Integrated Community Response Service
Simone Spray

Mind in Salford, Manchester Mind, Self Help Services, Salford and Manchester CAMHS and 42nd Street

Evaluated by the Anna Freud Centre

GM Definition of Mental Health Crisis

"Mental Health Crisis occurs when the level of distress and risk presented by a young person is not supported or contained by the care system that is place for them. It may be the view of the young person themselves and/or the view of those involved in their care, that their current condition and situation represents a crisis. The crisis might be triggered by a worsening of the young person's condition, a weakening of the support system, or both. In reality, these are not independent factors and the young person's experience of weakened support frequently triggers a worsening of their condition."

Integrated Community Response Genuine co-creation

- ✓ Manchester and Salford Commissioners
- ✓ Manchester and Salford Integrated Social Care
- ✓ Education Representatives
- ✓ Manchester and Salford CAMHS
- ✓ The Bridge Salford
- ✓ Self Help Services
- ✓ Manchester Mind
- ✓ Mind in Salford
- ✓ 42nd Street

Memorandum of Understanding is in place

Integrated Community Response Pilot settings

"young people aged 13-18 years regularly present with episodes of psycho-social distress and risk and where there is a recognition that the current configuration of services and support does not appropriately respond to or contain young people's immediate needs"

- PRU Salford, (1xFTE MHP)
- The Missing From Home Team and the Early Help Outreach Team (Early Response and the Family on Track Team) Salford. (1xFTE MHP)
- Manchester PRU (1xFTE MHP)
- The Adolescent Support Unit – ALONZI, Manchester (1x FTE MHP
- Manchester Central Early Help Hub2 (2 x FTE MHP)

Across the project
- 2 x FTE Welfare workers
- 1x FTE Self Help Services Online Therapist
- 0.2 FTE CAMHs specialist support
- Duty team made up of MHPs and defers to CAMHs out of hours

Eligibility

✓ Is their enough support with the current system to adequately care for their needs?

✓ Is the young person able to think rationally about what will keep them safe or put them or others in harm or at risk?

✓ Has something specific triggered an escalation of their condition?

• Self- referrals or referrals from agencies outside of the pilot teams identified for the first stage of the project were not accepted at first to ensure consistency of support and to enable the pilot team to develop and test new ways of working and refine the model

The support package

- Requests for service/referral
- **Initial meeting/assessment providing an opportunity for the young person to talk with the MHP and identify the key issues that are causing them distress and the triggers that have caused a worsening of their condition**.
- Where the assessment indicates that the young person requires more intensive acute crisis support they will be supported into the crisis support pathway (currently being developed by GM Team), in consultation with the referrer.
- If the needs of the young person are appropriate for continued support from the MHP then the young person and the MHP will agree to continue together and discuss the following options:
- ✓ Continued sessional support from the MHP for up to 4 further sessions
- ✓ Identification of welfare needs
- ✓ Identification of e-therapy
- ✓ Identification of fast track to statutory CAMHs
- ✓ Development of an action plan with the referral agency and the young person
- ✓ Support for the young person to access other relevant local services e.g. Kooth, social prescribing
- ✓ Or a combination of these.
- Young people will be disengaged from the support of the MHP after a maximum of 1 + 4 sessions at which point there will be a three way meeting with their original referrer to ensure continuity of care

•27th September 2018

Interim Findings: ICRS Evaluation

Dr. Anna Moore

Anna Freud
National Centre for
Children and Families

Factors enabling success

1. Developing innovative models requires strong collaborative leadership enabling co-creation
   a) Commissioning
   b) Providers

2. Relationships

3. Listening to young people - engagement

4. Set-up time

5. Freedom to evolve and improve

Learning

1. Burden of responsibility for engagement lies with services, not young people
2. Voluntary sector collaborations are likely to be most ideally suited to provision for cohorts with exceptional needs
3. Practical aspects:
   - Timing critical, especially to be considered depending on the sector e.g. schools
   - Staff turnover – minimising this wherever possible
   - Communication & engagement with wider system

Ideal characteristics of services targeting this population

- Flexibility: appointments at times that suit YP
- Meeting places: convenient and suitable environment
- Therapeutic relationship needs to be built in-attachment
- Emphasis on engagement and recognition of this as a specific activity
- Flexible criteria for accessing service
- Freedom to address the needs facing YP... NOT dictated by 'what we do here'
- Models targeting particular populations, integrated with wider system, may be more effective than provision by CAMHS in its existing format

Characteristics of the Young People

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Characteristics of young people

- 273 young people over 9.5 months
- 14 years (11 – 18 years)
- 50:50 M:F
- ~80% White, 9% Black, 6% Indian, 4% Mixed
- ~50% no details, ~40% Atheist, 8% Christian, 2% Muslim, 0.5% Sikh
- 96% no diagnosis- distinct from CAMHS?
- Distinct populations (and skills required) in settings

Young People's Needs

Reason for presentation

- ~90% are in crisis
- 10:30:30:30 (not in crisis, early, late, verge of A&E)
- Disengaged from services
- Complexity a better measure: number and range of problems they suffer from, together with length of time
- Anxiety, self-harm & anger management are most prevalent needs, psychosis & OCD very rare. This varies between settings.

