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Introduction

The World Health Organisation has identified a worldwide absence of mental health policy for children and adolescents (World Health Organization, 2005). In the UK, the call for such a policy has been answered by Improving Access to Psychological Therapies (IAPT) for adults, and the subsequent development of Children and Young People's Improving Access to Psychological Therapies (CYP IAPT).

The IAPT program recommends that commissioners should be "promoting health and wellbeing through strong partnerships with professionals" (http://www.iapt.nhs.uk/). Most recently, the Department of Health paper, "Future in Mind: Promoting, protecting and improving our children and young people's mental health" (2015) recommends "collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation" (p. 16).

Within health more widely, there is an interest in collaborative commissioning. Ham (2008) draws on an analysis of international health commissioning to make a case for "relational contracting" and integrated systems that 'make' rather than 'buy' care". The concept of relational contracting versus transactional contracting was first introduced by the lawyer, Ian R. Macneil (1969). He argued that "exchange represents a species of human cooperation" (p.405). The distinguishing characteristics of relational contracting include the exchange relationship occurring over time and that because of the extension over time, parts of the exchange cannot be measured or precisely defined at the time of contracting. Thirdly, a complex cooperative relationship between contracting parties may expand over time to include others who support or rely on the exchange relationship (Speidel, 2000).

Recently, the attention to relational contracting has intensified with the introduction of integrated care offering opportunities to systematically investigate the real-time mechanisms

involved in contracting of health care. Shaw et al. (2015) in their study of three commissioning communities found that most of the work carried out by commissioning staff involved collaborative activities. These included building consensus, addressing priorities, and drawing on the views of stakeholders. The services with the greatest progress were characterised by leadership which ensured that there was clear commitment to agreed priorities and change was taken in incremental steps. Flexibility and reciprocity were seen as critical for maintaining momentum for change. Likewise, Porter et al. (2013) found that commissioning practice in the six communities they investigated was dominated by a relational approach involving trust, common values, and networks. They suggest that the relational aspects of contracting were an effective way to overcome the barriers of limited provider competition, poor information on demand and resource, complex motivations and uncertain transaction costs. There appears to be agreement that "contractual vehicles do not replace the need to establish high-functioning local relationships" (Addicott, 2015).

To date, however, there has been no published literature that we are aware of in the area of child and adolescent mental health exploring the mechanisms underlying collaborative commissioning. The paper, "Guidance for Commissioners of Child and Adolescent Mental Health: Practical mental health commissioning" (2013) advocates a multi-agency approach to commissioning of child and adolescent mental health services (CAMHS) and offers information on why CAHMS is important to commissioners, what a good service would look like, and how to support the delivery of good mental health services. However, if we are to develop relational commissioning in CAMHS, we will need detailed examples of best practice in local contexts.

In this paper, we offer the "1419" pilot as a case study of collaboration between commissioner and provider, between partner agencies, and within mental health teams. We had from the outset a purpose shared by the commissioner, the entire provider team,

communication, shared decision making, co-location of staff, co-working by staff, and shared infrastructure. Many of these features are those identified in the integrated care research. In addition, we will argue that the small team size and iterative demand capacity planning were critical to the collaborative approach.

In 2010, CLC, the General Practitioner Mental Health Lead within the Cambridgeshire & Peterborough Primary Care Trust (the commissioning organisation),recognised the need for early intervention for young people with mental health difficulties in our community (Jones, 2013; McGorry, 2013; Wang, 2005). She set out to design a pilot service with Cambridge and Peterborough Foundation Trust, and supported by the commissioning team of the Primary Care Trust.

This team was the first of its kind in Cambridgeshire, designed by a unified professional community to target young people as their mental health needs were emerging without a wait for treatment. We were responsive to the needs of teenagers who could see our clinicians in school, in public spaces, or in our clinic. We provided evidence based treatments and used routine outcome measures to ensure these treatments were working. The process of developing the service was iterative in that we kept going back to referrers and young people to ask what was needed. Our clinical team believed in and took direct responsibility for the goals of the service. Young people told us that they appreciated our availability, use of routine outcome measures, and communication style. Professionals recognised our availability, flexibility, communication style, and treatment approach (see Table 1).

