LIVERPOOL PRIMARY MENTAL HEALTH CARE STRATEGY FOR ADULTS

2013 – 2016

Version 20th December 2014, updated February 2014
FOREWORD

This report has been prepared on behalf of Liverpool’s Health and Wellbeing Board and describes a new way of working in primary care and local communities which will directly contribute to the successful implementation of the Healthy Liverpool Programme and help Liverpool respond to the challenges it faces in meeting the mental health needs of the population. Proposals for primary mental health care aim to address dominant risk factors and make use of the evidence base for ‘what works’. These proposals have met with substantial support and approval throughout the stakeholder consultation and engagement process.

The key drivers for change and improvement in primary mental health care stem from increasing mental health need and a significant increase in demand for services, set in the context of unprecedented pressures on public services. The need for a preventive and recovery focused model of mental health care is well-recognised, but the current model remains one which prioritises the care of people with severe and enduring mental health, the majority of whom first come into contact with specialised mental health services at a time of crisis.

The strategy will build provision in primary mental health care for people across the spectrum of severity, using clinical leadership across the whole system, and harnessing local expertise. Approximately a third of people with serious mental illness are cared for in primary care, and though inpatient care relates to only 5% of Mersey Care activity it receives the lion’s share of the funding. Even a small shift in the balance of investment towards a community-based, prevention and recovery focused model of care could open up access to effective treatment for greater numbers of people. Making this shift while maintaining long-term financial sustainability will be one of the most significant challenges to the implementation of these plans and will require a collaborative and whole system approach, and the full engagement of our partners and local providers.

The new primary mental health model also requires us to listen to service users more effectively, to work in partnership with service users and patients to help them maintain their mental health and well-being, and co-produce recovery plans. Service users tell us that recovery is as much about talking and making sense of experience as it is about excellent clinical treatments, and report increasingly on the transformational nature of psychological therapies¹, and the importance of art, peer support, drama, spiritual dimensions, human connections. These types of services and support will become more accessible as the new strategy is implemented.

In response to increased pressures of household incomes, we have also incorporated an anti-poverty approach into the model. Benefits advice and debt management will be provided for those who face the double jeopardy of low income and poor health.

Finally we have included plans to improve the transparency and accessibility of services and support through the provision of an integrated gateway through which all primary mental health care services can be accessed.

The government has set out a national strategy for addressing mental health in No Health Without Mental Health\(^2\) and will issue an updated action plan early 2014. The Liverpool primary mental health strategy provides a local focus for the implementation of overarching objectives for improving mental health:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Liverpool Clinical Commissioning Group is committed to ensuring that existing NHS funded psychological therapies and related services are maintained until the new model of care is operational. We will work with our partners to deliver this primary mental health strategy on behalf of Liverpool’s Health and Wellbeing Board, working towards the realisation of the City’s strategic mental health objectives\(^3\) to:

- Support communities to achieve high levels of mental well-being
- Improve the integration of physical and mental health care
- Ensure that good mental health services are available for people experiencing an episode of mental illness.

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Chair of the Governing Body
Executive sponsor for mental health
Liverpool Clinical Commissioning Group

20\(^{th}\) December 2013


\(^{3}\) Liverpool City Council/Liverpool Primary Care Trust: *Liverpool Health and Wellbeing Strategy 2012 - 15: Laying the Foundations*, 2012
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1. EXECUTIVE SUMMARY

This report outlines plans for a new system for primary mental health care in Liverpool, which includes significant improvements to psychological therapies and access to non-clinical mental health support. Proposals are based on needs analysis and stakeholder engagement carried out between March – May 2013.4

The new model of primary mental health care in Liverpool will have a clear focus on prevention and early identification, and will promote self-management by patients, including use of personalised care plans. The approach to primary mental health care will be holistic: mental health has physical, psychological, social and spiritual elements.

For most people in Liverpool, their mental health problems will 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. This will prevent the need for secondary health or social care services for some, for others it will aid recovery and prevent a return to more intensive treatment.

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. To address this, services will be integrated and use a stepped care model. This will deliver evidence-based treatments that can be accessed via flexible referral routes, including self-referral, and offer a choice of psychological and non-clinical interventions. Care co-ordination (case management) and methodical management of care pathways will be improved.

This new approach will require GPs and other primary care workers to become much more aware of the ways in which appropriate support can be accessed and personalised, and to be prepared to use creative approaches to involve people at the receiving end of services. Co-production is much more than consultation. A creative approach will be taken to involving patients, service users, carers and their communities in designing and delivering the services they use at an individual and community level.

Access to mental health support and services for people with common mental health problems will become easier, helped the introduction of a primary care-based gateway into services, and supported by a new and detailed directory of services. The outcomes of primary mental health care services will be systematically measured and reported.

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4 http://www.liverpoolccg.nhs.uk/Health_Services/mental_health.aspx
The new model of care for Liverpool will include the following four core ‘offers’, accessible via self-referral or through an integrated gateway:

- **Practical**: to include debt management, access to safe and settled accommodation, and employment support in order to tackle poverty and social exclusion.

- **Social**: to include community learning, social prescribing, time banking, peer support and volunteering in order to reduce loneliness and social isolation and promote health and wellbeing.

- **Psychological**: to include access to a range of evidence based psychological therapies for the treatment of mild, moderate and severe mental health problems.

- **Physical**: primary and secondary care will work together to anticipate physical and mental health care needs in order to help a patient with a specific condition or set of symptoms to move progressively through clinical care, with a positive outcome.

Key milestones will include:

- Directory of mental health and wellbeing services, December 2013
- Primary mental health liaison service, full roll out, December 2013
- Welfare and benefits advice available in all primary care settings, June 2014
- Integrated gateway, fully operational, April 2015
- Psychological therapies at step 2 and 3, reprocured April 2015
- Improved care pathways between third sector and NHS psychological therapies steps 2, 3 and 4, implementation and roll-out by March 2014
- An organising framework for the provision of non-clinical mental health services is established by April 2014
- Systems to enable service users and carers to take a lead role in programming non-clinical mental health provision are in place by September 2014
- Workforce and development: training programme, roll out Sept 2014
2. WHAT IS PRIMARY MENTAL HEALTH CARE?

The development of primary mental health care has come about as a response to the 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. The case for improving preventive responses to heart disease, cancer and many other physical health conditions has long been accepted. However, there is also strong evidence for practical steps that we can take to reduce mental health problems and promote wellbeing. As thresholds for acute and social care services change, and the recession impacts adversely on the mental health and well-being of Liverpool people, it is essential that preventive mental health approaches are implemented effectively in primary care and the community.

Primary mental health care is a relatively recent concept in health care, defined by the World Health Organisation as the delivery of:

- 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.

Primary care is often first port of call in times of health care need and the majority of people who come into contact with NHS services as a result of mental illness do so in general practice. For most patients, developing a good relationship with their general practitioner (GP) is central to continuity of care, as this facilitates engagement with and communication across, the whole of primary care. Good engagement and communication allows the GP, and indeed any member of the primary care team, to deliver collaborative care, working with other members of the team and with mental health specialists as needed. Patients require access to appropriate interventions ranging from active monitoring and guided self-help through to higher intensity interventions such as psychological therapy. Crucial to the effective functioning of a primary mental health care system is expert supervision and case management with a consistent and systematic focus on outcomes.

Nevertheless, findings from recent research and enquiry show that primary care on its own not sufficient to tackle the health inequalities experienced by underserved communities. As a way of increasing equity of access to high-quality mental health services through primary care, Dowrick and colleagues recommend simultaneous and

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co-ordinated intervention at three different levels: community engagement, primary care quality, and tailored psychosocial interventions.

