Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Guidance for commissioners of

primary mental health care services

Volume
Two:

Practical
mental health
commissioning

Contents

Executive summary

- Mental health problems should be managed mainly in primary care by the primary health care team working collaboratively with other services, with access to specialist expertise and to a range of secondary care services as required.

- Effective treatment of common mental health disorders in primary care requires integrated services using a stepped care model. This should deliver evidence-based treatments that can be accessed via flexible referral routes, including self-referral, and offer a choice of psychological and non-psychological interventions.

- Primary mental health care services should have a clear focus on prevention and early identification.

- Primary mental health care services should promote self-management by patients, including use of personalised care plans.

- Care co-ordination (case management) and methodical management of systematic care pathways are essential to good primary mental health care services.

- Primary mental health care should be holistic – mental health has physical, psychological, social and spiritual elements.

- The outcomes of primary mental health care work should be systematically measured and reported.

- Allocation of funds to reflect these principles will result in better integrated patient care pathways that are able to meet a wider range of needs. Currently, gaps at the interface between primary mental health care and secondary mental health and acute services can mean that patients disengage, revolve or get 'stuck' in different parts of the system.

- Improving the management of mental illness in primary care will contribute to meeting the objectives of the *No Health without Mental Health* mental health strategy and the Quality, Innovation, Productivity and Prevention (QIPP) Challenge.

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, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- Service users 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
- 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 service users, carers, clinicians, commissioners, managers and others to work towards values-based commissioning

- to integrate scientific evidence, service user and carer experience and viewpoints, 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

- provides practical guidance and a developing framework for mental health

- will support commissioners of public mental health to deliver the best possible outcomes for community health and wellbeing

- has published a series of short guides describing 'what good looks like' in various mental health service settings.

WHO IS THIS GUIDE FOR?

This guide is about the commissioning of good quality, integrated primary mental health care and should be of value to:

- the NHS Commissioning Board, as it will hold the contracts for general medical services which should reflect what this guidance is saying about primary mental health care

- Clinical Commissioning Groups, as the commissioning of both specialist and acute secondary mental health services needs to reflect the increased activity in integrated primary care teams, and reduced activity in secondary care suggested by this guide, and

- Health and Wellbeing Boards, as the commissioning of public mental health and wellbeing should sit alongside the preventative activity in primary care described in this guidance.

HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of primary mental health care experts, in consultation with patients and carers.

The content is primarily evidence-based but ideas deemed to be best practice by expert consensus have also been included. By the end of this guide, readers should be more familiar with the concept of primary mental health care and better equipped to:

- understand what good quality, modern, primary mental health care services look like

- commission primary mental health care services

- understand how and why a good primary mental health care service contributes to achieving the aims of the mental health strategy and improves quality and productivity, both in itself and by enabling changes in other parts of the system.

This guide also covers issues relating to commissioning primary mental health care services. It describes:

- the benefits of primary mental health care services
- the optimum skill mix in primary mental health care teams.

The guide draws on and refers to previously published guidance, including NICE guidelines for common mental health problems (CG123), depression (CG28, 90, 91), various anxiety disorders (CG 26, 31,113), eating disorders (CG9) and self-harm (CG16).

What are primary mental health care services services?

Primary mental health care is a relatively recent concept in health care. It is defined by the World Health Organisation as follows[3]:

- first line interventions that are provided as an integral part of general health care, and
- mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services.

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.

For many patients, developing a good relationship with their general practitioner (GP) is central to continuity of care, as this facilitates good engagement with, and communication across, the whole of primary care. Primary care is also most people's first port of call in times of health care need. Good engagement and communication allows the GP, and indeed any member of the primary care team, to deliver good collaborative care, working with other members of the team and with mental health specialists.

Patients will need appropriate evidence-based interventions, ranging from active monitoring and guided self-help through to higher intensity interventions such as psychological therapy. Crucial to the effective functioning of primary mental health care teams is expert supervision and case management with a consistent and systematic focus on outcomes.

Continuous professional development and training curriculums that reflect current NICE guidance ensure that relevant skills are gained and maintained. Ideally, these will be organised so that different members of the primary care team train together.

