

Joint Commissioning Panel for Mental Health

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Guidance for commissioners of
**community specialist
mental health services**

Practical mental health commissioning	

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Co-chaired by:



Membership:



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Ten key messages for commissioners

- 1 This guide has a primary focus on Community Mental Health Teams (CMHTs), recognising them as the essential component of specialist community mental health services that may, locally, also include Assertive Outreach Teams and Early Intervention Teams among others.
- 2 CMHTs will be part of a specialist mental health service that includes acute care (crisis and home treatment, inpatients), rehabilitation, and highly specialist teams working with specific conditions, as well as a range of statutory and non-statutory services that support the delivery of care.
- 3 Commissioners must recognise that people with mental disorders are entitled to equitable, non-discriminatory access to support and treatment in primary care for their mental and physical needs. These primary care services should be supported by specialist mental health services for those patients whose complex needs require additional expertise over and above that available within primary care.
- 4 Clinical Commissioning Groups (CCGs) have the opportunity to make primary care the hub for all mental health care and support so as to ensure that services are better integrated and able to meet the spectrum of need of the wider population, as well as of those with severe mental health problems.
- 5 Existing models of specialist mental health care delivery vary considerably across England as a result of local interpretation of national service agendas over the past 20 years. No one service model is ideal for all areas and CCGs should consult with experts from local mental health providers to develop a model that best suits their local demographics.
- 6 Any agreed final model of mental health care delivery can only be as good as the commitment of local professionals to collaborate to deliver good quality patient-focused care.
- 7 This guide advocates a wellness and recovery approach. This involves supporting people to live in their communities and moving resources (investment and skilled professionals) towards the community component of the mental health pathway. Delivery of specialist community mental health care in primary care settings enables improved management of patient journeys into and out of specialist care.
- 8 This guide is strongly supportive of the 'Recovery Model'. Nevertheless, CCGs should recognise that entirely new, emerging, or evolving models in service delivery will offer both opportunities and risks. Any model should be sufficiently flexible to accommodate current thinking and evidence without requiring wholesale reorganisation.
- 9 Careful attention to service specifications and operational policies is needed from CCGs and providers, to ensure that the maintenance of a functioning patient care pathway is not made secondary to the drive to preserve team boundaries through inclusion/exclusion criteria. Similarly CCGs, in commissioning services must ensure that there is primary attention to the way in which organisations who deliver different components of the pathway will be made to work together so that patient care is not compromised.
- 10 Enhanced co-working and collaboration between primary care and specialist mental health teams, reinforced through service specifications, can help to minimise risk and maximise opportunities for recovery.

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The JCP-MH brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- people with mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities (prior to April 2013)
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*¹.

The JCP-MH has two primary aims:

- to bring together people with mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*², a briefing on the key values and principles for effective mental health commissioning
- has so far published nine other guides on the commissioning of primary mental health care services³, dementia services⁴, liaison mental health services to acute hospitals⁵, transition services⁶, perinatal mental health services⁷, public mental health services⁸, rehabilitation services⁹, drug and alcohol services¹⁰, and forensic mental health services¹¹.
- provides practical guidance and a developing framework for mental health commissioning
- will support commissioners to deliver the best possible outcomes for community health and wellbeing.

HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of specialist community mental health care experts in participation with patients and carers. Much is evidence-based but ideas that are felt to be best practice by expert consensus are included.

By the end of this guide, readers should be more familiar with the concept of specialist community mental health and better equipped to understand:

- what a good quality, modern, specialist community mental health service looks like
- how a good specialist community mental health service can help deliver the objectives of the mental health strategy and the Quality, Innovation, Productivity and Prevention programme – not only in itself but also by enabling changes in other parts of the system.

What are community specialist mental health services?

WHAT DO THEY DO?

Community specialist mental health services:

- work in partnership with people with mental health problems, carers, and primary care services
- design, implement and oversee comprehensive packages of health and social care
- support people whose complex mental health needs require care over and above what can be provided in primary care.

WHO USES THEM?

In England, almost 3% of all adults will be accessing secondary services due to a mental health need (this is equivalent to 54 patients from an average GP list of around 2000 patients)¹².

These patients are likely to include:

- people with severe depression, some anxiety disorders, psychosis (such as schizophrenia or bipolar disorder), and severe personality disorder
- people with complex needs (e.g. those who are mentally ill and homeless, or with addiction issues)
- people whose problems have proved intractable to primary mental health care (e.g. those with resistant depression)
- people with unusual or uncommon conditions
- people who present a risk to themselves or others, and whose management is outside the competency or scope of primary mental health care (e.g. suicidality).

It is important, however, to note that the unmet need for mental health interventions will be higher than the number of people accessing services.

HOW ARE THEY DELIVERED?

As described in the JCP publication *Guidance for commissioners of primary mental health care services*³, “the development of primary mental health care has reflected a need for earlier detection of problems, better management of chronic illness and improved partnership working between the patient, the extended primary health care team and local community support networks and providers”.

In practice, this means that the majority of mental health care (as well as the physical needs of patients with mental health problems) will be delivered either from (a) primary care alone or (b) in the case of the above conditions, from primary care in partnership with specialist community mental health services.

WHAT DIFFERENT SERVICE TYPES ARE THERE?

There is no single model of specialist community mental health service. Instead commissioners will need to commission:

- a core Community Mental Health Team (CMHT)
- supported by more specialist service components to meet local need.

