



**QUEEN'S
UNIVERSITY
BELFAST**

Mental Health Capacity Unit, Department of Health NI - Briefing Paper 2: Effective Treatment & Care

McCartan, C., Adell, T., Cameron, J., Davidson, G., Knifton, L., McDaid, S., & Mulholland, C. (2020). *Mental Health Capacity Unit, Department of Health NI - Briefing Paper 2: Effective Treatment & Care*. QUB.

Document Version:

Publisher's PDF, also known as Version of record

Queen's University Belfast - Research Portal:

[Link to publication record in Queen's University Belfast Research Portal](#)

Publisher rights

Copyright 2020 the Authors & QUB.

This work is made available online in accordance with the publisher's policies. Please refer to any applicable terms of use of the publisher.

General rights

Copyright for the publications made accessible via the Queen's University Belfast Research Portal is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The Research Portal is Queen's institutional repository that provides access to Queen's research output. Every effort has been made to ensure that content in the Research Portal does not infringe any person's rights, or applicable UK laws. If you discover content in the Research Portal that you believe breaches copyright or violates any law, please contact openaccess@qub.ac.uk.

Briefing Paper 2: Effective treatment and care

Claire McCartan¹, Tomas Adell², Julie Cameron³, Gavin Davidson¹, Lee Knifton³, Shari McDaid³ & Ciaran Mulholland¹

¹Queen's University Belfast, ²Mental Health & Capacity Unit, DoH, ³Mental Health Foundation

This briefing paper summarises key findings from three rapid evidence reviews (*Transforming mental health services; International policy guidance and response to COVID recovery; International learnings on mental health plans, policies and implementation*) commissioned by the Mental Health Foundation to help support the development of Northern Ireland's ten year mental health strategy. It highlights **some** of the national and international evidence, offers examples of best practice and innovation and may be of interest to those responsible for developing the new strategy.

There has been a concerted move away from institutional long-term care towards community-based care. Across Europe, community-based mental health care services have been expanded and the number of inpatient beds reduced. Quality of care relies on effective evidence-based interventions embedded within a community network of care that has a shared vision and is guided by core principles. Interventions are more likely to be effective if they take account of local settings and networks of formal and informal service users. The European Community Mental Health Services Provider (EUCOMS) Network members have developed a shared vision on the principles and key elements of community-based mental health care, recommending a blueprint for a regional model of integrated mental health care based on six principles (Keet et al., 2019). This reflects the wider conversation in the literature about transforming services:

1. Human rights – mental health services should be based on the Convention on the Rights of Persons with Disabilities (CRPD).
2. Public health – a public health approach to planning and implementing community-based mental health care should be adopted.
3. Recovery – Community-based mental health services should focus on treatment AND provide support on the recovery 'journey' – services that offer hope, decide with and not about the service user, and that focus on 'what is strong, not what is wrong'.
4. Effective evidence-based interventions that recognise the context of individual patients and are tailored for service users' values, preferences and choices.
5. Community network of care that operates within a broader network of self-help, family, friends, other informal resources and generic community services.
6. Peer expertise – third domain of expertise, alongside adding to scientific evidence and practical knowledge and skills.

Access to treatment and joined-up accessible services, primary multi-disciplinary care

- NZ's pilot of integrated general practice has been extended and offers brief, targeted mental health interventions on site delivered by an expanded GP team to include new mental health roles of health improvement practitioners (registered health professionals similar to American behavioural health consultants) and health coaches (health professionals or peer support workers). In the initial pilot in 8 surgeries, data from the first six months showed that 50-70% of clients were seen on the same day as disclosing their

distress compared to 5% referred to conventional talking therapies. GPs have a trusted relationship with the community and is considered a logical place to expand mental health capacity. The pilot demonstrated that this approach reduced waiting times and travel, costs and can provide immediate support when it is needed.