In Liverpool, since 2009, primary mental health strategy has focused largely on the establishment of a Liverpool-wide, stepped care model of psychological therapies (IAPT) for the treatment of common mental health disorders. While it is increasingly clear that the way services and support is provided needs to be adjusted for diversity, particularly culture, race, gender and age, and include community development approaches, the demand for psychological therapies continues to outstrip supply, and there is a gap in capacity to deliver treatments at the current rate of referral and level of service.

A new model of primary mental health care is an essential response to tackling these challenges and addressing changing health needs in Liverpool.

3. MENTAL HEALTH NEED IN LIVERPOOL

3.1 COMMON MENTAL HEALTH PROBLEMS

In order to inform strategic plans, a needs assessment of common mental health problems (CMHPs) was conducted by Liverpool CCG, summarised below.

CMHPs comprise a range of neurotic conditions, including depression, anxiety, obsessive compulsive disorder and panic disorder, that occur relatively frequently in the population and which can interfere with daily life.

**Prevalence**

Rates of common and severe mental ill health are higher in Liverpool than in most other parts of the country. Prevalence, duration and outcomes vary owing to socio-economic and environmental factors. Socio-economic deprivation and social isolation both contribute to the development of mental health problems and result from them. The findings from the North West Mental Wellbeing Survey 2009 support the wider literature on the relationship between mental health and a range of wider social and environmental factors, particularly low income, unemployment, poor housing, few educational qualifications, lower levels of satisfaction with personal relationships, and social networks. Poverty and unemployment tend to increase the duration of episodes of CMHP. (McManus et al, 2009).

It is estimated that 26% (86,025) of the Liverpool population experience CMHPs in any given year and that approximately 50% of people with CMHPs have conditions severe enough to require treatment (medication or psychological therapies). Of this number, it is estimated that 20% would both benefit from psychological therapies and be willing to

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9 Liverpool CCG/Egan A (July 2013) Needs assessment: common mental health problems
10 Liverpool CCG/Egan A (July 2013) op. cit.
receive them. However, three-quarters of adults with common mental problems are not receiving treatment.

A large proportion of these people will not become known to the health service and the majority of those who do so will only be in contact with primary care.

*Fig 1: Estimated percentage of Liverpool population with Common mental health problems in any year (based on NEPHO)*

*Fig 2: Estimated Liverpool population with Common mental health problems in any year, Count (based on NEPHO)*
Age and gender are significant factors. It is estimated that more women than men have CMHPs in all age groups and that there are significantly higher rates in females for all categories of CMHP except panic disorders and obsessive compulsive disorder (McManus et al, 2009). According to NEPHO, prevalence overall was highest in the 45-54 age group. Among women prevalence was highest in 45-54 year olds, almost 42%, and lowest in the 64-74 age group. For men the prevalence was highest in the 45-49 group where one third could have a CMHP. This chimes with the North West Health and Wellbeing survey which found lower levels of well being around middle age (Deacon et al, 2010a).

According to the NEPHO population estimates, this would mean 31,000 men and 55,000 women in Liverpool have at least one CMHP.

**Fig 3: Estimated Prevalence of CMHPs by age (NEPHO)**

Prevalence also differs between ethnic groups. The white population overall was least likely to have a CMHP although it should be noted that this category may hide some groups of high need such as the Travelling/Roma communities and white migrants. In
all ethnic categories women were more likely to have CMHP than men with black and Asian women most likely to be effected.

**Table 1: Prevalence of CMHP by ethnicity and sex, Percentage (APMS)**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>11.9</td>
<td>19.2</td>
</tr>
<tr>
<td>Black</td>
<td>16.3</td>
<td>25.3</td>
</tr>
<tr>
<td>Asian</td>
<td>11.3</td>
<td>23.4</td>
</tr>
<tr>
<td>Other</td>
<td>19.4</td>
<td>21.1</td>
</tr>
</tbody>
</table>

Although rates of mental health problems are thought to be higher in minority ethnic groups, in the UK, they are less likely to have these detected by a GP and are less likely to be referred to services (Mental Health Foundation, 2007).

Lesbian, gay and bisexual (LGB) people have higher risk of mental health problems, suicide attempts, substance misuse and self-harm than heterosexual people (King 2008). Overall, this group has at least one and a half times the rate of depression or anxiety and double the rate of suicide attempts.

**Assessing demand for services**

In the 12 months up to August 2012, 12732 people were diagnosed with depression by Liverpool GPs (2.9% of the practice population) whereas about 56000 could have a depressive condition.

Untreated depression and anxiety disorders are associated with increased health care usage, not only ongoing consultations and treatment in relation to the specific mental health condition, but also increased health care usage more generally. People with common mental health problems have on average nearly three times more GP consultation, 25% more inpatient bed nights and 60% more outpatient procedures than people with out CMHPs.

IAPT services are expected to reduce this gap in the two years following successful treatment, generating reductions in healthcare usage. Additional productivity and gain to the economy is expected to be realized through people regaining or retaining work.
3.2 KEY MESSAGES FROM CONSULTATION AND STAKEHOLDER ENGAGEMENT

Between March and May Liverpool CCG engaged with local stakeholders on its plans to transform primary care mental health. Stakeholders included members of the public, service users and carers, clinicians, GPs, service providers across the voluntary and statutory sectors, commissioning and planning leads.

The consultation sought not only to find out people’s experiences but also their views about how services could be improved. The process included a variety of forms of engagement so that a wide range of stakeholders could take part. These included GPs, service providers, service users and interested members of the public.  

Focus groups were targeted at six sections of the community identified as facing barriers accessing talking therapies. There was also a group of current service users. There were 41 attendees in total, who were largely positive about the effectiveness and quality of therapy once they received it. Barriers to accessing therapy were reported as being largely connected to sensitivity to the particular issues (cultural, socio-economic) facing each group. Waiting times were a barrier to access and some felt may reduce the impact of therapy once received. Greater support on exiting therapy was also reported as helpful.

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11 All event reports are logged on the REACT database and available upon request from Liverpool CCG

12 BME communities; older people; younger adults; veterans; people with long term conditions and people from LGBT communities
An **Open Space Event (27th March 2013)** was used to encourage dynamic discussions about how the future of primary care mental health could be shaped. The whole cross-section of stakeholders was represented at the event by approximately 70 attendees. This generated ideas around the following topics:

- Integrating non-clinical approaches into the care pathway for psychological therapy
- Overcoming barriers of cultural and social disconnection, racism and gender inequalities experienced within BME communities
- Overcoming the transmission of powerlessness and despair across generations within families and communities
- Using partnerships across statutory and voluntary sectors to stimulate innovation in practice
- How to broaden the range of therapies available (including non-clinical support)
- How to ensure age appropriate provision of services for people aged 18-25
- How to ensure high quality within the workforce
- How to overcome barriers for people with more complex needs

**Online Questionnaire Survey (May 2013).** This allowed access to a greater number of participants and to compare the views of recent service users with those of non-recent service users, as well as GPs and other service providers.

