Transforming mental health care: a rapid review of emerging international evidence


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Transforming mental health care

A rapid review of emerging international evidence
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This is a rapid review of emerging and established international evidence of efforts to transform mental health services and help improve design, delivery and outcomes. Key databases were searched for academic research and grey literature describing changes to both policy and practice.

As a rapid review, there will be areas that have not been included. This paper is intended to give a brief overview of a range of international developments, presenting some key evidence and new approaches for policy makers to consider.
Transforming mental health care

**Background**

Delivering efficient and effective mental health services is an ongoing challenge and attempts to restructure and reorganise to improve care and increase efficiencies has been characteristic of NHS reform since the 1980s.

From the early 2000s, efforts have been redirected to modernise working practices and improve systems and processes of care with the revision of job roles and workforce expansion. The review of the NHS set out to offer greater integration and flexibility for staff, better training, education and regulation and established clearer management roles and responsibilities developed on 1960s business strategy paradigms (business process-engineering and role redesign) (Hyde, McBride, Young, & Walshe, 2005).

In mental health services, the process of change has included additional challenges such as deinstitutionalisation, developing an evidence base and tackling stigma and discrimination. The ongoing focus within mental health services of what can be achieved within existing resources is important but the context of the overall proportion of health and social care funding allocated to mental health, and the prioritisation of health and social care within public spending, is also central to positive transformation.

Austerity and the likely inevitable long-term impact of COVID-19 will increase the imperative to seek further efficiencies and improve patient care as demands on the health service continue to increase.

**New Ways of Working (NWW)**

Over the past 20 years, attempts to tackle skill shortages by improving workforce configuration have included the redrawing of professional boundaries, often amid institutional resistance to change.

Arising from concerns raised by consultant psychiatrists and mirrored within other mental health professions, the National Institute of Mental Health in England introduced a guide to New Ways of Working (NWW) (Department of Health, 2007) outlining a new approach and proposed the development of changed and enhanced roles in mental health.

Recruitment and retention problems, unmanageable caseloads were leading to rising levels of burnout. The associated costs of locum support were creating problems and affecting the ability to provide quality and continuity of care.

A common framework was established to facilitate a multi-disciplinary approach to NWW with the aim of meeting service users’ needs better. It included a redesign of systems and processes to help staff to deliver person-centred care within an efficient and
sustainable setting at both individual and institutional level. A range of new roles were established, with a greater emphasis on information sharing placed across professions, promoting collective responsibility for the care of individuals.

Routine practice such as outpatient clinics were down-sized and a more flexible approach to providing care was promoted and early evidence suggested higher levels of service user and caregiver satisfaction. Changes in mental health policy also reflected these new approaches to working (Vize, 2009).

**Effectiveness of NWW**

Despite this reform, longer-term research concluded that there was a range of challenges around introducing the new job roles (such as peer support workers) and NWW did little to distribute responsibility beyond the consultant psychiatrist across community mental health multi-disciplinary teams (Gillard, Edwards, Gibson, Holley, & Owen, 2014; Proctor, Harrison, Pearson, Dickinson, & Lombardo, 2016).

The move away from traditional, institutional models of care has been slower in Northern Ireland than in many other jurisdictions for a range of reasons, some that are directly related to mental health care (Davidson & Leavey, 2010).
Transforming mental health care

Transforming policy

Changes in mental health policy have started to transform the landscape. Scotland (Scottish Government, 2017) and Aotearoa New Zealand (Flett, Lucas, Kingstone, & Stevenson, 2020; Ministry of Health & Health Promotion Agency, 2014) have developed comprehensive frameworks to tackle the stigma and prejudice surrounding mental health using a rights-based, person-centred approach. New Zealand has also invested in a standardised national data set collecting a range of health data including mental health service use and consumer outcome data, placing them in a stronger position to plan, deliver and evaluate services.

In New Zealand, a Mental Health and Wellbeing Commission was established in 2020 as part of the response to the 2018 Government Inquiry into mental health and addiction. Accepted recommendations have included a commitment to increase investment, expand access and choice, and delivery of universal school-based interventions and parenting support programmes. The new Action Plan from the Department of Health NI also sets out similar priorities.

These policies also recognise the importance of supporting the physical health of people with mental health problems. In a specific response to the COVID-19 emergency, Sport New Zealand has dedicated $68 million to fund community led play, active recreation and sport to support mental wellbeing (Ministry of Health Manatū Hauora, 2020). Support will be directed to high deprivation communities in the first year where physical activity has been affected most.

There have been a range of different innovations that have sought to improve services. Looking back over the last decade, the literature covers key themes centred on a human rights perspective, recovery and evidence outcomes-based care. Increasingly, a public health approach has been adopted that aims to protect everyone, including people with mental illness. The service user perspective that combines the recovery approach and acknowledges peer expertise is also influencing service design and delivery.

There is recognition of the work that has been conducted internationally, particularly in low- and middle-income countries (LMICs) that has been successful in mobilising personnel quickly with capability to upscale service provision where resources are limited. Programmes often draw on the skills and experience of peer support workers, employing task-shifting and delivering care in emergency response settings helping to de-escalate mental health crises and reduce inpatient admissions.

Many of these changes have been accelerated in light of the restrictions that COVID-19 has demanded but there is an evidence-base to draw on as these systems and interventions are developed to respond to current and growing need. We will consider these (interlinked) themes in more detail.
Transforming mental health care

Promotion, prevention and early intervention

Universal interventions that promote good mental health and wellbeing should underpin a whole society approach to supporting mental health, help reduce stigma and promote help-seeking and early intervention.

The European Community Mental Health Services Provider (EUCOMS) Network members have developed a shared vision of the 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):

1. Human rights
2. Public health
3. Recovery
4. Effective evidence-based
5. Community network of care
6. Peer expertise

The Scottish Government has identified health and wellbeing as one of the three core areas of responsibility of schools (alongside literacy and numeracy).

In their ten-year mental health strategy, they have made a commitment to promote wellbeing within schools and further/higher education and provide appropriate access to emotional and mental wellbeing support, targeted parenting programmes and evidence-based interventions that help address behavioural and emotional problems in children and young people.

Mental health training is not only delivered to those providing support within educational settings, but includes non-mental health staff across health and social care services, “Training in first aid approaches for mental health should become as common as physical first aid.” (Scottish Government, 2017). At risk groups have been identified and a range of targeted actions to provide support for disabled children, children in out-of-home-care, children involved in offending and young carers for example.

Tackling health inequalities relating to mental health are also recognised as a priority with specific strategies outlined for rural communities, housing issues, poverty, policing and the justice system.

Prevention and treatment must include targeted interventions that promote social contact and anti-discrimination messages that can reduce stigma and increase integration (Keet et al., 2019).
People with mental health problems continue to face discrimination and face a large gap in mortality, health, economic and social inequality. They are also more likely to experience violence, sexual abuse, homelessness and incarceration. The right to fair and equal treatment of people experiencing mental health problems and upholding their human rights is set within the legal context of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD entitles people with disabilities to the full spectrum of human rights without discrimination. While the whole of the CRPD is relevant to people with mental health problems, certain articles are particularly significant, such as Article 12 on legal capacity, Article 15 on freedom from torture or inhuman or degrading treatment, Article 19 on community living, and Article 25 on health. People with mental health problems are often excluded from the wider disability advocacy movement.

The United Nations Human Rights Council Resolution on Mental Health and Human Rights calls for a rights-based approach to mental health care based on the 3P Model (Preventative – Participatory – Predictive). The World Health Organisation also states that mental health services should be rights-based and recovery oriented (Funk & Drew, 2017). Particular issues of concern have been highlighted:

- The premature mortality of people with mental health problems is a human rights issue.
- Funding for mental health needs greater parity with physical healthcare. Globally, mental health promotion, prevention and services have lacked significant investment with an average spend of only 2% of health budgets set aside for mental health (United Nations, 2020). Locally, 5.2% of the NI health budget was spent on the Mental Health Programme of Care by HSC Trusts in 2016–17 (not including spend on mental health services delivered by GPs or the Public Health Agency). Spend in the other UK nations was higher (in 2017–18, the mental health budget allocation was 13.3% in England, 11.4% in Wales, and in 2019–20, 7.6% in Scotland) (Northern Ireland Affairs Committee, 2019).
- Training staff on a human rights perspective is important. Health and social care staff trained on recovery and rights can help reduce human rights violations that can occur in the context of mental health services. Practical tools include the WHO’s Quality Rights Toolkit (WHO, 2012) which provides a training framework for assessing and improving quality and human rights standards in mental health.
- Right of access to treatment and care – freedom from coercive interventions, respect the right for legal capacity, promotion of autonomy, choice and inclusion.
- Development of a civil society movement to influence policy making and advocate for policy and legislative reform that integrates a human rights approach in mental health (Funk & Drew, 2017).
Public mental health

Public health has been conceived as “what we, as a society, do collectively to assure the conditions for people to be healthy” (Institute of Medicine, 1988, p. 6), with a responsibility to protect and improve the public’s health and reduce health inequalities (Public Health England, 2020).

Achieving equity requires looking beyond treatment and, to date, there has been insufficient focus on the public health function of mental health care (Saxena, 2018). The relationship between mental health and wellbeing and physical health is clearly established, but further work is necessary to develop a public health approach across mental health promotion, prevention and recovery (Mental Health Foundation, 2016).

This approach needs to be recognised in identifying risk and protective factors and understanding the determinants of mental health in the design and delivery of interventions, research and for practitioners working in the sector (Mental Health Foundation, 2016).