CMHT

The CMHT will be a:

- multidisciplinary team
- that provides assessment and treatment interventions
- to a defined catchment population
- with an interface with primary care services (enabling patients with more complex needs to ‘step up’ to the CMHT for more specialist care, and to ‘step down’ to primary care as the patient’s circumstances improve)
- and which also acts as a ‘gate-keeper’ to more specialised community mental health services.

In some parts of England, CMHTs are known as ‘recovery teams’. However, regardless of their label, CMHTs are normally expected to have a skill mix of community psychiatric nurses, social workers, occupational therapists, clinical psychologists, medical staff (including a consultant psychiatrist), mental health support workers and administrative staff.

What are community specialist mental health services?

Specialist service components

In addition to the CMHT, other specialist services will also need to be commissioned. As described on page 9, these include (but are not limited to):

- assertive outreach teams (AOT)
- early intervention in psychosis teams (EIP)
- crisis response and home treatment teams (CRHT)
- access and recovery teams
- rehabilitation services
- personality disorder teams
- services for autistic spectrum (and other neuropsychiatric) disorders
- perinatal mental services.

The best evidence for these components appears to support properly constituted EIP teams, and CRHT teams^{13,14}.

WHAT ARE THE CORE PRINCIPLES?

The core principles of community specialist mental health care are:

- recovery: working alongside patients to enable them to follow their own recovery path
- personalisation: meeting the needs of individuals in ways that work best for them
- co-production and partnerships: delivering services with (rather than for) people with mental health problems
- collaborative care: working with people as experts in their own mental health
- promoting social inclusion
- prevention through public health strategies and early interventions
- promotion of mental health
- pathway working: building on the stepped care approach from primary care and viewing mental health services as a system rather than a series of isolated services.

Throughout this, the General Practitioner (GP) remains at the heart of a patient's care. About a third of people with serious and enduring mental illness are managed solely by GPs in primary care¹⁵. Although community specialist mental health services may play a key role in assisting the patient's recovery this is likely to be time limited.

Why are community specialist mental health services important to commissioners?

There are at least three reasons why community specialist mental health services are important to commissioners:

- 1 they provide key support for primary care services
- 2 they provide effective treatment for people with complex mental health needs
- 3 commissioners have statutory responsibilities to provide certain types of community mental health services.

1 KEY SUPPORT TO PRIMARY CARE

Community specialist mental health services are a key component of mental health pathways, and should work in seamless collaboration with primary mental health care services.

Critically, this means that primary care *continues to be responsible* for the physical health and provision of medication (including depot injections) for their patients even when they are receiving community specialist mental healthcare.

One consequence of such a continuing responsibility is that concepts of 'referral to' and 'discharge from' specialist mental health care no longer easily apply. This is because every patient will receive (or have an entitlement to receive) primary care services regardless of any specialist care they are getting.

Within this structure, one key role of community specialist mental health services – and the reason they are so important to commissioners – will be to manage interfaces with other specialist services including child and adolescent psychiatry services, learning disability services, older people's services, as well as acute inpatient and crisis services. Significant links to other statutory and non-statutory services will also need to be managed.

Failure to consider and manage these interfaces could lead to quality and efficiency failures in the system such as an unnecessarily increased demand on inpatient care, or reduced capacity to respond to emergencies and new referrals. Commissioners may experience such developments as increased costs for reduced productivity.

2 EFFECTIVE TREATMENT FOR PEOPLE WITH COMPLEX NEEDS

Community services can help provide effective treatment to people with complex needs. For example:

- **CMHTs** – a Cochrane review of the value of CMHTs for people with severe mental illness and personality disorders concluded that they promoted greater acceptance of treatment (than non-team standard care), and may also be superior in reducing hospital admission and avoiding death by suicide¹⁶.
- **Assertive outreach** – these can offer better engagement of people with mental health problems, especially in under-served, hard-to-reach communities, and higher rates of satisfaction¹⁷. Evidence suggests that AOTs are somewhat better than CMHTs with crisis and home treatment provision in (a) reducing hospital admissions and (b) improving clinical and social outcomes¹⁸. This must be balanced against the benefit of an intensive approach to difficult-to-engage service users with complex and risky presentations.
- **EIP** – these show clinically important benefits over standard care including reduced use of the Mental Health Act¹⁹, improved engagement with treatment, lower hospital admissions and relapse rates²⁰, reduced symptom severity²¹ and more favourable course of illness with a greater likelihood of remission²² and improved medication adherence²³,

increased independent living, reduced homelessness, lower levels of substance use, better global functioning^{19,24}, higher employment rates²⁵, reduced suicide rate¹³, and reduced homicide risk²⁶

- **CRHT** – these teams have demonstrated considerable benefit in allowing reduction and closure of beds²⁷.

These issues are discussed in more detail on page 9.

3 COMMISSIONERS HAVE STATUTORY RESPONSIBILITIES

It is important to recognise that community specialist services care for a range of severity of illness. Consequently, some patients require care under provisions of the Mental Health Act 1983/2007 and the Mental Capacity Act 2005.

This places statutory responsibilities on commissioners to ensure that services are sufficiently staffed and resources are available to fulfil the legal requirements of this legislation including:

- after-care services for mental health patients and direct payments (s117, MHA)
- power to discharge NHS patients from detention in independent hospitals and authorise visits (s23/s24, MHA)
- duty to provide the courts (when requested to) with information about availability of hospital places (s39, MHA)
- duty to make arrangements for independent mental health advocates (IMHAs) to be available to qualifying patients (s130A, MHA)
- duty to notify local social services of availability of suitable hospital places for emergency admissions and for under-18s (s140, MHA)
- duty to consult an Independent Mental Capacity Advocate (s37/s38, MCA)
- duty to maintain a list of approved doctors (S12, MHA).

