

**REPORT**



**UNIVERSITY OF  
BIRMINGHAM**

Centre for  
Mental Health



## **Filling the chasm**

**Reimagining primary mental health care**

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## Acknowledgements

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## Executive summary

Primary care is at the heart of the NHS and it has a pivotal role in supporting and promoting our mental as well as physical health. Yet in recent decades national policy has left this to chance: mental health has been on the margins of primary care policy, and primary care has likewise been marginal to mental health policy.

Despite this, a growing number of local areas have sought to fill the gap with new services that meet people's needs in a range of ways. These innovations provide a starting point for the more systematic approach we need to support primary mental health care nationwide.

We visited eight local areas which provided a range of different approaches to meeting people's mental health needs in primary care:

- Bradford
- Cambridgeshire and Peterborough
- Catterick
- Cornwall
- Norfolk and Suffolk
- Northamptonshire
- Swindon
- Tower Hamlets

We found that many of the innovative services were successfully meeting the needs of people who are not helped by existing primary or secondary care mental health services. None provided a complete primary care mental health service with the capacity to address the broad and diverse range of needs of people using primary care. Nonetheless, all had developed creative solutions to longstanding problems and gaps in support.

Learning from these new approaches, we have been able to identify the likely key elements for future developments in primary mental health care:

### 1. Identifying the opportunities for prevention and the promotion of positive mental health

- Promoting mental health in the perinatal period;
- Ensuring early intervention for mental health problems, particularly for children and young people;
- Providing information and resources to enable people to manage their mental health including community assets.

### 2. Maximising social interventions for mental health

- Moving away from prescriptions for anti-depressants and psychological therapy as the only solutions to common mental health problems;
- Building awareness of community resources that GPs seldom know about, through 'linkworker' or 'navigator' roles;
- Embracing social prescribing as an opportunity to bring together community resources and maximise social interventions;
- Linking to voluntary sector initiatives focused on promoting mental wellbeing and providing crisis support.

### 3. Culture change – embracing the holistic approach

- Valuing social support that is not necessarily labelled as 'mental health' care – covering multiple dimensions e.g. social contact, employment/vocational support, housing, benefits, debt advice, exercise, healthy eating, alcohol management, sleep etc;
- Linking to physical health initiatives – e.g. smoking cessation, long term conditions, integrated care pilots;

- Embedding a holistic approach into ‘usual’ primary care services rather than seen as an extra – which requires different reporting techniques to NHS England (measuring social recovery rather than traditional clinical scales).

#### 4. Empowering the person – moving ‘from patient to person’

- Enabling people to make their own decisions about what they need to focus on in their life – whole life mapping, recovery college style approach;
- Identifying clear routes into support to address social factors and the causes of their mental health problems – domestic violence, sexual abuse, debt, housing, welfare benefits;
- Valuing social contact, volunteering, hobbies and employment.

#### 5. Bridging the gap between primary and secondary care

- Employing senior staff (such as a psychiatrist or psychologist) to provide supervision, consultancy or support to GPs and other workers;
- Giving staff powers to refer onwards (e.g. Primary Care Liaison Workers in Northants can refer to the crisis team and act as gatekeepers between primary and secondary);
- Co-locating primary, secondary and ‘in-between’ services: information sharing is easier when co-located especially if involving third sector partners – it happens naturally rather than having to set up new processes or platforms;
- Funding sourced from both primary and secondary care budgets.

To support the future development of primary mental health care across the country, we need to see a far greater focus on this in national policy, and significant investment. Specifically we recommend:

1. NHS England should make primary mental health care a central strand of the NHS Long-Term Plan and all future strategies for both mental health and primary care. This needs to be supported by clear implementation guidance and a set of standards to provide a basis for development and accountability.
2. NHS England should support clinical commissioning groups, Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to commission differently to support the development of new models of primary mental health care. This could include commissioning models that support a system-wide approach, for example through alliance contracting, pooled budgets (health and social care) and population-based funding models.
3. Public Health England should identify the scope and activity for health promotion and prevention in relation to mental health in primary care.
4. NHS England should develop appropriate outcome measures for mental health in primary care. In particular, the IAPT programme should review its outcome measures to incentivise and support local services to support people with more complex needs.
5. Health Education England should develop workforce plans to build the capacity of primary care in relation to mental health. This is likely to include both upskilling of existing primary care staff and expanding specialist roles including peer supporters and link workers.

## Introduction

GPs and primary care are the first port of call for many people experiencing poor mental health. The vast majority of people with mental health conditions in England do not have contact with specialist mental health services. About two-thirds receive no support at all from the NHS, and most of those who do are in contact only with primary care services. This includes a growing number of people who are ‘stepped down’ from specialist services as well as those who are referred but do not meet local secondary care thresholds (which are variable across the country), including many with complex psycho-social situations implicated in either poor mental health or physical health problems, or both.

Because of its relative accessibility and universal coverage, primary care has a critical role to play in both treating mental health difficulties and preventing problems from occurring or escalating. However, GPs and their colleagues often find themselves without the time, resources or capacity to respond effectively and make the most of their potential. Thus, key opportunities to address poor mental health for individuals and their families, and to build the resilience of people living in their area, may be missed.

This challenge has not gone unrecognised and yet the role of primary care in mental health has rarely been the focus for policy development or attracted the same level of attention as specialist mental health services in England. As a consequence, individual practices and clinical commissioning groups (CCGs) have developed their own arrangements, and there has been a burgeoning of initiatives that seek to offer more effective support for people’s mental health needs in primary care (NHS Clinical Commissioners, 2017a). The scoping of developments across London by the Healthy London Partnership, for example, highlighted a lack of confidence and capacity in primary care to respond effectively, a lack of clarity of

roles between primary and secondary care, and concerns about the sustainability of initiatives that are being developed to address the need for support at a primary care level (NHS Clinical Commissioners, 2017a).

