

ETHICS Initiative for Integration of Mental Health Promotion into Primary Care.**In collaboration with the London Journal of Primary Care and the Ionian University of Corfu****The ETHICS/LJPC/RCGP Think Tank**

These proposals arise from an expert Think Tank, convened by ETHICS in collaboration with the London Journal of Primary Care and Royal College of General Practitioners, and kindly hosted at the Ionian University of Corfu. The Think Tank included professionals from primary care, public health, psychiatry, community development, clinical practice and commissioning. There was expertise in qualitative and quantitative research, epidemiology, guideline development, education and training, inter-sectoral collaboration, situation appraisal and policy development.

The Think Tank made recommendations for each level of the service (community, GP, practice, cluster of practices, CCG and HWB) and each stage of the life course (preconception to end of life), and these are set out in this document.

The background briefing supporting them can be found on the ETHICS website. www.ethicsfoundation.org.

A brief guide for GPs will be launched on October 9th 2015, and will also be available on this website.



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The members of the think tank include

Rachel Jenkins MA, MB, BChir, MD (Cantab), FRCPsych., FFOHM (Hon), MPH (by Distinction), Distinguished Fellow, APA. Professor Emeritus of epidemiology and mental health policy, Kings College London. .Chair of ETHICS board of trustees and Convener and chair of ETHICS /LJPC/RCGP collaborative Think Tank.

Rachel Jenkins was previously Director of the WHO Collaborating Centre, Institute of Psychiatry 1997-2012, engaged in mental health policy support, research and training in low and middle income countries; Principal Medical Officer, Department of Health (1988-1996) undertaking mental health policy and implementation; and consultant psychiatrist and senior lecturer Maudsley Hospital, Institute of Psychiatry, and then St Bartholomew's Hospital and Medical School (1982-87) combining clinical services and research programmes. She has wide experience in scaling up mental health services in low, middle and high income countries, including national situation appraisal, mental health policy development, national programmes of primary care training, epidemiological surveys and randomized controlled trials to evaluate primary care training, and mentoring and capacity building in relation to research, training and policy.

Paul Thomas MB ChB, DCH, FRCGP, MD, DSc (Hon). Paul Thomas is a GP, professor of primary care at University of West London and editor-in-chief of London Journal of Primary Care. He has 25 year's experience of developing community-oriented integrated care, and has devised several university courses for leadership in complex healthcare contexts. He received the RCGP Commendation for outstanding contribution to primary care and general practice, 2012. Co-convener of ThinkTank.

Nigel Mathers BSc. MB ChB. MD. PhD. FRCGP. DCH. Dip Ed. . Professor and Head of the Academic Unit of Primary Medical Care, University of Sheffield, Nigel Mathers qualified in 1979. Taking over a single handed General Practice in inner city Sheffield in 1989 which has now grown to a 4 partner teaching practice. From 2010-2013 he was Vice Chair of the Royal College of General Practitioners (RCGP) and was elected to the role of Honorary Secretary of the RCGP in 2013.

Brian Fisher MB, BChir, MSc, MBE, GP, Co-director of PAERS Ltd and lead for Health Empowerment Leverage Project. Brian Fisher is a semi-retired GP, living and working in SE London. He is committed to finding practical ways of supporting the energy and confidence of citizens and patients to improve health. In particular, he has worked on community development as a means to share decisions at a population level to co-create health. He is also enabling online access to our own health records as a way at an individual level of sharing decision, information and power. He is on the executive of the NHS Alliance, is co-director of PAERS Ltd and a patron of Carers Lewisham."

Shamini Gnani MB, ChB, MSc, MRCP, FFPH. GP and Senior Clinical Adviser Imperial College London.

Fiona Wright MB, ChB, MSc, FFPH, Senior Lecturer in Global Health, Queen Mary's, University of London. Fiona Wright is a senior public health practitioner and educator. She has worked across all areas of public health practice as a consultant in public health medicine in London for more than 14 years. She has taught on undergraduate and post-graduate public health courses and trained and mentored staff, professionals and peers. She is passionate about addressing inequalities in health, primary prevention and improving mental health. She has worked with Professor Sir Michael Marmot's team on addressing the social determinants of health and is the wellbeing editor of the London Journal of Primary Care

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Lise Hertel MBBS, BSc. GP, Mental Health Clinical Lead, Member of Strategic Clinical Network for Mental Health, London. Long experience in setting up effective and accessible services for people with mental health problems, including a service for people with SMI in primary care. Involved in winning the HSI award for innovation in Mental Health in 2014. Champion for people dealing with domestic violence and Named GP for safeguarding.