Why is primary mental health care important to commissioners?

POLICY IMPERATIVES

A number of relevant recent policy imperatives make the provision of good quality primary mental health care services a priority for clinical commissioning groups. These include:

- the emphasis on providing care as close to the patient's home as possible
- the need to take patients' views into account ('No decision about me without me'[1])
- patients' and their carers' preference for being treated in primary care, where the environment is less stigmatising and where physical and mental health care can more easily be delivered together.

MENTAL HEALTH PROBLEMS ARE COMMON AND COSTLY

Some 17.6% of the adult population (21.0% of women and 11.9% of men) have a common mental health problem (anxiety or depression).[4]

A further six per cent have alcohol dependence, three per cent have drug dependence and 21% have nicotine dependence (42% of tobacco consumed in England is by people with a mental illness).[4,5] Rates of personality disorder are 5.4% for men and 3.4% for women[6] and 0.4% have psychosis (schizophrenia or bipolar disorder).[4] A further 17% of the population experiences sub-threshold common mental problems,[4] six per cent have sub-threshold psychosis[7] and 24% drink alcohol at levels defined as hazardous to their health.[4] Sub-threshold health status presents an important opportunity for prevention and early intervention.

Broadly, this means that, in a group of 2000 patients at any one time, an average general practice will be treating:

- 352 people with a common mental health problem
- 8 with psychosis
- 120 with alcohol dependency
- 60 with drug dependency
- 352 with a sub-threshold common mental health problem
- 120 with a sub-threshold psychosis
- 176 with a personality disorder
- 125 (out of the 500 on an average GP practice list) with a long-term condition with a co-morbid mental illness
- 100 with medically unexplained symptoms not attributable to any other psychiatric problem (MUS).

This means about one in four of a full-time GP's patients will need treatment for mental health problems in primary care.

The overall annual spending on the NHS in England was approximately £105 billion in 2009.[8] Of this spend, around eight per cent is allocated to (all) primary care services[9] and around 12% to secondary and tertiary mental health services.[10] However 23% of the overall burden of disease is due to mental disorder and self-inflicted injury (by comparison, just 16% is due respectively to cancer and to cardiovascular disease).[1] In England, most people with a mental disorder except psychosis receive no intervention.[4] For common mental disorder which is the most prevalent mental disorder, only 24% receive any intervention

PREVENTION AND EARLY INTERVENTION

Early intervention is vital, both to improve people's life chances and reduce health care costs. Primary care is where this should happen.

Different levels of prevention include primary (preventing illness from occurring in the first place), secondary (early identification and treatment) and tertiary (promotion of recovery and relapse prevention early intervention).

Why is primary mental health care important to commissioners? (continued)

Prevention activities may avoid the need for specialist secondary care, and its associated higher costs. But primary mental health care teams need to be resourced to undertake pro-active and outreach work with at-risk groups, and to develop self-referral routes into services. This means that clinical and service leads and commissioners need to understand the high-risk groups and the ages at which mental illnesses are more likely to occur. They also need to ensure that skill mixes and service models include specific roles to deliver preventive and early interventions, such as, for example, psychological wellbeing practitioners.

Particular groups are at much higher risk of mental illness and therefore need to be targeted for preventive and early interventions. They include:

- people on low incomes (people with household incomes in the lowest 20% are at higher risk of mental health problems than those with incomes in the highest 20%[4])

- black and minority ethnic groups (they are at two- to three-fold increased risk of suicide[11] and a nearly four-fold increased of psychosis[12])

- people with learning disability (they have a two-fold increased risk of depression and a three-fold increased risk of schizophrenia[13])

- lesbian, gay and bisexual people (they are at higher risk of common mental disorders, suicide attempt, psychosis and alcohol dependence[14])

- people with a chronic physical illness (they have a two- to three-fold increased risk of depression in comparison with people in good physical health, and this increases to a seven-fold increased risk in those with two or more chronic physical illnesses[15] – one in two people with advanced cancer also develop mental health problems[16])

- older adults (they are at increased risk of depression and, particularly if living alone, suicide)

- children with conduct disorders (a significant proportion of adult mental health problems are preceded by emotional or conduct disorders in childhood[17]).