This means that the mental health support that people are offered in primary care will depend on local developments and the interest and commitment of local GPs and colleagues to strengthen the mental health offer. We therefore know very little about what constitutes good quality primary mental health care and how to improve access to effective support for those who currently do not get the help they need as well as fully realising primary care’s role in prevention. But there is a lot we can learn from the many different initiatives that are emerging in order to build a more solid evidence base and raise the profile of primary mental health care nationwide.

This briefing paper seeks to identify promising initiatives that could provide the basis for a framework or set of standards for primary mental health care to support commissioning and provision. It is a collaborative effort between GPs with an established track record in this area, in partnership with the Health Services Management Centre and Centre for Mental Health, who each bring expertise in mental health systems and service development. To create this report we have held meetings, undertaken a rapid appraisal of the literature informed by the review undertaken by the Healthy London Partnership (NHS Clinical Commissioners, 2017b), sought examples of good practice through a call on the Centre’s website and followed these up with telephone interviews or visits to eight local areas. We have also interviewed GPs who are leading developments in this area in their practices. The aim of these interviews has been to identify emerging positive practice, the challenges to developing capacity in primary mental health care, and how these may be overcome.

## The value of primary care in mental health

Primary care is uniquely positioned as a front-line universal service to provide an effective and early response to people experiencing poor mental health and to play a critical role in prevention. It is the first port of call for many people and, therefore, the decisions made at this point can be critical in determining access to effective support and securing continuity of care when people are discharged from specialist services. Primary care has a pivotal role to play in integrating mental and physical health, including managing the physical health needs of people with severe and enduring mental illness, people with medically unexplained symptoms and people experiencing psychological symptoms associated with their physical health, for example cancer, chronic pain and other long-term conditions.

Being located where people live means that primary care can also provide a more holistic response working with other local services to respond to the complex difficulties people may face. Therefore, there is the potential for primary care to work closely with other health services, local authorities, and community and voluntary sector organisations to co-produce not only primary care provision but to influence the development of specialist mental health support and other services that meet people's needs.

People who would benefit significantly from improved primary care support for their mental health and emotional wellbeing include:

- People with difficulties linked to childhood adversity and other traumatic life events, and ongoing violence and abuse;
- People with co-occurring long-term physical conditions and mental health problems;
- People with medically unexplained symptoms (or persistent physical symptoms);
- Women during pregnancy (and their partners) and with young children;
- Children and young people with early signs but not diagnosable mental health difficulties;
- People with a diagnosis of personality disorder or complex post-traumatic stress disorder;
- People who make regular use of emergency services;
- People with neuro-developmental difficulties;
- People with learning disability and co-existing mental health needs;
- People in or on the edges of the criminal justice system;
- People with a severe mental illness and poor physical health.

## Challenges facing primary care to respond to mental health needs

Despite the clear value of primary care in supporting people’s mental health and wellbeing, there are distinct gaps in capacity, which have emerged as a result of system design problems.

In particular there has been a lack of national focus on primary mental health care and thus very little investment. A major challenge is that there is no national mandate and no support to establish primary mental health care as a priority. As one GP told us: “It is like pushing a rock up a hill trying to get any traction on primary mental health care.”

Consequently practices and CCGs have developed different initiatives and this pragmatic approach has led to variations in access and quality of provision. The key challenges facing the capacity of primary care to support mental health include:

- Complexity and variety of people’s needs coupled with limited time for GP consultations;
- Wider challenges and changes in primary care that focus resources and attention on other issues;

- The lack of data and intelligence to drive service development;
- Inconsistency in interest and skills of the primary care team;
- Rising thresholds and changing patterns of secondary mental health services in many areas;
- Inconsistencies and gaps between local and regional commissioning;
- Inconsistency in the inter-operability of primary and secondary software systems.

All of this is in a context of the challenge of investment in both primary care and mental health more generally, both of which are under pressure from rising demand. It is therefore often challenging to reinvest fully when the locus of care and support shifts from specialist mental health services to primary care. This requires rethinking capacity in primary care and developing models for provision that integrate primary care with community mental health support; maximising the opportunities in primary care for prevention, early intervention and self-management; and ensuring that there is continuity of care to provide a safety net for people with enduring mental health problems, including self-harm and suicidal thoughts.

## The current context

Since the conclusion of the National Service Framework for Mental Health in 2009, there has been an increasing volume and breadth of mental health policy output from central Government. Mental health has risen in profile as a policy priority and policymakers have sought to make mental health both a bigger priority for the NHS and a concern for the whole of government, locally and regionally as well as nationally. Yet most of this has bypassed primary care and left gaps in the system for some groups.

### ***Improving Access to Psychological Therapies***

The highest profile, and arguably highest impact, policy has been the creation and continued expansion of the Improving Access to Psychological Therapies (IAPT) programme, which began in 2008 in two local areas for adults with common mental health problems and which has since expanded to cover the entire country and a wider range of client groups, including children and people with long-term physical conditions.

