COVID-19 pandemic and their lockdown experience. Young people may have had minimal involvement with specialist mental health services in the past, but at the time of entry onto Advantage, they did not meet the threshold for specialist support and were not open to CAMHS.

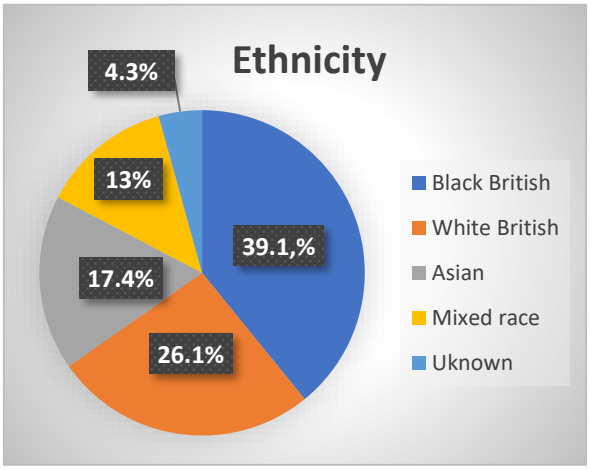
Participants – Demographics

As of August 2021, 23 young people were participating in the Advantage programme (10 in Hackney, 9 in Newham, and 4 in Waltham Forest). The age of participants ranged from 14 to 20 years old, with the **average age being 16.2 years old**.



The majority of participants were male, with there being **15 males (65.2%) and 8 females (34.8%).**

The majority of participants identified as being from ethnic minority backgrounds, with **16 (69.6%) identifying as Black, Asian, or Mixed Race** and **6 (26.1%) identifying as White British**. Within the 69.6% of participants who identified as being from ethnic minority backgrounds, the largest number identified as being Black British (39.1%). The second largest number identified as being Asian (17.4%), and the third largest number identified as being Mixed Race (Black British and White British) (13.0%). The ethnicity of 1 participant was unknown.



The **majority of participants were in education (78.2%)**; however, 5 were not in education or training (21.6%).

Three participants had **special educational needs (13.0%)**, and two participants were **looked after children (8.7%).**

Assessment of impact of COVID-19

In their initial assessment before starting Advantage, young people reported being affected by COVID-19 in various ways. Two themes described the young people's experience of the impact of COVID-19: disruption to daily life and lack of access to coping strategies. Regarding the first theme (disruption to daily life), young people who lived in overcrowded housing or with difficult family dynamics found it difficult spending a large quantity of time at home and often did not have a private place to access online education. Some had finished education, but their employment or training opportunities fell through due to COVID-19, and they struggled to find alternative opportunities.

Regarding the second theme (lack of access to coping strategies), many young people reported having emotional or interpersonal difficulties which they had previously managed through keeping themselves busy and engaging in activities, such as sports. Not having these outlets and coping mechanisms during lockdown resulted in their difficulties escalating.

Design

The evaluation of Advantage was delivered through a mixed methodology of quantitative and qualitative analyses.

Quantitative Data

Looking to capture outcomes that are representative of the aims and objectives of the overall pilot, the following validated outcome measures were used:

- The Outcome Rating Scale (ORS)
- The Perceived Stress Scale (PSS)
- The WHO-5 Wellbeing Scale (WHO-5)
- Goal Based Outcomes (GBOs) – embedded within the mentoring process

The Outcome Rating Scale (ORS) is designed to measure areas of life functioning known to change as a result of therapeutic intervention (Miller et al., 2003). These areas include individual wellbeing, interpersonal wellbeing, satisfaction with relationships, and overall wellbeing. A total score is also calculated, with higher scores representing better life functioning (Miller et al., 2003).

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress (Cohen & Williamson, 1988). It measures how stressful an individual finds their life and the individual's ability to cope with stressful life situations. It also contains questions about current levels of experienced stress.

The WHO-5 Wellbeing Scale (WHO-5) is a self-reported measure of current mental wellbeing (Topp et al., 2015). Questions enable a focus on physical as well as emotional wellbeing, and the overall score ranges from 0, representing the worst imaginable wellbeing, to 100, representing the best imaginable wellbeing.