Key issues that emerged from the survey are summarized as follows:

- long waiting times are off-putting
- role of the GP is important in accessing service
- Strong agreement on the value of self-referral
- Strong recognition of cultural needs by GPs and providers
- Choice of various therapies supported by clear information is valued by all
- preference for one-to-one, face-to-face contact
- GPs prefer online therapies but service users aren’t so keen
- Information in a choice of formats with an emphasis on printed materials
- Support from friends and family valued by service users
- Internet valued as a source of information more by service users than by GPs and other service providers
- Strong agreement on the need to be listened to and to be treated with respect

Consultation sessions were also held as part of three other related events, reports available from [http://www.liverpoolccg.nhs.uk/Health_Services/mental_health.aspx](http://www.liverpoolccg.nhs.uk/Health_Services/mental_health.aspx). These were:

**TOTAL 159 responses**

*GPs and other service providers :103*
- (GPs = 53; other service providers = 50)

*Service users and residents of Liverpool: 56*
- (Service users in last 3 years= 22; Non service users in last 3 years = 34)
BME Event (11th April 2013) Liverpool CCG presented its plans to an independent event aimed specifically at BME community members and supported by Community Development Workers. Feedback indicated that BME communities face a double jeopardy in respect of maintaining their mental health, on the one hand facing social isolation and exclusion, and on the other hand facing barriers to accessing services based on cultural inappropriateness, geographical distance and lack of community credibility. Experiences of racism and violence and gender roles/inequality are also key factors in understanding mental health needs of people from BME communities.

Well Being in Hard Times (16th April 2013) was hosted by LMHC to address issues arising from the negative impact of the economic downturn on mental health. Key themes that emerged were co-production; peer support; equality and diversity; social prescribing; education; communication.

Mental Health: A Community Response (29 November 2012) was jointly organised by LCVS and LCCG to scope out the contribution of the 3rd Sector to Liverpool’s mental health. Key recommendations were to forge stronger links across sectors, improve access to 3rd sector support for people in need and to align third sector services with primary care neighbourhood structures.

3.3 FINANCIAL MAPPING: CURRENT INVESTMENT

Table 2: Current investment 2013 – 14 (approximate)

<table>
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<th>Service area</th>
<th>CCG</th>
<th>LCC</th>
<th>Comments</th>
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<tr>
<td>Secondary mental health services</td>
<td>£61 million</td>
<td>£2.6 million</td>
<td>2013 – 14 contract values. LCC funds mental health social work in Mersey Care (MCT). Excludes addictions services, secure and specialised services</td>
</tr>
<tr>
<td>Supported living and community placements, including nursing care</td>
<td>£7 million</td>
<td>£21 million</td>
<td>LCC is lead commissioner and main funder. NHS funding is approximate, subject to in year variation.</td>
</tr>
<tr>
<td>Psychological therapies (excluding step 4 and other specialised therapies)</td>
<td>£5.3 million</td>
<td>N/A</td>
<td>IML is the main NHS provider of therapies. Funding into the third sector is in the region of £200,000</td>
</tr>
<tr>
<td>Non-clinical mental health support</td>
<td>£955K</td>
<td>£2 million</td>
<td>Includes a mixture of third sector &amp; local authority provision</td>
</tr>
<tr>
<td>Service user and carer involvement</td>
<td>£43K</td>
<td>N/A</td>
<td>MCT also fund service user and carer involvement</td>
</tr>
<tr>
<td>Primary care prescribing</td>
<td>£4.3 million</td>
<td>N/A</td>
<td>Figure is subject to variation and does not include MCT prescribing costs</td>
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<td>--------------------------</td>
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<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£80 million</td>
<td>£25.6 million</td>
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*For note, figures 2014 – 16 are subject to change and LCC expenditure on mental health related services funded via public health and the community resources unit is not included.*

### 3.4 ACCESS TO SERVICES

In Liverpool, access to most, but not all, secondary mental health services was found to be largely via referral from the GP or Accident and Emergency services into Mersey Care’s single point of access.

For psychological therapies, Liverpool operates a single point of access from a single provider, Inclusion Matters Liverpool, for therapies at Step 2 and 3.

For some areas of psychological therapies, there were good working protocols in place to ‘re-route’ referrals to a more appropriate service without inserting an additional step in the patient journey. However, this arrangement had been put in place for only a small number of service areas.

There is currently no mechanism in place to support the safe and easy navigation of third sector services for people experiencing mental distress. Fig. 4 shows most mental health NHS, local authority and third sector services and highlights the complexity and the lack of co-ordination from a general practitioner perspective.

### 3.5 CONCLUSIONS FROM CONSULTATION AND REVIEW

There are high levels of mental ill health the population, and considerable unmet need. The lack of clarity highlighted by the review regarding access (assessment, provision, eligibility criteria and choice) resulted in duplication, multiple assessments and long waits for services, and this in turn contributed to poor outcomes and ineffective use of resources. This needs to be addressed.

Demand for psychological therapies continues to exceed supply but it was also noted that referrals for therapies are sometimes made in the absence of there being alternative provision. The re-procurement of step 2 and 3 therapies will not be sufficient to manage demand and improve outcomes and integration, nor will it be able to address gaps in non-clinical provision, unless other improvements are made to the primary mental health care system. Referrals could be managed more effectively if there were a greater range and better co-ordination of non-clinical mental health support services and interventions.
Neighbourhood-level support systems are critical—families and communities—so the new model needs to harness and utilise community development approaches. It is vital that people at the receiving end of services are involved in the design and delivery of these services. Patients, service users, carers and their communities have to be able to take a full and sufficiently resourced part in designing and delivering the services they use.

Investment in, and development of an organised and co-ordinated system of non-clinical and clinical provision would help address demand management and improvements to preventive and recovery outcomes.

Services need to do more to provide tailored approaches in order to improve access for certain groups, for example, people from BME groups, disabled people, people with learning disabilities, older people, young people, single parents, lesbian gay, bisexual and trans people, people who use sign language, and people with dementia.

The development of an effective single point of access for people with common mental health problems and their carers would also help improve transparency, accessibility and co-ordination.

A detailed and regularly updated directory of mental health and well-being resources and activities would help promote access to all services, in particular non-clinical services. Ideally this would be supported by a navigation or advocacy support service.
Waiting times for psychological therapies remain a concern and there is a need to ensure that there will be no interruption to psychological therapy services as a result of re-procurement.

4. A NEW PRIMARY MENTAL HEALTH CARE SYSTEM FOR LIVERPOOL

What will be different?

The new model of primary mental health care in Liverpool will have a clear focus on prevention and early identification, and will promote self-management by patients, including use of personalised care plans. The approach to primary mental health care will be holistic: mental health has physical, psychological, social and spiritual elements.

For most people, mental health problems will 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. This will prevent the need for secondary health or social care services for some, for others it will aid recovery and prevent a return to more intensive treatment.

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. To address this, services will be integrated and use a stepped care model. This will deliver evidence-based treatments that can be accessed via flexible referral routes, including self-referral, and offer a choice of psychological and non-clinical interventions.

Care co-ordination (case management) and methodical management of care pathways will be improved. The outcomes of primary mental health care services will be systematically measured and reported.

Primary care will be ‘joined up’ with psycho-social initiatives and community development approaches. A creative approach will be taken to involving patients, service users, carers and their communities in designing and delivering the services they use at an individual and community level.

The new proposed model of primary mental health care will build on the best of current services and pathways but, importantly, it will place a renewed emphasis on tackling dominant risk factors i.e. health inequalities, social exclusion, stigma, loneliness and isolation.

Access to mental health support and services for people with common mental health problems will become easier, helped the introduction of a primary care-based gateway into services, and supported by a new and detailed directory of services. This will help introduce a fair and transparent system across all of Liverpool at the same time as
managing the need to provide individualised support and make better use of local third sector and self-help networks.

Each of the key service elements of the new model of primary care will be fully integrated into primary care, accessible to those who need services and support the most.

**What will it look like?**

The new model of care for Liverpool will include the following four core ‘offers’, accessible via self-referral or through an integrated gateway into services:

- **Practical**: to include debt management, access to safe and settled accommodation, and employment support in order to tackle poverty and social exclusion.

- **Social**: to include community learning, social prescribing, time banking, peer support and volunteering in order to reduce loneliness and social isolation and promote health and wellbeing.