The development of the IAPT programme over the last decade has enabled more people with common mental health problems (according to recent estimates, close to one million a year) to receive psychological therapy for depression or anxiety (NHS England, 2017). But it has been noted that many people with more complex mental health needs either do not 'recover' through contact with IAPT services or are excluded from them altogether (Durcan *et al.*, 2017). At the same time, however, specialist mental health services have faced many years of financial pressure and reductions in both inpatient and community service provision at a time of growing demand for their support (Centre for Mental Health, 2017). This has generated some concern about a perceived gap between IAPT and secondary mental health care, as community mental health teams seek to discharge people from their caseloads or raise their thresholds to manage demand.

### ***Primary care and complex needs***

Four years ago, Centre for Mental Health published an economic analysis of a service designed to address a significant part of this gap, the Primary Care Psychotherapy and Consultation Service in City & Hackney (Parsonage *et al.*, 2014). The service provides both direct psychological therapy to people with complex mental health needs (including those with medically unexplained symptoms, personality disorder diagnoses, and complex mental and physical health difficulties) and consultation with GPs. In a subsequent report to the Mental Health Taskforce, the Centre called for this approach to be replicated nationwide and identified the economic as well as health benefits of doing so (Parsonage *et al.*, 2016).

Despite this evidence, plans for a service of this type were not included in the *Five Year Forward View for Mental Health* (Mental Health Taskforce, 2016) and few CCGs have been noted to have commissioned equivalent services in their local areas.

Indeed it is notable that neither *No Health without Mental Health* (the cross-Government strategy published in 2011) nor the *Five Year Forward View for Mental Health* has any significant focus on primary care beyond the development of IAPT. Neither makes specific recommendations for the development or improvement of primary mental health services.

### ***Sustainability & Transformation Partnerships and Integrated Care Systems***

For the NHS as a whole, the predominant policy drive over the last two years has been the development of Sustainability and Transformation Partnerships, which in some areas are already evolving into Integrated Care Systems, with an aim of eventually creating Integrated Care Organisations that will bring together commissioners and a range of providers to meet health needs within an area.

These new arrangements have been created in order to bring about service change on a larger scale than has been possible through existing commissioning arrangements and have seen a growing number of local areas establish new integrated services in primary care – predominantly for older patients with complex physical health needs. Very few of these have yet explicitly included a mental health dimension in their service offer (Naylor *et al.*, 2017).

Last year, the Centre examined a sample of six (out of a total of 44) randomly selected, widely dispersed Sustainability and Transformation Plans (as published in October 2016)<sup>1</sup> to assess how far they had identified and prioritised the needs of people with complex mental health needs within primary care.

None of the STPs examined had a specific focus on meeting complex mental health needs in primary care. All had a work stream for mental health but for the most part their priorities were aligned with the key deliverables of the *Five Year Forward View for Mental Health* and focused on making improvements to secondary mental health services (particularly in relation to crisis care and hospital admissions) and/or on meeting nationally mandated targets (for example for IAPT access and recovery).

The partial exception to this point was Norfolk and Waveney, whose mental health work stream included the provision of: “Psychological Therapists in out-of-hospital services...for people with physical health needs targeted at conditions with high co-morbidity” and “additional primary care support targeted at local practices with the highest levels of need, including mental health practice nurse roles, and GP champions” (Norfolk and Waveney STP, October 2016).

Bristol, North Somerset and South Gloucestershire STP, meanwhile, set out plans (similar to those described in the Vanguard programme) to “include mental health

professionals in locally based multi-disciplinary teams at ‘GP cluster’ level...”

*“All staff within multi-disciplinary teams will have the skills to provide psychologically informed interventions... Some will additionally provide talking therapies, counselling and social prescribing to address mental health issues, including depression and anxiety.”*

(Bristol, North Somerset and South Gloucestershire STP, October 2016)

It is, however, notable that STPs all set out plans to manage demand and improve experience in relation to primary care (though not on the whole in relation to mental health) and to develop multidisciplinary teams around general practice to improve care for populations needing long-term support. Birmingham and Solihull STP, for example, describes plans for an ‘integrated primary and community care service’ in Solihull that combines existing primary care and community care in a way that “wraps around the needs of the patient, using an MDT [multi-disciplinary team] approach for at risk cohorts such as complex health and frailty” (Birmingham and Solihull STP, October 2016).

A number of STPs are evolving into ‘Integrated Care Systems’ that bring together a range of providers of health and care services in a local health economy. They include Frimley, in parts of Surrey and Berkshire, whose proposals include a major work stream to “lay the foundations for a new model of General Practice provided at scale” through GP federations. Improved mental health support is cited as a major focus of this development: specific proposals for achieving this include integrating “mental health practitioners in extended primary care teams” and “clinician to clinician video consultation” (Frimley STP, October 2016).

All of these developments bring with them an opportunity to embed mental health support into the proposed new models at scale: it remains questionable how many will take it.

<sup>1</sup> Birmingham and Solihull; Bristol, North Somerset and South Gloucestershire; Frimley; Lancashire and South Cumbria; Norfolk and Waveney; West Yorkshire and Harrogate

## Profiles of local services

### 1. Bradford

The Primary Care Wellbeing Service (PCWBS) works with patients with unexplained medical symptoms and long-term conditions who are flagged by GPs as frequent attenders to primary, secondary and/or emergency services. These patients will have gone through numerous treatments, assessments and sometimes invasive and traumatic investigative surgical procedures. PCWBS therefore focuses on a group of patients who both individually and collectively are extremely costly to the NHS, and whose presentation to statutory services is likely to have a psychological element.

The service is funded by the CCG and works primarily in four practices. It has a multi-disciplinary team with clinical psychology leadership and a range of psychological therapists. The PCWBS has attracted significant interest locally due to its holistic approach and collaborative work with GPs to support people who attend frequently more effectively. PCWBS has also attracted further interest in funding in other clinical populations and now offers a community tertiary service to patients presenting with chronic fatigue who historically would go out of area.