Robert White, BSc, MSc. Occupational Therapist, Ealing Primary Care Mental Health Service Lead Practitioner, West London Mental Health Trust.

Steve Thomas MB, ChB, MRCP, MMedSci, Cert.Med.Ed. GP and Clinical Director, Mental Health/ Learning Disabilities/ Dementia Portfolio, NHS Sheffield Clinical Commissioning Group. Steve has been a GP in Sheffield for 18 years. Having previously worked in A&E and as Clinical Lecturer at the University of Sheffield Medical School, he has always had an interest in mental health and was involved with developing the role of the Primary Care Mental Health Worker (now IAPT).

He has been involved in commissioning since the introduction of Practice Based Commissioning. He took up the role of clinical portfolio lead for the Mental Health, Learning Disabilities and Dementia Portfolio of NHS Sheffield CCG in 2012 and has been involved in service redesign, delivery of primary care education and contract negotiation for the portfolio. He was appointed as an Executive Clinical Director for NHS Sheffield CCG in April 2015.

He is particularly keen to see how increased clinical influence affects how the CCG does its business, not only within the CCG, but importantly with other key organisations such as the Local Authority, Provider organisations and 3rd Sector colleagues. He is particularly keen to see a reduction in the inequalities we see (for example, life expectancy) in mental illness and to see mental ill health treated on a par with physical illnesses.

Catherine Millington-Sanders MB, BS, MRCP. Kingston CCG Macmillan GP and RCGP / Marie Curie National Clinical End of Life Care Champion. Catherine is a Macmillan GP, clinical commissioner and has 7 years experience as a specialty doctor in palliative medicine. Catherine is RCGP / Marie Curie National End of Life Care Champion, RCGP South London Faculty Educational Chair and Clinical Lead for Difficult Conversations training. Catherine supports the development of Compassionate Communities and the implementation of the Compassionate City Charter.

Tony Burch (MB BS, FRCGP) has recently retired after thirty years as a GP in NW London, with particular clinical interests in Mental Health and Older People. As an educator, he taught undergraduate students and for the current workforce set up CPD and Appraisal support. He now works for Health Education NW London, helping to set up and support multiprofessional education networks in primary care.

Baljeet Ruprah-Shah MA, Primary Care Commissioner and development consultant. Baljeet grew up in a diverse community in Southall West London. Non-white children were bussed to schools outside of the borough, and any kind of community engagement was frowned upon. For the last 30 years she has advocated for community engagement and used her experience in the voluntary sector; the NHS as a commissioner and provider of services at a senior level to build the links necessary to strengthen social networks and co design services that are sustainable. Baljeet used these networks to lead and redesign an award winning integrated primary care mental health service in Ealing

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working successfully with hard to reach and vulnerable groups leading to a 40% increase in BME communities accessing the service.

Laura Calamos Nasir, PhD RN FNP FHEA.

Dr Laura Calamos Nasir is a primary care clinician, educator and researcher. As an advanced practice nurse in both the UK and US she has over 20 years of healthcare experience. She lectures internationally about health promotion, clinical assessment, diagnostic reasoning, and leadership and is currently on faculty at the University of North Carolina at Chapel Hill. She is passionate about working with multidisciplinary teams to develop professional communication strategies that support high quality, client-centred service.

Kurt Stange MD, PhD Professor of Family Medicine & Community Health, Epidemiology & Biostatistics, Oncology and Sociology, Case Western Reserve University, Cleveland, Ohio, USA Kurt C. Stange is a family and public health physician, practicing at Neighborhood Family Practice, a federally-qualified community health center in Cleveland, Ohio,, USA. At Case Western Reserve University he is a Distinguished University Professor, and is the Gertrude Donnelly Hess, MD Professor of Oncology Research, and Professor of Family Medicine and Community Health, Epidemiology & Biostatistics, Oncology and Sociology. He is an American Cancer Society Clinical Research Professor, and serves as editor for the *Annals of Family Medicine* (www.AnnFamMed.org). He is working on Promoting Health Across Boundaries (www.PHAB.us), and is active in practice-based, multimethod, participatory research that aims to understand and improve primary health care and community health. He is a member of the Institute of Medicine of the US National Academy of Sciences.