Carers

Carers of people with long-term illness and disability are at greater risk of poor health than the general population. They are particularly likely to develop depression. In an Office for National Statistics survey, 30% of carers rated their health status as fair or poor, and 33% said that caring made them depressed at least some of the time. Those caring for a spouse or partner were most likely to report mental health problems. Thirteen per cent of carers said they had consulted a GP about being anxious or depressed or about a mental, nervous or emotional problem, and one per cent had done so in the previous two weeks.[18]

Commissioners could work proactively with practices to identify carers who could be at risk of mental health problems. They could also ensure that social services departments systematically offer the assessments to which carers are legally entitled and follow up any findings with appropriate referral or intervention. There is a statutory requirement to act on the outcomes of the carer assessment if a critical risk is identified; systems should be put in place to ensure this happens.

Early intervention in psychosis

Early intervention in psychosis services provide care for young people aged 14–35 years for periods of up to three years after a first episode of psychosis. These early intervention services are recommended by NICE, are effective in changing the early course of psychosis,[19] provide net savings to the NHS and are rated highly for patient satisfaction.[20] (Further details can be found in the forthcoming commissioning guidance on Specialist Community Mental Health Services.)

THE OVERLAP BETWEEN MENTAL AND PHYSICAL HEALTH

People with mental health problems have much higher rates of physical illness. For instance, depression is associated with increased risk of coronary heart disease[21] and diabetes.[22] The presence of mental illness can also complicate the management of a physical illness and worsen the prognosis.

The health consequences of mental illness are most extreme for people with a psychosis (schizophrenia or bipolar disorder). Men with schizophrenia living in the community have a 20.5 year reduced life expectancy; women have 16.4 year reduced life expectancy.[23] The main cause of these excess deaths is cardiovascular disease, suggesting that the deaths are mostly preventable.

THE QUALITY AND PRODUCTIVITY CHALLENGE

One of the three main themes of the national Quality, Innovation, Productivity and Prevention (QIPP) programme for mental health is the alignment of physical health care with mental health care services.

If long-term conditions, co-morbid physical and mental ill health and medically unexplained symptoms can be managed more effectively in primary care settings, this will reduce demand on acute inpatient services. Effective prevention and early intervention will also reduce demand on all types of secondary care, and integrated primary care services are ideally placed to deliver this.

What do we know about current primary mental health care services?

There is no standardised model for the commissioning and provision of primary mental health care services. The current patterns of service provision vary greatly and in most areas are likely to result from historical factors.

Signs that current primary care mental health systems are not working well include the following:

- the primary–secondary care interface in mental health fails to meet patient need, leading to:
  - delays in access
  - disparity between estimated numbers with illness and those receiving treatment
  - complex and changing care pathways
  - gaps in service provision where patients' needs fall between service providers
  - rigid, access criteria that do not reflect actual patient need.
- response to people with common mental health problems is variable – some, but not all, are diagnosed and receive evidence-based treatments – and there is no systematic process for allocating patients to appropriate care pathways (most of which should be in primary care)
- there is inconsistent assessment of the impact of mental distress and symptoms of common mental illnesses on a person's capacity to work, or on their family life and relationships, and often no clear systems in place for early intervention to help people recover and return to work more rapidly

- there is a lack of understanding of how collaborative care works, the roles and responsibilities of specialists operating in primary care settings and the importance of the interface between psychiatrists and GPs
- the majority of patients experience good consultations with GPs but there is sometimes a delay in getting a diagnosis, not all patients receive information about and an explanation of their diagnosis and treatment, and medication may be over-used because there are no alternative options
- people with mental health problems are not engaging with primary care either because they feel they would be wasting the GP's time, or because they feel GPs do not have time to listen to them and do not understand how they feel[24]
- there may be a mismatch between the GP's views of the cause of the mental health problem and how to treat it and those of the patient – the GP may adopt a 'one-size-fits-all' model, and the patient may want simply to be listened to and helped to self-manage their mental health, using a personalised care plan
- GPs may lack confidence in their ability to provide appropriate services, particularly for people with psychosis, and may require patients to be seen in the psychiatric outpatient clinic once or twice a year for monitoring against risk criteria.