The original PCWBS was across three GP practices and identified with the practices their 'top ten' most costly patients with unexplained medical symptoms and long-term conditions. The patient profile is very variable and include children, older people, people with learning disabilities, those with autism or neurodevelopmental disabilities, palliative care and drug and alcohol difficulties. Most patients will very often have had treatments, numerous assessments and invasive investigations including surgery, as well as being on substantial amounts of medication (including high levels of opioids).

Because of its particular focus, PCWBS places a huge emphasis on assessment and this includes a detailed file review prior to referral by GPs. A GP is required to do this before

referring someone who is a frequent attender and who has unexplained medical symptoms.

*"...it is often not until we have had such a detailed look at all the patient's history that we see likely particular explanations for the patient's symptoms...usually we suspect something is amiss, and suspect that referral for more medical investigation is not likely to be helpful...but the nature of GP practice is that there is little time for such reflection...I have found people who have histories of significant psychological trauma and others with possible neuro-developmental or autistic spectrum disorders through file review..."*

The PCWBS reviews each referral in a multi-disciplinary meeting and generally offers an appointment within two weeks. PCWBS delivers a matched care approach, meeting the patient's needs and offering the patient access to the professionals they need to see at that time. This reduces the risk of multiple assessments and may require joint appointments with GPs, consultants etc. It is a proactive service and will pursue patients who do not attend appointments and will put energy into engaging them.

PCWBS describes itself as a 'cost saving' service, due to its intensive nature working with all agencies in the patient's care and its holistic focus on physical and psychological wellbeing. The model has a shared understanding with patients on reducing unnecessary and potentially harmful investigations, medications and surgery, and supporting patients with adherence to necessary treatment plans.

### 2. Cambridgeshire and Peterborough

The development of PRISM (Primary Service for Mental Health – for planned care) happened in tandem with the introduction of a First Response Service for people experiencing a mental health crisis (unplanned care). PRISM takes responsibility for the whole population and the service is based on need, not diagnosis.

The PRISM mantra is “don’t just screen, intervene”. The initial development consisted of aligning and basing mental health staff within practices and having clinical records from secondary care accessible on the primary care system. The next phase of development involved aligning Consultant Psychiatrists with practices and ensuring that mental health service users ‘stepping down’ from secondary care are managed collaboratively. The role of primary care in the physical health of people with mental health problems and in medication monitoring is also being developed.

At the time of our visits, the CCG had retendered, jointly with the local authority, for a recovery service to be integrated with PRISM and had on their agenda integration with social care and review of secondary care treatment pathways.

These developments in Cambridgeshire and Peterborough are ambitious and provide an example of the redesign of primary mental health care as one element of a whole system approach to mental health. PRISM links to developments in secondary care and is supported by improved integration between mental health and substance misuse services (with a Memorandum of Understanding in place). There is clear recognition of the value of the contribution that the voluntary sector makes, and the CCG and local authority have developed an alliance model for commissioning third sector services.

The early outcomes indicate a reduction in referrals to secondary care, a reduction in the time that people are waiting for an assessment, and positive feedback from GPs on the consultant involvement and pilot of case discussions.

### 3. Catterick

A Consultant Clinical Psychologist was involved in a pilot project over two years, embedded in a GP practice in Catterick Garrison, North Yorkshire. The aim of the pilot was to see if a psychologist could work like a GP, offering brief 15 minute appointments that could be booked

by anyone registered in the practice as either single or double appointments.

The service was a non-referred service, with no exclusion criteria; and it was available to all ages. The consultant worked five days per week, and had a third year trainee clinical psychologist on placement for three days per week for six months in the second year of the pilot. This service was part funded in its first year by GP grant monies and Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV). The second year was funded entirely by the Trust and the service ran up to June 2018. At the time of Centre for Mental Health’s visit, the service had been running for 17 months. The statistics provided below are from an evaluation at 22 months.

GPs and other primary care practitioners could book an appointment with the psychologist or patients could refer themselves. Capacity was always maintained, appointments were embargoed for on the day or 48 hour access. On the day we visited a cancellation was near enough instantly filled so that a patient was seen within a few minutes of the appointment being booked.

The aim of this service was to fill the increasing chasm between what is easily managed in primary care and that which meets the threshold for entry to secondary mental health care. The service enabled earlier intervention, preventative working, more open access and flexible service provision (compared to secondary care), and also a form of triage and assessment for people who may ultimately be referred to secondary care. The practice that the service worked within was perceived as a high referrer to secondary care and this was part of the motivation in establishing it. Audits of the service indicate that referrals to secondary care reduced from the practice by 27% when compared to pre-pilot figures.

The style of operation was very much like that of a GP with twenty 15-minute appointments offered during the day, 70 appointments per week, as well as additional telephone consultation appointments. Some people would receive double appointments, particularly

when they received guided psychological intervention. In practice 42% of appointments offered were 15 minutes long and 58% of appointments were for 30 minutes. The proportion of people who had one appointment was 35%, with 65% having more.

There were no exclusion criteria and the consultant saw people with relationship, substance misuse, mood, anxiety, psychological trauma, and parenting problems, as well as people on the autistic spectrum and with marked mental health problems. Many of the patients seen had a level of complexity that meant services such as IAPT would not be suitable, would be unlikely to accept them, and the IAPT therapeutic offer would not be enough to meet their needs. The service on offer at Catterick attempted both to be highly accessible and also tailored to individual need. The age range of patients was equally diverse with the youngest patients just a few months old and the oldest being over 90 years.