Lady Marina Marks, PhD. Founder President of ETHICS.

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EXECUTIVE SUMMARY

Aim: This document sets out a range of options for the integration of mental health promotion and prevention into primary care and the primary care role in practice, commissioning, service design and the creation of healthy communities. These proposals arise from an expert think tank, convened by ETHICS in collaboration with the London Journal of Primary Care. The think tank included professionals from primary care, public health, psychiatry, community development, clinical practice and commissioning. There was expertise in qualitative and quantitative research, epidemiology, guideline development, education and training, intersectoral collaboration, situation appraisal and policy development.

Rationale: There are a number of key drivers supporting this initiative: the strong evidence for the value of mental health promotion and prevention to improving human, social and economic capital; the magnitude of the global burden of mental disorder and the importance of its prevention; the current evolution of the role of clinical commissioning groups; and the timely focus in the NHS's Five Year Forward View (2015-2020) policy on improving health and wellbeing, health promotion and prevention, and on developing a closer relationship between primary care and the community. Thus there is an opportunity and imperative at this time to give guidance on how to address the complex issues that are the scope of this paper. This multi disciplinary think tank provided a unique opportunity to draw on evidence and expertise to make recommendations within this context.

The core principles by which the ETHICS think tank guided its work included the WHO definitions of health and mental health (MH), the public health framework for health promotion and prevention, the need for parity between mental and physical health and the value of a biopsychosocial approach to health.

The key proposals of the ETHICS think tank.

These are summarised for different "levels" of the system.

Communities: communities are diverse in their needs and assets and should be key to identifying local resources and solutions. *Community engagement and development* should be an integral part of every level in the health system. Community development may be assisted by inclusion of:

- mapping of social determinants and resources and developing community supports and resilience in a way that prevents mental health problems and disorders.
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- community development workers posts which would facilitate community building, social capital and thus health promotion and prevention.
- citizenship discussions *in* schools, the community and PHC and how they might be improved
- efforts to support gender equality.

GPs, practice nurses and other primary care health professionals. Professionals have the opportunities and challenges of day to day contact with clients and responsibility for their own professional development and well being. They should incorporate:

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- mental health promotion and prevention in their *daily work*, so that all clients have access to evidence based mental health promotion and prevention
- *a systematic and proactive biopsychosocial approach in all consultations*. This will include assessment and management of mental and physical disorders, addressing comorbidity where necessary, and following NICE guidelines for stepped care and appropriate referral if necessary.
- consideration of every *teachable and learning moment* to promote mental health and prevent illness.
- consideration of the individual's *social determinants* to inform prevention and management of illness
- consideration of the local *community context*, to inform collaborative intersectoral action on social determinants of health and illness.
- mental health promotion and prevention in their *continuing professional development*, to develop knowledge, skills and behaviours so that all front line health professionals are confident and able to promote mental health, prevent ill health as well as to assess and manage mental disorders across the life span in all consultations, taking into account the interrelationship between physical and mental wellbeing and social risk factors such as unemployment and debt.
- consideration of their *own physical and mental health* promotion and self-care as health professionals and employers within their practice, workplace and daily lives, conducting reflective practice and supporting a culture of improving quality
- development of *integrated multiprofessional professional networks and teams* (examples include: primary care networks and inter professional teams, nurse networks and integrated nursing teams).

Practices are well placed to create systems and environments for patients and staff where

- individuals can flourish under supportive and inspirational leadership. Key to this will be ensuring there are opportunities for personal and *professional growth*, an enabling environment that supports *shared learning* and prioritising the mental and physical health and wellbeing of staff at the workplace.
- all members of the primary healthcare team are engaged in *promoting mental health*, including receptionists and Health Care Assistants (HCA)
- the practice organisation including protocols and information systems are set up so that:
 - staff members have *timely access to information and resources*, which can be shared with other members of the primary health care team, and used with patients for promoting mental health ; individuals can find what they need, when they need it, and match their need with what is available
 - mental health promotion and prevention activities are *prompted and recorded* to maximise opportunistic approaches. Examples would include: new patient checks, pregnancy checks and immunisation consultations as well as in routine consultations. Call and recall systems may support this.
 - staff members receive *clinical reminders* about the severity and range of social risk factors and how to address them
- support and information on social risk factors and the local community context is well understood and utilised. Information is available and utilised on how to address these by

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direct action, by *signposting* to other relevant agencies, and by *intersectoral collaboration* eg debt, unemployment, housing problems, marital problems, alcohol, tobacco and drug misuse. Community development workers would be a useful resource to make this possible. Social prescribing may be one approach.