Universal interventions also form a central strand of any public mental health approach. Campaigns such as Five Ways to Wellbeing (Connect, Be Active, Take Notice, Keep Learning, Give) (NHS, 2019) is a good example of a public health perspective on population mental health that champions health and wellbeing for all. During COVID-19, there has been an increase in public messaging about the importance of maintaining mental wellbeing (see for example Scotland’s ‘Clear your head’ campaign https://clearyourhead.scot/). There may be more opportunities emerging from the pandemic to harness public mental health approaches that engage at a universal level whilst also placing an increased focus on tackling the social determinants of mental health problems.

Schools and workplaces are other obvious settings for universal delivery of mental health promotion and there are many examples of effective interventions (Collins, Woolfson, & Durkin, 2014; Knapp, McNaid, & Parsonage, 2011).

The EUCOMS Network has set out practical guidance about adopting a public health approach in community-based settings, which includes defining the catchment area for services, performing a needs assessment and developing well-defined plans that map services and supports for different sectors of the population (Keet et al., 2019).

The regional area must be small enough to integrate the team within the local community and have a strong relationship with primary care and social stakeholders but large enough to mobilise a multi-disciplinary response. Prevention and treatment must include targeted interventions that promote
social contact and anti-discrimination messages that can reduce stigma and increase integration. Anti-stigma strategies include education and contact (planned exchanges between people with lived experience and the general public). Corrigan and colleagues have developed the Targeted, Local, Contact, Credible and Continuous (TLC3) formula for interventions (Corrigan, 2012). Successful programmes using the TLC3 model include ‘Time to Change’ (England), ‘One of Us’ (Denmark), and ‘SeeMe’ (Scotland).

The European Alliance Against Depression is a network of experts with the aim of implementing action-oriented, community-based public health interventions to improve depression treatment and reduce suicidality.

Based on the Nuremberg Alliance Against Depression concept, it bases interventions on four levels:

- Co-operation with GPs
- Information awareness campaign for the broad public
- Educational training for multipliers such as teachers, priests, or geriatric care-givers
- Support and initiative of self-help activities

After two years of the intervention, suicides dropped by 24% from baseline and compared to a representative control region (Hegerl & Schäfer, 2007). The campaign has been extended across Germany, and with funding from the European Commission, has been implemented in 17 European countries.
Physical activity

People with mental ill health report lower levels of physical activity with levels considerably lower than the general population (De Wit et al., 2010; Vancampfort et al., 2017) and are at greater risk of chronic health conditions such as cardiovascular disease, diabetes and obesity.

Many have co-occurring medical conditions (comorbid conditions) caused by lifestyle behaviours (e.g. smoking, hazardous alcohol use, sedentary behaviour) that can lead to poor health outcomes (Cohen, Edmondson, & Kronish, 2015; Strine et al., 2008). While there may be a range of social and genetic determinants of mental health disorders (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013; WHO, 2014), being physically active can have positive benefits and may help improve the mental and physical health of those with some disorders (Ströhle, 2009).

Physical activity can improve self-esteem (Firth et al., 2016; Lubans et al., 2016), cognitive functioning and help reduce symptoms (Ashdown-Franks et al., 2020; Firth et al., 2016; Gerber et al., 2014; Stubbs et al., 2018; WHO, 2010). Based on secondary analysis of available data, physical activity has been shown to be potentially as effective as many drug interventions (e.g. statins, beta blockers) at preventing cardiovascular disease mortality (Naci & Ioannidis, 2013).

Physical activity is cited in the National Institute for Health and Care Excellence (NICE) clinical guidelines as a potential treatment option for people with persistent subthreshold depressive symptoms or mild to moderate depression (NICE, 2009) and generalised anxiety disorder and panic disorder (NICE, 2011). The European Psychiatric Association (EPA) has also made clinical practice recommendations for physical activity as a treatment for mild-moderate depression (Stubbs et al., 2018). Not engaging in sufficient physical activity is also a risk factor for developing depression and anxiety in children and adults (Abu-Omar, Rütten, & Lehtinen, 2004; Goodwin, 2003; Motl, Birnbaum, Kubik, & Dishman, 2004; Schuch et al., 2018; Zahl, Steinsbekk, & Wichstrøm, 2017).

Physical activity is relatively easy to deliver in home-based, clinical, or community settings. It carries a relatively low risk of negative side effects (Wright & Cattan, 2009). A recent meta-review informing the European Psychiatric Association (EPA) guidelines for physical activity did recommend, on the basis of good-quality evidence, that an intervention delivered 2 to 3 times per week of supervised aerobic and/or aerobic and resistance training of 45 to 60 minutes duration would achieve optimal outcomes and less attrition (Stubbs et al., 2018).
Studies evaluating the efficacy of physical activity interventions as treatment for anxiety or depression disorders, or both, generally find a reduction in anxiety or depressive symptoms (Carek, Laibstain, & Carek, 2011; Jayakody, Gunadasa, & Hosker, 2014), and that exercise may be as effective as antidepressant treatment (Stubbs 2018).

The overall health benefits of being more active can also have a positive impact on quality of life and wellbeing. Physical activity is increasingly used in consultant, allied health professional, and general practitioner referrals as a treatment option or as a complementary therapy (Price et al., 2018), and exercise referral schemes are outlined in public health guidance by NICE and recommended as treatment by the EPA (NICE, 2014; Stubbs et al., 2018).
Innovation in interventions

Physical activity

Positive findings from an RCT in 4 community mental health outpatient programmes in Maryland have been reported (Carlo, Barnett, & Unützer, 2020). Comprised of an 18-month multi-faceted intervention incorporating behavioural counselling, care co-ordination and care management designed to reduce overall cardiovascular risk in adults with SMI.

The intervention involved individually tailored cardiovascular disease risk reduction coaching sessions (weekly 20–30 minutes for first 6 months, and at least every 2 weeks for the next 12 months) provided by a health coach and a nurse based in the community mental health setting. The nurse and coach also collaborated with doctors to implement appropriate risk factor management and co-ordinated with mental health staff to encourage attainment of mental health goals.

The programmes also ran physical activity classes and offered consultation on serving healthier meals. Of the N=132 in the intervention group and N=137 in the control group, outcomes after 18 months included:

- Statistically significant reductions of global FRS (reduction of overall cardiovascular risk) at 18 month follow-up in adults with SMI.
- Rates of tobacco smoking were statistically significantly reduced in the intervention group compared with the control group.
- Differences in blood pressure and lipid risk scores were not statistically significant but the direction of change was towards improvement in the intervention group.
- The results support the use of interventions embedded in routine outpatient specialty mental health settings.

In Northern Ireland, a 2019 qualitative feasibility study of a physical activity intervention for people with severe mental health problems reported the benefits of providing structured support for physical activity (McCartan et al., 2019). One of key benefits was the opportunity it created to increase social contact and support. Central to the success of this programme was the quality and skills of the trainers supporting participants. However, one of the main barriers to participation was difficulty getting the approval of GPs to allow participants to take part in the professionally risk assessed and supervised activities.

Smoking cessation

People with SMI problems such as schizophrenia or bipolar disorder are three to four times more likely to smoke than the general population. Whilst smoking rates are falling in the general population, they have remained unchanged among people who use mental health services. The Smoking Cessation Intervention for People with
Severe Mental Ill Health (SCIMITAR) research team developed a bespoke smoking cessation intervention to help people with SMI cut down or quit smoking (Gilbody et al., 2019). The SCIMITAR+ trial recruited 526 people who were randomly allocated to either the intervention or usual smoking cessation services.

The intervention consisted of a mental health professional trained in smoking cessation interventions (MHSCP) who worked in conjunction with the patient and the patient’s GP or mental health specialist to provide a smoking cessation service individually tailored to each person with SMI. It was delivered in accordance the Smoking Cessation Manual: A Guide for Counsellors and Practitioners which forms the basis of smoking cessation interventions in the NHS via the National Centre for Smoking Cessation Training (www.ncsct.co.uk).

It complied with current NICE guidelines for smoking cessation services and included support sessions specifically adapted for patients with SMI run by the MHSCP and GP-prescribed pharmacotherapies to aid smoking cessation (NRTs, bupropion or varenicline either separately or in combination, as decided by the GP), in addition to regular follow-up by the MHSCP.

In the training of the MHSCPs, attention was paid to the content of the intervention to ensure that evidence-supported behaviour change techniques (BCTs) were incorporated.

**Examples of specific adaptations to the needs of those with SMI are:**

1. the need to make several assessments prior to setting a quit date;
2. recognising the purpose of smoking in the context of their mental illness, such as the use of smoking to relieve side effects from antipsychotic medication (and how this will be managed during a cessation attempt);
3. the need to involve other members of the multidisciplinary team in planning a successful quit attempt for those with complex care needs and multiagency programmes of care;
4. a greater need for home visits, rather than planned visits in GP surgeries;
5. providing additional face-to-face support following an unsuccessful quit attempt or relapse; and
6. informing the GP and psychiatrist of a successful quit attempt, such that they can review antipsychotic medication doses if metabolism changes.

Pharmacotherapies were provided as long as was deemed necessary and the MHSCP offered advice on the range of treatments options available to patients under the NHS (including medication, counselling and follow-up).
The SCIMITAR+ trial found that after six months, participants who received the bespoke intervention were twice as likely to have stopped smoking than those who received usual care. The difference was still evident at 12 months, in a combined analysis of pilot and full trial data.

**Service user and family member/care involvement**

In the Republic of Ireland, service user and family member/carer involvement in planning and delivering mental health services has a history dating back to the late 1990s. A key impetus for its development was the recommendation in the national mental health policy of 2006, *A Vision for Change*, that “Service users and carers should participate at all levels of the mental health system.” (Expert Group on Mental Health Policy, 2006).