After 22 months of operation the consultant had offered 2,668 appointments to 844 individuals, and 2,047 of these appointments were attended face to face by 755 individuals. The service also provided telephone interventions and 211 individuals received 394 telephone appointments. Some of these also had face to face appointments, but 89 people had telephone interventions exclusively. Therefore, the total clinical interventions offered over 22 months was 3,062 appointments with 844 individuals.

A third of the people who were seen face to face were referred on to other services for further intervention, for example to TEWV or other services including Help for Heroes, while the remaining two thirds were supported within primary care.

GPs and primary care staff highly valued the pilot project and benefitted not only from having a readily accessible psychological and mental health service, but also from rapid access to consultation with the consultant psychologist. The service was very much integrated into the practice and present at all practice clinical meetings.

## 4. Cornwall

A community link worker support service is delivered by Pentreath, a registered charity operating across Cornwall. Referrals for the project come exclusively from primary care. Anyone referred gets a one-to-one community link worker assigned to them.

This service is co-funded by Cornwall Council and NHS Kernow and is commissioned separately from the IAPT service.

Referrals are accepted from GPs and Outlook Southwest (the local IAPT service). The link workers then offer between three and six one-to-one sessions. These sessions are flexibly delivered in a location which is convenient for the client. The service uses a 'Whole Life Map' approach to identify the life domains which the client wants to work on, viewing wellbeing holistically, rather than physical and mental health being separate domains.

The link workers build up a toolkit of what support and activities are available in the local area, then help individuals complete an action plan, tailored to their needs and goals. This may include wellbeing workshops or peer learning/development courses which help to share good practice.

*"The idea is that when someone takes responsibility for these decisions, they are learning more about their own mental health and they have a better chance of getting better. It's a bit like the Recovery College model – moving the person from being a patient to being a student."*

The service was intended to broaden the options available to people presenting in primary care or IAPT with a mental health need, beyond psychological therapy and medication.

The key intervention through the project is to identify what psychosocial support is required and ensure the person is engaged with that support. This is often provided by organisations other than Pentreath, for example support with benefits or housing.

## 5. Norfolk and Suffolk

Five CCGs in the two counties partnered with three local Minds and Relate to put together a full bio-psycho-social model of primary care. They aim to provide both psychological interventions and social support to help people access activities and resources that sustain their recovery. The five CCGs purchased the service as part of a large contract for primary care mental health services, including IAPT. There are two years left on the contract with the possibility of a further two years.

The service is open to anyone over the age of 16. Referrals can come from anywhere, including self-referral and referrals from professionals and workplaces. The service has worked closely with local employers and communities to develop these routes. The service offers a named clinician for every GP to support them. The service offers interventions through group work or one-to-one through skype and instant messaging.

The aim of the service is to provide an offer that includes IAPT but also goes wider. Many people's needs were greater than what IAPT could offer, and there were people who needed social support without psychological therapy. To achieve this, it sought to create networks and deliver a service in close partnership with the voluntary sector. And peer support was an integral part of the service – a conscious decision was made to spend on recruiting paid peer support workers and to introduce peer-to-peer supervision and 'lead' peer support roles.

The team comprises a wide range of disciplines, including IAPT therapists and 23 peer support workers, who co-facilitate most groups run by the service. For example, people who may feel they are experiencing stress, anxiety, and low mood can come in and the initial story will be from an individual who was in their position a year ago, who talks about their experiences. The rest of the session may then be run by a clinician. These clinical groups are based in one of a number of hubs or in a GP surgery, depending on the area.

Everyone using the service makes their own decisions about what they want to do for their

recovery and the peer support worker supports them to achieve it.

The service looked at how to build community resilience and introduced posts called Local Associate Coordinators (LACs) which are similar to a community development worker and which provide training to significant members of communities in how to open up conversations about mental health and refer people to the service.

LACs help people who come through to the service to set up "socials". The service asks people to register their interests and then the LACs set up events in local places: for example running or gardening. These aren't labelled as mental health groups; they are groups where people who have similar interests can come together.

Anyone who comes into contact with the service is invited to become an 'associate' of it and help reach further into communities and coproduce the service offer. This underpins the pathway through to paid peer support work. There are around 4,000 associates currently listed.

Psychiatrists are also part of this service and will hold people on their caseload while they are accessing the service. GPs can call the psychiatrist for advice and then deliver that to their patients. In addition the service has its own GPs who have a special interest in mental health.

If someone is at imminent risk there is a fast track programme where the service can ask the crisis team to undertake an assessment in four hours. There is also an out of hours crisis line.

Mental health practitioners within the service can hold small caseloads of people who have more complex needs – this has helped to some degree to address people in the 'grey zone' between primary and secondary care services. This could be increased and help to address need rather than be driven by 'clusters'.

We asked about the impact the service has had in the wider system. We were told that it has generated wider culture change in both the Trust and primary care, and helped embed a holistic approach to wellbeing in the local area.

We were also told that the service has created a trusted ‘brand’ in wellbeing – people know it and it has a positive reputation. It has generated increased demand for prevention-based activities such as workshops in schools. Language has also been identified as important: calling it ‘wellbeing’ rather than a ‘mental health’ service, and avoiding labelling. Lived experience and peer support have also become normalised – often the first contact in the service is someone with lived experience.

## 6. Northamptonshire

The service model has developed from a partnership between commissioners, mental health providers and the third sector. The model is based on a stepped care approach, a single point of access within a multidisciplinary model of care.