- **Psychological**: to include access to a range of evidence based psychological therapies for the treatment of mild, moderate and severe mental health problems.

- **Physical**: primary and secondary care will work together to anticipate physical and mental health care needs in order to help a patient with a specific condition or set of symptoms to move progressively through clinical care, with a positive outcome.

The success of this model will be predicated on improvements to: the transparency and accessibility of services and systems, integration between primary and secondary care, as well as social care and the third sector; use of collaborative and co-production approaches; the involvement of service users and carers; provision of non-clinical services and interventions; use of personalised approaches to care and treatment; improvements to suicide prevention and mental health awareness; a continued focus on risk management.

Genuine partnerships with service users will be established, so that different types of support and solutions can be co-produced in support of the move from dependency to empowerment and reciprocity.
This new approach will require GPs and other primary care workers to become much more aware of the ways in which appropriate support can be accessed and personalised, and to be prepared to use creative approaches to involve people at the receiving end of services.

Sections 5 and 6 describe the key elements of the new model in greater detail.

**Fig 5: Primary mental health care by 2015**

**Examples**
- Psycho-education
- Time banking
- Peer support
- Day activities
- Community learning
- Counselling
- CET
- DBT
- Group therapy
- Psychotherapy
- FMDR
- Other
What will the benefits and outcomes of the new primary mental health care strategy be?

**Table 3: Anticipated overarching outcomes of the strategy**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Overarching outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better use of the evidence-base for prevention and recovery</td>
<td>More people with mental health problems will recover</td>
</tr>
<tr>
<td>Addresses dominant risk factors</td>
<td>Strengthens resilience</td>
</tr>
<tr>
<td>‘No wrong door’ encourages people to seek help and promotes self-care</td>
<td>A reduction in numbers of mental health crises and admissions</td>
</tr>
<tr>
<td>Greater range of services and supports are available through primary care</td>
<td>Common mental health problems are detected earlier</td>
</tr>
<tr>
<td>A directory of services provides up to date information about safe and effective services and activities</td>
<td>Improved access, help available when needed and wanted</td>
</tr>
<tr>
<td>Pathways between a suite of services in primary, community and secondary care are activated</td>
<td>Reduction in duplication and unnecessary assessments</td>
</tr>
<tr>
<td>Wellbeing and primary mental health services are delivered as part of a coherent system of provision</td>
<td>Levels of wellbeing in the population improve</td>
</tr>
<tr>
<td>GPs and Mersey Care work closely together to anticipate the health needs of people with serious mental illness</td>
<td>More people with mental health problems will have good physical health</td>
</tr>
<tr>
<td>Non-clinical mental health services are jointly commissioned</td>
<td>LCC and CCG make better use of resources in order to reduce the impact of cuts</td>
</tr>
<tr>
<td>Service users and carers programme a range of non-clinical mental health activities for the City</td>
<td>Mental health support is relevant and wanted, and more effectively utilised</td>
</tr>
<tr>
<td>All providers of psychological therapies work together to provide a stepped model of care</td>
<td>Improved integration and co-ordination across key service areas</td>
</tr>
<tr>
<td>Community development, advocacy, advice, befriending and navigation services are available to those in need via the integrated gateway</td>
<td>Helps address the inverse care law - fewer people will experience stigma, discrimination and social isolation as a result of poor mental health.</td>
</tr>
<tr>
<td>Workforce development and training to embed co-production and strengths based approaches in services</td>
<td>Cultural shift across all services away from dependency towards recovery</td>
</tr>
<tr>
<td>Proactive identification of the most vulnerable</td>
<td>Tackles health inequalities, improves access.</td>
</tr>
</tbody>
</table>
5. THE FOUR KEY ELEMENTS

5.1 TACKLING POVERTY AND SOCIAL EXCLUSION

Why this is important

Health inequalities are closely related to social and economic inequalities and in order to reduce health inequalities, sustained action by all partners is required on the social determinants of health. Clinical Commissioning Groups (CCGs) have a duty to reduce health inequalities. Welfare advice in GP practice is an effective intervention to do so. The association between poverty, deprivation and ill-health, particularly mental ill-health is well-established.

Liverpool is disproportionately affected by the changes to the benefits system with many thousands facing job loss and reduced income due to changes in eligibility criteria for welfare benefits. People who are already ill are particularly vulnerable and many people have had their benefits cut or removed.

‘Evidence seems to suggest that people with serious health conditions are sometimes being declared fit for work. The frequency of successful appeals seems to us to demonstrate the mechanism’s shortcomings.’ (Scottish BMA GPs committee chair May conference 2012)

Findings from a local pilot suggests that anti-poverty strategies targeted at vulnerable people needs to be a key component of an effective and integrated primary mental health care system.

National figures cited by the Royal College of Psychiatry indicate that:

- One in two adults with debts has a mental health problem.
- One in four people with a mental health problem is also in debt.

Liverpool levels of morbidity and of benefits claims are significantly above the national average. There is a potential 23,250 people with mental ill health and debt issues requiring support at any one time. Unmanageable debt increases the risk of developing depression/anxiety disorders by at least 33% in the general population. As levels of indebtedness and deprivation increase, it is anticipated that the burden of mental illness will rise accordingly resulting in increased demand on NHS services relating to common mental disorder.

There is also evidence that the reforms are having a negative impact on GPs, with increased workloads leading to the reduced availability of GPs to the wider range of

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13 CAB Evaluation Report
14 Lloyd, K., Liverpool Healthcare Public Health Team Welfare Advice in General Practice, July 2013
What will the new advice service look like?

A citywide welfare advice service will be delivered from health care settings, organised on a neighbourhood footprint. The service will operate as part of a primary mental health care system, but it will also be fully integrated into mainstream primary care services.

Its main aim is to increase community resilience by supporting those individuals vulnerable to mental ill-health to develop practical strategies in the face of hardship and deprivation.

Key features of the service are as follows:

- Addresses health inequalities by identifying the most vulnerable
- Referrals gate-kept by primary health care teams and Mersey Care staff in order to ensure limited resource is targeted at the greatest need
- Advisors work as integrated members of extended primary care team, and with Mersey Care staff
- Triage service to address urgent concerns on the spot with referral to high street advice bureaux to manage ongoing case work if required
- Centrally managed outreach provision across the city in order to ensure that resource can be adjusted to reflect demand
- Nationally accredited complying with high quality assurance standards¹⁶
- Stakeholder reference group to monitor and evaluate impact
- Extends into other health settings e.g. Cancer services
- Provides training and guidance to help people improve their financial management skills and reduce repeated need to access advice services.

The service will not replace mainstream high street advice services and members of the public who are able to access will be encouraged to do so, leaving the limited number of practice-based appointments free for people who are particularly vulnerable to deteriorating health and circumstances. Referred patients will have access to advice, information and support in relation to:

- Housing and Homelessness
- Fuel Disconnection
- Evictions due to housing benefit reduction/suspension
- Benefit Suspension/reduction
- Job Loss
- Illegal Lending (loan sharks and pay day loan providers)
- Bailiff Action

¹⁵ Blane, D. & Watt, G., *GP experience of the impact of austerity on patients and general practices in very deprived areas*, March 2012.
• Complex Debt Issues
• Budgeting and managing a household budget
• Understanding Credit and Financial Services

Benefit and outcomes

Learning from a recent pilot project covering 10% of the Liverpool practice population has been used to inform the design of a new service for Liverpool, and to provide insight into anticipated outcomes and benefits. The pilot provided a service for 593 people between August 2012– July 2013, and based on the pilot, the outcomes are described in the table below.