With support from the Assistant National Director for mental health services, and within the newly-centralised Health Services Executive, developing structures for user involvement became a priority for the policy’s implementation. Implementation included early appointment of a service user as a member of the national mental health management team and the establishment of a national forum for service user and family member/carer feedback – the National Service User Executive (NSUE).

NSUE’s role, starting in 2007, was formative in developing expectations on the part of service users and family members/carers across the country that there would be regular opportunities for them to express their views about services. By 2016, although NSUE’s role had changed, expectations of user involvement were sustained. The HSE organised a national consultation in 2014, with listening meetings in every county, in order to gather feedback on the services (HSE Mental Health Division, 2016b). Following on from this consultation a national reference group of service users and family members/carers was formed to develop recommendations on user involvement structures and processes (HSE Mental Health Division, 2016a). This group met between August 2014 and July 2015.

**In summary, it recommended:**

1. The role and function of the head of Mental Health Engagement as a member of the national mental health management team.
2. The role and function of the nine Area Leads for Mental Health Engagement as members of the mental health services area management teams.
3. Structures and mechanisms for feedback and consultation through Local and Area Forums.
4. Training and capacity building required to support the engagement structures and roles.
5. The role of the Mental Health Engagement Office.
The Mental Health Reference Group’s recommendations provide the basis for current structures for user and family member/carer involvement within the HSE, which include:

- A national Office for Engagement and Recovery
- A national lead of Engagement and Recovery who is involved in planning mental health services at national level, and who is an expert by experience
- Engagement Leads in every healthcare region, employed by the HSE, who sit on that area’s mental health service management team
- Local and regional forums for service users and family member/carers, organised by the Engagement Leads

Parents and families

Think Family

The Think Family (NI) Project was established in 2009 by the Health and Social Care Board in Northern Ireland and over the last ten years a range of initiatives have been introduced to promote health and social care professionals’ response to families where parental mental ill health is present. Influenced by SCIE’s ‘Think Child, Think Parent, Think Family’ work (Social Care Institute for Excellence, 2011), Dr Adrian Falkov’s commissioned consultation and The Family Model (TFM) (Falkov, 2012) has been the main theoretical basis for more recent developments.

This work included the development of an ‘Adult and Children’s Services Joint Protocol for Responding to the Needs of Children whose Parents have Mental Health and/or Substance Misuse Issues’ (Health and Social Care Board, 2011) which sought to help parents understand their mental health issues. It also considered their treatment plan and the impact their mental ill health could have on their parenting and their relationship with their child.

A recent case file audit of social work files concluded that while practitioners were working in a family-focused way, more needs to be done to embed this across services and further work to promote interagency collaboration could help improve outcomes for families (McCartan et al., 2020).

Young people

Direct access services for young people

A focus of innovation in children and young people’s mental health has been the development of youth-specific direct access early intervention services at primary care level. These services provide information on mental health in accessible, youth-friendly settings, brief interventions and referral onwards to specialist mental health services. They can also incorporate universal provision through education programmes in and liaison with schools. Three leading examples are Headspace in Australia, Youthspace (now Forward Thinking Birmingham) in the UK, and Jigsaw in the Republic of Ireland. Reflecting the experience of these types of services, McGorry, et al. (2013) describe a set of features, principles and targets for the redesign of services to better meet the needs of young people:
• youth participation at all levels, essential to create youth-friendly, stigma-free cultures of care;
• a holistic, preventive and optimistic stance with sequential/stepwise care governed by risk/benefit and shared decision-making principles;
• early intervention, social inclusion and vocational outcomes as core targets;
• care reflecting both the epidemiology of mental ill health in young people and the new developmental culture of emerging adulthood in the early 21st century;
• elimination of discontinuities at peak periods of need for care and developmental transition;
• positive and seamless linkages with services for younger children and older adults.

A key benefit of these services is provision of an integrated hub for youth-friendly primary care-level mental health services. Settipani et al. (2019) describe how such integrated, community-based youth mental health hubs seek to provide youth-focused integrated supports in a ‘one-stop-shop’ approach, though the range of services varies. In addition to mental health interventions, supports on offer may include physical healthcare and/or substance misuse services, social services and/or peer support.

While Settipani et al. (2019) found limited information on the outcomes of integrated, community-based youth mental health hubs, they report generally positive outcomes, particularly improvements in psychological distress and psychosocial functioning have been found.

Organisational processes in services such as Headspace (Australia), Jigsaw (Republic of Ireland) and Youthspace (Birmingham) emphasise youth participation in the development, implementation and evaluation of services. In this way, youth participation is embedded within the ethos of the organisation (Simmons et al., 2020).

Young adults are the age group least likely to engage in mental health services – in part because services and supports are neither engaging or developmentally optimal (Kim, Munson, & McKay, 2012; Moore, 2018; Pottick, Bilder, & Vander Stoep, 2008; Stewart, 2013; Substance Abuse and Mental Health Services Administration, 2018; US Government Accountability Office, 2008). A number of studies have examined the role of young peers to reach other excluded young people (Zlotowitz, Barker, Moloney, & Howard, 2016). Zlotowitz and colleagues used contemporary music skills and other co-produced activities to help build relationships with practitioners and address young people’s multiple needs. The intervention was valued by young people who did not easily engage with professionals and services and led to a number of new co-produced pilot projects to look at health and social inequalities in a group of excluded young people.

## Schools

### Digital health

TrustCircle is a peer-centred mHealth care start-up that allows individuals to assess, track and learn about their emotional wellbeing, gain access to on-demand care and community support anytime, anywhere, anonymously.
Based on the 3P Model (Preventative – Participatory – Predictive) it uses AI technology to improve emotional resilience and wellbeing with a focus on prevention and early intervention (MH Innovation). It has five different components:

1. **mHealth Smiles**: A research-backed platform that helps you understand your emotions better to improve your wellbeing.

2. **mHealth Tests**: Free validated mental health assessment tests for life, preventative & early intervention public health model, empower all individuals to assess, track, learn about their mental health proactively.

3. **mHealth Connect**: Builds an inclusive society and collaboration model of carefree community support for life, anonymous peer-peer support locally or globally.

4. **mHealth Insights**: Organisations will gain access to real-time mental health insights for its community, identify high-risk areas/population and take action.

5. **mHealth Care**: An on-demand care network of trustworthy experts for individuals and enterprises.

### Public mental health awareness

A project designed to improve the understanding of mental health and suicide and improve wellbeing was set in 4 railway stations in Victoria, Australia. The Community Stations Project was designed to address railway suicides by improving the station environment with four types of interventions (arts and culture, music, food and coffee, and special events) (Ross, Reavley, Too, & Pirkis, 2018). These aimed to improve community wellbeing, raise awareness of poor mental health and the likelihood of reaching out to at-risk individuals. 48% of the 1,309 survey respondents noticed the improvements in the stations and this was associated with positive views of the station, improved understanding of poor mental health, and a greater likelihood of reaching out to someone who might be at risk of poor mental health.

### Public mental health and the arts

Arts-based therapeutic approaches have been successfully used in different populations (Coholic, 2011; Coholic & Eys, 2016; Coholic et al., 2020; Van Lith, 2016) however, the arts has also been used effectively as a public health approach. The Scottish Mental Health Arts and Film Festival has evolved into one of the largest mental health events, engaging with over 30,000 people each year. Starting out as an anti-stigma campaign, it has developed over the last decade to become a broad-based social movement harnessing grassroots activism throughout Scotland involving people with and without mental health diagnoses to help reframe ideas of mental health and illness (Aldam, Dickie, Knifton, & Davidson, 2017).

### Criminal justice

**Mindfulness**

A randomised controlled trial of a six-week mindfulness training programme in a prison population in China showed significant improvements in mindfulness and measured by the Symptom Checklist-90 saw positive improvements in aggression, sleep quality and total mood disturbance (An, Huang, Zhou, Zhou, & Xu, 2019).
While there has been a move away from institutional care across Europe, different strategies have been employed to triage people more effectively, reduce inpatient admissions, monitor chronic co-morbid conditions and innovate within psychiatric inpatient settings. These junctures in treatment can also provide important opportunities for collecting data to monitor care and outcomes.

These approaches include better emergency responses, in-patient treatment, and transforming the long-term management of serious mental health problems. We describe some developments that have been trialed in different settings.

**Changing the emergency response to mental health crises**

New York City’s Mayoral mental health programme, NYC Thrive, has adopted a new approach to emergency responses in a direct move to reduce inpatient admissions. They have 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:

- Piloting the addition of telehealth to shelters
- Diverting emergency 911 calls to NYC Well where appropriate
- Exploring walk-in services
- Expanding peer/police training opportunities
- Creating a data flag for frequent 911 callers

In Southern California, a pilot of a Mobile Psychiatric Treatment Team (Krekler, 2020) will provide mobile interdisciplinary care to patients presenting at accident and emergency (A&E). Immediate crisis intervention for people in a mental health crisis in A&E will be evaluated and treated by a team comprised of a (24-hour virtual) psychiatrist, a psychiatric registered nurse, a social worker and a mental health worker. They will provide case management for up to 30 days to decrease readmission to A&E.

The team will have 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.

Closer to home, the London Ambulance Service (LAS) 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. Between 19 January 2020-12 April 2020, LAS crews operating a ‘business as usual’ model attended 1,386 incidents where a person was presenting with a mental health problem. 54% of these people were taken to the Emergency Department (ED), 4% were referred to a mental health pathway.