It was commissioned by Nene and Corby CCG and Northamptonshire County Council in partnership with the voluntary sector. The initial workforce included:

1. Primary Care Liaison Workers (PCLWs)
2. Psychological Wellbeing Practitioners and High Intensity workers from the Improving Access to Psychological Therapies (IAPT) programme
3. Consultant psychiatrists
4. GPs and primary care staff
5. Community Navigators employed by Mind
6. Voluntary sector staff (Mental Health Northants Collaborative is a partnership of mental health charities working together across the county)
7. Wellbeing Navigators (navigators based on traditional public health and wellbeing roles) – this service was decommissioned in 2018
8. Social workers (these were intended to be part of the team however were withdrawn almost at the start)

The service was set up in the context of a strong existing network of voluntary sector organisations in the county, which have been commissioned collectively for some time.

PCLWs are Northamptonshire NHS Foundation Trust employees, who are based in a GP surgery and are the first point of contact for people who are referred into mental health services. They have up to six one-to-one sessions and provide:

- Triage, assessment, extended assessments;
- Problem identification and goal setting;
- Psychosocial and psychological therapeutic interventions;
- Mental health promotion, to include information and self-help;
- Gate-keeping role to secondary mental health services;
- Practice staff training and support;
- Community interventions, delivered in line with the stepped care model;
- Access to psychological therapies where the individual does not meet the criteria for IAPT due to risk, complex problems or enduring poor mental health.

Referrals into the navigator service are through self-referrals, GP or other health care professionals, schools and Job Centres. Navigators provide up to six weeks of one-to-one support or signpost individuals on to other services. Unlike PCLWs, the navigator service may work with children and young people in transition. Its functions include liaising with local community groups, providing information to people experiencing difficulties with their own wellbeing or that of family members’, and providing assessment and intervention, usually through motivational interviewing, ensuring people are supported and provided with the necessary signposting.

The service also aims to expand peer support and employment/vocational advice, building an understanding of the effect that meaningful activity has on a person’s overall wellbeing and ability to self-manage and stay well. It also recognises a need to maximise the spiritual elements of wellbeing which are largely ignored even in a bio-psycho-social model.

In interviews during our visit, it was felt that the service did successfully provide a step-down service for people being discharged from CMHT.

This offered one-to-one support for a period of time, provided information about community resources and facilitated access to Mind support groups and wellbeing workshops which smoothed the transition.

The PCLW element also performed a step-up and step-down role. It was able to refer people to secondary care where necessary, and refer for rapid/crisis assessments within two days. This avoided the need for being sent back to the GP for referral on to secondary care, and enabled a quicker crisis response. Community Navigators can also refer people to the crisis team if they are concerned.

## 7. Swindon

The LIFT Psychology service in Swindon is attempting to provide for the huge and increasing gap between what can be feasibly offered by a GP and the level of need which will be accepted into secondary mental health care. What it also provides is a model of what an upscaled primary care psychological wellbeing service can look like. It is the commissioned IAPT service for Swindon, but makes a much broader offer. It services all 26 GP practices in Swindon (population estimated in excess of 216,000) and is available by self-referral for any patient registered at one of those practices.

Unlike many established IAPT services, it has few exclusions and aims to be widely accessible. It does not have an upper age limit, but only sees those aged 16 years or older. About a quarter of those who use the service are aged 25 years or under. The only exclusion criteria are for people with an acute episode of psychosis requiring more urgent help and those who cannot guarantee their safety overnight. LIFT does however work with people who have stable psychosis, and in some cases jointly works with secondary care on more complex cases. It also reports working with people with levels of risk that most primary care psychological wellbeing and IAPT services would not be able to manage.

More than 90% of people referred into mental health services from Swindon by primary care will be seen by LIFT first. LIFT sees around 650 people per month.

Normally those referred to the service are seen within 2-4 weeks; LIFT tries to give access to an intervention very quickly.

There are 43 practitioners working in the service (equating to 28 full-time equivalent posts), and within this there is a breadth of skills and specialisms, allowing the service to offer a range of psychological interventions.

LIFT aims not to exclude anyone (except those who require an urgent response from specialist mental health care) and offers a range of groups called psycho-education classes (a more acceptable label and style of offer to many people) covering topics such as mindfulness, anger management and bereavement. LIFT offers walking groups, singing groups and many more besides, and most of these are on regular rolling programmes. For people who require a more intensive response, more formal therapy groups are on offer, as are one-to-one psychological therapy sessions. More formal offers are not usually made unless someone has been to LIFT for 2 appointments. Many people will attend once or twice but are encouraged to come back if they want further help.

Mindfulness has been found to be particularly useful for many patients and especially for those for whom CBT is unlikely to be helpful.

*“...usually people can find something of use in our service...”*

Typical session lengths are in the region of 45 minutes in the GP surgeries. LIFT sees itself as an early intervention service and so places much less emphasis on lengthy assessment processes than secondary care services.

As an IAPT service, LIFT reports achieving above average results in terms of access and waiting times and average recovery outcomes, which is a significant achievement given that it works with people with a wide range of difficulties and not solely anxiety and depression.

A major challenge for LIFT (and indeed primary care) is that secondary mental health care has become increasingly stretched and consequently LIFT has had to support people with more complex needs.

## 8. Tower Hamlets

The Tower Hamlets service, provided at the time of our visit by Compass Wellbeing (a London-based Social Enterprise) was funded by Tower Hamlets CCG to provide several services:

- A GP surgery-based psychological therapies service;
- An Improving Access to Psychological Therapies (IAPT) service;
- An Eating Disorders in Primary Care service;
- A Primary Care Perinatal and Under 5s Psychological Therapies service;
- An Asian Counselling service;
- A Disability and Health Counselling service.