A single questionnaire (utilising the validated scales) was developed to incorporate the ORS, PSS, the WHO-5 outcome measures. Participants completed this questionnaire with

assistance from a CAMHS clinician at the start of the project (T1) and at 6 months into the project (T2). Although it was originally anticipated that young people would participate in Advantage for 1 year, most young people had met their goals by 6 months. This, combined with the fact that their mentor was leaving, meant that all participants decided to stop Advantage at, or soon after, 6 months of involvement. As such, the T3 measure will now be 6 months post involvement in the project and there will not be a T4 measure.

Over the time that the young people engaged in the programme, they also worked on Goals with their mentor. Mentors were trained by CAMHS clinicians to be able to elicit Goal Based Outcomes (GBOs) as another part of the evaluation. Goal Based Outcomes (GBOs) are a way of evaluating progress towards a goal that a person has set (Law & Jacob, 2015). GBOs compare how far a person has moved towards reaching a goal they set at the beginning of an intervention. Goals are rated on a scale of 0 to 10, where '0' means the goal is not met in any way, '10' means the goal is met completely, and '5' means they are half-way to reaching the goal.

Qualitative Data

Qualitative data was collected in an effort to capture and learn from young people's experience of the programme; both in terms of what they felt had made a difference as well as what could be improved.

The qualitative evaluation of the project involved two key areas of exploration:

- Semi-structured interviews – The Assistant Psychologist for the project conducted semi-structured interviews with 5 young people (4 from Newham and 1 from Hackney) after they were involved with the programme for 6 months. The interviews looked to explore the young people's views on Advantage, the impact it has had on their lives, and what they learnt by being part of the programme (see Appendix A for a list of interview questions).

- Goals Based Outcomes (GBOs) – The actual goals that young people set while they participated in Advantage formed part of the qualitative data set.

Thematic analysis was used to analyse the qualitative data because it is designed to capture the meaning of what participants communicate (Willig, 2013) and, thus, was consistent with the evaluation's aims. The Assistant Psychologist analysed the interview data and goals by identifying overarching themes and explicating how these give meaning to the data (Braun & Clarke, 2006). The themes derived from the data represent the participant's experience in addition to the researcher's attempt to give meaning to it.

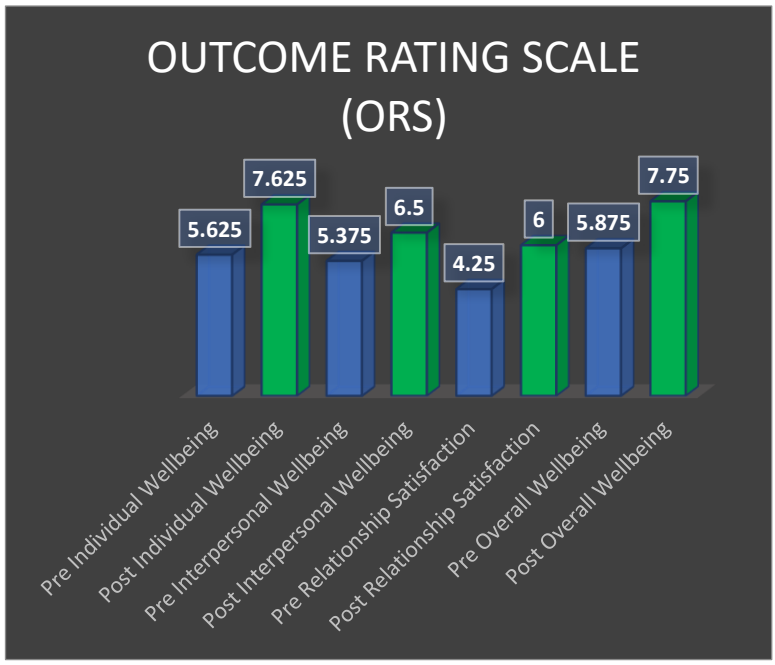
Results

Quantitative Results

At the time of evaluation, 8 young people had participated in the Advantage programme for 6 months or more, so 8 young people were included in the quantitative dataset.