- all health professionals are actively able to participate in *regular continuing professional development* as above (see recommendations for primary care staff). This should include training in multi- disciplinary and in integrated professional networks). It may include how to manage the mental health or psychological aspects of consultations eg treating clients with dignity, breaking bad news,
- Mental Health First Aid (MHFA) training and annual updates are given to all practice staff.

Clusters of practices, whilst varying in size and function, are well positioned for intersectoral collaboration and developing programmes at supra practice level. They could develop

- appropriate *leadership models and support for community development* and social action on health. This may include community development workers working across the cluster
- *Intersectoral working*. One example is working with schools to help them implement the whole school approach to mental health. Staff could offer talks to teachers on common childhood mental health problems and thus strengthen the capacity of teachers to recognise and support children with mental health problems and to refer to primary care where necessary.
- *Educational and professional development and networking including:*
 - *Mutual practice support and training* for MH Promotion
 - *Multidisciplinary education* opportunities and a hub of educational resources
 - *Integrated professional networks and teams* eg integrated nursing teams so health visitors, district nurses and practice nurses work together.

CCGs as responsible local commissioners, and members of the local community as leaders with a place on the health and wellbeing board could:

- *Include mental health promotion and prevention where appropriate in all commissioning contracts*
- Include mental health promotion, prevention, and a biopsychosocial perspective in all provider contracts , including addressing comorbidities..
- *Undertake joint commissioning with local authorities of evidence-based interventions to promote mental health* such as:
 - Parenting classes in schools
 - Parenting classes of all age groups in low income families
 - a whole school approach to mental health promotion
 - MH First Aid training for all
 - Community development and integrated joint community-based work
 - Identify and address major social risk factors such as personal debt, in people with existing mental health problems, and in all routine clients.
- *Collaborate with research centres* to support local efforts for good mental health
- *Collaborate on professional and patient educational initiatives* to support local efforts for good mental health
- *Support practitioners and managers* to undertake learning and inquiry that help them to make iterative improvements in their practice

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- *Utilise equality and diversity obligations* to empower mental health promotion in all work streams

Health & Wellbeing Boards can utilise the Board and the Joint Health and Wellbeing Strategy (JHWS) and their legal responsibilities to harness multi agency collaboration to promote positive mental health and address determinants of mental ill health for the local community:

- *Utilise JSNA and conduct a bespoke needs assessments* to map the needs and assets of the community relating to mental health and its determinants
- *Develop intersectoral relationships across the Community*
- appoint a *Mental Health Champion* on the Health Well-Being Board to link to all sectors
- Agree and ensure implementation of *multiagency priorities in the JHWS* to improve mental health and its determinants. Examples include:
 - suicide risk reduction
 - debt and related issues
 - the Healthy Workplace agenda: renew, implement within the health system and prioritise actions across organisations to support the mental health and wellbeing of workers
 - *Utilise equality and diversity obligation* to empower mental health promotion in all work streams

End note: We hope this document will save lives and save money by contributing to the increased emphasis on mental health promotion and prevention in primary care in the NHS, other sectors and the wider community.

MENTAL HEALTH PROMOTION IN PRIMARY CARE**RATIONALE**

Rationale: There are a number of key drivers supporting this initiative: the strong evidence for the value of mental health promotion and prevention to improving human, social and economic capital; the magnitude of the global burden of mental disorder and the importance of its prevention; the current evolution of the role of clinical commissioning groups; and the timely focus in the NHS's Five Year Forward View (2015-2020) policy on improving health and wellbeing, health promotion and prevention, and on developing a closer relationship between primary care and the community. Thus there is an opportunity and imperative at this time to give guidance on how to address the complex issues that are the scope of this paper. This multi disciplinary think tank provided a unique opportunity to draw on evidence and expertise to make recommendations within this context.

