September 2016

Support from the start

Commissioning early intervention services for mental ill health

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

Introduction

The characterisation of mental health care as a Cinderella service has at times felt as long-lived as the fairy tale itself. The call for parity of esteem with physical healthcare has been made for many years. So too has the argument that early identification and intervention could significantly reduce the burden of mental ill health.

Suddenly, two years ago, it felt like national leaders started to pay attention. In 2014, 22 nationwide organisations signed the Crisis Care Concordat – pledging to unite to better support those experiencing mental health crisis.

Later that year, the NHS England Five Year Forward View made parity of esteem a key theme. By the 2015 general election campaign, politicians were not only talking about the challenges in mental health care – they were making competing pledges on how to address them. And earlier this year, the Mental Health Taskforce published its vision of future services which – along with its subsequent implementation plan – sets out a roadmap for change backed by promises of additional funding from NHS England.

All of this national action is incredibly welcome. But for change to become a reality, it will have to be implemented at a local level. Clinical commissioning groups (CCGs) are integral to this. Commissioners don't need persuading of the importance of mental health – as front-line clinicians and GPs like myself, we see the impact that poor mental health has on our patients every day. We understand the importance of first-class services being available and are determined to make this happen.

Doing so will not be without its challenges. Reversing mental health care's neglected status will take time, and much learning will be needed along the way.

That is certainly the case when it comes to early intervention. Too often, mental health services have only been available once a problem starts to severely impact on an individual's life. Commissioning services which intervene before that point may mean developing new expertise and knowledge.

It is the firm belief of the Mental Health Commissioners Network that we can much more readily confront these challenges by sharing experiences. It is one of the reasons for the network's existence, and it is the key reason we have published this paper on commissioning early intervention services.

The paper centres on four case studies – examples of CCGs which have already grappled with the challenge of early intervention. It contains top tips from those at the sharp end, which we hope will be simultaneously helpful and inspiring.

The tide has finally turned on mental health care, and we must keep the momentum going so that our local patients and populations get the services they need and deserve.

Dr Phil Moore
Chair of NHSCC Mental Health Commissioners Network
Deputy Clinical Chair NHS Kingston CCG and GP

Six top tips for commissioning early intervention services in mental health

1. **Seek to understand the true impact of mental ill health**
2. **Use engagement as the basis of everything**
3. **Evidence and evaluation are important**
4. **Clinical leadership is key**
5. **Never forget the importance of strong working relationships**
6. **Make sure that the service is person centred**

For more information on each of the above, please see page 7.

Hounslow: Helping to boost the resilience of young people

In some schools in the London borough of Hounslow, a somewhat non-traditional lesson appears on pupils' timetables. For one hour a week, over ten weeks, certain students are taught resilience skills. The aim is to give children techniques to deal with life's stresses, promoting wellbeing and reducing their risk of developing clinically significant anxiety or depression.

The borough first introduced the Friends for Life programme six years ago. It uses cognitive behaviour therapy principles, and primarily aims to both treat and prevent anxiety disorders. Such disorders are known to affect 10 per cent of children by the age of 16, and to increase the risk of developing other mental health problems in adolescence and adulthood.

The programme comes with a significant international evidence base – something clinical psychologist Ben Aveyard argues is a rarity in early intervention programmes. "Friends for Life is very well evidenced, and quite uniquely you know how much effect you're going to get for what cost," explains Dr Aveyard, who works in the area's child and adolescent mental health services (CAMHS).

In Hounslow's case, that effect is an average 15 per cent reduction in children's self-reported anxiety and depression scores at a health service cost of less than £100 per child.

Initially, the programme was targeted to the children assessed as most anxious in a year group. New funding from the clinical commissioning group, however, has made an extension of the programme possible: in four primary schools this year, the programme has been made available to every single child in their penultimate year. The same will happen again next year in at least eight more schools.

Susie O'Neill, senior joint commissioning manager – children and young people at London Borough of Hounslow and Hounslow CCG, explains that "the CCG is keen to invest in early intervention for mental ill health, and the strong existing results of this programme meant it was a clear candidate for investment."