Conclusions

1. Wider determinants & family support are crucial to de-escalation & stabilisation of crisis, and should be addressed concurrently.

2. High levels of risk are managed.

3. Support for those disengaged from services is an important part of the work.

4. Previous experience of care is critical for future engagement and therefore outcomes.

5. Chaotic lives – services need to fit YP, not other way around.

6. Lack of engagement should not be a reason not to provide support – onus is on services to meet needs & active engagement/ outreach is important.

7. Appropriate measures: avoiding specialist services may not be a good measure of success for this population.

Service Functioning

Young People's Feedback

What did you like about the service?
1. I was listened to. I received good support and advice. The activities helped a lot.
2. She was very understanding and helped with my issues a lot and helped me find a bunch of care and coping mechanisms.
3. It was extremely comforting. It wasn't formal and stressful. I believe it helped a great deal.
4. Helped me in a lot of ways that other people couldn't help me.
5. That it's shown me that I'm not on my own and that others have been through what I`m going through and that there is always someone to talk to. Felt like I can open up more and somebody to actually listen to me and give advice.

Settings-based improves access and impacts on culture

1. Being based in settings means access is improved most of the time
   - ✓ Earlier identification & intervention
   - ✓ More convenient to attend
   - ✓ Improved referral rates into service
   - ✓ Difficulties in EHH with no available rooms
2. Environment is important
   - ✓ Safe place (not always case in PRUs)
   - ✓ Not all YP want to access care in settings
   - ✓ Home visits
3. Build capacity & impact on culture within settings
   - ✓ Training setting staff in MH
   - ✓ Changing attitudes towards MH problems
   - ✓ Influencing ways of working (flexible & cross boundary)

Person centred & holistic

1. Help is drawn in from the system to address the YP's needs
2. Traditional organisational boundaries are crossed
3. Flexible approach including addressing family and social needs
4. Not constrained by complex needs eg drugs & alcohol/ homelessness etc
5. Involve other organisations, not just their immediate partners
6. Single assessment highly valued by YP

Engaging Young People

1. Engagement is critical as many YP have attachment and trust problems

2. Aim to enable YP to take up therapeutic intervention in medium term

3. Specifically designing in engagement work should be a priority in service development for this cohort

4. Probably will need smaller services that can be flexible, in convenient places with staff who are able to work 1-1 and create a positive therapeutic relationship

5. Third sector well placed to deliver this

6. **Implications for development of 'Getting Risk' services – YP need to have the opportunity to engage with 'Getting More Help' before they are assigned to Getting Risk Support Quadrants**

7. Evidence that some YP may be struggling to engage with CAMHS in its current form

Outcomes
Therapeutic Alliance

- The CSRS and SRS are used to measure the YP's perceptions of respect & understanding, relevance of the goals and topics, client-practitioner fit and overall alliance.

- For both measures, the scores improve across the course of treatment and this reaches statistical significance in all cases.

- From this we can conclude that **over the period of treatment the therapeutic alliance moves from being 'of concern' to being within the normal range.**

- This indicates that contact with ICR service is supporting YP to develop positive therapeutic relationships.

- This is of particular value in this group, as we have indicated in the first report that attachment and engagement with services is a particular problem.

- It should be noted that this is also likely to have longer term impact on outcomes. Therapeutic alliance is one of the best predictors of treatment outcomes across different types of therapy (Symonds 1991, Warpole 2001, Norcross, 2010).

"Interventions that can positively improve therapeutic alliance are more likely to lead to improved clinical outcomes. "

Outcomes

- The ORS and CORS assess areas of life functioning known to change as a result of therapeutic intervention to real time functioning across personal or symptom distress, interpersonal well-being, social role and overall wellbeing.
- There is an increase in the average scores for the CORS between the beginning and end of treatment, although this does not reach significance.
- It is recognised that YP with **attachment difficulties struggle with endings such** as discharge and often scores dip in the sessions prior to discharge. Given this, results that show no worsening of symptoms at the end of treatment can be interpreted positively.
- This is supported by the finding that the best scores are significantly improved indicating that the service **significantly improves symptoms during the course of treatment although as expected, symptoms do worsen immediately prior to discharge**.
- The positive therapeutic alliance created may be buffering the expected reduction in scores at the end of treatment and improving resilience enabling YP to be better able to manage difficult endings.