- The Netherlands has a similar system that embeds mental health professionals within GPs, available to give patients advice up to the point where they need specialised mental healthcare.
- Co-ordinated case management that can be delivered by a medically supervised nurse in cooperation with the patients' GP and psychiatrist can improve affective and chronic disease in multiple conditions (Katon et al., 2012). Case managers spend more time with the patient than their GP and may promote better engagement, treatment adherence and ultimately better outcomes and this has been demonstrated in patients with depression and anxiety (Coventry et al., 2015; Zimmermann et al., 2016) however, multi-morbidity conditions may be more difficult to treat.
- Successful implementation of integrated care can improve services by creating therapeutic spaces, improving patient access to care, developing collaborative relationships and personalising patient care to address individual needs (Youssef, Chaudhary, Wiljer, Mylopoulos, & Sockalingam, 2019).
- The Netherlands has successfully trialed and extended the operation of Medical-Psychiatric Units (MPUs) across the country enabling the early detection of comorbidity and initiation of multi-disciplinary treatment. Forty 40 MPUs are operational, field standards have been published and evaluated along with a general module on hospital psychiatry (Nederlandse Vereniging voor Psychiatrie, 2014; Van Schijndel et al., 2017).

Population based approaches

- NZ's National Telehealth Service has seen a 23% increase in calls or texts seeking mental health support (Moore & Smith, 2020). As part of the evaluation, qualitative interviews cited reasons for contacting the service were related to previous negative experiences of barriers and stigma accessing face-to-face care, they were unsure whether they needed professional help, and a small proportion of callers used the service frequently as part of a suite of ongoing support.
- Collaborative care models are a scalable population health intervention that has been shown to be effective in 80+ RCTs (Carlo, Barnett, & Unützer, 2020). The model enables the delivery of high quality mental health treatment by supplementing existing services with a designated team and has been demonstrated to be effective through remote healthcare delivery. Inherently integrated multidisciplinary strategy for treating chronic physical and mental health problems and uses a population health approach that can easily be directed towards high risk populations.

Emergency care

- New York City's Mayoral mental health programme, NYCThrive, has adopted a new approach to emergency responses in a direct move to reduce inpatient admissions. ThriveNYC has expanded their intensive, community-based mental health model over the last four years. Mobile intervention and treatment teams bring intensive, ongoing, high-quality behavioural treatment to people in their communities. The programme is targeted at difficult to serve populations and people experiencing homelessness. The scheme

includes a Crisis Prevention and Response Task Force to help reduce the need for calls to 911.

- Mobile psychiatric treatment teams have also been trialed in Southern California (Krekler, 2020). The multi-disciplinary team has 23 hours and 59 minutes to stabilise the acute crisis or transfer the patient to an inpatient facility. Treatment will focus on the least restrictive level of care and the team will collaborate with hospitals to create quiet spaces away from A&E to help provide specialised care in a calm and therapeutic setting. This differentiates from other mobile services by providing 24-hour psychiatric care alongside short-term case management in order to provide some continuity of care until outpatient connections are established. It will provide inpatient behavioural support to patients presenting at A&E rather than transferring to acute mental health care.
- London Ambulance Service has recently completed a pilot of the effectiveness of mental health nurses working alongside paramedics to ensure calls related to mental health are handled in an appropriate and sensitive manner (NHS England & NHS Improvement & London Ambulance Service, 2020). The 'Mental Health Joint Response Car Pilot' enabled mental health nurses to work alongside call handlers to decide whether a mental health car is dispatched alongside a paramedic during an emergency call. This provided the opportunity for both clinicians to assess the patient, including assessment of mental health, provision of brief psychological interventions where appropriate while the paramedic tended to any emergency medical treatment. The projected cost savings are considerable and feedback from staff and patients has been extremely positive.

Improving acute treatment and care

- The 333 Model applies time-limited pathways for assessment (≤ 3 days), treatment (≤ 3 weeks) and recovery (≤ 3 months) aims to improve access, delivery early treatment and shorten hospital stays (Kar Ray et al., 2019). NHS patient flow data was compared with NHS benchmarking and 333 targets, bed numbers in the More than 74% (N=2,679) of patients who were admitted to the assessment unit between 2015 and 2017 were discharged back to the community, minimizing fragmentation of care. Median length of stay was one-sixth as long as the national rate, but readmission rates were higher than the national mean because of the model's innovative approach to managing treatment of patients with personality disorders. Bed occupancy was below the national average, with beds available every night for 2 years.
- The recovery approach has also been used successfully in other inpatient populations, Zuehlke and colleagues (2016) evaluated a recovery-oriented model of care in the US. Recovery interventions on the unit included recovery-focused interdisciplinary team meetings, opportunities for stakeholder feedback, recovery staff education, increased group programming, peer support, and changes to treatment planning to include increased Veteran engagement and responsibility. The unit consisted of 352 patients and 27 staff and results showed an overall decrease in restraint/seclusion use by over 50% and an increase in staff satisfaction.
- The South London and Maudsley Trust looked to LMICs for innovation and it has implemented Tree of Life groups across all adult acute mental health wards. This is a narrative therapy-based approach developed in Zimbabwe to support high-risk children affected by HIV/AIDS, poverty, war and conflict. Using a co-production approach, it focuses on facilitating collaborative recovery in a multicultural, multi-ethnic setting, minimizes stigmatising narratives using a strengths-based approach, helping to build

positive therapeutic relationships between staff and service users. Ten service users were trained as Tree of Life workshop facilitators.