In addition, Compass Wellbeing provided a school health service within the borough, and a Family Nurse Partnership service (for teenage mothers from pregnancy to the child's second birthday). With the exception of these and the perinatal service, Compass Wellbeing worked with people aged 18 or over who were registered with a Tower Hamlets GP.

The model Compass Wellbeing provided aimed to:

- Deliver accessible, high quality, psychological therapies in primary care in a way that involves active collaboration with other members of the primary care team as well as patients;
- Support the primary care team to navigate the system of mental health services in order to help patients to receive the right help as soon as possible;
- Raise the quality of mental health input and delivery across primary care;
- Provide responsive, culturally appropriate and effective psychological support in primary care, facilitating referral to secondary care mental health services only when necessary.

They provided a practice-based service with a psychologist or counsellor attached to each GP surgery across the borough delivering the following:

- Training, advice and consultation to GPs to enable and support them to address mental health issues with their patients more effectively and confidently;
- A comprehensive assessment of patients where GPs are unclear about the presenting difficulty or about where to refer a patient;
- 'Bridging interventions' for a group of patients who require psychological work out of the scope of IAPT, but needing additional support to attend the secondary or tertiary care services they may ultimately require;
- Collaborating with GPs on prescribing;
- Providing training and advice to primary care staff;
- Working in close collaboration with the GP practice service, with patients being stepped up or down as needed.

The eating disorder service was provided by a specialist psychologist who offered psychological therapies for people with mild to moderate eating disorders and regular internal training to the wider staff team, to aid identification and engagement from point of referral.

The Perinatal and Under 5's Psychological Therapies Service comprised a small team of perinatal clinical psychologists based in primary care and children's centres. The service provided both direct clinical work to parents and their infants, couples work and group work to promote secure attachment and address perinatal mental health issues, as well as support and advice for the wider team in primary care and the community. They had also developed a more specialist IAPT perinatal offer.

The Asian Counselling service was delivered by counsellors from Asian communities providing therapy in Bengali, Sylheti, Urdu and Punjabi involving:

- A culturally specific service which works through issues such as stigma, feeling judged and fear of people within the community discovering they have used mental health services;

- Working on a variety of issues from common mental health difficulties to management of domestic and family violence.

The Disability and Health Counselling Service worked with patients with physical disabilities, sensory impairments and long-term health conditions, including neurological and auto immune conditions and cancer. It also worked with carers. This client group faced complex challenges, resulting from their physical and mental health problems, including impact on their economic, family and social lives and having to navigate the social care and benefit system. A holistic approach was therefore taken bringing mind and body together.

Compass Wellbeing said it saw the importance of building relationships with the general practices it supported and did this primarily by integrating practitioners into primary care surgeries. This, and building links with local communities, was seen as key to understanding and meeting need using a relational integrated approach with primary care staff, community services and local people.

Compass Wellbeing therapists provided a range of evidence based therapies including Cognitive Behavioural Therapy, Dynamic Interpersonal Therapy and Systemic Therapy, as well as specialist counselling for people with disabilities and health conditions, and cross-cultural counselling.

## Analysis

The eight models of support we visited for this project offer a diverse range of services.

Several face significant funding challenges, and two have closed or been recommissioned from other providers since we visited them. It is notable that the service that faced the least funding challenge and which was the most secure, LIFT in Swindon, is also an IAPT service, but makes a much broader offer and with none of the exclusions that are present in many IAPT services. Many of the services we visited were established, at least in part, in recognition of a considerable number of people who cannot, for a variety of reasons, have their needs met by IAPT alone.

None of the services make a total or complete primary care psychological or mental health offer, even though many of the models serve a range of clients and some have very few exclusion criteria. Yet by combining the different approaches we have seen, a comprehensive primary mental health care service could be envisaged. Some of the key elements in such an approach would include:

- 1. Identifying the opportunities for prevention and the promotion of positive mental health**
  - Promoting mental health in the perinatal period;
  - Ensuring early intervention for mental health problems, particularly for children and young people;
  - Providing information and resources to enable people to manage their mental health including community assets.
- 2. Maximising social interventions for mental health**
  - Moving away from prescriptions for anti-depressants and psychological therapy as the only solutions to common mental health problems;
  - Building awareness of community resources that GPs seldom know about, through ‘linkworker’ or ‘navigator’ roles;
  - Embracing social prescribing as an opportunity to bring together community resources and maximise social interventions;
  - Linking to voluntary sector initiatives focused on promoting mental wellbeing and providing crisis support.
- 3. Culture change – embracing the holistic approach**
  - Valuing social support that is not necessarily labelled as ‘mental health’ care – covering multiple dimensions e.g. social contact, employment/vocational support, housing, benefits, debt advice, exercise, healthy eating, alcohol management, sleep etc;
  - Linking to physical health initiatives – e.g. smoking cessation, long term conditions, integrated care pilots;
  - Embedding a holistic approach into ‘usual’ primary care services rather than seen as an extra – which requires different reporting techniques to NHS England (measuring social recovery rather than traditional clinical scales).
- 4. Empowering the person – moving ‘from patient to person’**
  - Enabling people to make their own decisions about what they need to focus on in their life – whole life mapping, recovery college style approach;
  - Identifying clear routes into support to address social factors and the causes of their mental health problems – domestic violence, sexual abuse, debt, housing, welfare benefits;
  - Valuing social contact, volunteering, hobbies and employment.