What do we know about the current provision of community specialist mental health services?

NO STANDARD MODEL EXISTS

There is currently no standard model for the commissioning and provision of community specialist mental health care services.

In England, this is due to differing interpretations over the past 30 years of national service design. For example, the 1999 National Service Framework for Mental Health (NSF-MH)²⁸ prescribed a model of “functional teams”, including CRHT, AOTs and EIP, in addition to defining the boundaries of primary care services and acute inpatient provision.

Meanwhile, the 2002 advent of Primary Care Trusts and commissioning introduced a local perspective on health economies, together with the recognition that some services, derived from urban settings, did not translate fully into all localities.

It is recognised, therefore, that the challenges of delivering good quality community mental health services will vary according to the way in which services have developed locally. Regardless of the local ‘model’ of delivery, it is essential that all specialist community mental health services work within a set of key guiding principles.

INDICATORS OF PROBLEMS

Signs that current specialist community mental health services are not working well include:

- the primary-secondary care interface is perceived as not working and is failing to meet patient need
- rigid boundaries exist between different parts of the service that enforce inclusion/exclusion criteria without considering (a) the needs of the person or (b) joint-working such as:

- between different parts of the same service (crisis, home treatment, assertive outreach, inpatients, EIP, community mental health/recovery teams)
- between different services (child and adolescent, learning disability, adult, older people, substance misuse)
- with other service providers (social services, primary care, non-statutory sector)
- no working policy or protocol exists to manage inter-service disagreements on provision of care
- not all patients have an up-to-date care plan and know their care-co-ordinator, and not all have a diagnosis/formulation and receive appropriate evidence-based treatments
- there is no systematic process for allocating to appropriate care pathways – access to treatment, particularly tertiary specialist treatment is variable and inequitable across the service
- medication is over-used as there are no alternative options
- the service lacks the capacity to undertake psychological therapy with patients with personality disorder and/or those with psychosis
- waiting times for access to initial referral are excessive according to national criteria
- rates of admission and delayed discharge from inpatients are high because it is not possible to discharge to community services in a timely fashion – crisis teams are overwhelmed by demands for urgent assessments from GPs who cannot obtain timely assessments from standard referrals
- there is lack of understanding of how collaborative care works and the shared care arrangements between primary and secondary care are poorly defined or not operated – GPs, for example, do not have the confidence to manage patients with stable psychosis as they fear they would not receive prompt and smooth ‘re-access’ to services in the event of crisis
- caseloads are excessive and patients have access only to a single team member as care co-ordinator so that true multidisciplinary working is not attained for the majority
- psychiatrists have large outpatient clinics in which many stable patients have routine appointments re-booked thus preventing easy access for patients who need active medical involvement
- ‘New Ways of Working’ remains an ambition rather than a strategy through which all patients’ care is owned by the entire team
- there is an inconsistent assessment of the impact of mental illness on a patient’s capacity to work, their family life, and wider relationships
- social inclusion is an aspiration rather than an embedded strategy informing all service interventions
- those indicators listed in the JCP guide for primary mental health services³.

What would a good community specialist mental health service look like?

When commissioning a 'good' community specialist mental health service, at least five key issues should be considered:

- A core purpose
- B service overview
- C service components
- D service standards
- E service outcomes

A CORE PURPOSE

The essence of community specialist mental health care is the ability to:

- provide a single multidisciplinary assessment process, and treatment through integrated health and social care
- provide ready access to a range of evidence-based physical, psychological and social interventions (with these being organised to put the recovery needs of the patient at their heart)
- avoid patients being subjected to multiple assessments at service interfaces
- operate on an equitable, non-discriminatory and patient-centred basis.

Underpinning principles

The other underpinning principles of specialist community mental health care are that it is:

- capable
- outcome-focused
- founded on a recovery-based approach
- recognises the personalisation agenda
- and operates with collaborative care, prevention and pathway-working at the centre of all its activities.

B SERVICE OVERVIEW

Commissioners should consider:

- the core Community Mental Health Team
- other specialist community services (to support the CMHT and primary care)
- the integrated care pathway (stepped care)

The CMHT

There is no single or 'optimum' model of community specialist mental health service. Instead, a core CMHT will need to be commissioned, which is then supported by the commissioning of a range of more specialist service components to meet local need.

The CMHT will be based on a generalist multidisciplinary team that provides assessment and treatment interventions, that are compatible with current evidence-based guidance, to a defined catchment population.

The CMHT will have an interface with primary care services from which patients will usually be referred (see 'stepped care' on page 10). All referrals should usually be assessed by experienced clinicians and allocated to an appropriate care pathway (see page 14).

Where patients have physical health care needs, the CMHT will also facilitate access to primary services.

In some parts of England, CMHTs are sometimes known as 'recovery services'. However, regardless of their label, CMHTs are normally expected to have a skill mix of community psychiatric nurses, social workers, occupational therapists, clinical psychologists, medical staff (including consultant psychiatrist), mental health support workers and administrative staff.