Good mental health is important for the educational achievement of children and their future prospects, for the physical health of the population, for the social capital of communities, and for the economy. We can say good mental health is important for human, economic and social capital. However, 9.5% of children and 17.6% of adults have a mental disorder of some kind at any one time and mental disorders in the UK cost around £100 billion a year. Mental disorders are the leading cause of sickness absence in UK, leading to 70 million sick days lost per year. Indeed, 44% of employment and support allowance benefit claimants report a mental disorder as the primary diagnosis. The cost of crime by those who had conduct problems in childhood is £60 billion in England and Wales.

The factors associated with higher rates of mental disorder among children include Child abuse; bullying, institutional care in childhood; Physical health problems; Having special educational needs; Lone parenthood; Reconstituted families; Poor educational levels; Unemployment; Low income; Psychological distress among mothers and family discord; Poor parental mental health; Separation of parents; Parents in trouble with the police; Deprivation and Lack of social cohesion.

The factors associated with higher rates of mental disorder among adults include: being Female, Aged between 35 and 54, Social class V, Tenants of Local Authorities and Housing Associations, Separation or divorce, Living as a one person family unit, or as a lone parent; Debt; A predicted verbal IQ of 70–85, Impaired personal functioning, no formal educational qualification, One or more physical complaints, being in prison.

(see Appendix 2 for further information about mental health and mental disorders, their risk factors and consequences, costs, interventions and policy parameters.)

PRINCIPLES

The ETHICS/LJPC think tank conducted its work based on a number of principles, set out here.

WHO definition of health 1948¹

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

WHO definition of positive mental health. 2001 and 2005.

Mental health is more than the absence of mental illness: it is vital to individuals, families and societies. It is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In this positive sense mental health is the foundation for well-being and effective functioning for an individual and for a community.

Parity of esteem between mental and physical health. This means parity of time, energy and resources, and commissioning expertise between

- mental health promotion and physical health promotion
- prevention of mental disorders and prevention of physical disorders
- early detection and treatment of mental disorders and early detection and treatment of physical disorders
- rehabilitation of mental disorders and rehabilitation of physical disorders
- prevention of premature mortality in people with mental disorders and people with physical disorders

Parity of esteem also means parity of

- data availability
- measures in outcomes framework
- standards
- expectations of services

General practice plays a crucial role in delivering population health

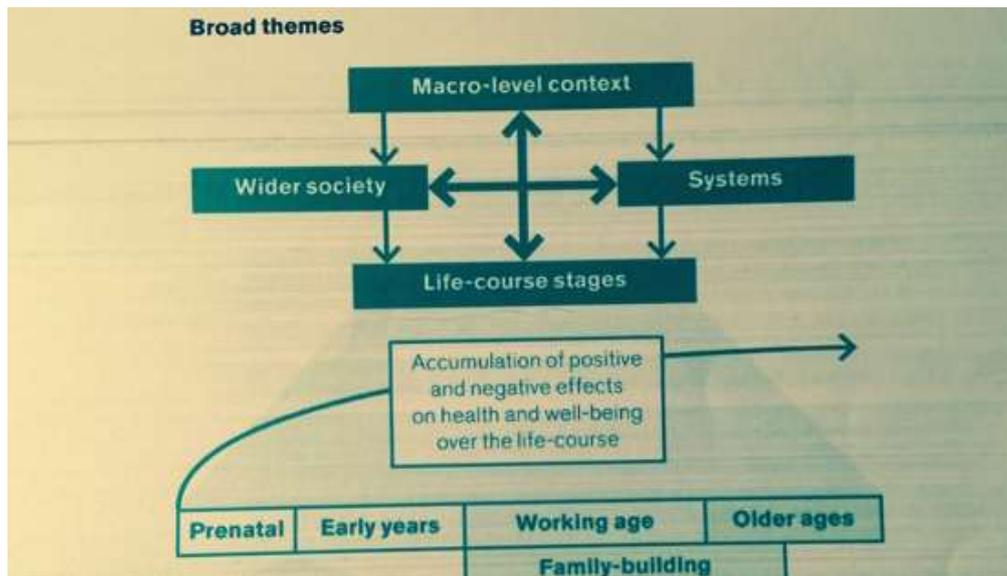
To get maximum benefit, primary care needs to be well integrated with specialist care, other sectors and communities

It is crucial to take a life course approach when considering interventions

A life course approach was recommended by the Foresight project on mental capital and wellbeing because it ensures attention to each stage of the life course, takes account of the cumulative impact of exposures to risk factors at each stage of the life course, addresses the intergenerational impacts of health, illness and risk factors; and contributes to a comprehensive biopsychosocial perspective. Life course stages include Preconception, Pregnancy, Baby, Childhood, Adolescence, Young adult, Working adult, Older adult, and End of life