The pilot service ran for two years. It was hoped that funding would be picked up through already existing statutory services. Unfortunately, this did not happen due to funding limits, although the staff members involved in the pilot continue to influence service culture.

Methods

We have used a participant observer qualitative research design to describe our commissioning and service design. The development of our service was recorded as it occurred by AH and CLC. In order to build on existing literature and to frame the process which we report here, we chose to use a model of implementation developed by Aarons et al. (2011). This model enables a description of the "extension in time" aspect of relational contracting, identifying four factors that have a strong influence on the success of evidence based practice in publically funded services for children and families -- exploration, adoption, implementation and sustainment. We describe our own experience under these four headings.

We have also analysed our treatment outcomes using a quantitative design and found significant improvement in service user mental health and daily function. These results will be reported elsewhere.

Results

Establishing "1419" on the basis of a conceptual model

Exploration. Aarons et al. (2011, p. 6) defined the exploration stage as "awareness of either an issue that needs attention or of an improved approach to an organisational challenge". Although GP referrals typically accounted for 41.5% of all referrals to our child and adolescent mental health service, the likelihood of a GP referral being rejected had been three times that of other referral sources (Hinrichs et al., 2012). In view of this, we sought to provide a service which would be easy to access.

CLC began by looking for a colleague in mental health services with whom these goals could be shared. AH had worked with managers and the Primary Care Trust to develop early intervention mental health services, and was aware of the need to employ evidence based therapies to young people with emerging mental health difficulties. CLC and AH set

out to establish a service for young people offering evidence based treatments and using routine outcome measures (Table 2) in keeping with the national Improving Access to Psychological Therapies Program. The synergy between a commissioner and a provider sharing a common vision was the first critical step and the foundation upon which all further developments were based.

Adoption. Cambridge and Peterborough had an Adult IAPT service and information about the rationale for CYP IAPT was emerging (Layard and Dunn, 2009). We were working in a health environment where there was already relevant information which had not yet been exploited in our services. CLC and AH shared the intent of using this information to help us meet the needs of our community choosing treatments and outcome measures from IAPT and CYP IAPT and maintaining a focus on participation of service users.

We understood that on-going demand/capacity planning had not been possible with bloc commissioning. CLC had experienced this as a commissioner and as a GP unable to get quick access to mental health services for her patients. As a provider, AH had experienced the pressures in Tier 3 CAMHS of increasing demand for a service with static resource. This bi-focal perspective enabled us to hold onto the common goal of accessible mental health care. The provider perspective meant we could construct an evidence-based package of care including the right treatments provided by the right professional over the right period of time. The commissioner perspective meant that from the outset, we could identify outcome measures that would demonstrate value for money and could roll-out the service in a cost efficient manner. Funding would not permit us to serve the entire City of Cambridge while at the same time providing immediate care without a wait. We decided to target 14 to 19 year olds, hence the title of our pilot, "1419". We adopted a "needs led" approach using epidemiological data and service demand data (Harrington et al., 1998; Rutter and Stevenson,

2008). Uncertain of demand, we agreed a phased start up, beginning with three general practices and building to nine.

We built relationships into our service design to soften the "edges" of our service with existing child and adolescent mental health services, referrers, partner organisations, and adult mental health.

The interface with existing mental health services was bridged by employing a Child and Adolescent Psychiatrist based in specialist targeted mental health team (Tier 3 CAMHS) who was able to co-work cases where needs required this. This person along with AH was key to articulating the rational of our service to the specialist mental health team and conversely, informing us of the needs of that service so that we could respond accordingly.