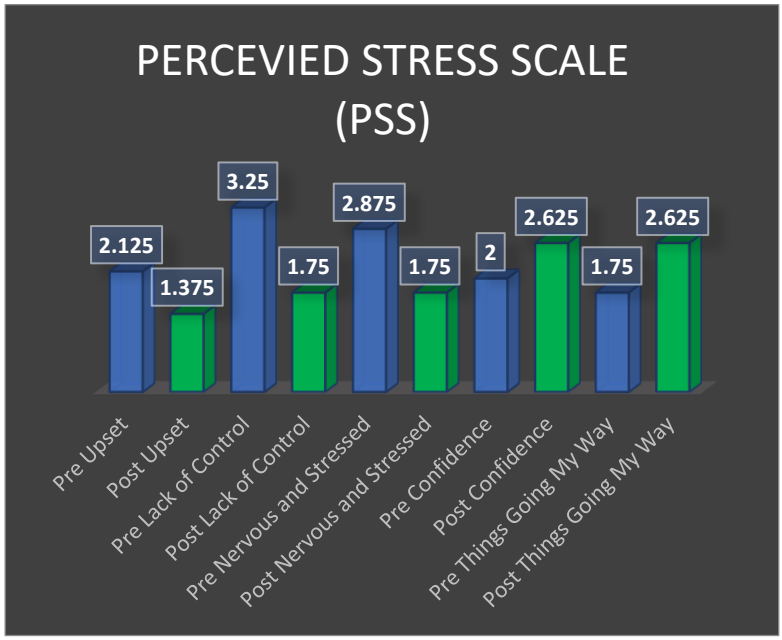
Outcome Rating Scale (ORS)

After 6 months participating in Advantage, on average, young people's individual wellbeing increased by 2 points, interpersonal wellbeing increased by 1.13 points, satisfaction with relationships increased by 1.25 points, and their overall wellbeing increased by 1.38 points. Out of a total possible score of 40 (with higher scores representing better life functioning), young people's average total score when they began Advantage was 21.13. **After 6 months of participating in Advantage, their average total score was 27.88, demonstrating an average increase of 6.75. This indicates better life functioning.**

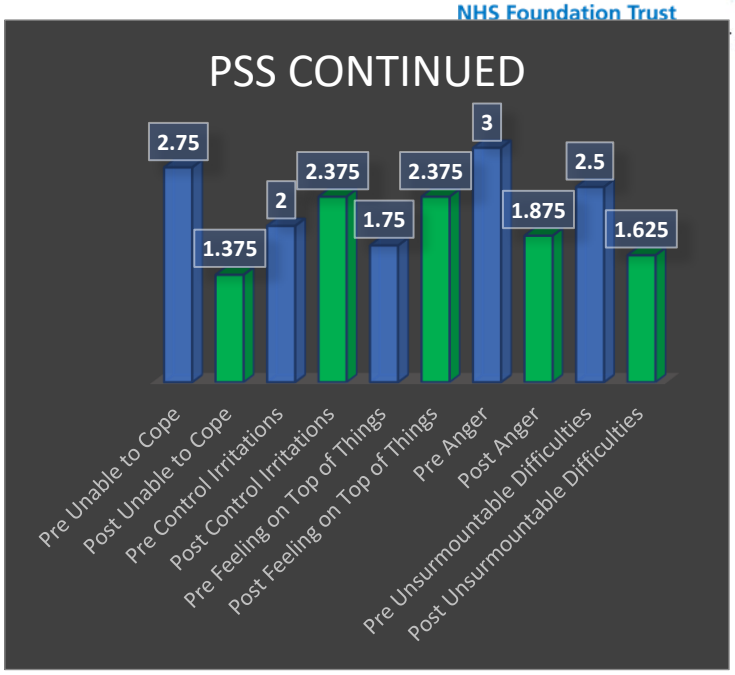


Perceived Stress Scale (PSS)

After 6 months participating in Advantage, on average, young people reported that they felt less upset (a decrease of 0.75 points), less unable to control the important things in their lives (a decrease of 1.5 points), less nervous and stressed (a decrease of 1.13 points), and more confident about their ability to handle their personal problems (an increase of 0.38 points). They felt that things were increasingly 'going their way' (an increase of 0.63 points), and they reported a decrease in not being able to cope with the things they had to do (a decrease of 1.38 points). There was also an average increase in ability to control irritations in their lives (increase of 0.38 points) and increase in feeling 'on top of things' (increase of 0.63 points). Young people reported feeling less angry because of things that were outside their control (a decrease of 1.13 points) and reported a decrease in feeling that difficulties were piling up so that they could not overcome them (a decrease of 1.13 points). Out of a total possible score of 40 (with higher scores representing higher levels of stress), young