Table 4: Anticipated benefits and outcomes

<table>
<thead>
<tr>
<th>Health &amp; social care outcomes</th>
<th>Evidence from pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addresses health inequalities through improved identification by primary care staff of those at risk of ill-health, poverty and social exclusion</td>
<td>Referrals came from primary health team members (including admin/reception staff). 95% were from vulnerable groups and the majority had mental health problems.</td>
</tr>
<tr>
<td>Relief from worry and anxiety results in improvement in mental health and well-being of clients</td>
<td>High levels of satisfaction with the service reported. DNA rates under 10%</td>
</tr>
<tr>
<td>Disabled people supported to remain at home</td>
<td>240 employment support allowance appeals, 183 went to tribunal - 124 successfully appealed, 57 were overturned at review stage.</td>
</tr>
<tr>
<td>Reduced amount of GP consultancy time spend on welfare issues</td>
<td>GPs observed reduced consultancy time spent on social issues.</td>
</tr>
<tr>
<td>More appropriate use of clinical/psychological support</td>
<td>Close working links with psychological therapies services established</td>
</tr>
<tr>
<td>Reduced hardship and crisis</td>
<td>Average household income significantly below Liverpool average with over a third with average monthly household income less than £400 pcm. 367 patients presenting with benefit (not debt) issues. Household income increased by the project 12 months for all benefits = £1,110,890.00 (£1.1 million in benefits)</td>
</tr>
<tr>
<td>Increased problem solving/money management skills to reduce risk of future crisis</td>
<td>Total amount of debt handled £720,000.00 (£0.7 million debt)</td>
</tr>
</tbody>
</table>

17 CAB Evaluation Report
5.2 TACKLING SOCIAL ISOLATION, PROMOTING WELL-BEING

Why this is important

Evidence shows that people with mental health difficulties are among the most isolated of all communities, with an over-dependence on secondary services for their social networks\(^{18}\). Local consultations show repeatedly that service users need and want a choice or accessing both mental health specific support groups as well as mainstream and mixed support. Furthermore, research shows the importance of fostering social capital and reciprocity within communities.\(^{19}\)

There is an emerging evidence base for the health promoting benefits of a wide range of services and activities, sometimes called ‘wellness’ or ‘well-being’ services. This can include community-led developments, co-production, social prescribing, time banking, psychosocial and psychoeducational groups, peer support, volunteering, arts for health, and others\(^{20}\).

As well as offering opportunities for prevention, these developments can also contribute to improved recovery outcomes. Driven largely by the efforts of mental health service users, the language of recovery has become increasingly apparent in government policy to transform mental health services from focusing on deficits, symptoms and risk management to ones based on hope, control and opportunity, emphasising people’s assets and abilities and potential to live well in spite of (and because of) their experiences of mental distress. The aim is to enable people to lead fulfilling lives, and secondarily, to reduce reliance on health and social care services.\(^{21}\)

However, people with poor mental health are usually further away from services than many other groups in the population and while a range of ‘wellness’ initiatives and activities are already available in Liverpool, access is not even across groups. It is essential to tackle the ‘inverse care law’ and take action to ensure that interventions that promote social inclusion and well-being are made more accessible and relevant to the people who need them most.

The Health and Social Care Act refers to these changes and takes its cue from the patients’ rights slogan ‘nothing about me without me.’ If this ambition is to be meaningful then it is vital that a significant cultural shift takes place, and that Liverpool starts to do things differently.

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\(^{19}\) Friedli, L, Mental health, resilience and inequalities, WHO/Mental Health Foundation, 2009


\(^{21}\) The Mental Health Strategic Partnership (2013) Building resilient communities
http://nhs.us5.list-manage.com/track/click?u=fe51aa41404c764f7d454491&id=d54d149e83&e=915b4fe874
What will the new arrangements for non-clinical mental health support look like?

The new model will include the following:

- A central information service which is staffed by people who are friendly, empathic and knowledgeable, and who provide active listening
- A regularly updated web-based directory of services and activities which includes a discrete section aimed at, and relevant to, people with mental health difficulties.
- Access to additional support for those people who would like to participate in activities, but who are lacking in confidence. This could look like an advocate, or a navigator, or a peer support worker.
- A range of activities and initiatives which have and mental health and well-being focus, including access to ‘recovery colleges’ (Appendix 1)

The following approaches will underpin its development:

- A collaborative approach: the development of solid organising framework to support the provision of non-traditional and non-clinical mental health and wellbeing services requires the CCG and local authority to work together and with local providers.
- Local participatory processes will be used in order to generate fresh insights and new strategies to overcome the challenges of change.
- People at the receiving end of services are involved in the design and delivery of services. Patients, service users, carers and their communities have to be able to take a full part in designing and delivering the services they use.
- A personalized approach – the ‘social’ offer will look different for each individual.
- A community development approach – staff and volunteers make a particular effort to build relationships with the most marginalized communities, spreading the word and putting a friendly face to a name.
- A significant cultural change is required – ‘culture eats strategy for breakfast’. Doing and thinking differently will be essential.
- Entrepreneurialism and innovation will be at the heart of developments.

Table 5: Summary of non-clinical outcomes

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in social isolation and loneliness</td>
</tr>
<tr>
<td>Community resources, peer support, self-management support are better utilised</td>
</tr>
<tr>
<td>Health promotion and well-being</td>
</tr>
<tr>
<td>Quality of life is improved</td>
</tr>
<tr>
<td>Social networks are improved</td>
</tr>
<tr>
<td>Information, knowledge and opportunity for skills development are made easily available</td>
</tr>
<tr>
<td>Citizenship and making a contribution is encouraged</td>
</tr>
</tbody>
</table>
5.3 WIDENING ACCESS TO PSYCHOLOGICAL THERAPIES

Why this is important

There is growing evidence for the effectiveness of psychological therapies ranging from impact on overall mental wellbeing, treatment of common mental health problems through to reducing an individual’s usage of NHS services, thus leading to efficiencies and cost savings.

Psychological therapy shows benefits over no treatment for a wide range of mental health difficulties:

- Evidence of counselling effectiveness in mixed anxiety/depression, most effective when used with specified client groups, e.g. postnatal mothers, bereaved groups.
- Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT) effectively reduce symptoms of depression. Benefit has also been found for other forms of psychological therapy, including focal psychodynamic therapy, psychodynamic interpersonal therapy and counselling.
- CBT effectively reduces symptoms of panic and anxiety.
- Psychological therapies have benefit in a range of somatic complaints including gastrointestinal and gynaecological problems.
- CBT has been found more effective than control in improving functioning in chronic fatigue and chronic pain.
- Post traumatic stress symptoms may be helped by psychological therapy, with most evidence for cognitive behavioural methods.

There is national recognition of the importance of psychological therapies, the Improving Access to Psychological Therapies programme (IAPT) is a large scale initiative that aims to significantly increase the availability of National Institute for Health and Clinical Excellence (NICE) recommended psychological treatments. This is described in the next section. This approach promotes inclusive, equitable services that meet the needs of the whole community.

The Improving Access to Psychological Therapies Programme

IAPT offers improved access to NICE approved treatments for people with depression and anxiety disorders by delivering:

- A trained, competent workforce
- Implementing quality standards (recovery, choice, equity)
- Routine monitoring of patient reported outcome measures (for 90% of contacts)
- Defined care pathways in a stepped care model

| Need for mental health services is reduced |
| Participants grow in confidence and self-esteem |

26
IAPT is a key plank of the government mental health strategy, “No health without mental health”, and as well as the adult IAPT programme, clinical commissioning groups are now required to extend it to children and young people, older people, those with a severe mental illness, personality disorders, long term physical health conditions.

**Fig 6: The stepped care model**

IAPT operates within a five step model, focusing specifically on Step 2 and Step 3. The national programme ‘Talking therapies: a four year plan of action’ estimates that two-thirds of people with common mental health disorders have mild mental health disorders and so need low-intensity treatment at step 2. One-third have moderate or severe mental health disorders and so need higher intensity treatment at step 3.