Other specialist services

In addition to the CMHT, other (more) specialist services should also be commissioned to provide community-based care. Some of these services are often referred to as the product of a 'functional split' in a patient's care pathway. This is where separate specialist teams or services provide different 'functions'. Arising with the development of services such as crisis response, assertive outreach, and early intervention teams (as prescribed by the NSF-MH), some services have split functions even further.

Described later in this section, these services include:

- CMHTs
- AOTs
- EIP teams
- CRHT teams
- access and recovery teams
- rehabilitation services
- personality disorder services
- services for autistic spectrum and other neuropsychiatric disorders
- perinatal mental health.

The best evidence for these components appears to support properly constituted EIP¹³ and CRHT¹⁴.

What would a good community specialist mental health service look like?

Integrated care pathway

The 'stepped care' model describes how care pathways can be integrated to support a patient's journey through a range of often increasingly specialised services. Summarised in Box 1, the stepped care model is also described (from a primary care perspective) in the JCP guide on primary mental health care services³.

Step 3

In the 'stepped care' model, the role of specialist community mental health services begins within Step 3 (at a point sometimes referred to as 'Step 3.5'). Here, specialist services will expect to become involved with patients whose (a) social care needs or (b) needs for high intensity psychological therapy/complex medication regimes cannot be met in primary care.

For example, a person with bipolar disorder who has had good support from her CMHT, is well engaged with her care plan, is compliant with medication, and has a stable home environment with long periods of being well and a crisis plan to be activated in the event of relapse, could be supported (within Step 3) through primary care.

By contrast, the same patient with bipolar disorder who becomes estranged from her family, is at risk of homelessness, is in debt, struggling with insight into her illness and poorly compliant with treatment, will need support at this period of her illness from specialist mental health services and would fall within 'Step 3.5'.

Importantly, in this way, people with severe and enduring mental health problems obtain their usual support from primary care, but may require specialist input (to a greater or lesser degree) depending upon their individual circumstances.

Step 4

During periods where a patient has severe and unstable mental health needs, the stepped care approach described above continues through to Step 4 (specialist mental health care including intensive and extended therapies).

Throughout the stepped care model, patients should be cared for in the expectation that their care will allow them to 'step down' to less intensive support as their circumstances improve. This can form a basis for local outcome measures.

C SERVICE COMPONENTS

This section describes in more detail some of the service components that commissioners should consider.

CMHTs

CMHTs work with two broad groups of patients (whose ages are determined within local protocols for transition from child and adolescent services^{6,29} and decisions around non-organic mental disorders in later life):

- the first patient group will comprise of people with conditions that require time-limited interventions of weeks or months, with discharge on completion of the intervention
- the second patient group will require ongoing treatment, and care and monitoring for prolonged periods, but should be managed within the recovery model with an expectation of eventually improved functioning to allow discharge. This group will also have the complications of severe and enduring mental disorders including psychosis and personality disorder, where there is a substantial risk of harm to the individual or others. They may be poorly concordant with treatment,

difficult to engage and/or subject to conditions of the Mental Health Act, including forensic mental health service interventions. Many of the second group will be managed by other specialist teams such as assertive outreach.

CMHTs fulfil the following functions:

- **interface with primary care** – including discussion of new patients, advice and support
- **assessment and allocation** – referrals will (a) usually come from primary care (where they may have been triaged); (b) be assessed and allocated to an appropriate care pathway (as the quality of information and referral may vary; see page 14), and (c) carry the expectation that new patients will be seen within 28 days by experienced clinicians with appropriate competencies and experience (to ensure good quality diagnosis/formulation)
- **Care Programme Approach** – each patient will receive care consistent with CPA best practice guidance³
- **multidisciplinary team work** – supported by weekly meetings enabling discussion and coordination of joint care and can be extended to provide supervision for, and linkages with, primary care
- **caseload management** – the team caseload is 'owned' by the whole team and cross-cover/multidisciplinary input is available accordingly
- **training** – specialist community mental health teams offer a valuable forum for training the next generation of professionals (this should be accepted by commissioners, and allowed for in staffing profiles)

BOX 1: STEPPED CARE MODEL**STEP 1**

Step one includes supported self-management of psychological and emotional wellbeing, social prescribing, peer experts and mentors, health trainers, psychological wellbeing practitioners trained in cognitive behavioural treatments for people with mild to moderate anxiety and depression, and access to e-mental health services such as on-line peer support groups.

STEP 2

Step two comprises co-ordinated care involving the primary care team, and includes provision of low intensity therapies and links to employment support, carer support and other social support services. Many patients will be supported well by an individual clinician – most commonly a GP, but it could be a practice nurse, a health visitor, a psychological wellbeing practitioner or a counsellor.

STEP 3

Step three comprises high intensity psychological therapies and/or medication for people with more complex needs (moderate to severe depression or anxiety disorders, psychosis, and co-morbid physical health problems)³⁰⁻³². Initial treatment should be NICE-recommended psychological therapy delivered by a high intensity worker, and/or medication. For people with moderate to severe depression whose symptoms do not respond to these interventions, NICE recommends a multi-professional collaborative care approach³⁷.

IAPT services for 'Serious Mental Illness' (which include people with diagnoses of psychosis or bipolar disorder who are currently excluded from other forms of existing IAPT services) are currently being piloted. The reports on the pilots will provide further guidelines for commissioners.