The setup in Hounslow is such that it is not just the pupils who are offered a unique learning opportunity. All Friends for Life sessions are delivered by school staff, who have been trained by members of the CAMHS team.

"There's a really good capacity building element to it," explains Dr Aveyard. "It's not just mental health professionals parachuting into schools to deliver something; it's training school staff to teach children evidence-based coping skills."

Dr Aveyard stresses the support for teaching staff does not end once the one-day intensive training is complete. "There's a strong ethos of not just delivering some training and leaving a programme with a school and letting them get on with it," he says. "By supporting the schools and staying with them we can help promote fidelity to the programme and deliver ongoing training for therapeutic skills and group skills and so on."

Results from the first school to provide the programme to all year five pupils are encouraging. In one class, 21 out of the 25 students said they were less anxious and less prone to low mood following the programme.

The value of early mental health intervention in childhood

It is thought that between a quarter and a half of adult mental illness could be prevented through early intervention during childhood and adolescence. Being emotionally and mentally resilient also makes it far more likely a child will achieve his or her full potential. In addition, such interventions improve a person's ability to parent, so their children in turn have a decreased risk of mental ill health.

Salford: Early intervention in psychosis

In early 2015, commissioners from Salford CCG visited the area's early intervention in psychosis (EIP) team. The meeting was a scheduled one, part of the CCG's quality visit programme. "The visits enable us to check that, for the services we're commissioning, staff teams on the ground feel they're able to deliver them in the way they, and we, need them to," explains Judd Skelton, interim head of integrated commissioning.

In the case of the EIP service, the answer at the time was no. Caseloads were high, and staff were concerned "they weren't able to give the patients as good a service as they would like," remembers Mr Skelton.

The visit made the need for change clear, and coincided with the introduction of a new two week referral to treatment time target from NHS England. "We came away from the meeting saying there's clearly a piece of work we need to do around the referral to treatment time, but actually we want to go beyond that and really explore what we need to do to ensure we can better support people with first onset psychosis," explains Mr Skelton.

To that end, commissioners have worked with provider organisation Greater Manchester West Mental Health NHS Foundation Trust to make several important changes to the local EIP service.

One of the most significant is the introduction of support workers. "Previously, there were no support workers in the team," says Mr Skelton. "What that meant is supporting people to access activities, or engage with job centres, or help with physical health, was all falling on the shoulders of

care coordinators. Their caseload was already higher than it should have been, and it was inefficient and often impractical for them to do this work."

Commissioners have therefore approved funding for four and a half support workers in the service, as well as an assistant practitioner to focus on physical health checks for those experiencing psychosis. Five more care coordinators will also be recruited.

"There's some opportunities to get in there early and start talking to people about lifestyle," says Mr Skelton. "So we've actually now got the resource to be able to say there's a walking group down the road from you, or there's a dance group on your corner, how about someone supports you to access that?"

There will be extra support for carers, too. "We had a carer support service via the voluntary sector, and we decided to change the focus of one of those carer support workers and make them purely focused on working with carers of those with first onset psychosis," explains Mr Skelton. "Because everything that a service user goes through when they're diagnosed with first onset psychosis, there's a similar sort of experience and learning that the carer and family member has to go through, whether it's mum, dad, husband, wife, whatever."

The commissioning of these new service elements is not only in response to staff feedback. A focus group, led by one of the CCG's engagement workers, asked those who had experienced psychosis and their carers what would make their lives better. Mr Skelton explains that "they were the things that keep us all well: having a job, seeing friends and family, having a settled home, having something to do. The support in getting to those outcomes and reaching those outcomes is absolutely crucial." Such input will also inform the development of the outcomes framework for the service.

Specific feedback on consultant cover, meanwhile, has seen a dedicated consultant reintroduced to the team. A previous redesign of community services meant a generic community consultant resource replaced a specific consultant for early intervention in psychosis, but the collective opinion was the redesign had not worked for EIP.

Mr Skelton suggests commissioning strong mental health services will sometimes be a matter of reconsidering previous changes.