As well as the development of the stepped model, IAPT has been responsible for a number of other large scale improvements to the mental health system. For example, prior to the launch of IAPT in 2008 there were no national waiting time targets within mental health services and most psychological therapy services had small numbers of therapists and closed waiting lists. Recovery rates for psychological therapies were not routinely measured. Now this is no longer the case. The programme has also overseen the training and recruitment and training for 4000 therapists nationally.

**Current provision in Liverpool**

The main provider of psychological therapies in Liverpool is Inclusion Matters, delivering treatments at step 2 and step 3. A small number of other providers are commissioned to provide mental health services on behalf of Liverpool CCG; this includes anger management, bereavement counselling, and sight loss. The CCG also commissions dedicated services for veterans and deaf people.

There are also a number of charity-run counselling agencies that do not currently receive funding from the public sector, but because they raise funds from other
charities, or income generate, they are able to provide free or subsidized services to the people of Liverpool.

An unknown number of people seek private treatment. This may be because they are not aware of the support offered by the NHS or they do not find it suitable to them. According the BACP website (Accessed June 2013), which is just one of many accrediting bodies, there are 40 independent therapists accepting private patients in and around Liverpool.

Mersey Care NHS Trust also provide specialised and step 4 psychological services including eating disorders, psychotherapies and services for people with a diagnosis of personality disorder.

**Local IAPT services**

Since 2009, as required by national policy, local strategy has focused on the establishment of a Liverpool-wide, stepped care model of psychological therapies known as Improving Access to Psychological Therapies (IAPT) for the treatment of common mental health disorders.

The Department of Health requires that 15% of the population with common mental health problems (CMHP) should be receiving IAPT treatment by 2014/15. At the moment, the services sees about half this and according to current estimates meeting this target would require the numbers of patients to double.

Referrals to Liverpool IAPT service have been just under 13000 on average in the last 3 years [Fig 7]. The current year is forecast to see in the region of 12,600 referrals. This represents approximately 14% of the estimated population in Liverpool with CMHP. With the current configuration of the referral and demand either 23,000 referrals would need to be made or all current referrals would have to enter treatment. Annually, in the region of 7000 referrals receive treatment through the IAPT this is about 8% of the estimated population with a CMHP.

Not all referrals result in an episode of care. Currently over 35% of people referred do not ‘opt-in’ to the service when they are contacted. No further action is taken unless these patients return to their GP. Demand is therefore the proportion of referrals that result in an opt-in to the service. It is worth noting that opt-ins are increasing with the implementation of choose and book for this service, as this option does not require contacting the patient. This means that even if referrals remain relatively stable the demand on the service will continue to increase as the proportion of referrals made through choose and book increases. Once opt-in is achieved the patient is assessed and subsequently accesses therapy.
The data shows that almost two thirds (63.1%) of service users were women. This was reflected in all age groups and appears commensurate with the higher estimated prevalence among women where almost two thirds of all cases of CMHP are thought to be in this group. 94% of users were between 18 and 64 and 4.5% were over 65 which broadly reflects expectations.

**Table 6: IAPT Opt-in Age (2011/12)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Female Count</th>
<th>Male Count</th>
<th>Total Count</th>
<th>Female %</th>
<th>Male %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>68</td>
<td>31</td>
<td>99</td>
<td>68.7</td>
<td>31.3</td>
<td>1.3</td>
</tr>
<tr>
<td>18-64</td>
<td>4493</td>
<td>2672</td>
<td>7165</td>
<td>62.7</td>
<td>37.3</td>
<td>94.1</td>
</tr>
<tr>
<td>65+</td>
<td>237</td>
<td>106</td>
<td>343</td>
<td>69.1</td>
<td>30.9</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4798</strong></td>
<td><strong>2809</strong></td>
<td><strong>7607</strong></td>
<td><strong>63.1</strong></td>
<td><strong>36.9</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Waiting time for the service has improved over the course of the contract. In 2013 patients waited 16 days, on average, from referral to assessment and 44 days from referral to treatment at Step 2. At Step 3 patients received an appointment within 67 days on average.

**Problems with current psychological therapies**

The demand for psychological therapies continues to outstrip supply, and there is a gap in capacity to deliver treatments at the current rate of referral and level of service.

Some groups have particularly poor access, for example people with serious mental illness. The Schizophrenia Commission reported in 2012 that fewer than 10% of people with a diagnosis of schizophrenia are able to access psychological therapies, in spite of the growing evidence base in support their efficacy.

Though the overarching model is a stepped care model, it works most effectively for step 2 and 3. There are good working arrangements between Inclusion Matters and Mersey Care, but access to step 4 provision needs to be clearer.

Waiting times for step 4 provision remain unacceptably high, reflecting high levels of need for specialised and step 4 services. Though significant improvements have been made to waiting times for eating disorder services, this has not been possible across all step 4 services.

The current process, in which access is usually via GP, means that those who are not registered or those not comfortable talking with their GP cannot access an IAPT service.

Though a large proportion of GP consultations, around 1 in 3, are thought to be for CMHPs, there is evidence that most people with common mental disorders do not receive treatment, even when their disorders are severe and disabling\(^2\)\(^2\).\(^\)

There are many reasons for not seeking treatment,\(^2\)\(^3\) and more needs to be done to address this through the implementation of the primary mental health care strategy.

In Liverpool access to psychological therapies for common mental disorders is primarily through general practitioners. If an individual is not registered, or does not go to their GP, they will not access the service. It is likely that some sections of the population will be disproportionately affected by this.

A number of third sector providers of counselling therapies raise funds from a variety of charitable and not-for-profit sources. The sustainability of this sector is very likely diminishing as a result of recession.

\(^2\)\(^2\) Adult Psychiatric Morbidity Survey 2007
\(^2\)\(^3\) McManus et al, 2009 referenced in CMHP needs asst,
There are a range of treatments not currently available in Liverpool, particularly for people with multiple and complex needs, or a diagnosis of personality disorder.

**How will these concerns be addressed?**

*Table 8: Improving Counselling & Psychological Therapies*

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>The testing out of an integrated gateway for clinical and non-clinical services (see section 6) will facilitate the pathway development and test the model for entry to services</td>
<td>Improved access to a wider range of psychological therapies, but also information and non-clinical services.</td>
</tr>
<tr>
<td>Scoping work will establish the current provision of adult psychological therapies across all sectors working in Steps 2 to 4, as well as contextualise the ideal model and identify the additional investment required to deliver it.</td>
<td>Improved understanding of current investment, value of the third sector, whole system review. Gaps in services for particular groups, and specific treatments are better understood.</td>
</tr>
<tr>
<td>An ideal model of provision will be developed with local stakeholders addressing key service improvement re access, stepping, liaison, collaboration, quality, risk management and safeguarding</td>
<td>Effective and timely access systems into evidence based psychological therapies for the treatment of mild, moderate and severe mental health problems</td>
</tr>
<tr>
<td></td>
<td>Seamless movement across the system and standardized collection of information and outcome measures.</td>
</tr>
<tr>
<td></td>
<td>Services working cooperatively: sharing and managing risk and responsibility</td>
</tr>
<tr>
<td></td>
<td>Engages service providers in a wider Liverpool alliance for mental health</td>
</tr>
</tbody>
</table>
The proportion of the CCG budget currently invested in Psychological Therapies will be reviewed against the ideal model of provision. The balance of investment and benefits will be agreed by the CCG. The aspiration will be to ensure that investment follows the evidence base.

Better and more transparent use of resources. Improved understanding of levels of under-investment.