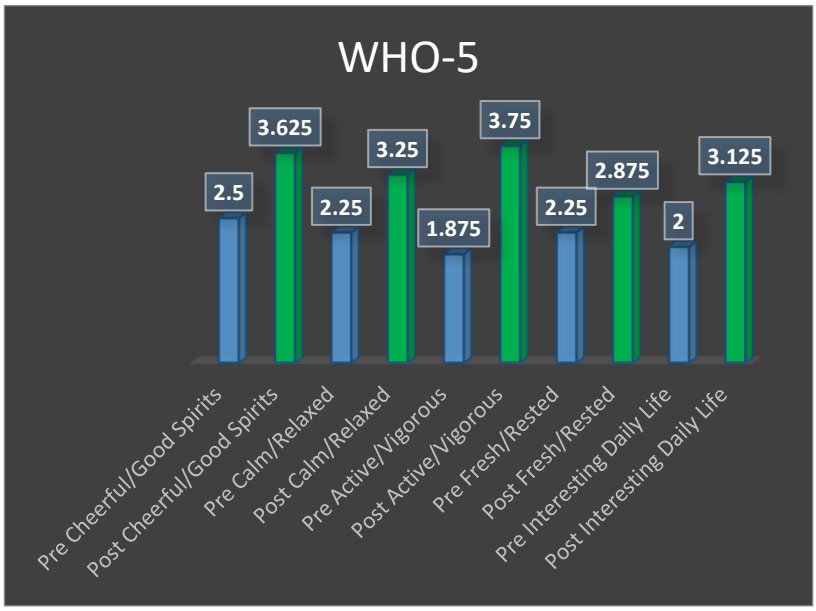
people's average total score when they began Advantage was 24.38. **After 6 months of participating in Advantage, their average total score was 16.5, demonstrating a decrease of 7.88. This indicates a reduction in perceived stress.**