"Overall these results provide a positive evidence of improvement in symptoms and may suggest that resilience is also improved."

- Goal based outcomes provide an indication of the progress towards a goal in clinical work.
- **On average there was an improvement in goals achieved through the course of treatment**. This pattern was replicated and reached significance in all settings.
- The RCADS is a score of the frequency of the symptoms of anxiety & low mood. High scores indicate more symptoms and so improvement is indicated by a reduction in the scores. This measure was not used in Alonzi House. On average the scores improved between the start and end of treatment, and peaked during treatment. This improvement reached significance. This improvement was most marked in EHHs, where the score improved by 21%. The scores in the PRU stayed fairly constant, although the PRU only used the score three times and so these results cannot be seen as a reliable indication of the outcomes achieved here.

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Consistency between sites

- In all sites symptoms improved during treatment and this reached significance in all sites.

- No sites had average scores which got significantly worse.

- YP had worse symptom scores in all sites prior to discharge, which is consistent with expectations. In no sites did this change reach significance.

- The symptom scores improved during treatment in all settings, and this reached significance in Early Help Hubs.

- The symptom scores across the three setting types were fairly consistent. Baseline symptom scores were worse for Alonzi House and EHH's.

- The average ESQ score (service satisfaction) was 33.47 (SD = 2.86). The maximum score possible is 36, indicating this is a high score and YP have a good experience of the service. There was no difference between the settings.

Outcomes
Welfare

- 22 families were referred to the welfare team. Of these, 19 were identified to have financial problems. 10 YP received help with welfare support and all gained income as a result.
- ✓ The average amount received was £1260.77 (SD = £1463.84).
- Of these, 7 had debt problems, and 4 had this reduced as a result of the intervention.
- ✓ The average amount of reduction was £516.67 (SD = £246.64).
- 17 had housing problems
- ✓ 4 had this situation improved
- ✓ 5 avoided homelessness as a result of the intervention
- ✓ 8 were provided advice about housing which led to them not losing their homes.
- ✓ 3 received advice and were able to secure new improved housing and
- ✓ a further 3 are waiting to move.

Value for money, savings

Savings as a result of the service

- Savings to Acute services through A&E avoidances:= £109,889
- Ambulance savings = £6074
- Savings to NHS through improved Mental Health using the GM Cost Benefit Analysis Tool = 42,531

= £158,493

- Savings to Local Authority through avoided homelessness=

£ 76,571

- Total savings=**£235,064**

THRIVE Assessment

- **<u>Macro</u>**
- Good use of data for strategic decision making.
- Strategically aligned with GM aims & objectives for crisis care.
- **<u>Meso</u>**
- Consider age limits as GM has 0-25 age range. In particular upper ages?
- ESQ is good
- Use of data for service improvement is good
- Delivery of care according to needs-based groups is good
- Could improve integration with wider community services
- Strengths-based approach achieved
- Consider formal staff feedback
- **<u>Micro</u>**
- SDM is at heart of practice
- Training is evidence based but could be extended
- THRIVE language is integral to ways of working – its not always explicit and used for conversations eg around endings, which could be considered
- Staff have had endings training and are aware of signposting
- Clear system for collection of outcome data, although this needs to be reviewed to increase numbers of cases with complete data collected.
- Jointly written safety plans with YP and other agencies could be implemented

Crisis Pathway

- ICRS is well aligned with the pathway
- Ideally placed to build its work and presents as 'easy win' for delivery of GM pathway
- Capitalise on the relationships and capacity in the pilot
- Opportunity to support delivery of 'safe zones'
- Main work to do would be integrate ICRS with existing/ planned crisis pathways better.
- Align approach to risk management and safety plans

Phase Two

1. Quantitative analysis of performance including a review of outcome data for all parts of the service, including the time taken between referral and seeing the young person.
2. Economic analysis of value for money
3. Qualitative investigation of the views of young people
4. Review of safety, risk management and clinical governance
5. Quantitative assessment of the effectiveness of early intervention
6. Assessment of the effect of the service on the wider system, e.g. CAMHS and A&E
7. Assessment of unmet need and how this could be targeted by this service or others
8. Provide recommendations for scaling up, in particular in the context of GM i-THRIVE Transformation