"We had to provide our assurance to our executive team that this was new investment, but there had to be acceptance that those decisions were made [to introduce a generic resource rather than have a specific EIP consultant] but the referral to treatment time is new. It does represent a significant shift in terms of timescale and in eligibility criteria. So there were new things that we needed to play in."

These sort of complex considerations are, he believes, greatly aided by the clinical input offered by the CCG setup. "When you have the GP clinical lead who's respected by the clinicians in a service, it is a huge advantage in terms of credibility and invaluable in really understanding and informing what a clinical pathway needs to look like."

The value of early intervention in psychosis

Early intervention in psychosis (EIP) services were introduced across the country 15 years ago and are designed to help people aged 14–35 recover from a first episode of psychosis. EIP teams generally consist of a range of mental health professionals, as well as social workers, and accept referrals from any source – including self-referrals. Once under the care of a team, a young person is normally supported for a minimum of three years and up to a maximum of five.

Research suggests those with access to EIP services are less likely to commit suicide, less likely to require hospital care, and have improved education and employment prospects.

The quicker a young person can get access to support, the better. If someone receives EIP care within two months of first symptoms of psychosis appearing, their chances of recovery are significantly improved. A delay of six months greatly reduces the odds they will make a long-term recovery, however.

The new access targets for early intervention in psychosis

Access targets have long been familiar in physical healthcare, but they are a novel concept in mental health provision. In October 2014, the government announced a series of new standards. The one on early intervention in psychosis came into force on 1 April 2016. It requires that more than 50 per cent of patients presenting with symptoms of first onset psychosis receive specialist input within two weeks of referral. The hope is the new standard will mean more consistent early intervention for those with new psychosis.

Coventry and Warwickshire: Maternal mental health

It has been estimated that as many as 20 per cent of women will suffer mental ill health during pregnancy or the first year of their child's life. Perinatal mental illness increases the chance of a child experiencing behavioural, social or learning difficulties. In some cases, the outcome is more serious still – perinatal mental illness is a leading cause of maternal mortality.

Specialist early intervention and support can greatly mitigate the risks, but services remain inconsistent across the country and even within individual geographic patches. Such was the case in Coventry and Warwickshire. Following the death of a mother who had experienced perinatal mental illness – an outcome which was considered potentially avoidable – Coventry and Rugby CCG asked Arden and Greater East Midlands Commissioning Support Unit (Arden and GEM CSU) to review services. The immediate conclusion was that services were highly fragmented.

"Historically Coventry PCT [Primary Care Trust] had commissioned a service, but it wasn't really meeting need and the Rugby population didn't have access to it," remembers Jo Dillon, now deputy director of commissioning at the CCG but who then worked at Arden and GEM CSU.

"So there was an issue of equity for the Coventry and Rugby CCG in that their women were accessing maternity services from the same hospital, but Rugby women couldn't get access to the specialist perinatal mental health services. Neither of the Warwickshire CCGs had ever commissioned a specific perinatal mental health service, and the referral routes for women were just into core adult psychiatry."

Following the review, Coventry and Rugby immediately offered earmarked resources to close gaps and redesign services. But Ms Dillon says it was critical to consider provision across all three local CCGs. "I knew a redesign would only work if we could have the whole of the Warwickshire footprint included as well [Warwickshire North CCG and South Warwickshire CCG].

"Empowering Arden and GEM CSU to project manage the review and redesign ensured effective engagement and continuity across the three CCGs and two health trusts involved."

Sharing resources and pooling funding made it possible to capitalise on economies of scale, and recruit a full-time specialist team operating across the region. All members of the multidisciplinary team are specialists in perinatal mental ill health, and the service has been operational since November 2015. It means any woman living in Coventry and Warwickshire who experiences perinatal mental ill health can be referred to the same range of support.

It also means all local staff now receive consistent training in perinatal mental illness, helping them to identify possible sufferers early and to make the right referrals at the right time.

"We now have a consistent perinatal mental health training package across the three acute hospitals, for all the midwifery services, and for our community services and partnership trust," explains Ms Dillon.