What would a good primary mental health care service look like?

MODEL OF SERVICE DELIVERY

The key to developing patient-centred primary mental health care services is to put the patient's needs at their heart. This means ensuring services are conveniently located and easily accessible in the primary care setting. It also means being emotionally available and interested in the patient.

A good primary mental health care service is:

- **evidence based** – treatments should be based on sound clinical judgement informed by NICE guidelines.

- **patient-centred** – care should be personalised, people should be given time to talk, should be listened to, provided with information and offered a choice about their care. Patients should actively participate in decision-making, feel engaged and have a sense of ownership.

- **Based on need** – services should be commissioned and provided on the basis of need and the estimated prevalence of mental health problems

- **age inclusive** – services should recognise that opportunities exist for prevention at all life stages, that the origins of most major mental health problems lie in the early years, and that care should not be compartmentalised or interrupted on grounds of chronological age alone.

- **capable** – the primary mental health care team needs to have the knowledge and skills to understand how best to provide appropriate services for people with mental health problems. This may require additional education and training opportunities.

- **integrated** – commissioning primary mental health care services should be integrated with the commissioning of specialist mental health services. The interfaces between different parts of the system and with other agencies (such as social services) need to be seamless, because people's needs straddle health and social care.

- **accessible** – care pathways should include treatments that can be accessed through self-referral and should address diversity in local communities. This includes making reasonable adjustments for people with special needs. Patients should be treated promptly; they should not have to wait until they become ill or their condition becomes more complex and they require more intensive treatment.

- **Sufficient capacity** – commissioned services should have the sufficient capacity to treat numbers estimated to have different types of mental health problems

- **outcome-focused** – treatments should be systematic and their outcomes monitored continuously using a common set of measures appropriate to the patient's problems. Accurate assessment requires high levels of pre–post data completeness. For people with depression and anxiety disorders, this is most easily achieved by routine, session-by-session outcome monitoring. This approach also facilitates the choice of interventions and other clinical decisions.

- **recovery-focused** – a recovery focus is essential to effective service delivery. Practitioners should support patients to help themselves and reinforce the message that recovery is possible, and that they can regain employment and social networks. This is particularly important for people who have been out of work for some time. Recovery is not simply about a reduction in, or removal of, symptoms; it is about communicating hope and restoring opportunity and a sense of agency to patients.[25]

- **community-linked** – primary mental health care services should be linked to a range of voluntary and community sector services that patients can choose (ie. they are not limited to what commissioners choose to fund), and that either work alongside or are integrated with the primary mental health care team.

- **preventative** – interventions should be targeted at individuals identified from GP service 'Read Codes' as at risk of developing mental health problems.

KEY COMPONENTS OF THE SERVICE

NICE guidelines for depression (CG90 and CG91)[15,26] and some anxiety disorders (CG31,113 but not CG26)[27-29] talk about a stepped model of care (see below).

This framework for service delivery describes the patient's journey in the care of a multi-disciplinary team that offers the full range of evidence-based interventions within an integrated care pathway.

The core principle of stepped care is that people are matched to an intervention that is appropriate to their level of need and preference. The clinician needs to make a balanced judgement based on what would deliver the best, sustained health outcomes. The patient should also be able to change treatments as they progress, and their expectations, their confidence in the therapist, and their views about the suitability of the treatment should also be taken into account.

The key operational consideration for stepped care models is that the patient care plan is constantly reviewed through active case management, using session-by-session outcomes. Appointment times and locations should also be flexible and responsive. Patients can move between types of therapy depending on their level of need, but will still receive these treatments in primary care.

NICE recommends cognitive behavioural therapy (CBT) for anxiety disorders but suggests a broader range of treatments for depression.[15] The Department of Health's Improving Access to Psychological Therapies (IAPT) initiative has produced a useful patient information guide, *Which Talking Therapy for Depression* (available at www.iapt.nhs.uk/news/which-talking-therapy-for-depression/), which describes the different psychological therapies

recommended by NICE for treatment of depression, how they work, and the outcomes patients can expect from each of them. IAPT has also produced a Patient Experience Questionnaire that can be used to ensure that patients receive the care they want, delivered in a person-centred way (www.iapt.nhs.uk/search/?keywords=patient+experience+questionnaire).