STEP 4

Step four comprises specialist mental health care, including extended and intensive therapies. Well understood pathways must be in place between the primary care mental health team, Improving Access to Psychological Therapies (IAPT) services and specialist mental health services. Specialist mental health teams may operate across several practices, in which case each practice could have a practice-affiliated specialist team member (for instance a community psychiatric nurse) with whom the primary care mental health team can work. Specialist mental health care can be provided in a primary care setting so primary care staff can access expertise without the need for cumbersome referral processes and the stigmatisation that sometimes affects patients in secondary care settings.

What would a good community specialist mental health service look like?

- **leadership** – clear clinical leadership and management should be established which crosses the disciplines
- **review** – regular clinical review of outcomes
- **choice of interventions** – the provision of a range of high quality evidence-based physical and social interventions, and psychological therapies
- **access to physical health care** – facilitation of access to primary care for those with severe and enduring mental illness
- **family and carer support** – including an annual carer's assessment and support to meet identified needs
- **relapse planning** – this should include advance statements, as well as any wellbeing or recovery action plan (e.g. Wellness Recovery Action Plan).

In a CMHT, each full-time care co-ordinator will have a maximum caseload of 35 patients with adjustments based upon complexity, local demographics, and the availability of other functional teams to support the patient³³.

CMHTs would normally be expected to have a skill mix of community psychiatric nurses, social workers, occupational therapists, clinical psychologists, medical staff (including a consultant psychiatrist), mental health support workers and administrative staff.

Mental disorders usually managed by these teams are covered by parts of the NICE guidelines for anxiety disorders (CG113, CG31, CG26), depression (CG90, CG91), bipolar disorders (CG38), schizophrenia (CG82), personality disorders (CG77, CG78), eating disorders (CG9), self-harm (CG16, CG133), antenatal and postnatal mental health (CG45) and dual diagnosis (CG120) (see www.nice.org.uk)³⁴⁻⁴⁷. Highly specialist areas of these guidelines will be delivered by specialist teams interfacing with CMHTs.

Assertive outreach teams

Assertive outreach teams were established under the NSF-MH to provide focused, intensive mental health and social care to patients with challenging, complex presentations who do not engage with CMHTs. They offer better engagement of people with mental health problems, especially in under-served, hard-to-reach communities, and higher rates of satisfaction¹⁷. Evidence suggests that they work somewhat better than CMHTs with crisis and home treatment in reducing hospital admissions, clinical and social outcomes despite having smaller team caseloads¹⁸. This must be balanced against the benefit of an intensive approach to difficult-to-engage people with complex and risky presentations.

In rural areas, where qualifying patients are likely to be sparsely distributed over a large geographical area, the assertive outreach function can be delivered by intensive case management (ICM).

ICM evolved from two original community models of care, Assertive Community Treatment (ACT) and Case Management (CM), where ICM emphasises the importance of small caseload and high intensity input. Specialist clinicians within the CMHT provide intensive input into a caseload of no more than 15 cases⁴⁸.

Alternatively, within the Dutch Functional Assertive Community Treatment model⁴⁹, assertive outreach-augmented CMHTs replicate an assertive outreach and crisis resolution functions to 10-20% of the caseload at any given time with the rest receiving a traditional case management approach directed by individual care coordinators. A recent Cochrane review of ICM⁵⁰ concluded that compared to standard care, ICM reduced hospitalisation and increased retention in care. It also improved social functioning globally.

Early intervention in psychosis

Proponents of early intervention have argued that outcomes might be improved if more therapeutic efforts were focused on the early stages of schizophrenia, or on people with prodromal symptoms (early symptoms that might precede the onset of a mental illness).

Early intervention in schizophrenia has two elements that are distinct from standard care: early detection and phase-specific treatment (phase-specific treatment is a psychological, social or physical treatment developed, or modified, specifically for use with people at an early stage of the illness). An important outcome goal for EIP is reducing the duration of untreated psychosis.

Early intervention in psychosis teams work alongside CMHTs, accepting younger patients in their first episode of psychosis and working with them for up to 3 years. They overlap with CAMHS services at their lower age range and take referrals from school and youth groups as well as from primary care. Patients may also be passed to EIP after assessment within the CMHT.

There is strong evidence that this form of intervention is cost-effective²¹, and also much valued by patients and carers⁵¹. The EIP team will aspire to discharge the majority of its patients to primary care but some may need further work from a CMHT or AO service at the conclusion of their work in EIP.

EIP shows clinically important benefits over standard care including:

- reduced use of the Mental Health Act¹⁹
- improved engagement with treatment, lower hospital admissions and relapse rates²⁰
- reduced symptom severity²¹ and more favourable course of illness and greater likelihood of remission²²
- improved medication adherence²³
- increased independent living, reduced homelessness, lower levels of substance abuse and better global functioning^{19,24}
- higher employment rates
- reduced suicide rate¹³
- reduced homicide risk²⁶.

These benefits translate into savings of £17.97 for each pound spent on EIP services⁸. However a recent Cochrane Review⁵² was less positive about the longer-term effects of EIP. The authors found emerging, but as yet inconclusive, evidence to suggest that people in the prodrome or early stages of psychosis can be helped by some interventions. However, there is a question of whether any gains are maintained. There is some support for phase-specific treatment focused on employment and family therapy, but again, this needs replicating with larger and longer trials.