"So whichever professional group you belong to, you will receive the same training – everybody's got exactly the same messages in terms of what to be looking for, and who to refer to at what point and when. There's also been a lot of work done to launch the new service with GPs: protected learning time sessions and presentations about the new service and pathway."

When asked about the success factors behind the redesign, Ms Dillon is quick to point to the value of clinical leadership. A multidisciplinary clinical team helped design and now runs the perinatal mental health service.

Ms Dillon also feels the introduction of clinical commissioning groups made it easier to push for change. "I do think having objective clinical commissioning support does make a big difference because straight away clinical commissioners are looking at prevalence against the outcome against the cost. And clinically [specialist perinatal mental health services] are a no brainer – we can actually invest some money here because of what it will release later on."

In the first three months alone, the perinatal mental health team received 329 referrals and high levels of patient satisfaction. "It's a new service, so we're just beginning to gather data about outcomes. But we're already seeing reports from services that the early intervention work is really making a difference."

The value of early intervention in perinatal mental illness

When a women has previously been diagnosed with mental illness, offering her support early in her pregnancy – or even pre-conception – can prevent a deterioration or exacerbation of her condition.

For some women, pregnancy brings previously unfamiliar feelings of anxiety and depression. When healthcare professionals recognise and respond early, it can be possible to prevent the onset of a clinically significant problem. If a mental illness does develop, then offering the right support early will prevent many of its potential negative effects – not only on the woman, but also on her child and partner.

Kernow: Suicide liaison service

Each year in England, thousands of people take their own lives. To consider that figure is to get only a small sense of the number of people affected by suicide, however. When someone takes his or her own life, the friends and family left behind have to deal with what can be a particularly devastating bereavement. Their own risk of developing mental ill health grows, and research has shown adults bereaved by suicide have a much higher probability of attempting it themselves.

In Cornwall and the Isles of Scilly, a special service is in place to support those who have experienced such a loss. Commissioned by NHS Kernow Clinical Commissioning Group (NHS Kernow), the suicide liaison service specifically cares for those bereaved by suicide, offering early support with a view to reducing the risk of mental illness. Provided by Outlook South West, the service provides friends and family with both face-to-face contact and practical support, such as dealing with the Coroner's Office, the police or media where necessary.

"Someone who has lost somebody to suicide is in a very different place to someone who has lost somebody through illness," explains Sandra Miles, joint programme lead for mental health and learning disabilities at NHS Kernow and Cornwall Council.

"Many people bereaved by suicide can feel alone and unable to talk about their feelings openly, and they may often have long lasting anger and guilt. The liaison service hopes to remove this stigma so people do not feel ashamed or embarrassed to come forward for help when they need it the most."

Another issue is that suicide is only officially confirmed by a coroner. "That can be an incredibly lengthy process," explains Ms Miles. "The suicide liaison service aims to support people as early in that process as possible. If there's a suspected suicide, it's being picked up early rather than waiting for the whole coroner process to conclude."

People can refer themselves to the service, or be referred by any healthcare professional or member of the emergency services. "If police or the ambulance service are called to a suspected suicide, they can link people up to the service at that time if it's appropriate," explains Ms Miles.

Once a referral has been made, somebody from the service will make contact via phone within 72 hours. The person bereaved by suicide will then be offered a face-to-face appointment within three weeks, or given the chance to come along to a group session.

The latter is a relatively new addition to the service, piloted in 2012 due to a recognition that "some people would prefer to be in a group setting rather than in one to one," Ms Miles says. "It's designed to promote resilience and wellbeing in a supportive environment where other people have experienced the same outcome."

Data suggests access to the service – which is run by accredited counsellors and psychotherapists who have had additional bereavement training – makes a real difference to wellbeing. "The liaison workers take [wellbeing] scores at the start of the planned interventions and then they take the scores at the end as well. The evidence is there's a consistent drop in scores, meaning that people are feeling better."

Patient satisfaction data is also encouraging. "In recent questionnaires, 100 per cent of the people who've used the service would say it's either excellent or good.

"The data evidences that the service continues to be very positive and very impressive in terms of its outcomes, and our service lead has visited Australia and New Zealand – where similar support services are known to be exemplary – to talk about the service, as well as bringing ideas back with her to develop it further," adds Ms Miles.