The joint response team attended 2,036 incidents, 18% were taken to ED, 19% referred to mental health care pathways. More than 4 out of 5 people seen by the joint team were seen, treated and discharged at the scene compared to 2 out of 5 in the treatment as usual group. The majority of people treated had a history of mental health problems and 52% were in current treatment. The projected cost savings are considerable (NHS England & NHS Improvement & London Ambulance Service, 2020). Although a pilot scheme, feedback from patients and staff was extremely positive and LAS is keen to extend the service.

**Improving inpatient treatment**

National reviews of inpatient mental health wards have criticised the lack of meaningful approaches to services, engagement and empathy from staff. 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 services users have been trained as Tree of Life workshop facilitators.

In Northern Ireland, Crisp and colleagues (2016) reported the multiple system-wide challenges facing mental health services, including a shortage of community and specialist mental health services and supported accommodation.
They highlight the lack of parity between mental and physical health services and argue that someone with a severe mental illness should be able to expect the same level of care as someone suffering from heart attack or stroke. Recommendations are made about how mental health services should be organised including the creation of a single Mental Health Service for the region, increasing investment in crisis resolution and home treatment teams, specialist psychiatric services and psychological therapies.

**Integrated care models**

Integrated care is defined as “health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, co-ordinated across different levels and sites of care within and beyond the health sector, and according to their needs, throughout the life course.” (WHO, 2016). One of the earliest examples of integrated care was embedding mental health services within cancer centres in the 1980s and 1990s, which lead to the development of psychosocial oncology but mental health services have not been embedded in other specialisms such as cardiac care (Lichtman et al., 2014).

Mental health conditions are typically comorbid with many non-communicable diseases and managing long-term conditions effectively must take account of service users’ physical and mental health. Screening and case identification may improve through integrated care models and data collection.

Singer’s concept of ‘syndemics’ extends the understanding of disease beyond medical/biological models, acknowledging the considerable social, environmental and economic factors present when two or more diseases cluster within a population (see Figure 1).
A. How do the biological processes and pathophysiology of co-occurring conditions interact?

- **Pathophysiology** of one condition contributes to the other.
- Medical treatment of one condition contributes to **iatrogenic development** of the other condition.
- **Genetic and epigenetic** factors predispose both health conditions.

B. How are the conditions experienced by patients and their social networks?

- **Somatic experience**
  - Perceived pain, functional limitations, changes in physical appearance

- **Daily activities**
  - Perceived ability to perform physical, socio-emotional and cognitive tasks

- **Meaning**
  - Effect on social role, personal value and moral experience

C. How do medical institutions address co-occurring conditions?

- **Referral**
  - Specialists co-ordinate with primary care referral
  - Specialists might or might not co-ordinate with each other

- **Primary care services**
  - Treatment guidelines and collaborative care models for commonly co-occurring conditions. **Financing models** to reduce all-cause hospital readmission incentivise comprehensive care. Social policies address inequalities.

- **Referral**
  - Social policies address inequalities that shape risk of exposure to environmental and social stressors that contribute to inflammatory responses, antiviral activity and other disease processes.

- **Culture shapes meaning associated with suffering and social responses to suffering, illness and disability. Structural and social factors impede adherence to clinical recommendations.**

- **Culture influences categorisation of medical specialities, training models for health workers, financing of health systems and stigma among health workers. Structural and social inequalities impede access to care, and social policies promote or impede good health.**
Managing chronic comorbid conditions within general hospital settings

Health care systems traditional focus has been on acute care but, increasingly, the need for providing care for people with chronic conditions is also a challenge (Thornicroft et al., 2019).

One US-based project examined the proactive involvement of psychiatry services with all patients requiring constant observation (CO) in a general hospital setting (Pinkhasov, Singh, Chavali, Legrand, & Calixte, 2018; Wulsin et al., 2019). Psychiatric comorbidity in general health is high and this study introduced a Behavioural Health Management protocol (Figure 2: the ACE Intervention). 491 patients were subject to the protocol over a 6-month period.

There was a 33% reduction in the average monthly costs of CO and 15% in length of stay (LOS). It also reduced falls, inadvertent extubations, elopements and readmissions. The model can be implemented in any hospital setting and highlights the collaborative approach between the medical and psychiatric care of patients in CO.

Figure 2: The ACE Intervention (Pinkhasov et al., 2018)
The proactive psychiatric consultation model is one example of how systems innovations may deliver cost savings, make quicker changes and improve care (Sledge et al., 2015). Sledge and colleagues’ before- and after-design study compared conventional consultations to proactive, mental health professional-initiated, multidisciplinary intervention delivered by a behavioural intervention team (BIT) comprised of a psychiatrist, nurse and social worker on the same units.

Patients were treated in 3 different inpatient settings with a total capacity of 92 beds (15,858 patients) over 3 comparison years. Each professional performed the tasks associated with their discipline while collaborating together and with other healthcare staff. There was a statistically significant reduction in length of stay of <31 days for the BIT patients.

**Medical-psychiatric units**

More patients receive treatment for mental disorders from GPs than in mental health specialty settings (Olfson, Kroenke, Wang, & Blanco, 2014). Patients that present with somatic symptoms will often experience comorbid psychiatric complaints but there are many obstacles to providing integrated psychosomatic care.

Medical disciplines and research areas are often accused of working in silos, which can isolate areas of expertise (Leue et al., 2020). Primary care providers have been criticised for insufficient training or interest in managing comorbid mental disorders (Leue et al., 2020).

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 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). Learning from similar programmes include:

- Creating multi-disciplinary teams that conduct multi-disciplinary research could be transformative
- Shared clinical protocols
- Specialty-transcending information system (with electronically accessible patient files)
- Co-located work environment
- Multi-component strategy to tackle stigmatisation – including stigma-related obstacles that hamper compliance, treatment adherence

**Collaborative chronic care models**

Few individuals with mood disorders have access to evidence-based collaborative chronic care models (CCMs). CCMs provide ongoing psychological support in conjunction with treatment co-ordination. RCT for individuals hospitalised for unipolar major depression or bipolar disorder enrolled in a large national health plan were randomly assigned to CCM (self-management sessions and care) by telephone or usual care (Kilbourne et al., 2019). The care manager delivered the CCM intervention over a 6-month
period including clinical information systems (health provider clinical database to track and contact eligible patients), self-management support (10 weekly sessions by phone adapted from the Life Goals programme) and ongoing care management (up to 6 monthly brief contacts to determine status and symptoms).

Thirty-minute assessments of primary outcome measures and covariates were conducted at baseline, 6-month and 12-month follow-up. Covariate information included demographics, health behaviours (including the Alcohol Use Disorders Identification Test (AUDIT)). Those receiving CCM had lower overall depression symptoms (PHQ-9; mental health component of the SF-12) and potentially improved mental health quality of life in 12 months.

Drop-out rates were higher in the treatment group in 0-6 months, but similar at 6-12 months. Based on the model fit with main effects of 12-month and treatment arm (CCM) indicators, adjusted mean±SE PHQ-9 scores among patients receiving the CCM were lower by –2.34±0.92 points (95% confidence level [CI]=–4.18 to –0.50, p=0.004), compared with those receiving usual care. Although not statistically significant, adjusted mean SF-12 MCS scores for patients who received the CCM were higher (indicating better quality of life) by 3.21±2.09 points (95% CI=–0.97 to 7.38), compared with scores of those receiving usual care.

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.

The ACCESS-SMI (Advancing Collaborative Care to Ensure Systematic Screening in Severe Mental Illness) was a modified collaborative care model for people with severe mental illness using a population-based registry, patient-centred team care, measurement-based treatment to target for medical outcomes and a stepped care model.

**Their goals were to:**

1. Examine the feasibility and acceptability of creating an SMI registry within primary care;
2. Document baseline screening rates on the following metrics – metabolic monitoring (Body Mass Index, haemoglobin, cholesterol, blood pressure) hepatitis, HIV, smoking status, referral to community mental health treatment and track outcomes after intervention to improve screening;
3. Use the registry to conduct psychiatric caseload review at weekly primary care/behavioral health team meetings; and
Outcomes were assessed as part of a prospective cohort study to evaluate the implementation of the model. There are a number of SMI patients who are treated in primary care alone, but barriers to care outside the community setting include limited time, lack of provider knowledge and stigma. This model can be implemented in integrated primary care clinical settings especially in urban, safety net centres with high baseline rates of mental illness within the primary care population.

In addition to the integrated care team (e.g. primary care provider, psychiatrist, therapist), resources include a person tasked with generating and maintaining the registry, which could include a care manager, referral coordinator, or other designated staff member. The clinic would also need to invest in the IT resources to create and maintain a registry. Health centres provide a common setting for implementing this model. By adapting the collaborative care model to focus on people with SMI, we can highlight the unique needs of this population and leverage resources towards improving the health of people with SMI in the primary care setting.

Patients’ experiences of integrated care

A scoping review conducted by Youssef et al. (2019) found that integrated care (IC) models have the potential to improve patients’ experiences but there can be variability across settings. 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.
They reported that:

- Studies that were sensitive to population specific barriers to accessing care were more successful in addressing patient care needs and building relationships with staff.
- Understanding stigma, illness acuity, cultural, and ethnicity factors enabled appropriate changes to be made to provide better care.
- There will be individual needs in patients’ care plans and these must be considered e.g. the acceptability of m-health interventions in terms of privacy may affect treatment engagement.
- Current patient-reported measures will not capture important data about the effect of IC structural components on patients’ experience, e.g. the Patient Assessment of Chronic Illness Care Instrument (PACIC; (Gugiu, Coryn, & Applegate, 2010)).