Our relationship with referring GPS's was strengthened by providing referral criteria in a clear and easy to use form (Table 3) and repeatedly visiting referring general practitioners to discuss and agree service goals and operating procedures. As a consequence, in two years we rejected only three referrals out of one hundred forty two.

Working relationships with local partner agencies were enhanced through a 1419 Project Board including colleagues in local government and the voluntary sector. The Project Board met every four weeks from the early planning stages and its members were included in all strategic decisions including mechanisms for roll-out, review of outcome measures and service changes based on outcome measures. This board became the CYP IAPT Steering Board in 2011 preparing the Cambridgeshire bid for to become a CYP IAPT Partnership in the first year of the DH initiative and continues to meet to oversee the sustained implementation of CYP IAPT principles throughout the county.

Gaps between our service and the voluntary sector were also bridged by including in our team a counsellor from a highly attended local voluntary organisation. She facilitated

transfer of young people to a counselling service if indicated and had experience of working in a "walk-in clinic".

The relationship with Adult Mental Health services was enhanced by co-location in Adult IAPT offices in the city centre, easily accessible to young people. We co-worked cases where there was parental mental health difficulty or where a young person could be better served by Adult IAPT, thus providing holistic care without the seams between services that reduce accessibility. Use of the Adult IAPT database also gave us the opportunity gain cost efficiencies.

Implementation. Using the "innovation-values fit" model we organised our service structures in line with our mission (Klein & Sorra, 1996).

We knew that the majority of our patients would be presenting with low mood and anxiety requiring cognitive-behavioural therapy. We recruited three full-time staff: (i) a senior clinical psychologist with additional CBT accreditation providing a strong clinical lead (ii) a family therapist, considering evidence from other IAPT sites which piloted, with good results, a systemic therapy service for anxiety and depression (Kuhn, 2011) (iii) a psychology assistant with previous research experience who could help manage the database and provide guided self-help and computerised cognitive behavioural therapy programs for patients.

Aarons et al. (2011) describe the "receptive context" as providing "openness to change, minimising competing demands characterised by support for creative innovation and new ideas, tolerance of differences, personal commitment and psychological safety". Our team was small and developed a cohesive identity through meeting regularly, agreeing common goals, and adapting as needed in response to the needs of our patients and referrers.

The operating procedures of our team were designed to support the goals of the service (see Table 4).

Sustainability. After funding for "1419" pilot was put in place we merged with an Early Intervention Consultation Service (EILS) which already existed for children and young people with moderate mental health needs. The age range was brought in line with this service, lowering it to seventeen rather than nineteen. This meant we could no longer serve the critical period of transition from child to adult services, as we originally planned. However, we were able to maintain other crucial aspects of the program including daily referral intake, assessment and treatment within two weeks, routine outcome measures and evidence-based practice.

Unfortunately, our clinicians were soon asked to pick up emergency and high need cases in other areas, leading to "competing task demands" and an increase in waiting times as demand/capacity calculations no longer applied. In 2013, we were obliged to cease all direct patient care with young people who had mild to moderate mental health needs as our team were fully absorbed into child and adolescent mental health services for those with moderate to severe needs.

Organisational philosophy, critical mass, social network support, and staff retention and replacement are critical to sustaining innovation (Aarons et al., 2011). All of these went into decline once the funding and innovative early intervention practice of the "1419" ceased.

Costs

The two year duration of the 1419 service, from 2010 until 2012, cost £223,270 including staff pay, non-pay costs such as travel, equipment and stationary. The service saw 139 patients in this time providing an effective service at £2,637 per patient treated including 64.2% overhead costs as estimated by the Personal Social Services Research Unit (Curtis, 2011). In comparison, the average cost per case for generic single disciplinary CAMHS teams has been estimated at £4,409 and for multi-disciplinary CAMHS £4,823. (Curtis,

2011). We have demonstrated improvements in the mental health of the young people we have helped at below average cost of service.