## 5. Bridging the gap between primary and secondary care

- Employing senior staff (such as a psychiatrist or psychologist) to provide supervision, consultancy or support to GPs and other workers;
- Giving staff powers to refer onwards (e.g. Primary Care Liaison Workers in Northants can refer to the crisis team and act as gatekeepers between primary and secondary);
- Co-locating primary, secondary and ‘in-between’ services: information sharing is easier when co-located especially if involving third sector partners – it happens naturally rather than having to set up new processes or platforms;
- Funding sourced from both primary and secondary care budgets.

Achieving change has not been easy in any of the sites, however, and all have faced challenges. Rising thresholds for secondary care mean that some people seeking help from primary care services or IAPT need a higher level of support which they may be unable to offer. Funding constraints have also meant that many services emerge as ‘pilots’ with short-term funding and budgets ‘patched’ together from different sources that may not be sustainable.

There are also cultural challenges to overcome. In many areas, not all GPs have understood the value of social interventions, leading to variable levels of engagement and referral, particularly to voluntary and community sector services. Similarly, national policy for IAPT still favours a clinical model of ‘recovery’ that undervalues the approaches being taken in many of the services we visited, and puts their future at risk as a result.

## Implications for policy and practice

We now need system wide thinking to drive national policy, local strategies and workforce development. We need national policy that focuses on primary mental health care with clear implementation guidance and a set of standards to provide a basis for development

and implementation. This needs to be underpinned by principles that emphasise a population approach, that are responsive to people’s needs, with the flexibility to enable this, and that cover the full spectrum of need.

The changes required to enable this include:

1. **Commissioning models:** they need to be fit for purpose and enable a whole system approach.
2. **Changes to IAPT:** to recognise complexity in the measurement and evaluation of outcomes to enable people with more complex needs to get an effective level of support.
3. **Data:** Activity data needs to be transparent and shared between primary care and specialist mental health services. Any local health economy should be able to find out who is getting mental health support from what services, what is delivered and with what outcomes.
4. **Coordination:** Coordinating existing wellbeing and mental health services in primary care, linking self-help, social prescribing, appropriate therapeutic interventions, navigation and recovery. Elements include peer support, voluntary sector organisations, digital media, care bridging and navigation, and self-management.
5. **Collaborative care:** Narrowing the gap between generalist and specialist care, enabling people to step up and down between the two as their needs change, and providing integrated mental, physical and social care support. (See the box on page 21 for more information about the principles of collaborative care.)
6. **Coproduction:** Enabling shared goals and a shared understanding of holistic care, which should underpin everything. The National Survivor User Network’s 4PI principles (NSUN, 2015) are a useful framework for ensuring services are designed in partnership with the people they seek to serve.

7. **Workforce development:** GPs have very little training to address mental health in primary care. There is limited knowledge of up-to-date interventions such as motivational interviewing, and very few GPs have training in suicide mitigation despite being the commonest cause of death in people aged under 35. Only around 5% of practice nurses have training in mental health (despite increasing numbers providing frontline care). National and local workforce development plans need to prioritise primary mental health care, both to build the knowledge and skill of the core workforce and to ensure specialist input is available when needed.

## Collaborative care

Collaborative care is based on the principles of chronic disease management, and involves the addition of new staff ('case managers') who work with patients and liaise with primary care professionals and specialists in order to improve the quality of care for people with common mental health problems.

Case managers provide support, medication management and brief psychotherapies directly to patients, while liaising with the primary care and receiving support from a mental health specialist.

Collaborative care ensures that people are systematically followed up. If a person does not attend an appointment, for example, this is not assumed to be a reason for discharge: quite the opposite, attempts are made to re-engage.

Considerable efforts are made to work closely with primary care – including regular access to and entry in GP records, and supervision (clinical and case management) which is methodically organised and delivered by more experienced (and specifically trained) mental health professionals.

This approach was developed and extensively researched in Seattle. There is now considerable evidence for its effectiveness, especially for older people and also for those with co-morbid physical health problems, and it has been successfully rolled out in North America. It has now been successfully tested out in two large UK randomized controlled trials – the CADET and COINCIDE studies.

In these studies – and in Six Degrees Social Enterprise in Salford, where this approach has been successfully implemented in a service delivering step 2 IAPT services over several years – Psychological Wellbeing Practitioners (PWP) were successfully trained and supervised to deliver collaborative care.

Collaborative care has also been utilized for step-down/seamless step back up services for people with severe mental illness who are moving back to primary care. Evidence here is more limited, but a large UK study PARTNERS2 is in progress – and a naturalistic study in East London has demonstrated its potential benefits.

*Information kindly provided by Dr Linda Gask, University of Manchester*

## Recommendations

1. NHS England should make primary mental health care a central strand of the NHS Long-Term Plan and all future strategies for both mental health and primary care. This needs to be supported by clear implementation guidance and a set of standards to provide a basis for development and accountability.
2. NHS England should support clinical commissioning groups, Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to commission differently to support the development of new models of primary mental health care. This could include commissioning models that support a system-wide approach, for example through alliance contracting, pooled budgets (health and social care) and population-based funding models.
3. Public Health England should identify the scope and activity for health promotion and prevention in relation to mental health in primary care.
4. NHS England should develop appropriate outcome measures for mental health in primary care. In particular, the IAPT programme should review its outcome measures to incentivise and support local services to support people with more complex needs.
5. Health Education England should develop workforce plans to build the capacity of primary care in relation to mental health. This is likely to include both upskilling of existing primary care staff and expanding specialist roles including peer supporters and link workers.

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