Youssef’s review highlights the strong need to expand existing evaluative processes of patient experience in IC to include patients’ perspective on additional care integration domains, such as structural components.

Community-based mental health care

A model of community-based mental health care

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. 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 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.

The authors describe a move towards a ‘third era’ of community-based mental health care as the ‘moral era’ – where mandatory measurements are reduced, the professional prerogative is removed and there is a transition to civility and collaboration with patients and carers. The move towards the third era is driven by limited evidence of improved outcomes of biological and psychological approaches alone in mental healthcare, and the growing knowledge on the powerful influence of social factors, like inequality in mental health. EUCOMS recommends the use of interventions that integrate a focus on evidence-based psychological treatment (such as cognitive behavioural therapy (CBT), motivational interviewing (MI), and psychodynamic therapy with the use of medication as a tool and not as an aim. Furthermore, there is a focus on improving physical health and social inclusion. Best practices that focus on social inclusion include the use of resource groups (Norden, Malm, & Norlander, 2012), dialogue approaches (Seikkula & Olson, 2003), housing first (Tsemberis, Gulcur, & Nakae, 2004) and individual placement and support (IPS) (Bond, Drake, & Becker, 2012).

**Meta-community mental health care**

Bouras, Ikkos and Craig (2018) identify a move from community to meta-community mental health care offering several examples:

- There is an increasing recognition that mental health professionals have a responsibility to try and increase understanding of mental illness and the damage that prejudice, discrimination and neglect can have.

- There has been a move away from reliance on shared accommodation with live-in staff towards greater separation from housing and support, using a ‘housing first’ approach. This has not been shown to carry more risk of drop-out of wider care, harm to self or others and is preferred by patients compared to more gradual ‘stepped down’ models.

- 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 – because they are seen as social rather than health provision and therefore not adequately supported by health care funders.

- Personalised budgets that give the service user control over the purchasing of social and health care. There have been some small-scale pilot programmes, although they have been criticised as being tokenistic and it may be possible to ensure that people have more control over their care and support without necessarily devolving responsibility for commissioning them. However, the approach reflects a growing consensus that citizens should be at the heart of public services.

- Socially focused interventions – e.g. parenting and school based programmes that address conduct disorder in childhood (one of the strongest risk factors for adult...
disorders (Baker-Henningham, Scott, Jones, & Walker, 2012; Webster-Stratton, Reid, & Hammond, 2001), befriending for older adults (Forsman, Nordmyr, & Wahlbeck, 2011) and peer support in depression (Pfeiffer, Heisler, Piette, Rogers, & Valenstein, 2011).

- 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 (Forrester, Singh, Slade, Exworthy, & Sen, 2014; James, 2010).

Community networks of care
This 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. It is important that the different disciplines in a community mental health team take a shared responsibility for the interventions. This implies an interdisciplinary and a multi-expert way of working in which there are no exclusive domains. Expertise varies per discipline, and it is a task of the experts in the team to share their expertise, e.g. by organising clinical lessons. Furthermore, the professional expertise of team members is combined with the lived experience of users. The integration of services can be hindered by a financing system that favours institutional care (e.g. by rewarding bed occupation (Knapp et al., 2007; Knapp, McDaid, Mossialos, & Thornicroft, 2010). The introduction of a flexible finance system that allows incentives for different services could help to address the relevant life domains of people with a mental illness.

Clubhouse
Although this scheme has been running for a number of years, it can be an effective way to engage people in social and economic interactions. Members get opportunities to re-join worlds of friendships, family, employment and education, and to the services and support they may individually need beyond the mental health care system (Clubhouse International; Mowbray, Lewandowski, Holter, & Bybee, 2006).

Assertive Community Treatment (ACT)
Assertive Community Treatment (ACT) is an evidence-based integrated community-based mental health care model. ACT has shown to offer significant advantages over standard case management models in reducing homelessness and symptom severity in people with severe mental illness (Coldwell & Bender, 2007). Good practices of integrated community-based mental health care with less conclusive evidence include: Flexible Assertive Community Treatment (F-ACT) (Nugter, Engelsbel, Bähler, Keet, & van Veldhuizen, 2016), and integrated dual disorder treatment (IDDT) (Harrison, Curtis, Cousins, & Spybrook, 2017).

iFightDepression is one of the main eMental Health interventions of EAAD is an online platform with 3 parts: an awareness website; a guided internet-based self-management tool for
individuals experiencing milder forms of depression; training materials for healthcare professionals.

**Improving access to psychological therapies**

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. IAPT is widely-recognised as the most ambitious programme of talking therapies in the world and in the past year more than one million people accessed IAPT services for help to overcome their depression and anxiety, and better manage their mental health. IAPT services are characterised by three things:

1. Evidence-based psychological therapies
2. Routine outcome monitoring
3. Regular and outcomes focused supervision

**Targeting hard-to-reach groups**

**People experiencing homelessness – Housing First**

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. In the last 6 months of the two year pilot:

- 62% were housed all of the time (vs. 31% TAU)
- 22% some of the time (23% TAU)
- 16% none of the time (46% TAU)
- Most participants were actively engaged in support and treatment services and there was a general move away from crisis and institutional services to community
- People with previously unmet needs were able to access appropriate and needed services
- Quality of life and community functioning improved

Over the two-year period following study entry, every $10 invested in HF services resulted in an average savings of $21.72.

**Conflict/disaster-affected populations**

Self-Help Plus (SH+) is a form of CBT using mindfulness based on acceptance and commitment therapy (ACT). The psychosocial self-help package can be delivered by facilitators with minimal training. Supported by the WHO, it aims to help stress management and coping with adversity, particularly in high risk situations, such as conflict or disaster-affected settings or humanitarian crisis.

Delivered in up to groups of 30 people, the 2-hour x 5 sessions self-help multimedia course can be implemented in areas where services are non-existent and can be scaled up.
Workforce

Training and staff development

Ongoing workforce planning processes are underway in NI to estimate the number of relevant professionals needed, including numbers of support workers, and the number of Approved Social Workers (Davidson & McCartan, 2020). This work also identifies the need for training in psychological interventions.

Walker and colleagues (2019) describe a remote training project that was designed to enhance providers’ skills in engaging and working effectively with emerging adults with serious mental health problems. Achieve My Plan (AMP) – strengthens providers skills in key areas needed for working with young people to create and carry out treatment or care plans. AMP focuses on promoting young people’s self-determination skills using a strengths-based approach, with treatment based on their perspectives and priorities, seeking to build positive connections. AMP training is delivered remotely, via a series of web conferences, an internet-based training and coaching platform (the “virtual coaching platform,” VCP), and telephone feedback calls (Achieve My Plan, 2018). Eight 1.5hr small-group interactive web conferences are held bi-weekly over a period of about 4 months, with “homework” assignments completed by trainees in between. Homework includes watching examples of expert and inexpert practice on VCP and/or videorecording samples of their practice with young people and uploading them into VCP for review and scoring by the trainers. Each trainee uploads a minimum of 8 videos:

- 2 short videos of 5-10 mins that focus on the practice of basic skills for active listening
- 6 remaining videos (45 mins) trainees are filmed working with young people, using a series of semi-structured modules designed to implement person-centred planning
- After each video is reviewed, trainees take part in an individualised telephone feedback session – this includes a description of key practice strengths and improvable and may also include links to clips to demonstrate skills and techniques that the trainer wants the trainee to review
- Total of around 20 hours training and coaching related activities

Effective Communication for Healthcare (EC4H) in Scotland have a range of training programmes including developing empathetic communication skills for NHS staff. Anecdotal evidence from the pilot suggested that it training can help enhance skills and have a positive impact on patient emotions and attitudes to care (McCluskey, Heywood, & Fitzgerald, 2011).
**Behaviour change wheel**

Bull and colleagues (Bull et al., 2019) describe the implementation of an Organisational Participatory Research study conducted with health organisations, health psychologists and health professionals in the North West of England.

Four teams from paediatrics, midwifery, cardiac and older adult mental health specialties from four organisations enrolled in the study wanting help to move care to the community, deliver preventative healthcare tasks, and become more integrated.

Using the Behaviour Change Wheel (BCW) they identified the key service delivery changes needed to implement the new model of care, understand the barriers and co-develop an evidence-based, tailored behaviour change intervention to assist with the implementation.

The three stages of the BCW are:

- Understanding the behaviour and determinants
- Identifying intervention options (functions & policy categories)
- Identifying content and implementation options

**Task-shifting**

Mental health as a proportion of the global burden of disease continues to grow (Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015) but receives only a small percentage of investment compared to physical health provision. Many LMICs have limited mental health service provision and uptake can be poor for a variety of cultural, geographic, and financial reasons (Chowdhary et al., 2014; van Ginneken et al., 2013; Weinmann & Koesters, 2016). Approaches to improve mental health services including integration within primary care have been taken to increase early diagnosis and prevention and help reduce the stigma often associated with mental ill health.

Task shifting has been one approach to try and help address health workforce issues by shifting specific tasks from professionals with higher qualifications to less qualified staff or by creating a new job level with appropriate training (WHO, 2007). The theory behind task shifting is to ensure that some level of support is available, alleviate the workload of specialists and allow them to focus on more complex cases (Patel et al., 2007; Weinmann & Koesters, 2016).