STEPPED CARE MODEL OF CARE

Commissioners may wish to commission a stepped care model that offers an integrated care pathway for primary mental health care services.

Step one

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.

Peer experts and peer mentors

Patients and carers can be supported to support each other in patient and carer groups. Peer mentors and patient experts can be employed in the primary mental health care team to work alongside patients. Experts by experience can coordinate and distribute information about self-management, co-ordinate mentorship programmes, and offer training and deployment of people with lived experience for specific purposes, such as advocacy.

Health trainers

Health trainers can help patients access computerised and internet therapies and support, teach techniques for enhancing

psychological resilience, promote wellbeing skills, teach the principles of mental health first aid and introduce them to relevant organisations in the community where they can get further help. The health trainer in each practice team could be responsible for liaising with their peers in other practice teams to map and carry out quality assurance of community services used by their patients. Graduate primary care mental health workers, who used to perform a similar role, have been shown to be cost effective and to improve patient satisfaction.[30,31]

Social prescribing

Social prescribing, or 'community referral', supports improved access both to psychological treatments and to interventions addressing the wider determinants of mental health, such as exercise on prescription and neighbourhood schemes. Research into social prescribing[32] shows benefits in three key areas: improved mental health outcomes, improved community wellbeing and reduced social exclusion.

There is a strong case for commissioning social prescribing for mental health, based on the relationship between mental health and other outcomes, and on the growing evidence of demand for a wider range of early responses to psychosocial problems. For further information please see the Karis Neighbourhood Scheme (see page 12). A number of patients presenting in primary care will prefer to find healing through non-traditional and social care routes. Some may feel their needs would be best met through faith environments and networks. Innovative forms of social prescribing include access to e-mental health and online support networks. The New Savoy Partnership has produced a resource directory and guidelines for good practice for these services (www.newsavoypartnership.org).

What would a good primary mental health care service look like? (continued)

Step two

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. This clinician will carry out the initial assessment and identify which care cluster best describes the needs of the patient. If the clinician feels that their skills alone are not sufficient, they will refer on, usually in-house, to a case manager or to another colleague with a different set of skills, for further assessment. Based on the further in-depth assessment, they will suggest additional low intensity psychological interventions or community resources.

Patients may want their therapist at Step two to act as a care co-ordinator in terms of signposting and navigating access to the various NICE-recommended options, such as structured exercise groups for depression. All primary mental health care teams should be able to make referrals to therapists trained in low intensity psychological treatments, such as the short-term cognitive behaviour therapies recommended for patients with depression and anxiety and other common mental disorders.

Step three

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).[33-35]

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 collaborative care.[26] There is evidence that this approach is effective with people with co-morbid long-term conditions, and some emerging evidence that it may be helpful for people with psychosis.

The key components of collaborative care are:

- a multi-professional approach provided by practitioners from at least two different disciplines.

- a case manager (for example, a community psychiatric nurse, psychologist or graduate mental health worker), who works with the GP in primary care and receives weekly supervision from specialist mental health, medical or psychological therapy clinicians. Their role would include the delivery of (some) psychosocial interventions, care coordination and liaison with other providers to ensure smooth transition along care pathways, step up or down as required, regular and robust reviews of progress, and the delivery of systematic outcomes measures.

- integrated communication between providers – for example, verbal/face-to-face contact between primary and mental health care providers, weekly team meetings, and shared records via the existing primary care electronic records system.

- education and facilitation of providers to ensure rapid development of new roles within a collaborative care environment.

The GP, in liaison with whoever is providing the psychological care, will continue to review and manage the prescribing of

psychotropic medication, if the patient wants it, and oversee their physical health care. One GP or a team of GPs may take this on for their whole practice or, in some cases, for a group of practices, as a designated mental health liaison role in the delivery of collaborative care.