Interface with acute services: crisis response and home treatment

It is probably easiest for commissioners to think of acute services as comprising traditional inpatients and home treatment, where a patient is managed at home as an alternative to admission. The basic criteria for both interventions are the same with (a) the suitability of the home environment and (b) the capacity of the home treatment team to keep the patient safe and persuade them to accept treatment being the principal issues

on which a decision to admit will be based. At a point where risk issues or the intensity of care required moves beyond the resources of the CMHT, they refer to the CRHT team who make a decision between home treatment and admission, involving the patient and family in the process. All patients thought to require admission are referred to the CRHT team who act as gatekeepers for usage and to maintain care as near to a patient's home environment as possible. CRHT teams have demonstrated considerable benefit in allowing reduction and closure of beds. Some services are also commissioned to provide 'crisis houses' or specialist day care as alternatives to acute admission²⁷.

Access and recovery teams

As noted earlier, the division of a care pathway into different and separate services that provide different functions (the 'functional split') has resulted in a range of service models. In addition to crisis response and assertive outreach, other teams have been developed with highly specific functions. These include, for example, 'access teams' (which provide triage for new referrals and, possibly, short-term psychological interventions), and 'recovery teams' (which provide focused, time-limited longer-term care within the recovery model). There is currently no evidence base to support or refute the access/recovery split as a useful approach.

Rehabilitation services

Around 10% of people entering mental health services will have particularly complex needs that cannot be met by general adult mental health services and may require rehabilitation and intensive support from mental health services over many years⁹. Rehabilitation services focus on addressing and minimising symptoms and functional impairment and supporting

people to achieve as much autonomy and independence as possible. In order to do this a graduated approach is required, supported by a care pathway that provides a range of treatment and support settings to facilitate and enable recovery on an individualised basis. These services are described in detail in the JCP-MH guidance on rehabilitation services for people with complex mental health needs⁹.

Personality disorder services

Historically, people with personality disorders had inconsistent input from specialist mental health services and the diagnosis was often used as a label to exclude them from care. Personality disorder comes with a variety of challenges that can be addressed at all levels of primary care and specialist services through evidence-based interventions⁴². These generic services should be supported through the development of multidisciplinary teams with specialist knowledge so that a consistent clinical model can be offered and generic teams supported in engaging those people who can significantly challenge health and social care services. Collaboration with the patient and with other services (including the GP and third sector organisations) will involve the development of multidisciplinary care plans which will include the means of accessing services in time of crisis.

Autistic spectrum disorder and other neuropsychiatric disorders

People with autistic spectrum disorder (ASD) can encounter difficulties in accessing appropriate specialism to establish the diagnosis they require to access social care. Whilst a firm diagnosis should be made only by those with sufficient understanding and knowledge of autism, it is important not to create unnecessary delays in diagnostic pathways

What would a good community specialist mental health service look like?

or restrict diagnostic 'know how' to any one clinical specialism. Instead, community specialist mental health services should take a multi-professional approach to assessing and signposting people with ASD to appropriate health and social care. The same situation applies to dementia in younger people⁴ and other neurological conditions including acquired brain injury through head injury and poisoning with alcohol (amnesic syndrome or Korsakoff's psychosis) and other substances. These services are described in detail in forthcoming JCP-MH guidance on autism services⁵³.

Perinatal services

It is reasonable to expect community specialist mental health services to provide basic advice on prescribing in pregnancy and to manage moderate levels of postnatal mental illness such as depression. However, the NICE guidelines on antenatal and postnatal mental health recommend the development of clear pathways to determine (a) at what point and (b) how a patient has access to specialist maternal mental health services⁴⁶. This may require referral to a regional centre for specialist or inpatient care and, in such circumstances, pathways must specify the liaison role of local teams.

D SERVICE STANDARDS

Commissioners will want to commission community specialist mental health services that can demonstrate that they meet the recognised standards for their service (such as the NICE evidence-based quality standards).

However, it is not possible to provide a single "one size fits all" model or measure for community specialist mental health services. Commissioners should therefore seek local interpretation of national policy, while the advent of Payment by Results for mental health (see below) is likely to have a significant effect upon service models and commissioning decisions.

Care Programme Approach

Since the early 1990s, the Care Programme Approach (CPA) has determined the system by which care is managed in community specialist mental health services. This is a systematic approach that recognises severity and complexity of illness, requires allocation of a care co-ordinator and provides a framework for developing care plans with the patient, reviewing, updating and monitoring progress. The approach changed in 2008 to recognise that only a proportion of patients with more complex issues require a formal CPA approach (this equates to the roughly one-third of patients who were previously designated as requiring 'enhanced' CPA). These are people who typically require multi-agency support, active engagement, intensive interventions, support with dual diagnosis of mental illness and substance misuse and those with a high risk profile³.

It is important that self-care and self-determination are encouraged as far as is possible. This requires a partnership approach as primary care services continue to fulfil an important role even for patients whose mental health needs require a substantial input from specialist services. The GP remains at the heart of a patient's care and the goal of both specialist and primary care services is to plan for the return of the patient's support exclusively to primary care. Specialist services therefore become involved periodically, in partnership with the GP, rather than taking responsibility for all aspects of the patient's healthcare. Patients who are not subject to formal CPA still have care plans and a case manager who oversees their care.

It is critical to remember that consultants will straddle two roles in this context: one as a member and clinical leader within the CMHT, and one as colleague and specialist support to the GP in primary care.