Regular supervision, adequate resources, quality training and in-service training can help enable the successful redistribution of tasks among staff (Agyapong, Osei, McLoughlin, & McAuliffe, 2016; Yaya Bocoum, Kouanda, Kouyate, Hounton, & Adam, 2013). The mhGAP was launched by the WHO in 2008 to provide technical guidance, tools and training to help address the challenges of providing care in resource poor settings (WHO, 2008).
 IDENTIFYING PHASE
Workforce lead and teams identifying 1-2 teams to work with, who are struggling to make changes to their practice.

EXPLORING PHASE
Meeting the team to identify priorities and explore using behavioural principles (methods could include observations, discussion with individuals, questionnaires or focus groups, base on availability of team members).

Time needed: flexible according to team availability

DECIDING PHASE
Feeding back our findings to the team and making plans on recommendations and interventions, ideally in an existing team meeting.

Time needed: 1-2 hours

IMPLEMENTING PHASE
Putting in place tailored behavioural interventions to help with identified issues. This could include training or changes to systems and processes to make practice changes easier or more motivating.

Time needed: to be decided

EVALUATING PHASE
Using the same methods to explore whether the interventions have helped.

Time needed: up to half a day

UP TO SIX MONTHS IN TOTAL
In Northern Ireland, progress has been made on involvement and co-production including the legal duty (Health and Social Care (Reform) Act (Northern Ireland) 2009), standards http://engage.hscni.net/what-is-ppi/policy-and-legislation/ and support.
Peer support

Peers reinforce that recovery is possible. In Europe, it is acknowledged as an area of expertise and recognised in policy documents and strategies however it is not always reflected in practice, few peer experts are paid appropriately, if at all, and there are still barriers around disclosure.

Promoting the involvement of service users as partners on policy and the design and evaluation of services can help build peer expertise. “Service users can only be empowered to take up their role as peer expert if there is community level understanding and acceptance about mental health and peer expertise.” (Keet et al., 2019, p. 7).

Resource allocation should allow for the organisation of user-led services and encourage the use of lived experience of professionals as a tool to support their clients. Training manuals developed by peer experts are a good example of using lived experience, e.g. the peer2peer vocational training course developed as part of the lifelong learning program funded by the EU (Christie, Smith, Bradstreet, & McCormack, 2015) and the Samen Sterk Zonder Stigma program that focuses on self-disclosure among professionals.

Using a person-centred recovery approach, peer support enables people with lived experience to foster a sense of connection by sharing their experiences.

Embedding it within routine clinical practice may be difficult – stakeholders may be unwilling to integrate it into existing practice or have difficulty operationalising it effectively (Ibrahim et al., 2020; May, 2013). Ibrahim and colleagues’ systematic review identified some of the key considerations introducing peer support in a clinical model:

- Concerns about the organisation and implementation of peer support
- Some professionals described peer support as increasing workload (R. Collins, Firth, & Shakespeare, 2016; Gillard & Holley, 2014)
- Successful implementation of peer support worker (PSW) schemes may only be possible in services which place value on lived experience as a resource that is of benefit to others (Gillard, Edwards, Gibson, Owen, & Wright, 2013)
- PSWs can reduce stigma (Henderson et al., 2014) and ‘them-and-us’ distinctions (Schrank et al., 2015)
- It can be an effective intervention (Johnson et al., 2018) but can also influence how other treatments and interventions are delivered (Meadows et al., 2019; Slade et al., 2015)

Ibrahim and colleagues’ systematic review identified organisational culture as the most influential factor in PSWs.
Evidence-based approaches that adopt a recovery focus are starting to change organisational culture (Ibrahim et al., 2020) including supporting strengths (Tse et al., 2016), self-management (Cook et al., 2012), hope (Kirst, Zerger, Harris, Plenert, & Stergiopoulos, 2014; Schrank, Bird, Rudnick, & Slade, 2012), wellbeing (Schrank, Riches, Bird, et al., 2014; Schrank, Riches, Coggins, et al., 2014; Slade, Oades, & Jarden, 2017), and the use of new interventions such as positive psychology (Slade, 2010; Slade, Brownell, Rashid, & Schrank, 2016), recovery colleges (Crowther et al., 2019; Toney et al., 2018; Toney et al., 2019) and a human rights focus (Funk & Drew, 2017).

Peer support can be an important tool in the Recovery approach and can promote shared decision-making especially in relation to medication. The UPSIDES (Using Peer Support in Developing Empowering Mental Health Services) programme began in January 2018. It aims to replicate and scale-up peer support interventions for people with severe mental illness through mixed-methods implementation research. A consortium of mental health researchers, providers and users have been established in 8 study sites in 6 countries in Europe (Germany & UK), Africa (Uganda & Tanzania) and Asia (Israel & India). The project aims are to:

- Establish an international community of practice for peer support across high-, middle- and low-resource settings
- Conduct a situational analysis of existing peer support initiatives in the participating countries
- Scale up peer support models with a focus on vulnerable populations where pilot initiatives already exist – this will include manualising existing interventions and build capacity in co-production and co-delivery of demonstrations
- Contextualise and adapt peer support models for those sites where there are no peer support initiatives – adapting existing tools, materials and strategies from demonstration centres to ensure cultural and situational appropriateness
- Evaluate inputs, processes, and outcomes of implementation – multi-site pragmatic trial augmented with qualitative methods which will assess user-, service- and system-level outcomes and investigate active ingredients and key barriers/ facilitators for research and practice
- Using case studies to evidence best practice from dissemination to local, national and international stakeholders.

In a systematic review of modifications to PSW for adults with mental health problems, only one of the 39 studies was from a LMIC. Six types of modifications were identified:

- Role expectations
- Initial training
- Type of contact
- Role extension
- Workplace support for peer support workers
- Recruitment

In the Republic of Ireland, Peer Support Workers have been employed by Mental Health Services.
Health Services to support service users’ recovery. An evaluation of the impact of the role was published in 2019 (Hunt & Byrne, 2019). Overall, the role had a positive impact on service users, service providers and Mental Health Services. Service users were overwhelmingly positive about the impact on recovery, acting as role models, inspiring hope and normalizing mental health difficulties and reducing stigma. They connected service users to engage in their community and act as advocates. Service providers saw the role of peer support workers helping to communicate service users’ wishes and goals and strengthened service providers’ recovery orientated thinking and practice.

Service readiness is key to implementation – providing training on peer support and recovery and additional support and supervision structures are required. 72% of peer support workers interviewed in the study felt that they had experienced barriers to fulfilling their role relating to:

- **Understanding the role and what it entails** – as a new role, it has taken time for both staff and service users to understand but this is beginning to improve. Similarly, service providers did not have a good understanding of what the role of a peer support worker was which could lead to inappropriate referrals or a reluctance to refer service users to a peer support worker in the first place. Peer support workers also reported lack of clarity about their job role which could hamper co-operation and full involvement in multi-disciplinary team work.

- **Attitudes towards the role** – some peer support workers interviewed for this evaluation felt on the periphery or separate from the rest of the team. Some described being perceived as the ‘recovery’ person on the team and while this may be the focus of their role, it should not preclude others from adopting this approach.

- **Support** – in order for the role to be accepted, service providers need guidance to understand the role and new ways of working. Peer support workers could also feel unprepared for the type of responsibilities with many reporting that learning was ‘on the job’ and while there was good quality professional training available, not everyone had access to it. Other difficulties associated with the role include low wages, part-time hours, requirements to work beyond their role and hours and lack of access to facilities including desk space, computers, and printers. This could contribute to workers feeling undervalued and disheartened and ultimately impeded their work. Peer support workers were satisfied with their supervision but felt that they should be supervised by someone in the same profession. This introduces the potential for progression, and career recognition with more senior support worker roles.

As a result the Health Service Executive has produced a toolkit (Mental Health Engagement and Recovery Office, 2019) to support peer support workers. This outlines the role of the peer support worker, service readiness, and supervision, providing examples of peer support worker job specifications and roles. This commitment to the role of peer support workers and the
promotion of equitable employment, supervision and career development has been outlined in Australian health policy, recognising the peer support worker role as one part of a specialist multi-disciplinary team (Australian Government Department of Health). Formalised guidance for governments, employers and the peer workforce will be developed by 2021 to inform the support structures required to sustain, grow and professionalise the workforce and ensure consistency across Australia (Australian Government National Mental Health Commission, 2020).

The NHS has given consideration to the peer support worker role and recently produced a draft competence framework for peer support workers in mental health service provision (Health Education England & UCL Partners, 2020). It includes a short section on the organisational competences required for employing support workers. It recommends robust recruitment and selection processes including detailed job descriptions, support for the application process and a strategy for integrating peer support workers within the workforce. Ongoing training, support and supervision is also recognised as key to enabling career planning and progression.

The Mental Health Commission in New Zealand has also given consideration to the components of effective peer support services and outlined the cost benefits of provision (Mental Health Commission Te Kaitātaki Oranga) (see Figure 3).
Figure 4: Components of effective peer support services (Mental Health Commission Te Kaitātaki Oranga)

- Given choice in match of peer worker
- Focus is on achievement of personal goals
- Social inclusion/community integration, employment, education and training are considered
- Support given to strengthen or reconnect with key relationships
- Increasing empowerment and self-advocacy
- Can feedback on satisfaction with the service
- Increased motivation

- Clear statement of the values an mission/philosophy and a joint view of recovery
- Fully developed organisational structure with overseeing board or advisory group
- Clear feedback process so people inform direction and practices
- Clear and responsive complaints mechanism
- Partnerships with key stakeholders
- Effective, sustainable relationships with funders and planners

- Awareness of the role of services, contacts etc.
- Inclusive attitudes toward mental distress and addiction
- Effective links with community groups providing:
  - financial and budgeting services
  - employment opportunities
  - housing
  - health services for mental distress or addiction
  - training and education

- Effective recruitment and retention process
- Evidenced-based training, professional development and career structure
- Clear understanding of scope and boundaries of peer support role
- Effective and accessible supervision
- Skills in self-awareness, self-reflection and relationship building
- Patience, persistence and compassion
- Role models of effective relationships, interested in others
Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness and involves a shift from pathologising mental illness and its symptoms to health, strengths and wellness. Hope is of central significance, without which recovery may not be possible and hope can emerge from many sources including being believed and believed in, and the example of peers.