Plans to address main deficits in service will be developed and appraised. Proactive attention will be given to health inequalities.

Numbers accessing psychological therapies increase, particularly from minoritised groups.

A detailed service specification for Step 2 and Step 3 services will be developed.

Clarity regarding the potential of the clinical pathway to meet waiting time, access rates and recovery targets.

Addresses currently unidentified or unmet need

Offers client choice

Demonstrates Value for Money.

The procurement process will culminate in the re-procurement of Step 2 and Step 3 psychological therapies by the end of March 2015

Improved service model and care pathways in place.

Complies with rules of competition and fair trading

### 5.4 INTEGRATING PHYSICAL AND MENTAL HEALTH CARE

**Why is this important?**

The new NHS mandate requires mental health care to have parity of esteem with physical health care. To do this, significant improvement is needed to the anticipation and management of care for patients with both mental health and physical health needs.

Improving the way we respond to co-morbid physical and mental health problems will have a high impact in terms of patient experience and clinical outcomes, since both of these are known to be poor, relative to those for people with a single condition\(^{24}\).

- Impact on costs: addressing underlying mental health or psychological needs can reduce costs related to physical long-term conditions. E.g. provision of

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\(^{24}\) Naylor C, Parsonage M, et al. *Long-term conditions and mental health: the cost of co-morbidities*, The King’s Fund and Centre for Mental Health report, February 2012
psychological support for angina patients in Liverpool achieved a reduction in hospital costs of £1,337 per patient per year

- Around 30% of people attending general practice have a mental health component to their illness

- There is a strong association between mental and physical health. For example, depression has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for

- Costs to the health care system are significant: co-morbid mental health problems exacerbate physical illness and raise total health care costs by at least 45% for each person

- People with long term conditions and co-morbid mental health problems disproportionately live in deprived areas and have fewer access to resources of all kinds.

- Unidentified mental health problems are linked to patients with medically unexplained symptoms, who can place heavy demands on health services without their problem being resolved.

**Overlap between long term conditions and mental health problems**

![Overlap diagram](image)

*In Long Term Conditions and Mental Health - Naylor, Parsonage, McDaid et al 2012*

*Fig 8: Overlap between long term conditions and mental health problems*
A systematic and proactive approach to improving service responses to people with a combination of physical and mental health care needs will result in the following outcomes:

- A reduction in the numbers of people with long term health conditions who go on to develop mental health problems
- A reduction in DALYs (Disability adjusted life years)
- Improved detection and management of physical illness in people with serious mental health conditions
- Improved self management and self care by people with physical and mental long-term health conditions.

What will it look like?

A range of changes will be introduced to support improvements to the way services respond to mental health and physical health care needs. These are summarised in the next table:

**Table 9: Improving physical and mental health care in Liverpool**

<table>
<thead>
<tr>
<th>New service improvement</th>
<th>Outputs and anticipated outcomes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mersey Care primary mental health liaison team</td>
<td>Identification and treatment of people with serious mental illness who have untreated physical health care need.</td>
<td>This is a new service, started April 2013. Early feedback about the new model is positive.</td>
</tr>
<tr>
<td></td>
<td>Improved joint working between mental health specialists and primary care eg shared electronic records, screening high risk groups, proactive use of disease registers, mental health specialists working closely primary care teams, better communications to support transfer of care from secondary to primary care</td>
<td></td>
</tr>
<tr>
<td>Neighbourhood based multi-disciplinary teams for integrated care</td>
<td>Identification and treatment of people with long term health conditions who also have co-morbid mental health problems</td>
<td>This is new service development, early feedback is positive</td>
</tr>
<tr>
<td>Liaison psychiatry</td>
<td>Liaison psychiatry services in acute hospital and care homes in order to improve care for people with dementia</td>
<td>This is new service development, early feedback is positive</td>
</tr>
</tbody>
</table>
6. MAKING IT WORK

6.1 INTEGRATED GATEWAY INTO SERVICES

Why this is important

The gateway will operate as a ‘no wrong door’ system for psychological therapies and non-clinical mental health support in Liverpool. It will help service users, families and carers and professionals make sense of the mental health system and although it will provide a gateway into psychological therapies, it will be able to facilitate rapid access to a range of non-clinical mental health supports.

Such an approach will be supported by a framework which standardises quality and service provision e.g. all practices will have access to advice and advocacy for vulnerable and at risk groups; all mental health and well-being services will be made visible through an up-to-date directory; those that need help in accessing services will be offered befriending or the aid of an advocate; all practices will have access to a single telephone or access point for information and referral.

Some of these services exist already, but require improved co-ordination and integration. Part of the task of the gateway will be to establish a more connected and transparent approach to the provision of preventive mental health support in primary care. The gateway will be supported by the new directory of services.

Key features for the gateway are summarised in the table below, though this will be subject to adjustment during the development phase.

Table 10: Building on existing provision and identifying gaps

<table>
<thead>
<tr>
<th>Key features</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single telephone number, an advice line, a trusted ‘brand’, perhaps also a place and</td>
</tr>
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</table>
The development or ‘incubation’ phase will involve local experts and stakeholders in the detailed design of the gateway. The viability of including other parts of the mental health system, including young people’s services, secondary care, and substance misuse services will be explored during the development phase.

**Key aims and objectives**

- To design a service model for a safe and accessible gateway for the following services:
  - Psychological therapies at step 2, 3 and 4, including services for young people aged 18 upwards
  - Non-clinical mental health support services
  - Practical support such as welfare benefits and debt management support, employment support

- To explore options for the inclusion of the following range of services
  - ‘Wellness’ services
  - Community-based substance misuse services
  - Young people’s mental health services
  - Secondary mental health services
  - Other services as identified during the design phase

- To develop a detailed and costed implementation plan which includes plans for informatics, accommodation, workforce recruitment, training and development, publicity and promotions, directory and information services.

- To lead a motivational and transformative engagement and communication programme which disseminates and develops ideas and proposals, provides regular updates regarding progress, and which supports a culture shift towards co-production.
• To identify the skills and training required by the workforce to support delivery of the new model and to develop a workforce development strategy.

• To support commissioners in estimating demand, and model throughput and capacity

• To develop detailed service specifications for core services accessed by the gateway

• To report to Joint Commissioning Group Mental Health Programme Board, delivering against milestones and objectives to time and within allocated resources

6.2 DIRECTORY OF MENTAL HEALTH AND WELL-BEING SERVICES

Access to up to date information about a wide variety of mental health and wellbeing services underpins Liverpool’s primary care mental health strategy. The directory of mental health and wellbeing services has been commissioned by the CCG and will be launched late 2013. It will provide real time information about the wide variety of groups, activities and services in Liverpool designed to support recovery from mental ill-health. The directory will operate as part of a wider system of health and social care directories co-ordinated by Healthwatch. Aimed specifically at people who are interested in mental health and well-being, it will be subject to continuous improvement based on feedback from its users. It will also be maintained so that information is up to date and useful.

*Fig 9: Mental health and wellbeing directory homepage*
7. SUMMARY

This strategy describes the vision for a new primary mental health care system for Liverpool. It sets out the drivers for change and highlights the new developments and initiatives that will be developed in Liverpool over the next two years. It is supplemented by a range of programme documents which will be available through the CCG website http://www.liverpoolccg.nhs.uk/Health_Services/mental_health.aspx

The strategy describes a significant transformation agenda, improving transparency and accessibility of the systems, integration between primary and secondary care, as well as social care and the third sector, use of collaborative and co-production approaches, the participation of service users and carers; provision of non-clinical services and interventions, the use of personalised approaches to care and treatment, improvements to suicide prevention and mental health awareness, a continued focus on risk management.