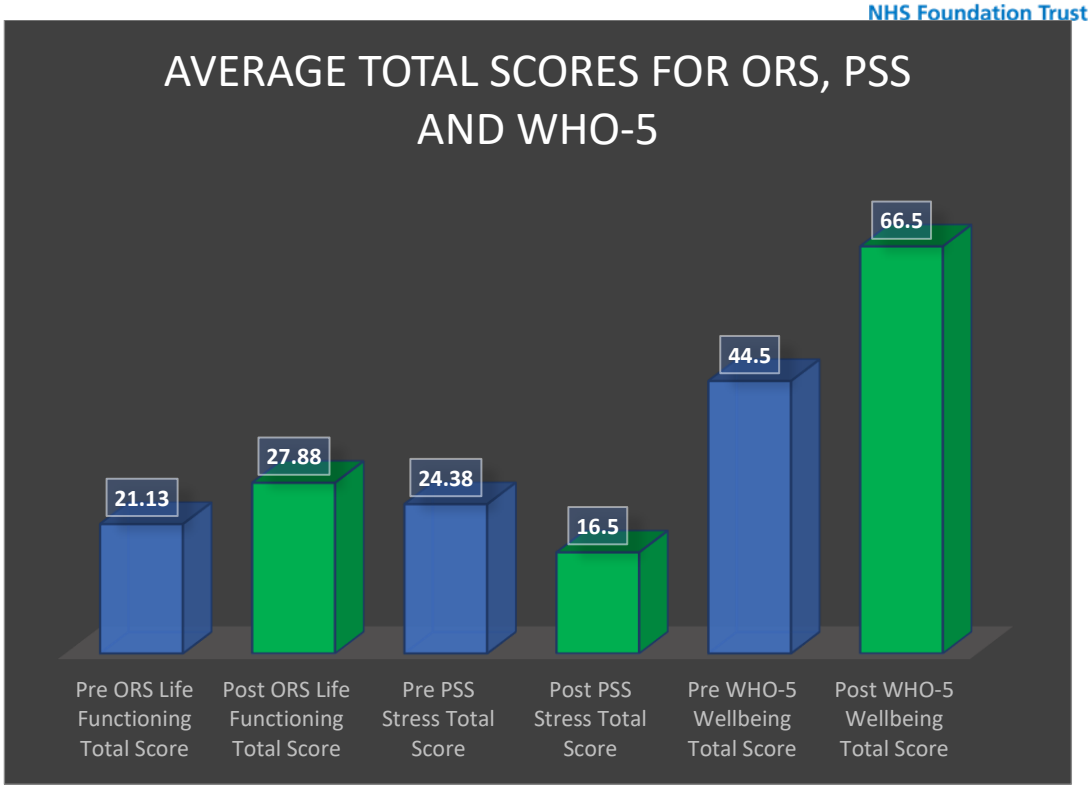


WHO-5

After 6 months participating in Advantage, on average, young people reported that they felt more cheerful and in good spirits (an increase of 1.13 points), more calm and relaxed (an increase of 1 point), and more active and vigorous (an increase of 1.88 points). On average, they woke up feeling more fresh and rested (an increase of 0.63 points) and felt that their daily life was increasingly filled with things that interest them (an increase of 0.88 points).

Out of a total possible score of 100 (with higher scores representing better wellbeing), young people's average total score when they began Advantage was 44.5. **After 6 months of participating in Advantage, their average total score was 66.5, demonstrating an increase of 22. This indicates better wellbeing.**





GBOs – progress towards goals

After 6 months participating in Advantage, **all of the young people made progress towards their primary goal**. On average, they made **5.4 points progress towards their primary goal**. Every young person's progress towards their primary goal was considered reliable change (3 points increase or greater). On average, it took young people 2 months of working towards their goal to achieve reliable change. In addition to their primary goals**,** five young people set a second goal, and they all made progress towards their second goal. On average, they made **4.1 points progress towards their second goal.** This was considered reliable change (3 points increase or greater) for 4/5 young people (80%) and took on average 1 month of working towards their goal to achieve reliable change.

Qualitative Results

Semi-structured interviews

At the time of evaluation, 8 young people had participated in the Advantage programme for 6 months or greater, so all 8 young people were asked if they would be willing to participate in an interview. Five interviews were completed with young people.

Three superordinate goals were derived from the semi-structured interviews with young people: accessibility, improved wellbeing through relationship, and seeing a change. Two subordinate goals were derived for each superordinate goal:

1. Accessibility	**A. Ease of accessing Advantage**
	B. Flexibility of intervention
2. Improved wellbeing through relationship	**A. Opening up**
	B. Growing in confidence

3. Seeing a change	A. Progress towards goals
	B. Noticing a difference in themselves

Accessibility

Many young people said they got involved with Advantage because it was easier for them to access compared to alternative options for mental health support, such as CAMHS. One young person said that he preferred accessing support from Advantage compared to CAMHS because CAMHS support 'would only last until I'm 18 and CAMHS has a waiting list'. He preferred to access support from Advantage because it could support him until the age of 21 and could see him more quickly. All of the young people said that they appreciated that they 'did not have to wait too long' to access support from Advantage and that the referral and screening process was 'smooth' and 'really easy'.

Multiple young people said that Advantage's connection to football clubs increased their interest in getting involved because they liked football. Another young person said that he liked the fact that Advantage takes place 'in the community' rather than in a school or health service and that it allowed him to 'do activities with other people'.

In addition to finding Advantage easier to access than other options for mental health support, young people also spoke about how they liked the flexibility of Advantage. Young people described liking the option to have their sessions in person, over video call, or phone call. Some young people expressed a preference for in person sessions because 'you can't hide how you feel in person' and it is 'easier to talk face to face'; whereas other young people expressed a preference for video call or phone sessions because they are 'convenient to fit around school and find time to do'. Numerous young people described how the option of video call or phone sessions made the intervention more accessible for them because they 'did not need to travel and leave the house' or 'miss out on lessons'. Regardless of what each young person's preference was, they universally agreed that having multiple options and giving young people a choice was helpful and made the intervention more accessible.

Improved wellbeing through relationship

Many young people described how Advantage differed from other forms of support they had accessed in the past, such as school counselling, and said they found it easier to open up. One young person said he 'liked having a mentor rather than a therapist' because his mentor felt 'more like a friend'. Other young people described there being 'no pressure to talk about mental health', which she found helpful, especially in the beginning of the intervention. Due to not feeling pressured, it was 'easier to open up' over time. Building a relationship with their mentor over time helped young people to feel like the mentor 'paid attention to everything I was saying and actually listened'. Young people liked being able to 'talk to your mentor as if they are your mate' and do 'practical things and activities' with their mentors rather than 'just talking'.