The role of peer support workers are becoming an important part of the recovery model in mental health. While there is no universal definition of recovery, the recovery model uses a strengths-based approach that doesn’t focus solely on symptoms and emphasises resilience and control over life’s challenges (Bonney & Stickley, 2008; Davidson, 2005). The recovery approach encourages goal setting, and participation in meaningful relationships and activities.

There a number of different models, with the Wellness Recovery Action Plan (WRAP) one of the most commonly used in Northern Ireland. While these models were originally designed for use within addictions and mental healthcare, they have been applied in other health and social care settings and across the UK-wide network of Recovery Colleges the ‘New Recovery’ approach refers to an education-based method rather than a general therapeutic process (Winship, 2016).

The CHIME recovery processes (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) are conditions that service users feel are essential to recovery and this approach is well established encompassing.

| CONNECTEDNESS | Having good relationships, being a part of the community, and getting support from others |
| HOPE | Belief in the possibility of recovery, inspiring relationships, positive thinking, valuing success, having dreams and aspirations, and having the motivation to change |
| IDENTITY | Having an identity with multiple facets, with a positive sense of identity, free from stigma |
| MEANING | Living a fulfilling life, with social roles and goals, with meaning of mental illness experiences, and quality of life |
| EMPOWERMENT | Taking personal responsibility, focusing on strengths, and having control over one’s own life |
Winsper and colleagues (2020) have mapped a logic model to intervention typologies and recovery outcomes and identified four common mechanisms which underpin the processes.

These four mechanisms are:
1. Providing information and skills
2. Promoting a working alliance
3. Role modelling recovery
4. Increasing choice

They conclude that interventions work best when they are pro-recovery and are delivered in a non-stigmatising environment.

During COVID-19, opportunities to communicate these models within public health messaging have been promoted, highlighting that good mental health is for everyone.

It is important to acknowledge that the recovery approach has its critics. The term has been considered misleading creating the potential for unrealistic expectations (Care Services Improvement Partnership, 2007). It has been criticised for its individualistic approach that fails to acknowledge the wider social, political and economic context. However, it looks like the recovery approach is here to stay.
Transforming mental health care

Technology

Digital healthcare

Web interventions, mobile health (m-health), telehealth

We know that technological approaches to offering support to service users has been accelerated as a result of the pandemic but there are concerns that as an emergency response, appropriate planning, preparation and outcome measurement may not have been fully considered in this context.

A number of recent studies have examined the opportunities and difficulties connected with providing digital health care and how and when it should be used to support mental health.

Aref-Adib and colleagues’ (Aref-Adib et al., 2019) systematic review and meta-analysis of 26 digital healthcare interventions for psychosis or bipolar disorder identified a range of barriers delivering remote care that are generalizable to many other mental health service users and care-givers.

Acceptability

The jury may still be out on how acceptable digital interventions are for everyone. High drop-out rates have been associated with computerised CBT for depression (So et al., 2013) and the reasons behind this are important to understand. Another review found that the failure of e-health interventions was related to the high cost, high staff turnover and the additional workload it created for staff.

Aref-Adib and colleagues identified the relative advantage of people’s perceptions of technology compared to treatment as usual, the main one being its accessibility. This could be particularly beneficial during a crisis episode where reassurance of having remote access was useful (Baumel, Correll, & Birnbaum, 2016). Being able to access interventions in a time and setting of their choosing (i.e. in their own home) and with the ability to involve friends/family where appropriate was important, especially for those wishing to stay at home (Nieves, Godleski, Stack, & Zinanni, 2009).

Accessibility

Mobile phone use is ubiquitous and there are growing numbers of mobile phone ownership in people with psychosis with many becoming more interested in using m-health for self-management (Firth et al., 2016). They also have the potential to support friends, family and other carers (Eassom, Giacco, Dirik, & Priebe, 2014; Rotondi et al., 2010; Sin et al., 2018).

Effectiveness

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, & Riefer, 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).

**Adaptability**

It is important that interventions are adapted alongside or within existing infrastructures. Getting the level right can also be important – some users can find psychoeducational components too complex, while others felt it was pitched a too low a level and this could lead to disengagement (Nicholas et al., 2010; Poole et al., 2012). Individually tailoring interventions will often work best (Koivunen, Hätönen, & Välimäki, 2008).

**Security**

The privacy and anonymity provided by an online platform is valued by some (Poole et al., 2012) but others can have fears about cybersecurity (Deegan et al., 2008) and guaranteeing privacy when relying on technology (Poole et al., 2012).

**Implementation**

Integrating digital interventions within clinical settings may not always be straightforward and there is some suggestion of an evidence-practice gap in delivery. There have been a range of difficulties integrating technology with other traditional settings. Providing additional remote support online or by telephone can be helpful in parallel with digital interventions (Lobban et al., 2017), particularly if the clinician is enthusiastic. Peer support can improve engagement (Deegan et al., 2008; Nicholas et al., 2010).

**Individual characteristics**

Knowledge and beliefs are important from both the perspective of the service user and practitioner. Service users are more likely to be engaged in an intervention if peers have been involved in their development (Lobban et al., 2017), have trust in the clinical team and have a positive and enthusiastic approach to the effectiveness of the treatment. However, where people held negative attitudes towards technology, or stated a preference for face-to-face interventions, treatment could be less successful. The setting can influence engagement – inpatient settings can take longer to complete sessions (Anttila, Valimaki, Hatonen, Luukkaala, & Kaila, 2012; Koivunen et al., 2008).

**Cost**

Although the long-term cost benefits have been highlighted, initial investment in staff training, space and equipment can be expensive (Deegan et al., 2008; Koivunen et al., 2008; Lobban et al., 2017; Nieves et al., 2009). Wi-Fi/internet
access can be poor (Deegan et al., 2008; Koivunen et al., 2008; Poole et al., 2012), particularly in rural areas (Wilson, Atterton, Hart, Spencer, & Thomson, 2018). Certain at-risk groups also may have difficulty accessing technology, safe spaces that offer privacy or do not have the resources to pay for technology or internet connections.

Cost can be a barrier, but Aref-Adib’s review identified that there had been a failure in implementation planning across all types of interventions (Bonfils et al., 2018; Deegan et al., 2008; Gyllensten & Forsberg, 2017). Staff turnover, high demands of clinical workloads and lack of investment in training can also cause problems (Bauer et al., 2017; Bonfils et al., 2018; Gyllensten & Forsberg, 2017; Korsbek & Tonder, 2016).

Reasons for non-engagement

Reasons for non-engagement include feeling unwell, worried that the digital intervention may exacerbate symptoms, or find the process tedious. Greater number of lifetime psychiatric hospital admissions associated with treatment non-completion (Ben-Zeev et al., 2014). The level of engagement over a time may decline (Ben-Zeev et al., 2014) and these needs to be monitored.

Mental health conditions

Engagement with technology can vary depending on the type of condition and this needs to be considered in tailoring individualised care. Females with schizophreniform disorder or bipolar disorder were more likely to engage in interventions than males. People with schizophrenia had fewer successful sessions than other mental health conditions (Anttila et al., 2012). Young people with psychosis or bipolar disorder (under age 30) were less likely to engage and complete treatment compared to older service users.

Other studies have shown that there is no statistically significant difference between digital intervention and age/education level. One study found evidence that bipolar participants had difficulty engaging when depressed (Koivunen, Häntönen, & Välimäki, 2008). Service users with a higher premorbid IQ and familiarity/long term use of technology are more likely to complete smartphone interventions (Granholm, Ben-Zeev, Link, Bradshaw, & Holden, 2012).

Consideration also needs to be given to what is effective engagement and how this can be measured? Research suggests that suggests the relationship is fairly central to outcomes regardless of the specific approach (Budd & Hughes, 2009).

Skills base

There can be a skills gap in both the delivery or participation in an intervention (Anttila et al., 2012; Kasckow et al., 2016; Koivunen et al., 2008; Korsbek & Tonder, 2016; Roberts, Liu, Busanet, Maples, & Velligan, 2017). This may require additional staff time or lead to disengagement from treatment (John, Yeak, Ayres, & Dragovic, 2017). Staff can lack the requisite IT skills and be reluctant to use technology.
(Koivunen et al., 2008). However, where staff recognise the opportunities technology offer e.g. time-efficient, could help foster a more positive attitude with service users. More skills training and the ability to adapt interventions for individuals were helpful (Gyllensten & Forsberg, 2017; Koivunen et al., 2008).

The complexity of interventions can be a barrier for people with psychiatric symptoms, lower premorbid IQ or lower IT skills.

Attitudes and beliefs about interventions were crucial factors in engagement – for both staff and service users. Negative attitudes and skepticism led to a lack of motivation to engage or complete interventions. Accessibility and adaptability of interventions were important but lack of resources, finances and staff time were barriers to implementation. Interventions need to be user friendly and adaptable. Co-production should facilitate the process of developing and implementing interventions.
Data collection

Outcomes-based approaches

Increasing data utility

Health systems routinely gather data and how these are interrogated to inform planning, care and support varies widely. Agahi (2019) describes a project to develop behavioural outcome measures (e.g. PHQ, GAD, AUDIT, Columbia Suicide Severity Rating Scale) in private health insurance recipients and integrate them into electronic health records (EHR) in Southern California.