Payment by results (PbR) and care clusters

It is Government policy that funding of mental health services will move from a block contract to payment according to locally-agreed tariffs or 'PbR currencies' associated with individual service users or patients and the interventions they access⁵⁴. The currencies are based upon 21 care clusters that define interventions based upon need rather than of diagnosis. Each cluster has a series of interventions associated with it and these can be used to inform local care pathways. Since the clusters are only loosely associated with diagnosis, there will be a significant challenge to ensure that interventions are evidence-based and compliant with relevant NICE guidelines (which are based on diagnosis). It is anticipated that the development of care clusters will have a significant impact upon the commissioning of community specialist mental health services.

What do GP commissioners want from specialist mental health services?

Although variability exists, most GPs are able to assess and treat the majority of mental health problems presenting to primary care. What most GPs might want from community specialist mental health services, and issues that might be included in any commissioning contract include:

- an easily accessible and helpful relationship with a named consultant (this might include agreements around email advice and mobile phone contact)
- clear care pathways, particularly for relatively low prevalence conditions such as early-onset dementia, and for people with learning disabilities
- coherent arrangements for access in general
- coherent arrangements for access to out-of-hours care
- agreed waiting times that are appropriate to the diagnosis and age of the individual
- referrals signposted to other services if the original care pathway is subsequently felt to be less appropriate
- individuals seen by trainees are supervised and the letter countersigned by the senior practitioner present in the clinic
- agreed criteria for discharge that preclude discharge secondary to failure to attend
- involvement in CPA reviews (where this is relevant) held at surgeries wherever possible

- a sensible approach to shared care, particularly for people felt to be at risk to themselves and/or others
- agreed arrangements for physical health reviews, particularly for people with serious mental illness and on antipsychotic medication, where data are shared across the interface.

E SERVICE OUTCOMES

The following measures could be used to ensure services achieve high clinical, cost, quality and safety outcomes.

For cost effectiveness:

- average duration of specialist mental health care by care cluster, assessment and discharge rates.

For effectiveness:

- basic clinical outcome measures (e.g. Health of the Nation Outcome Scale)
- social functioning outcome measures.

For safety:

- excess under 75 mortality rate in people with serious mental illness (outcome 1.5 of the NHS Outcomes Framework 2013/14)⁵⁵
- QOF incentives to assess and manage the physical health of people with severe mental illness⁵⁶ (related to shared objective 3 of the *No health without mental health strategy*¹)
- incidence of 'never events', completed suicide and homicide rates.

For recovery:

- percentage of patients with personalised care plans and goals
- percentage of people referred who are being offered psychological therapy
- employment rates of people with mental illness (outcome 2.5 of NHS Outcomes Framework 2013/14 and shared objective 6 of the mental health strategy¹)
- patient self-defined goals (e.g. using techniques such as Shapiro's Personal Questionnaire technique – see www.experiential-researchers.org/instruments/elliott/pqprocedure.html)
- the Warwick-Edinburgh Mental Well-being scale (see www.healthscotland.com/documents/1467.aspx)⁵⁷.

For patient and carer experience:

- local and national surveys of patient and carer satisfaction
- patient recorded outcome measures following a consultation
- local surveys of GP satisfaction with local mental health services
- review of complaints and compliments
- the CHOICE tool⁵⁸.

What would a good community specialist mental health service look like?

INNOVATIVE PRACTICE MODELS

The Haven Project

www.thehavenproject.org.uk

"I started at The Haven early this year. I've used mental health services for fifteen years or more. At last I've found somewhere that's right for me and my diagnosis. It's saved my life really. I have stopped cutting and overdosing."

The project is dedicated to the support and treatment of people with a personality disorder living in the North Essex area. The aims are to:

- empower clients in their journey of recovery
- help them to manage their problems of life more effectively
- develop under-used resources and seek missed opportunities
- to help build self-confidence and self-esteem, to enhance a sense of personal responsibility and, ultimately, to assist their clients in developing alternative coping strategies and preventing or managing their difficulties.

Crisis services are available to registered users of the project. Telephone contact is available 24 hours a day, every day, aiming to provide a swift response and early intervention at times of crisis. Travel can be arranged to ensure fast access to The Haven at any time of the day or night. Respite admission is provided by a four bedroom 'Crisis House' where clients can stay for up to three weeks or clients in crisis can use 'The Sanctuary', a safe location where they can manage their difficulties during stays of a few hours.

Fair Horizons

www.2gether.nhs.uk

"In order to deliver appropriate mental health services, now, more than ever before, we will need to be innovative and focussed on person-centred, outcome-driven care. The most appropriate way to do this will be to integrate specialist mental health services, allowing a single point of access, and then delivering care that is most appropriate to the person's needs."⁵⁹

Fair Horizons represents 2gether Foundation NHS Trust's response to the need to provide a person-centred model of mental health care that does not discriminate on grounds of age or intellectual level. It draws on concepts of 'capable teams' derived from New Ways of Working and attempts to steer specialist mental health services away from artificial 'silos' of working age adult, older people and learning disability services. Instead, it focuses on a more fluid approach where services can be offered in a multidisciplinary and *interdisciplinary* way so that patients can benefit from any aspect of the service that fits their needs and do not become caught on artificial team and service boundaries.