Step four

Step four comprises specialist mental health care, including extended and intensive therapies.

Clear, well understood pathways must be in place between the primary care mental health team, IAPT services and specialist mental health services. The most obvious relationship is with the specialist community mental health services, but there may also be a relationship with acute liaison services (see the companion commissioning guidance on acute liaison). These provide specialist mental health input to acute hospitals, and also oversee acute inpatient and community-based interventions for comorbid long-term conditions and medically unexplained symptoms.

Appropriate management of medically unexplained symptoms should lead to a significant reduction in the inappropriate use of acute inpatient resources. 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 (see the forthcoming companion guidance on Specialist Mental Health Community Services).

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.

STANDARDS

Commissioners will want to commission primary care mental health services that can demonstrate that they meet the recognised standards for their service, such as the NICE quality standard for depression.

The optimum primary mental health care team

To provide the range of services set out above, primary mental health care services will need to include a range of staff within a multidisciplinary team. The professional backgrounds of the team members will be specific to their local context.

Primary mental health care teams may include the following:

- the core primary care team of the GP and the practice nurse
- primary care mental health clinicians
- primary care-based mental health specialists
- third sector (not-for-profit) providers and social enterprises (eg. community organisations and networks, including faith groups)
- other community-based, non-specialist practitioners (for example, school nurses and health visitors)
- service user and carer experts by experience.

IAPT teams

IAPT services offer integrated talking treatments for depression and anxiety across a range of NICE-approved modalities. All IAPT therapies include routine, session-by-session outcome monitoring.

Treatment is provided by two types of psychological therapy practitioners:

- psychological wellbeing practitioners trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression (these approaches include guided self-help and psycho-educational groupwork)
- high intensity therapists trained in CBT, counselling for depression, interpersonal psychotherapy, dynamic interpersonal therapy, and couples therapy for depression for people with moderate and severe depression and anxiety disorders.

All IAPT practitioners receive routine, outcomes-focused supervision and services also include administrative staff, employment advisers and a GP adviser and have links with other services such as housing, drugs advice and welfare benefits advice.

OUTCOMES

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

For cost effectiveness

- locally agreed referral thresholds, including use of the mental health clustering tool
- percentage of people diagnosed with a long-term condition who have been screened for anxiety and depression
- percentage of people with medically unexplained symptoms receiving evidence-based treatment in primary care.[36]

For effectiveness

- personalised care plans and patient goals
- CORE (for effectiveness of talking treatments)

- compliance with IAPT data standard and sessional monitoring (see www.iapt. nhs.uk/services/measuring-outcomes).

For patient safety

- under-75 mortality rate in people with serious mental illness (outcome 1.5 of the NHS Outcomes Framework 11/12)
- QOF incentives to assess and manage the physical health of people with severe mental illness (relates to shared objective 3 of the *No Health without Mental Health* mental health strategy[1])
- completed suicide rates (relates to shared objective 5 of the mental health strategy and the forthcoming cross-government suicide strategy).

For recovery

- employment rates of people with mental illness (outcome 2.5 of NHS Outcomes Framework 11/12), IAPT targets and shared objective 6 of the mental health strategy[1])
- patient self-defined goals.

Also worth consideration are:

- the Mental Health Recovery Star, a self-assessment tool that patients can use with clinicians to chart their own progress towards their self-defined goals (see www.outcomesstar. org.uk/mental-health/), and
- the Warwick–Edinburgh Mental Well-being Scale (WEMWBS), a scale for assessing positive mental health (see www.healthscotland.com/ documents/1467.aspx).

For patient experience

- patient ratings of consultations (relates to shared objective 4 of the mental health strategy[1] with a good application to 360 Degree Appraisal and, in time, medical revalidation).

What would a good primary mental health care service look like? (continued)

INNOVATIVE PRACTICE MODELS

Karis Neighbour Scheme
www.karisneighbourscheme.org

Karis Neighbour Scheme has been operating in Birmingham for over 12 years. A voluntary sector organisation, it is underpinned by the belief that spirituality is an important factor in personal and community health. The scheme seeks to meet a variety of unmet needs, largely through volunteer support. Partnership working with local services, especially medical centres and faith based organisations, is central to its work.