(Key reference is Jessica Allen, SDH paper)

Figure1: Life course model. WHO 2014



It is crucial to consider the wider environmental determinants of health and illness and therefore to take a biopsychosocial approach to prevention, assessment, diagnosis and management. Good medicine always encompasses the psychological and social dimensions

The 5 Year Forward View :

“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health”

THE ETHICS/LJPC THINK TANK

These proposals arise from an expert think tank, convened by ETHICS in collaboration with the London Journal of Primary Care. The think tank included professionals from disciplines including primary care, public health, psychiatry, community development, clinical practice and commissioning. There was expertise in qualitative and quantitative research, epidemiology, guideline development, education and training, intersectoral collaboration, situation appraisal and policy development.

We worked through a five day residential programme. We alternated small group discussions and plenary sessions devoting: half a day to introductory matters, 2 days to consideration of the life course, two days to consideration of the system levels, and half a day to concluding summaries (see Appendix 1 for details). The background documents including evidence summaries and real time information sharing was available to the whole group.

THE GROUP CONSIDERED THE FOLLOWING QUESTIONS**How can primary care contribute to:**

- mental health promotion?
- primary prevention of mental illness?
- early detection and prompt treatment of acute illness?
- prevention of premature mortality of people with mental illness?
- the creation of healthy communities and addressing the social determinants of mental health?

For all the above questions we considered the role of primary care, the support needed for action and the important external cross linkages to other sectors at the following levels:

- communities
- professional staff
- general practice
- clusters of practices
- CCGs
- Health and Wellbeing Boards

For all the above questions we also considered issues and solutions across all stages of the life course (see xx above)

THE CURRENT CONTEXT OF PRIMARY CARE

Primary care is overwhelmingly trusted by the patients that use the service. It is rooted in community and place, usually has local people working in it and offers a wide range of skills and links to serve its populations. It represents the key part of the commissioning process and, theoretically at least, wields significant power over the local NHS and the populations it serves.

It is also underfunded, overstretched, increasingly inaccessible and demoralised.

It is therefore uncomfortable to offer the recommendations suggested here at this time. Nonetheless, we think that the benefits to system, to community and to people are so significant that these evidence-based interventions cannot wait.

Many of the interventions can be part of routine primary care, mainly by GPs and nurses. Once integrated into routine care, they may not actually create more ongoing work. Much of the wider work can be organised at CCG and HWB levels.

ETHICS PROPOSALS AT SYSTEM LEVELS**COMMUNITIES AND COPRODUCTION**

Communities should be considered at every level in the health system, to enable mapping of social determinants and resources, and development of community supports and resilience. The creation of community development workers could facilitate this process. Work needs to begin from the issues that matter to local people, emerging through discussion. Agencies tend to see community problems through their priorities – better eating habits, drug avoidance, less crime. Evidence suggests that it is targeting the key issues as seen by the community that results in health protection and resilience. Community development (CD) has to inform and guide agencies at the same time as it motivates and energises communities. Local agencies need to be persuaded to enable their front-line to get involved, learning to see local residents as assets and sources of solutions, not merely as presenting needs.

For residents deeply involved, it can be life-changing – finding new skills and influence. For others who help occasionally in the process it can raise confidence and provide a sense of purpose, and to gain new skills; sometimes increasing employability. For the majority, the benefit may be a service change or an improving neighbourhood. Achievements lead to new strata of community involvement and the benefits to health become apparent as seen in the examples below – link....

What's in it for GPs and practices?

CD can offer a practice an insight and an inroad into the communities it serves. CD can enable a practice to have some impact on the social determinants of health. It can help a practice begin and hold a dialogue with local people. And there are opportunities for practices to work with CD to offer facilities and ideas for local people that could at little cost make a big difference to some groups. Offering premises to local groups can make a significant difference to the viability, effectiveness and reach of local groups and practices and hospitals should consider this as a routine offer, if space is available.

In Lewisham, for instance, a CD project helped a practice solve some difficult ethical and practical conundrums by opening up a dialogue with local groups. These included whether to charge immigrant patients and how to deal more effectively with the housing department. The project, by working with young people and the council, created a whole new service which operated out of hours in the surgery, bringing young people and health services together in new ways. The project also helped the practice see itself through others' eyes. Feedback was enhanced and understood – and acted upon.