Ethical Review

The protocol was reviewed by the Research and Development Department, Cambridge and Peterborough Mental Health Trust and considered it to comprise service evaluation. Thus, according to the Health Research Authority guidelines relating to research involving previously collected, non-identifiable information, the evaluation presented here was excluded from REC review.

Discussion

The "1419" was the product of a confluence of factors permitting the emergence of a new, effective and efficient mental health service for young people. These factors are shown in Figure 1. The dynamics and structures we have described here enabled clear shared goals between service user, service purchaser, service provider, and service partners. Importantly, the goals and design of the service were not static and were subject to ongoing development using routine outcome measures and conversations between referrers, commissioners, service users and within the team about what was and wasn't working. Glasby et al. (2011) describe three levels of partnership working – the individual, the organisational, and the structural. We moved forward towards our shared goals across all of these levels. Health economies are defined by resource limitations. Our experience has been that when policy is imposed without these process mechanisms in place, limited resources are further eroded by misunderstanding leading to a service design which does not serve the needs of the community.

Modernisation of children's mental health services requires close collaboration of providers and commissioners because *how* we "make" mental health care is as important as *what* we make. Programs that monitor implementation obtain effect sizes up to three times

those of programs that do not (Durlack & DuPre, 2008) with the context of "empirically-supported treatments" for young people independently contributing to treatment outcomes (Weisz, 2014). In the UK, the focus of mental health commissioning has been on procurement and contracting. To allow whole system change such as that envisioned by IAPT and CYP IAPT, we need more trained and supported commissioners who are able to understand "the deeper . . . dynamics to purchasing and contracting relationships" and who can engage with "patients, family carers, community groups and providers of all sectors throughout the [commissioning] cycle" (Miller and Rees, 2014).

We propose the way forward includes:

1. Consideration of "relational commissioning" with purchasers, providers and service users designing services together. Perhaps, operationalising and quantifying the extent of collaboration (Hawe et al., 2004; Rousseau et al., 2012).
2. Case-level collaboration spanning the divides between services and partner agencies.
3. Smaller child and adolescent mental health teams eliminating competing task demands, permitting speed of action, providing psychological safety for staff, promoting shared goals and innovation.
4. Rigorous demand/capacity planning to inform funding.

In conclusion, our experience demonstrates the importance of local relational context in implementation in agreement with the literature on integrated care (Addicott R 2015; Lafortune, 2013; Porter et al. 2013; Shaw et al. 2015). The risk of not developing this approach to commissioning of services is what Williamson has coined "intractable transactions" (Williamson, unpublished, quoted in Ham, 2008).

Limitations and Future Research

Our methods are limited by the lack of a prospective independent systematic evaluation of our implementation process and by the time limitations of the service. We have chosen the participant observer qualitative research design which can increase the validity of a study enabling a deep understanding of the phenomena being studied (DeWalt and DeWalt, 2002) but can also challenge the objectivity of the analysis. We used an existing theoretical model from implementation science to mitigate a purely subjective interpretation of our qualitative data. Future research of child and adolescent mental health services should employ independent case study design such as that used by Shaw et al (2015). Dickinson et al (2013) point out that much of the joint commissioning literature is "faith-based" with little evidence of improved outcomes. We have analysed all of our treatment outcomes using a quantitative design and found significant improvement in service user mental health and daily function. These findings will be presented in future publications. We are, however, unable to draw a causal relationship between our service design and the outcomes presented having not included a comparator or control service and having not controlled for life events during the young people's treatment which may have effected outcomes.

Indeed, the effect of individual elements in relational contracting on treatment outcomes in child and adolescent mental health services has yet to be investigated. Some of these elements have been identified in discussions of barriers to "relational contracting" and include commissioner' lacking technical and managerial skills, information asymmetries between buyer and seller, the separation of commissioners and providers, low levels of administrative support for commissioners, insufficient understanding of different agencies, lack of shared definitions and common language (Ham, 2008; Miller and Ahmad, 2000). Future research in the area of commissioning child and adolescent mental health services will

need to control for these elements comparing different services and operationalising broad outcome variables including, for example, treatment outcomes, cost efficiencies across the relevant health economies, and experience of service across all stakeholders.