The basis of care within *Fair Horizons* is a 'one stop shop', providing the majority of mental health needs and supported by more specialist, tertiary teams:

- *interdisciplinary teams* (IDTs), comprise practitioners from different professions and subspecialties who share a common catchment population and have joint responsibility for complementary tasks
- staff are trained in developing a wider and more eclectic understanding of mental healthcare provision
- the active registration of service users/patients for equitable access to primary and secondary care
- 'practice-based mental health teams' to assist the primary care team in supporting people with chronic mental health problems and facilitate general healthcare, offering those with chronic illness easy access to secondary care in the event of deterioration
- patients whose needs cannot be met in an IDT, or whose outcomes would be better from a specialist service, will receive care within tertiary teams
- a 'first point of contact centre' where algorithms are used to assign new referrals to an appropriate part of the service including signposting to IAPT, partner agencies, crisis teams or an assessment component of the IDT
- highly specialist teams at tertiary level include specialist learning disabilities, dementia (including early onset dementia) and CAMHS teams
- job planning, where work plans will indicate the time staff give to each component of the service, maintaining specialist competencies through sessions within specialist tertiary teams.

Peer support

Peer support involves the use of people with experience of mental health problems to provide individualised support and expertise about treatment and care to people with mental health problems. This is an evolving field which is recognised as having the potential to transform the outcomes of people with mental health problems, and where a number of services are already reporting positive experiences⁶⁰. The evidence base for peer support reflects the fact that this is an initiative in its early stages in the UK, with some studies concluding that peer support may lead to a reduction in admissions and to health improvements⁶¹.

In addition to the large number of local and national groups that provide peer support, the following initiatives provide networking opportunities or examples of employed peer support workers within mental health care providers:

- Cambridge and Peterborough NHS Foundation Trust's "Peer Worker Programme" (www.cpft.nhs.uk)
- Peer Support 4 Mental Health – Sussex (www.peersupport4mentalhealth.org.uk)
- Peer worker research project – (www.peerworker.sgul.as.uk)
- Bromley MIND peer support training – (www.bromleymind.org.uk)

Implementing Recovery Organisational Change (ImROC)

ImROC is advocated by the QIPP programme for mental health. It is designed to move specialist mental health care from traditional 'treatment and cure' models offering open-ended support (sometimes amounting to community-based institutionalisation) to realistically optimistic, recovery-based services with time-limited, focused and evidence-based interventions that reduce distress and enhance self-determination, social inclusion and quality of life.

The ten challenges of ImROC are⁶²:

- 1 changing the nature of day-to-day interactions and the quality of experience
- 2 delivering comprehensive user-led education and training programmes
- 3 establishing a 'Recovery Education Centre' to drive the programmes forward
- 4 ensuring organisational commitment, creating the 'culture'; the importance of leadership
- 5 increasing personalisation and choice
- 6 changing processes for risk assessment and management
- 7 redefining service user involvement
- 8 transforming the workforce
- 9 supporting staff in their recovery journeys
- 10 increasing opportunities for building life 'beyond illness'.

Implementing recovery within specialist mental healthcare offers 'personalisation' of support leading to greater social inclusion (employment, engagement with social networks, community activities). Improved service user or patient satisfaction is expected to encourage the development of local, user-led training initiatives on recovery awareness, more effective partnership working and the creation of a 'common language' for discussions between providers and commissioners about recovery, thereby facilitating more effective commissioning and better informed agreements about contracts and performance measures.

Supporting the delivery of the mental health strategy

The JCP-MH believes that commissioning which leads to good community specialist mental health services as described in this guide will support the delivery of the *Mental Health Strategy*¹ in a number of ways:

Shared objective 1: More people will have good mental health.

Excellent links with primary care will ensure that the stepped care model of prevention, risk stratification and early intervention will result in serious mental illness being identified earlier. This will lead to a better response to treatment interventions and more people recovering.

Shared objective 2: more people with mental health problems will recover.

Mental illness will be managed through partnership working between primary care, community specialist mental health care and acute mental health care within a commissioned system that answers the needs of the local population. Equitable and non-discriminatory access to evidence-based physical, psychological and social interventions will result in patients enjoying a better quality of life, stronger social relationships, a better chance of maintaining safe and stable housing and more opportunities to participate in education and gain employment. The use of defined care pathways and outcome measures will ensure that the care provided is of good quality and informed by the evidence base.

Shared objective 3: more people with mental health problems will have good physical health.

Interventions addressing the comorbidity of physical and mental illness will be delivered better through collaborative working between primary care and community specialist mental health care.

Shared objective 4: more people will have a positive experience of care and support.

People who use community specialist mental health services will have their needs and wishes put at the heart of their care. Each will have a personalised care plan that supports access to the appropriate psychological, social and physical interventions required, and this will help inform regular reviews by the care co-ordinator. People with serious and enduring mental health problems will have equality of access to primary care and specialist care for physical health needs.

Shared objective 5: fewer people will suffer avoidable harm.

The provision of comprehensive, evidence-based mental healthcare is likely to reduce the morbidity associated with mental illness and comorbidity of physical illness. In providing equitable access to physical healthcare it is likely to reduce the incidence of avoidable pathology due to unrecognised physical illnesses. It will affect positively the occurrence of deliberate self-harm, suicide and homicide.

Shared objective 6: fewer people will experience stigma and discrimination.

People whose mental health is effectively managed are more likely to maintain social networks, housing and employment. Friends and family networks, education, employment and stable accommodation are central to quality of life. Maintaining contact with primary care and accessing mental health care through the GP where possible can avoid the stigma attached to engagement with secondary mental health services.

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Development process

This guide has been written by a group of community mental health service experts, in consultation with people with experience of mental health problems and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP's Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).

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Published May 2013

Produced by Raffertys