Karis Neighbour Scheme is guided by Christian beliefs and principles; its directors are Christian, as are many of the staff. This motivates the organisation, but in no way restricts its services to those who share their faith. It has close links with the community healthcare chaplains at a local medical centre that is known for the holistic health care it offers. Some of Karis Neighbour Scheme's programmes are joint projects with local churches.

Karis Neighbour Scheme aims:

A to reduce isolation, promote connectedness between people and enhance community cohesion by:

- providing individual befrienders for the isolated elderly, asylum seekers and refugees
- organising community activities and events that build relationships and create a sense of community, including:
  – day trips in the summer for young families
  – summer garden parties for the elderly
  – Christmas festivities for the elderly at residential homes and churches
  – a personal faith discussion and support group at a residential home and community centre
  – the annual Ladywood Community Fun Day
  – a community allotment project
  – art and craft or language sessions with free child care
  – a community engagement project (facilitated by The Nehemiah Foundation – Training People to Transform Communities www. regenworker.com), which initially conducted a detailed public health analysis of the area, then worked with local stakeholders to establish priorities for action, and has now set up a residence association and a community newspaper.

B to improve mental health and ability to cope with adversity, increase individuals' sense of control and independence and so reduce demand on services by:

- running drop-in advocacy sessions offering help with welfare benefits, utility bills, immigration and housing issues
- practical support such as gardening, decorating and supplying second-hand furniture
- free English language classes for those new to the UK
- accompanying individuals to appointments with doctors, housing or benefit agency appointments
- one-to-one counselling and groups dealing with issues such as depression, anxiety, self-esteem, anger management and confidence building
- working with families and young people to promote emotional health and reduce family dysfunction.

Changing Minds Education Centre
www.changingmindscentre.co.uk

Changing Minds Education Centre has developed over a number of years. Its work initially focused on primary care medication, but it has expanded to incorporate new ways of working and new workers, including graduate workers and community nurses trained in mental health. Following an audit in 2005/06 and in parallel with national initiatives such as the *National Service Framework (NSF) for Mental Health* and IAPT, the service has developed to provide a stepped care wellbeing service.

Changing Minds is now a practice-based initiative with an early intervention and recovery focus. It employs 37 full-time equivalent staff. The service includes peer support and a parent support service, in addition to the following three projects.

- Changing Minds Wellbeing Teams provide a person-centred service for people in Northamptonshire who may be at risk of, or who are experiencing, a period of mental distress. Their aim is to explain the information, resources and support available and help people make positive lifestyle changes to improve their mental wellbeing.

- Learn2B is a partnership between Changing Minds and the Northamptonshire County Council Adult Learning Service. The aim is to enhance wellbeing through a range of creative, social, recreational and therapeutic groups for people in their local communities. Currently 30 tutors are running a variety of clinical/task based/social interaction groups. www.mentalhealth.org.uk/publications/ learning-for-life/

- PhyHWell (pronounced 'fuel') is a two-year pilot funded by Northamptonshire Teaching PCT that aims to reduce mortality rates among people with severe mental illness, improve their physical and emotional health, increase their compliance with medication and help develop their support networks. It does this by improving skills in the primary care workforce and promoting data sharing and collaborative working. It offers GP practices individual bespoke training and, by inviting the practices' link community mental health nurse to participate, creates an opportunity to improve links with the local community mental health team. The project was the winner of the Nursing in Practice Award 2010. www.changingmindscentre. co.uk/v/phyhwell_project

Health and Wellbeing Centre with Navigators
www.echwc.nhs.uk

Launched in December 2011, this is a partnership between Turning Point, the Terrence Higgins Trust, Greenbrook Healthcare and NHS dentists. The health and wellbeing centre is designed to offer the community easy access to a range of primary healthcare services co-located under one roof. The building houses a GP-led health centre, community sexual health services and NHS dentistry, as well as offering space for use by other community groups.