The aim was to enable providers to monitor patient symptoms and improve patient care, and possibly reduce burn out (Agahi, 2020). The main objectives of the project were to:

- Provide targeted care with a review of outcome measures with each visit and improve patient reported symptoms
- Reduce documentation error through the use of automatically populating electronic health record treatment plans that use patient self-reported outcome measures
- Provide a more accurate diagnosis
- Provide more client centered treatment and engagement
- Provide professional development opportunities for providers
- Provide a large data set over an extended period of time to improve quality of care

EHR documentation often uses templates and drop-down options that providers can copy and paste. This may speed up the process but it “undermines the person-centred care ideals”, can often mean that patient specific outcomes aren’t included and may reduce patient engagement.

There is also limited and/or lack of technology use in EHR to standardize use of outcome measurements as part of routine follow-up utilised to improve care for patients receiving services for behavioral health disorders (Kennedy Forum, 2015).

Without the use of symptom rating scales, providers can be failing to detect patients who are not responding to treatment and poor patient outcomes. In a study by Bradshaw and colleagues (Bradshaw, Donohue, & Wilks, 2014), it was noted that documentation error and lack of outcome measures in documentation not only impacts service implementation, but also lead to significant trauma and fatalities among patients.
Life course approach to health

A life course approach considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and wellbeing. This has been conceptualised by the World Health Organisation (Figure 5).

Transitions between services can be problematic, particularly between adolescent and adult services where many young people can feel lost in the system, unfamiliar with the surroundings amid the termination of therapeutic relationships (Fegran, Hall, Uhrenfeldt, Aagaard, & Ludvigsen, 2014) and a shift away from a nurturing environment (Mulvale et al., 2016). Using artificial age boundaries (e.g. age of suffrage as a cut-off point may not always be the right or most helpful treatment setting), transitions can feel arbitrary, questioning the need for them in the first place (O’Loughlin, 2012). Moving into adult services automatically changes the relationship with parents/care givers, voluntary sector organisations and accessibility of care and may increase vulnerability connected to the various transitions in other aspects of their lives. The family approach familiar within CAMHS is in contrast to the autonomous adult, protecting privacy within adult mental services. However, Broad and colleagues’ (2017) qualitative thematic synthesis highlights the need for balancing autonomy and the need for support while there is a risk of a

Figure 5: Life course (WHO)

Social and environmental determinants of health: Families and communities, health services and systems and multisectoral factors related to sociocultural norms, economics, politics, physical environments and sustainable development

Principles in practice for the realisation of rights: Apply a human rights-based, gender-responsive and equity-driven approach
lack of understanding about diagnoses, available treatments and risks or benefits of medication. Having a continuum of care will have major implications for the planning and delivery of services and particularly for the workforce where age-specific specialisms have been developed at the expense of systemic, whole-family approaches to support and treatment.

Collaborative Relational Commissioning

Cambridgeshire and Peterborough Primary Care Trust piloted a relational contracting system for their CAMHS provision (Humphrey, Eastwood, Atkins, Vainre, & Lea-Cox, 2016). GPs typically accounted for 41.5% of CAMHS referrals, but the likelihood of a GP referral being turned down was 3 times that of other referral sources. The team set out to provide an easy to access service. The GP commissioner identified a partner in mental health to work with and they set out to establish a service for young people offering evidence-based treatments, using routine outcome measures in line with the national IAPT programme.

With bloc commissioning, ongoing demand/capacity planning hadn’t been possible and Tier 3 CAMHS were seeing increasing demand for services with a static resource. The team aimed to construct an evidence-based package of care offering the ‘right’ treatments provided by the ‘right’ professional over the ‘right’ length of time. Outcome measures that demonstrated value for money and could be rolled out in a cost-effective way were included. They targeted 14–19 years olds adopting a ‘needs led’ approach using epidemiological data and service demand data. The pilot started in three general practices, and was extended to nine. The staff team was based on local need (majority of patients had low mood and anxiety requiring CBT) and comprised three full-time staff: a clinical senior psychologist with CBT experience; a family therapist; and a psychology assistant with previous research experience who could help manage the database, provide guided self-help and computerised CBT. A Child and Adolescent psychiatrist was recruited to act as a bridge to existing mental health services. Based in Tier 3 CAMHS, they were able to co-work cases as appropriate.

Gaps between the service and the voluntary sector were also bridged by including a counsellor from a local voluntary organisation who facilitated referrals to counselling and had experience of working in a walk in clinic. Relationships with GPs were improved by providing referral criteria in a clear and easy to use format. Repeated visits to GPs enabled them to discuss and agree service goals and operating procedures. As a consequence, in 2 years, they only rejected three referrals out of 142. A Project Board made up of representatives including local government and the voluntary sector met regularly and all strategic decisions including mechanisms for roll-out, review of outcome measures and service changes based on outcome measures.

Relationships with Adult Mental Health services were also improved by co-locating the service. It was city centre based, easily accessible and provided the ability to co-work cases where there was a parental mental health difficulty.
or where a person could be supported better by AMH, “thus providing holistic care without the seams between services that reduce accessibility.” (Humphrey et al., 2016, p. 7).

The scheme offered value for money, over the 2-year duration of the service, the average cost was £2,637 per patient compared to generic single disciplinary CAMHS teams estimate of £4,409 and multi-disciplinary CAMHS £4,823 (Curtis 2011). Arguably the benefits of a focus on developing relationships with referrers and of co-locating services could be achieved without the introduction or re-introduction of complex local commissioning arrangements.

The authors made the following recommendations:

- Consideration of ‘relational commissioning’ with purchasers, providers and service users designing services together
- Case-level collaboration spanning services and partner agencies
- Smaller CAMHS teams eliminating competing task demands, allowing speed of action, providing psychological safety for staff, promoting shared goals and innovation
- Rigorous demand/capacity planning to inform funding.

Rocks and colleagues (2020) present findings of a quasi-experimental study conducted in CAMHS across one large NHS Foundation Trust in South East England. Under increasing pressure, sharp rises in CAMHS referrals and emergency department presentations, a 2015 UK Government review ‘Future in Mind’ (Department of Health, 2015) recommended how services should be changed. The need to transform services to improve accessibility, quality of care and health outcomes led to the development of local transformation plans in order to access CAMHS transformation monies.

Using the THRIVE model (Wolpert et al., 2016), there was shift towards treatment decisions based on level of need, or capacity to benefit, rather than specific diagnoses or interventions. This involved the redesign of pathways introducing ‘Getting Help’ and ‘Getting More Help’ pathways broadly in place of tiers 2 and 3 and the introduction of a Single Point of Access (SPA), encouraging self-referrals and changing the way they worked with the third sector.

Outcome measures include the number of referrals, waiting times and health outcomes (SDQ; RCADS). The intervention led to increased referrals, longer waiting times but SDQ and RCADS scores post-intervention were lower suggesting better quality of life. The authors conclude that there are trade-offs when major changes are made but indicate positives of greater access to services and improved outcomes.

The THRIVE framework replaces the tiered model with a whole system approach based on the concept of five needs-based groupings for young people. These groups are not distinguished by severity of need or type of problem but organised around different types of CAMHS supportive activities in response to needs but strongly influenced by client choice.
Figure 6: THRIVE framework (Wolpert et al., 2016)
Interfaces between services

Difficulties associated with transitions between services has been highlighted repeatedly in the literature and in practice. Moving between CAMHS to AMHS; between generic mental health services and forensic mental health services; community and inpatient services; primary and secondary care; these difficulties have been repeatedly identified. There needs to be caution that these difficulties may also simply reflect the under-resourcing of mental health services – is this a capacity issue rather than just a service design/transition issue?

Each person or family accessing services is entitled to the ‘respect’ agenda within THRIVE:

**Figure 7: RESPECT agenda (Wolpert et al., 2016)**

| REVIEW         | Know what options are available  |
|               | Know the pros and cons of the different options |
| EFFECTIVE HELP | Know the evidence for the help and support being suggested |
|               | Know if there are different types of help that may be affective |
|               | Know what is expected from me or others for the treatment |
| SELECT        | Make choices about what help I get when different evidence-based approaches exist |
| PROGRESS      | Be involved in setting and reviewing goals |
|               | Know how soon and to what extent things are likely to improve |
|               | Agree what will happen if things don’t get better |
| EXPRESSION    | Be listened to and have my views taken into account |
| CLARITY       | Know how those supporting me understand the difficulties |
|               | Know what is happening to information about me |
| TRANSITION SUPPORT | Be supported to find further help if needed |
As outlined in the Bamford Review, the effective implementation of organisational culture change and the appropriate funding to do this is crucial. It can be a stressful process for staff where burnout (Hanrahan, Aiken, McClaine, & Hanlon, 2010) and low morale (Morse, Salyers, Rollins, Monroe-Devita, & Pfahler, 2012) can already be issues and research has shown that improvements can be difficult to embed in mental health settings. There remains a disconnect between frontline practice and research evidence and developing methods/practice to promote staff autonomy and build confidence may be beneficial (Laker, Cella, Callard, & Wykes, 2018).
Conclusion

There is much to learn from a number of countries where innovative approaches have been trialled. Evaluating any similar innovations in Northern Ireland will help inform future planning, there is also a need to consider the process of change/implementation and the need for system-wide coordinated and sustainable change across NI (rather than just short-term project initiatives).


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