Many young people described how their relationship with their mentor had an impact on their confidence and ability to express themselves. One young person said she 'is more confident as a person' as a result of speaking to her mentor each week and 'having someone to talk to and not have to hide emotions'. Another young person described how

the sessions 'helped me be able to talk more about myself and tell people how I am feeling'. Another young person said Advantage sessions helped him feel confident to 'talk to new people' and 'keep applying for jobs'.

Seeing a change

All of the young people described how Advantage enabled them to see a change in their lives. Multiple young people described feeling pleased with the 'big improvement' in their lives. When asked what enabled them to see this improvement, they spoke about the process of setting goals for themselves as part of the Advantage programme. All of the young people found setting goals 'really helpful' and described how they 'liked seeing progress towards goals'. One young person said that setting goals was 'helpful to know what you are aiming for' and that it was 'encouraging to see progress' over time. Setting goals showed another young person that 'if you work hard, you will see a difference over time'. Another young person said that he started applying the skill of setting goals in other areas of his life and felt that 'many people don't set goals, but they should because it's a helpful thing to do.'

In addition to seeing a change through progress towards goals, young people also spoke about noticing a difference in themselves. When asked whether the Advantage programme had an impact on them, all of the young people said that it positively impacted their lives and that they had noticed changes in themselves. One young person said that she noticed she was 'more confident in talking to people and in myself, even the way I carry myself'. She went on to say that 'if you were to look back' on what she was like before, 'you would notice a change'. As a result of participating in Advantage, she felt that she 'changed for the better' and other people commented on the change and 'want to be around me' as a result. Another young person described a change in his ability to 'talk more about myself and tell people how I am feeling'. He said he 'used to keep things to myself and bottle them up', but now he is able to 'be more open'. Many young people spoke about their increased confidence and how this enabled them to improve their relationships with others, talk to people about how they are feeling, and make important life decisions, such as deciding to go to university or apply for jobs.

Overall, young people described Advantage as having an overwhelmingly positive impact on their lives, as seen through the themes of accessibility, improved wellbeing through relationship, and seeing a change.

GBOs – goals

The goals young people set were analysed to derive themes. **Young people's goals related to the following three themes: increasing emotional wellbeing, improving relationships, and developing life skills.**

Increased emotional wellbeing

Many young people expressed a desire to 'control emotions better' and cope with emotional difficulties, such as 'controlling temper', 'stress', and 'not letting anxiety get to me'. Multiple young people set a goal related to increasing 'positivity' in their lives and being more 'patient' and not 'so harsh' towards themselves.

Improving relationships

Many young people expressed a desire to improve the quality of their relationships and develop new relationships. One young person desired to 'be more social' while another hoped to 'find someone in life that she can have conversations with'. Another wanted to grow in their ability to 'discuss challenges' with other people in their life.

Developing life skills

Many young people set goals related to developing life skills such as 'being better with money', 'learning how to budget', and being 'more productive'. Many of these goals were related to the young person's long-term future and included things like 'achieving potential', 'staying motivated to be more active', and being 'more confident in applying for jobs'.

Discussion

Evaluating the Efficacy of Advantage

Quantitative results demonstrate that 6 months of participating in Advantage improves young people's life functioning, decreases stress levels, improves wellbeing, and helps young people achieve significant progress towards their goals. Young people's goals related to increasing their emotional wellbeing, improving their relationships, and developing life skills, all of which contribute to improved mental health and overall wellbeing.

Qualitative analysis revealed three themes for how Advantage supports young people: accessibility (through ease of accessing Advantage and the flexibility of the intervention), improved wellbeing through relationship (through opening up and growing in confidence), and seeing a change (through progress towards goals and noticing a difference in themselves). This demonstrates that Advantage was able to support young people in a different way compared to other mental health services, such as CAMHS.

Young people spoke about the ease of access to Advantage compared to other mental health services, including how Advantage saw them without a long wait and without having to meet a high threshold. This demonstrates a role for community-based forms of support like Advantage that can help fill the gap between young people needing mental health support but being unable to access CAMHS due to long waiting times or not meeting Tier 3 thresholds. It is noteworthy that young people praised Advantage for its flexibility in offering the intervention over the phone, video call, or in person. This kind of flexibility is also offered within traditional mental health services, such as CAMHS, which further demonstrates the value young people place on having flexible mental health interventions.