Commissioning early intervention services in mental health: Top tips

1 Seek to understand the true impact of mental ill health

"Understand what the issues are, the impact a particular diagnosis will have on somebody, and then ultimately what the outcomes are. I think it's about understanding the full picture because as we hear often mental health is the Cinderella service. I think you've got to take the time to understand what the impact of not intervening is going to be in somebody's life, and what difference you can make by making an intervention early and supporting somebody appropriately – about the opportunities for change that gives them."

Jo Dillon, Deputy Director of Commissioning, Coventry and Rugby CCG

2 Use engagement as the basis of everything

"If I think about the CCG business case process in the past, and the primary care trust [PCT] process before, it tended to focus very much more on clinical effectiveness, cost-effectiveness, and rightly so in many ways. But I think sometimes that's been at the expense of understanding and evidencing patient experience. Patient experience was really, really key [to the work on early intervention in psychosis]. It gave us something to anchor our work to, and keep revisiting and sense checking.

"Engagement with the staff team was really important, too. I think it's helped build up a relationship with our local services dispelling the idea that sometimes exists of commissioners being seen negatively, as people who just come in and say 'no' or 'more'. That actually we're trying to work in partnership to deliver something in the same way."

Judd Skelton, Interim Head of Integrated Commissioning – Adults and Older People, Salford CCG

The NHS England publication *Transforming participation in health and care* is specifically written for commissioners. Available online, it offers advice on how best to involve the public in commissioning decisions.

3 Evidence and evaluation are important

"What's great about Friends for Life from my point of view is that it has been around for a while, it is very well evidenced and you know how much effect you're going to get."

Ben Aveyard, Clinical Psychologist, Child and Adolescent Mental Services, Hounslow

"With the suicide liaison service (SLS), the person who uses the service is not only completing evaluation questionnaires and feeding back on the service, but the SLS is using various scoring tools to evidence outcomes for the individuals. So it's a clinical evaluation of how people are benefiting or not from the service. It's very much a way of collecting robust data."

Sandra Miles, Joint Programme Lead – Mental Health and Learning Disabilities, NHS Kernow and Cornwall Council

Collaborations for leadership in applied health research and care (CLAHRCS), academic health science networks (AHSNs), and strategic clinical networks are all excellent sources of advice when designing and evaluating new services.

4 Clinical leadership is key

"There's a clinical leadership team that is still meeting regularly and I think were absolutely instrumental in us implementing a total service redesign within nine months of the business case being approved."

Jo Dillon

"When you have the GP clinical lead [at a CCG] who's respected by the clinicians in a service, it is a huge advantage in terms of credibility and invaluable in really understanding and informing what a clinical pathway needs to look like."

Judd Skelton

5 Never forget the importance of strong working relationships

"I think a lot of the success is the relationships; getting through the door to speak to the right people is always about reputation and relationships. If you build strong relationships from the outset, it's a lot easier to do things going forward into the future."

Jo Dillon

6 Make sure that the service is person centred

"The service is very flexible. The service lead is part of the suicide prevention strategic group that has done an awful lot of work with the coroners over the years. This now means that people can be supported by the service to attend the coroner's court if that's felt to be in their best interest. It really is person centred, as all services should be."

Sandra Miles

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For more information on MHCN, NHSCC or any of the material in this paper, please contact office@nhscc.org

The Mental Health Commissioners Network

The Mental Health Commissioners Network's (MHCN) purpose is to enable members to become more effective mental health commissioners – achieving better mental health and wellbeing outcomes for the populations they serve.

The network is member led and aims to provide:

- a strong collective voice for mental health commissioners
- a place to share best practice with peers
- development opportunities and peer support to mental health commissioners.

The network is open to CCG clinical mental health commissioning leads and senior CCG managers working in mental health commissioning. It is chaired by Dr Phil Moore, deputy chair at NHS Kingston CCG, who sits on the NHS Clinical Commissioners board as the MHCN representative.

The network also has a number of national partners and a steering group to support its development.

NHS Clinical Commissioners

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.

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