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Figure 1. Conditions required for 1419.

Table 1.

Qualitative Service Feedback

	Young People	**Professionals**
Positives	Quick Friendly Clear Questionnaires/letters to see progression Convenient location Seen quickly Not trying to be cool Does what it says, 'young people's service'	Quick Flexible Communicate with us Not sent to different services Holistic Flexible Venue
Negatives	Use word 'mental health' Advertise more	On-line services not provided Simpler referral form Continue service Extend to younger age group

Table 2.

1419 Outcome Measures

Variable Measured	Measures and Properties
Symptoms	***Mood and Feelings Questionnaire (MFQ short)13 item form.*** Measures depressive symptoms. Designed for use as screening tools in adolescents. Widely used in treatment studies to demonstrate change. Range 26. Cut-off 7/8 ***Generalised Anxiety Disorder 7(GAD7).*** Measure of anxiety symptoms. Designed for adult IAPT. Can be low for patients with severe anxiety, hence the use of the phobia scale. Range 0-21. Cut-off 7/8 for anxiety 'caseness' in adult IAPT ***Phobia3.*** Measures phobic avoidance. Designed for adult IAPT. Range 0-24.
Behaviour and Functioning	***Children's Global Assessment Scale (CGAS).*** Semi-ordinal scale scored from 1-100, single score for functioning in all domains. High score represents better functioning. Cut-points include: 40/41: severe vs moderate disorder (severe generally rated as total non-function in at least one domain, eg not at school as too ill); 60/61: cut-off for entry into some CAMHS services. ***1419IAPT Function Questionnaire.*** Six item function questionnaire developed by the 1419IAPT steering group. First four items taken from the SDQ. The validity and psychometrics of summing items from this questionnaire are unproven. In such cases, using individual items scores is likely to be more valid than summing items. ***Strengths and Difficulties Questionnaire*** *(SDQ).* Designed as a screening tool. Less information (sensitivity to change) in patients with more severe illness. Young person version given. Five subscales, each with range 0-10. Four have higher scores representing more symptoms (emotional problems, conduct problems, hyperactivity and peer problems). These are added to give the total problems scale (range 0-40). One sub-scale has higher scores representing better abilities (prosocial). Cut-offs as a population screen, rather than being designed for clinical samples; they represent approximately 10% of the population and are not age/gender normed.

Table 3.

"1419 IAPT" Referral Criteria

Inclusion Criteria	Exclusion Criteria
Mild to moderate depression Mild to moderateAnxiety, i.e. specific phobia, social anxiety, generalised anxiety, separation anxiety, panic attacks Post Traumatic Stress Disorder (PTSD) Obsessive Compulsive Disorder (OCD) Deliberate self harm Mild eating disorders	Severe mental health difficulties, where the following presentation indicates: An on-call, outreach or crisis service may be needed due to the severity of symptoms, risk and severe effect upon activities of daily living (refer to CAMH) A long episode of care over a prolonged period of time is needed, due to factors such as co-morbidity and a history of complex problems that have not responded to previous community treatments (refer to CAMH) Significant eating disorder (refer to CAMH or Phoenix Centre) Psychosis (refer to CAMH) Drug/ alcohol use (refer to CASUS) **Or** Where the client is unable to access psychological therapies, due to e.g.: Developmental factors Medication Ongoing trauma

Table 4.

Operating Procedures Supporting Service Goals

Service Goals	**Operating Procedures**
Easy to access and collaborative	Self-referral No wait list Choice of venues Contemporary forms of communication Clear service criteria Constant collaboration with referrers and service users in treatment planning and service design
Evidence based	National Institute of Clinical Excellence (NICE) compliant Stepped-care interventions within service and across tiers and sectors Routine outcome measures reviewed in supervision