Having a mentor deliver the intervention rather than a therapist or school counsellor made Advantage more attractive to young people, perhaps because it decreased stigma and made young people feel more comfortable and able to open up to their mentor. In their own words, every young person described how Advantage made a positive impact on their lives. Community-based mental health support through Advantage empowered young people to achieve significant progress towards their goals and 'change for the better' as one young person put it.

Overcoming Barriers to Accessing Mental Health Support

Advantage successfully overcomes barriers young people face to accessing traditional forms of mental health support, such as minority ethnicity, stigma, age, and gender. Minority ethnic groups are underrepresented among referrals to traditional mental health services, such as CAMHS (Stern et al., 1990; Hillier et al., 1994; Skokauskas et al., 2010), but demographics analysis of Advantage showed that the majority of participants (69.6%) were from minority ethnic groups, demonstrating that Advantage may be well placed to reach young people from minority ethnic groups. Stigma about mental health (Bradby et al., 2007) and distrust of mental health professionals (Memon et al., 2016) are barriers to minority ethnic groups accessing support from CAMHS, so the fact that Advantage is based in the community instead of a clinical setting and has mentors delivering the intervention rather than mental health professionals may contribute to young people from minority ethnic groups being more likely to access Advantage compared to traditional mental health services.

In addition to helping to overcome the barriers of ethnicity and stigma, Advantage also helps overcome the barriers of gender, which can prevent young people from accessing mental health support. Studies show that females are more likely to seek support from traditional mental health services than males (WHO, 2002); however, the majority of Advantage participants were male (65.2%). It is possible that Advantage's connection to local football clubs helps decrease stigma and increase interest for males in accessing support from Advantage. Thus, Advantage may be well placed to reach males with mental health needs who may not want to access support from traditional mental health services.

Additionally, age can also be a barrier to young people accessing support. CAMHS only supports young people up to the age of 18, after which they can seek support from Adult Mental Health Services (AMHS). AMHS are focused on addressing serious and long-term psychiatric disorders, which can mean that young adults with less serious, but still significant mental health difficulties are less likely to receive support from adult services (Birchwood & Singh, 2013). This means that some young adults may slip through the cracks because they do not meet thresholds for AMHS. The age of Advantage participants ranged from 14 to 20 years old, with 7/23 (30.4%) of participants being over 18 when they started the intervention, which meant that they would have been ineligible for CAMHS and may not have met the threshold for AMHS. In an interview, one young person who was nearing the age of 18 expressed that he preferred to access support from Advantage compared to CAMHS because Advantage could support him until the age of 21, so there would not be a risk of his intervention having to end after he turned 18. Therefore, Advantage helps fill the gap between CAMHS and AMHS by supporting young adults who are no longer eligible for CAMHS or prefer to access a service that can support them from the age of 14 to 21 rather than having to discontinue support at the age of 18.

Limitations of Current Evaluation

The current evaluation is limited by the fact that it involved a small sample size (23 participants for demographics, 8 participants for quantitative data, and 5 participants for qualitative interview data). The small size of the data set did not allow for any statements about statistical significant of the change observed to be made. The small sample size was due to the fact that Advantage is a pilot programme and only had funding for a small number of participants in the beginning. Data was collected for all young people who had

been on the programme for a minimum of 6 months, which meant that young people who had been on the programme for less than 6 months were not included in the analysis. Additionally, as the sample only included young people who completed 6 months on the programme, young people who dropped out of the programme were not captured. Attempted were made to do follow-up interviews and obtain follow-up outcome measures with these young people, but this unfortunately was not possible. Thus, it is likely that the quantitative data and qualitative interview data results were influenced by the fact that the data only reflected young people who completed the programme, who were also the young people most likely to have found it valuable. As Advantage continues, the data set will grow as more young people reach the 6 month participation mark. Future evaluations will contain more data and will also be completed by an independent evaluator (Anna Freud) to maintain objectivity.

Recommendations

1. In light of the finding that Advantage overcomes barriers to accessing mental health support and successfully improves young people's mental health**, it is recommended that more community-based forms of mental health support like Advantage should be provided for young people.**
2. It is also recommended that **Advantage should be made available in other geographical areas in the U.K.** to provide mental health support for more young people.
3. It is recommended that Advantage **maintain its current inclusion criteria for age (14-21 years old)** and not reduce the upper limit to 18.
4. Based on young people's feedback, it is recommended **that goals continue to be set and used as outcome measures** because young people found setting goals to be a helpful way of measuring their progress.
5. Based on interviews with young people, it is recommended that Advantage continue to function as a flexible intervention by **allowing young people to choose whether their sessions take place in person, over video call, or over phone call** because this increases the accessibility of the intervention for young people.