Mental health infrastructure – supported housing & employment

- At Home/Chez Soi (Mental Health Commission of Canada, 2014) – Housing First provides immediate access to permanent housing with community-based supports. 2000 participants were provided with an apartment, a rent supplement and one of two types of supportive services (Assertive Community Treatment) and those with moderate needs received Intensive Case Management (ICM). Across the 5 Canadian cities where the scheme was piloted, Housing First lowered rates of homelessness compared to treatment as usual. Over the two-year period following study entry, every \$10 invested in HF services resulted in an average savings of \$21.72. Most participants were actively engaged in support and treatment services and there was a general move away from crisis/institutional services to community-based. People with previously unmet needs were able to access appropriate support.
- There is strong evidence that supportive employment schemes that help people retain or return to work without lengthy pre-employment training and rehabilitation are valued by patients, are cost effective, and benefit society are still poorly implemented in standard care (Bouras, Ikkos, & Craig, 2017).

Community support

- The community network of care model aims to bridge the gap between professionals and non-professionals, increase the resilience of users and the networks around them. Depending on the resources available, care can be provided through integrated care models with a community mental health care team as the central node, or by separate teams or functions of more generic teams if integrated care is not available.

Suicide and self-injury

- An implementation of a national strategy is an effective tool in reducing suicide rates but prevention programs aiming to help special age groups may play an important role (Lewitzka, Sauer, Bauer, & Felber, 2019) as well as at risk groups such as those bereaved by suicide.
- No one suicide prevention strategy is superior (Zalsman et al., 2016), different approaches appear effective in different groups according to age and gender for example.
- This approach will be of particular relevance locally considering recent data from the Youth Wellbeing NI Prevalence Study (Bunting et al., 2020) that identified elevated rates of self-injury, suicide ideation/attempts in girls aged 16-19 years.

Digital healthcare

- Digital interventions may be as effective as traditional methods for improving symptoms and medication management, and accessing information and support (Ben-Zeev et al., 2014; O'Hanlon et al., 2018; Rotondi et al., 2010). However, their effectiveness may hinge on the suitability of the intervention for an individual *and* the availability and reliability of the technology available (Granja & Johansen, 2018). A number of studies have also demonstrated the utility of digital interventions in helping communication and building relationships between service users and their medical team. Some users may feel more able to disclose information online that might have been difficult in a face-to-face context

(Deegan, Rapp, Holter, & M, 2008). Digital interventions without human interaction were considered impersonal (Kasckow et al., 2016; Lobban et al., 2017). Younger people may be more likely to accept a digital intervention (Poole, Simpson, & Smith, 2012; Thomas et al., 2016). Engagement with technology can vary depending on the type of condition and should be considered in tailoring individualized care.

Specialist treatment

- Eating Disorders – prevalence data from the Youth Wellbeing NI Prevalence Study (Bunting et al., 2020) also highlighted a pattern of disordered eating in 16.2% of 11-19 year olds including 7.3% engaging in induced vomiting. This indicates the need for universal preventative services and clear visibility for help seeking and screening and monitoring.

Mental health and the justice system

- There are examples of the expansion and refinement of services that reach out to offender populations to divert those with a mental illness from police custody, courts and prisons to appropriate mental health care (Bouras et al., 2017).