The service operates at the interface between primary and community services. The reception is staffed by a team of 'wellbeing navigators' who, in addition to dealing with patients' health questions, also deal with bookings for the community room space for local organisations, make links with other community hubs locally and signpost to other sources of support in the community. This navigator model is based on a pilot project in Hartlepool, evaluated by the University of Durham, which successfully engaged people with local health and wellbeing services.[37]

The partnership also plans to establish a wellbeing navigator apprenticeship scheme, which will recruit and train local people who have used the navigator service to work as navigators themselves. This will both expand the existing service and ensure its sustainability, and establishing a systemic and structured way to build on the strengths and experiences of patients.

Supporting the delivery of the mental health strategy

The JCP-MH believes that commissioning that leads to good primary mental health care, 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.

Prevention, risk stratification, and early intervention in primary care will result in fewer members of the registered practice population developing mental illness.

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

More mental illness will be managed in primary care, thereby reducing admissions to secondary care. Patients will enjoy increased agency, 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.

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

Co-morbidity of physical and mental illness will be better addressed by collaborative primary care delivered by multi-disciplinary teams that give equal importance to emotional, psychological and physical health care needs.

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

People with mental health problems prefer to be treated in primary care wherever possible, and say they prefer talking therapies to other forms of treatment.

Shared objective 5:
Fewer people will suffer avoidable harm.

Reducing the likelihood of admission to hospital also reduces exposure to avoidable harm.

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

People who are treated in primary care are at less risk of losing their home and more able to maintain their social networks in their community. Friends and family networks, education, employment and a safe and stable place to live are central to quality of life. Using primary care services can avoid the stigma attached to secondary mental health services.

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Development process

This guide has been written by a group of primary mental health care experts, in consultation with patients 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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Resources

Joint Commissioning Panel for Mental Health

http://www.jcpmh.info

The JCP-MH is a collaboration between leading organisations with an interest in mental health and learning disabilities. Its aim is to achieve better outcomes for patients by improving commissioning of services that meet patient need. It does this by:

- publishing briefings on the key values and principles for effective mental health commissioning

- providing practical guidance and a framework for mental health commissioning

- supporting commissioners in commissioning mental health care that delivers the best possible outcomes for health and well being

- developing guidance for best practice commissioning in areas where disparities in outcomes exist

- bringing together carers, service users, clinicians, commissioners, managers and others to deliver the best possible commissioning for mental health and wellbeing.

Wandsworth Community Empowerment Network

www.wcen.info

WCEN is a community based charity established as part of the National Strategy for Neighbourhood Renewal and based on the Doddington and Rollo estate in North Battersea. WCEN works with the poorest and most disadvantaged communities and people living in Wandsworth and surrounding boroughs. Its core mission is to link the issues and concerns of local people and communities with the organisations and public agencies that may be able to do something about them.

Foundation for Positive Mental Health

www.foundationforpositive mentalhealth.com

The Foundation for Positive Mental Health promotes Positive Mental Training through research, professional training and raising public awareness. It works with health care organisations and with businesses. Positive Mental Training is offered through the NHS in Edinburgh as part of a stepped care approach to treat anxiety, and is also offered by NHS primary care services in Halton and St Helens, Sandwell & Dudley and Eden Valley.

National Debtline and the Money Advice Service

www.nationaldebtline.co.uk
www.moneyadviceservice.org.uk

National Debtline provides a national telephone helpline for people with debt problems in England, Wales and Scotland. The service is free, confidential and independent (0808 808 4000; Monday–Friday 9am–9pm; Saturday 9.30am–1pm). The Money Advice Service provides free, unbiased advice nationwide to anyone seeking help to manage their money. The service is available online and over the phone on 0300 500 5000, Monday to Friday 8am–8pm.

Primary Care Mental Health and Education

http://primhe.ning.com

PRIMHE aims to promote and improve understanding, skills and knowledge of primary care practitioners to work with people in distress, with and without a formal diagnosis of a mental illness.

USEFUL PUBLICATIONS/WEBLINKS

Haddad, M., Buszewicz, M. and Murphy, B. Supporting people with anxiety and depression: a guide for practice nurses. London: Mind. www.mind.org. uk/assets/0001/4765/MIND_ProCEED_ Training_Pack.pdf

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