References

Audit Commission (1999) Children in Mind: Child and Adolescent Mental Health Services. *London: Audit Commission*.

Birchwood, M. & Singh, S. (2013). Mental health services for young people: Matching the service to the need. *British Journal of Psychiatry, 202*(s54), s1-s2.

Bradby, H., Varyani, M., Oglethorpe, R., Raine, W., White, I., & Helen, M. (2007). British Asian families and the use of child and adolescent mental health services: A qualitative study of a hard to reach group. *Social Science & Medicine, 65*(12), 2413-2424.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 2*(2), 77-101.

Cohen, S. & Williamson, G. (1988). Perceived stress in a probability sample of the United States. Spacapan, S. & Oskamp, S. (Eds.) *The Social Psychology of Health*.

Early Intervention Foundation (2020). *Adolescent mental health evidence brief 1: Prevalence of disorders.* Early Intervention Foundation.

Edbrooke Child, J. & Patalay, P. (2019). Ethnic differnces in referral routes to youth mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*, 368-375.

Hillier, S. Loshak, R., Rahman, S., & Marks, F. (1994). Av evaluation of child psychiatric services for Bangladeshi parents. *Journal of Mental Health, 3*(3), 327-337.

Lamb, C & Murphy, M. (2013). The divide between child and adult mental health services: points for debate. *British Journal of Psychiatry, 202*(s54), s41-s44).

Law, D. & Jacob, J. (2015). *Goals and goal based outcomes (GBOs): Some useful information.* Third Edition. London, UK: CAMHS Press.

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E. & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: Results of a household survey. *The NHS Information Centre for Health and Social Care.*

Memon, A., Taylor, K., Mohebati, L.M., Sundun, J., Cooper, M., Scanlon, T. & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ Open.*

Messent, P. & Murrell, M. (2003). Research leading to action: A study of accessibility of a CAMH service to ethnic minority families. *Child and Adolescent Mental Health*, 8(3), 118-124.

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2, 91-100.

Murphy, M. & Fonagy, P. (2012). Mental health problems in children and young people, In: Annual report of the Chief Medical Officer 2010. *Department of Health*.

National Statistics (2003). Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain. *Office for National Statistics.*

Skokauskas, N., Dunne., M., Gallogly, A. & Clark, C. (2010). Ethnic minority populations and child psychiatry services: An Irish study. *Children and Youth Services Review, 32*(10), 1242-1245.

Stern, G., Cottrell, D. & Holmes, J. (1990). Patterns of Attendance of Child Psychiatry Outpatients with Special Reference to Asian Families. *British Journal of Psychiatry, 156*(3), 384-387.

Topp, C.W., Ostergaard, S.D, Sondergaard, S. & Bech, P. (2015). The WHO-5 wellbeing index: A systematic review of the literature. *Psychotherapy and Psychosomatics, 84*, 167-176.

Willig, C. (2013). *Introducing qualitative research in psychology*. Buckingham: Open University Press.

World Health Organisation (WHO). (2002). *Mental Health and Substance Use*.

Appendix A

Semi-Structured Interview Questions

1. What was it about Advantage that made you want to get involved with it? (*Football club, community setting, not a traditional mental health service*)

2. How did you find the process for getting involved with Advantage? (*Being referred, having a screening session, waiting for sessions to start*)

3. Is Advantage different from other services/sources of support you have accessed in the past, such as school mentoring, school counselling, CAMHS, etc.? In what way(s)?

4. What has your experience of the Advantage programme been like?

5. Did your sessions take place over video call, phone, or in person? How did you find this?

6. How have you found the sessions with your mentor? What have you found most helpful? (*include content of sessions and their thoughts about what they have been doing*)

7. You were probably asked to set goals in your mentoring sessions. How did you find this?

8. How do you think Advantage could be improved? (*Workbook? More structure? Different ways of measuring your progress i.e. questionnaires, goals?)*

Has Advantage had an impact on you personally? If so, how? (*Confidence, relationships, jobs, etc.*