References

- Ben-Zeev, D., Brenner, C., Begale, M., Duffecy, J., Mohr, D., & Mueser, K. (2014). Feasibility, acceptability, and preliminary efficacy of a smartphone intervention for schizophrenia. *Schizophr Bull*, 40, 1244-1253.
- Bouras, N., Ikkos, G., & Craig, T. (2017). Meta-community mental health care: Towards a new concept. *The Lancet Psychiatry*, 4(8), 581-582. doi:<http://dx.doi.org/10.1016/S2215-0366%2817%2930108-6>
- Bunting, L., McCartan, C., Davidson, G., Grant, A., McBride, O., Mulholland, C., . . . Shevlin, M. (2020). *The Mental Health of Children and Parents in Northern Ireland*. Belfast: HSCB.
- Carlo, A. D., Barnett, B. S., & Unützer, J. (2020). Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2020.3216
- Coventry, P., Lovell, K., Dickens, C., Bower, P., Chew-Graham, C., McElvenny, D., . . . Gibbons, C. J. (2015). Integrated primary care for patients with mental and physical multimorbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. *bmj*, 350.
- Granja, C., & Johansen, M. (2018). Factors determining the success and failure of eHealth interventions: systematic review of the literature. *J Med Internet Res*, 20(5), e10235.
- Kar Ray, M., Lombardo, C., Syed, Z., Patel, N., Denman, C., & Jones, P. B. (2019). Embedding Recovery to Transform Inpatient Mental Health Care: The 333 Model. *Psychiatric services (Washington, D.C.)*, 70(6), 465-473. doi:<https://dx.doi.org/10.1176/appi.ps.201800284>
- Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., . . . Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Archives of general psychiatry*, 69(5), 506-514.
- Keet, R., de Vetten-McMahon, M., Shields-Zeeman, L., Ruud, T., van Weeghel, J., Bahler, M., . . . Pieters, G. (2019). Recovery for all in the community; position paper on principles

- and key elements of community-based mental health care. *BMC psychiatry*, 19(174). doi:<https://doi.org/10.1186/s12888-019-2162-z>
- Krekler, L. (2020). Closing the health gap: The development of a mobile psychiatric treatment team. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 81(9-A), No-Specified. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc16&NEWS=N&AN=2020-28116-127>
- Lewitzka, U., Sauer, C., Bauer, M., & Felber, W. (2019). Are national suicide prevention programs effective? A comparison of 4 verum and 4 control countries over 30 years. *BMC psychiatry*, 19(1), 158.
- Mental Health Commission of Canada. (2014). National Final Report. Cross-site At Home/Chez Soi Project. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/mhcc_at_home_report_national_cross-site_eng_2_0.pdf
- Moore, D., & Smith, L. (2020). *Phase 3 Report on the National Telehealth Service Evaluation*. Retrieved from Wellington: <https://www.health.govt.nz/our-work/national-telehealth-service>
- Nederlandse Vereniging voor Psychiatrie. (2014). MPU Field Standards. Retrieved from <https://www.nvvp.net/stream/veldnormen-mpu-juni-2014>
- NHS England & NHS Improvement, & London Ambulance Service. (2020). *Mental Health Joint Response Car Pilot – Evaluation Summary Report*.
- O'Hanlon, P., Aref-Adib, G., Fonseca, A., Lloyd-Evans, B., Osborn, D., & Johnson, S. (2018). Tomorrow's world: current developments in the therapeutic use of technology for psychosis. *BJPsych Advances*, 22(5), 301-310.
- Rotondi, A., Anderson, C., Haas, G., Eack, S., Spring, M., Ganguli, R., & al., E. (2010). Web-based psychoeducational intervention for persons with schizophrenia and their supporters: one-year outcomes. *Psychiatr Serv*, 61(11), 1099-1105.
- Van Schijndel, M., Jansen, L., Caarls, P., van't Veer, F., Wierdsma, A., van Wijngaarden, J., . . . van Busschbach, J. (2017). Medical Psychiatric Units in the Netherlands: an investigation into distribution and quality. *Nederlands tijdschrift voor geneeskunde*, 161, D890-D890.
- Youssef, A., Chaudhary, Z., Wiljer, D., Mylopoulos, M., & Sockalingam, S. (2019). Mapping Evidence of Patients' Experiences in Integrated Care: A Scoping Review. *General hospital psychiatry*, 61, 1-9.
- Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., . . . Balazs, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry*, 3(7), 646-659.
- Zimmermann, T., Puschmann, E., van den Bussche, H., Wiese, B., Ernst, A., Porzelt, S., . . . Scherer, M. (2016). Collaborative nurse-led self-management support for primary care patients with anxiety, depressive or somatic symptoms: Cluster-randomised controlled trial (findings of the SMADS study). *International journal of nursing studies*, 63, 101-111.
- Zuehlke, J. B., Kotecki, R. M., Kern, S., Sholty, G., & Hauser, P. (2016). Transformation to a recovery-oriented model of care on a veterans administration inpatient unit. *Psychiatric Rehabilitation Journal*, 39(4), 361.