The CCG and Local Authority will work together and with stakeholders, on behalf of Liverpool and the Health and Wellbeing Board, to implement this strategy.
## GLOSSARY

| **Common mental health problems** | Terms such as Common Mental Disorders, Common Mental Health Problems, Common Mental Illness are often used interchangeably to describe a group of neurotic conditions, including anxiety and depression, that can interfere with daily activity and cause emotional distress but which ‘do not usually effect insight or cognition’ (APMS 2007). These conditions occur relatively frequently in the general population and include: depression, generalised anxiety disorder, mixed anxiety and depressive disorder, panic disorder, obsessive-compulsive disorder, phobias (including social anxiety disorder and social phobia), post-traumatic stress disorder. |
| **Co-production** | Co-production is the contribution of service users to the design and delivery of health and social care services, challenging the notion of them as passive recipients of care. |
| **Healthwatch** | Healthwatch Liverpool provides: information about health and social care services and help with complaints. It is a free, confidential and independent service designed to help people understand their rights and make informed choices. |
| **Improving access to psychological therapies (IAPT)** | A large scale initiative that aims to increase significantly the availability of National Institute for Health and Clinical Excellence (NICE) recommended psychological treatments, through a ‘stepped care’, and ‘lowest dosage’ approach. |
| **The inverse care law** | In 1971 Julian Tudor Hart, a general practitioner in South Wales, proposed the inverse care law: “The availability of good medical care tends to vary inversely with the need for the population served.” |
| **Social prescribing** | Social prescribing is a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. |
| **Timebanking** | A timebank is a tool used to organise people or organisations in a system of exchange, whereby they are able to trade skills, resources and expertise through time. For every hour participants ‘deposit’ in a timebank by giving practical help and support to others, they are able to ‘withdraw’ equivalent support in time when they themselves need something doing. In each case the participant decides what they can offer. Everyone's time is equal, so one hour of my time is equal to one hour of your time, irrespective of the skills we might trade. |
**Wellness services**

A Wellness Service provides support to people in order to improve their health and well-being. The service aims to build people’s capacity to live healthy lives by addressing the factors that influence health and wellbeing.

**APPENDICES**

**APPENDIX ONE: A ‘Recovery College’ for Liverpool**

National mental health policy recommends the development of Recovery Colleges as a key lever for change. There is good evidence that a ‘Recovery College’ has the potential to transform mainstream services by moving the focus from treatment and risk management to education, growth and self-fulfilment.

The first Recovery College was developed by the South West London Recovery College, and the outcomes are impressive. The pilot study was based on four recovery courses co-delivered by mental health practitioners and peer trainers (Rinaldi, Wybourn and Clenahan, in press). On average, students had been using mental health services for six years and 45% had a diagnosis of psychosis.

**Recovery College outcomes**

An 18 month follow-up showed that:

- the majority (68%) felt more hopeful for the future than they had at the start of their course, most (81%) had developed their own plan for managing their problems and staying well; and 70% had become mainstream students, gained employment or become a volunteer;

- compared with those who did not attend courses, those who attended more than 70% of their scheduled sessions (67% of those who started) showed a significant reduction in use of community mental health services.

**What does a Recovery College look like?**

The College is not a day centre nor does it offer treatment or co-ordination of care. Students select courses from a prospectus, they are not told what is good for them. Selection is not based on diagnosis or clinical condition, neither are risk assessments conducted by the college to see if they are ‘suitable’ to attend. As in any college, a ‘student charter’ describes what the person can expect to gain and what the College can expect from them in terms of attendance and behaviour. People with mental health problems, families, carers, staff from mental health service providers and people from partner agencies can all attend courses. The ethos of the Colleges is that they are open to everyone and most do not turn away anyone who has an interest
The educational approach:

- Helps people recognise and make use of their talents and resources;
- Assists people in exploring their possibilities and developing their skills;
- Supports people to achieve their goals and ambitions;
- Staff become coaches who help people find their own solutions;
- Students choose their own courses, work out ways of making sense of (and finding meaning in) what has happened and become experts in managing their own lives.

The defining features of a recovery college

- Co-production between people with personal and professional experience of mental health
- It operates on college (not day care) principles
- It is for everyone – professionals, service users, carers, families and friends
- There is a Personal Tutor (or equivalent) who offers information advice and guidance
- The College is not a substitute for traditional assessment and treatment
- It is not a substitute for mainstream colleges
- It reflects recovery principles in all aspects of its culture and operation
- Access to a physical base (building) with classrooms and a library where people can do their own research

Developing a curriculum

Pilot sites have all begun with the appointment of core staff to facilitate the co-production of course content. This involves including key stakeholders from all perspectives to prioritise issues that are of most important from the service users point of view, and to draw in expertise from as wide a range as is possible. This co-production has a significant impact on the status of knowledge and therefore the balance of power between those involved. Service users' lived experience becomes a positive contribution, rather than a barrier to participation. Typical core modules have included:

- Understanding mental health issues and treatment options
- Rebuilding life with mental health challenges
- Developing life skills
- Capacity building among the peer workforce
- Family and friends

Mersey Care Recovery College

Mersey Care NHS Trust was one of the early adopters of the ‘Recovery College’ ideas, and now provides one as part of a comprehensive programme of organisational change. As well as the recovery college, this also includes workforce development and peer support, and the development of a recovery college.
Mersey Care launched its Recovery College in Sept 2013

Liverpool ‘Big Lottery’ Recovery Campus

A second College is planned, implementation in 2014, this one designed for people with multiple and complex needs and is a key part of Liverpool’s ‘Fulfilling Lives’ Big Lottery project.

Recovery in Practice Group, Liverpool Mental Health Consortium

The development of the recovery college idea has been led by secondary care and its outcomes have included a reduction in length of stay and bed occupancy and reduced reliance on community mental health team support. This is reflected in the leadership taken locally by Mersey Care on this issue.

It is also true, however, that the management of the boundary between primary and secondary care is of key strategic importance from many perspectives including social care as provided by the local authority. A ‘mainstreaming’ approach to recovery should also address the needs of people with mental health conditions, but who do not necessarily meet the threshold for secondary mental health services.

This is one of the key messages that has evolved from the service user-led ‘Recovery in Practice’ group. Run by the Liverpool Mental Health Consortium this community of practice was set up to support managers, service users and frontline staff in “mainstreaming” recovery based approaches across mental health services.

In Liverpool, one of the points of discussion has been to ask whether Recovery College approaches could be extended to the wider community of people with ‘languishing’ or common mental health problems. The boundary between primary and secondary care is a complex one and can be understood across a variety of key interfaces. Other ideas are as follows:

- **Common mental illness/severe mental illness:** While traditionally care has been arranged according to clinical categories, college approaches could organise learning around need and lived experience rather than diagnosis and symptomology.

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- **Mental/physical health**: The college approach has potential to develop learning about coping with the mental impact of long-term physical illness and vice-versa.

- **Statutory/voluntary sector**: Professional input from state provided health and social care can be complemented by input from third sector/community based expertise, peer support groups and self-directed learning.

- **Prevention/recovery**: Identification of factors that boost resilience and counteract stress, and learning about self-management and general support services can help prevent illness and also expedite speedier recovery from periods of mental ill health.

- **Early intervention/discharge**: Increased awareness of risk factors/triggers for mental ill health from all perspectives can help ensure that people receive timely access to services when they need to, and that discharge back to primary care is not delayed due to excessive caution.

- **Knowledge is power**: the College could usefully provide a framework to help organise a range of courses and activities, in much the same way as a course prospectus would. If information about all courses and activities about mental health and well-being were available in one central location, held by the Advocacy Rights Hub, this would create choice and encourage participation.
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