The simplest benefit of a strong local CD presence is the ease with which a practice can learn more about relevant third sector groups – and more easily refer to them. Improved relationships can also make it easier for practices to have groups working and offering services in the practice. The

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practice could identify patients with complex problems and the CD worker could work with them to identify social aspects of care that could be harnessed for their benefit. PPGs could be supported by CD workers to become more effective. There may be mutual interests faced by practices, their patients and local voluntary groups such as housing issues, education issues, poor food outlets. CD can help practices campaign to change these aspects of civic life. Collaboration for better services can be very powerful.

What's in it for the CCG?

Community development helps communities agree local priorities for change that matter to them. Community development helps them build local consensus and local structures, such as resident-led partnerships, that support a dialogue between the community and the CCG and other statutory agencies as appropriate. Representatives of health, education and the police can find themselves together in a room with residents solving problems spanning a range of issues. Often they have never met the other agencies before. Experience suggests that changes towards these local priorities can be rapid. Community development can be a powerful way of implementing the CCG's responsibilities for participation. Seeing the NHS, education and housing as common contributors to locality health becomes in effect a way of integrating services and attitudes from the grass-roots. The national movements bringing social care and health together can begin in localities. CD can also assist CCGs in their responsibility for improving health inequalities. Marmot is clear that community cohesion is a pre-requisite for tackling health inequalitiesⁱⁱ. There is some evidence that healthy behaviours can be enhanced through CD, or at least through peer support which CD can promoteⁱⁱⁱ.

Health and Well Being Boards can contribute greatly to the power and significance of CD, as they have similar coordinating responsibilities^{iv}. We see that joint commissioning through the LA and CCG is one route to sustained and more or less reproducible community health development. We suggest that each Health and Well-Being Board and CCG should have a community development strategy and/ or infrastructure/ workforce.

Mental health is an issue for all sectors, not just the health sector. The factors affecting resilience, vulnerability to illness and consequences of illness are to be found across all the domains of life. This means that interventions to promote health and prevent illness are needed all sectors, and so it is necessary to develop close intersectoral dialogue and collaboration at every level in the health system to promote mental health and prevent mental disorder.

GPs, PRACTICE NURSES AND OTHER HEALTH PROFESSIONALS

Primary care professionals have the opportunities and challenges of day to day contact with clients and responsibility for their own professional development and well being.

Here are a set of proposals that will integrate MH promotion into the daily work of practices.

Mental health promotion and prevention in daily work, so that all clients have access to evidence based mental health promotion and prevention.

- availability to patients of apps such as baby buddy <http://www.bestbeginnings.org.uk/babybuddy> Emmas diary www.emmasdiary.co.uk grandparents plus <http://www.grandparentsplus.org>
- mental health promotion and prevention are prompted and recorded eg at new patient checks, call and recall systems, immunisation consultations, as well as in routine consultations.
- Members receive clinical reminders about the severity and range of social risk factors
- Early identification and intervention especially for childhood disorders.

All staff skilled, confident and comfortable at assessing the severity of depression and severity of suicidal risk. If there is a hint of depression, its severity should be assessed, and if depression is present, then suicidal risk should be assessed. This includes:

- *a systematic and proactive biopsychosocial approach in all consultations for the assessment and management of mental and physical disorders*
- Consideration of the individual *social determinants* to inform prevention and management of illness
- *Consultations where the clinician shows respect, empathy and warmth while none the less systematically exploring and analysing the key issues*

Use every teachable and learning moment to promote mental health and prevent illness.

- Clinicians can ask open questions about mental wellbeing–
 - How is work? How is home? Are you feeling stressed?
- Clinicians can also be aware of common ways in which people with depression and anxiety may present, for instance:
 - Sick Note requests
 - Fatigue
 - Back Pain
 - Headache
 - Mood change
 - Life transition
 - Any Long Term Condition
 - Attendance by someone who rarely visits the practice especially older male.

Harness the local community context, to inform collaborative intersectoral action on social determinants of health and illness.

- Solid links to be built up with existing local community development workers and support at CCG level for new ones.

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- The social risk factors, when identified can be addressed by direct action, by signposting to other relevant agencies, and by intersectoral collaboration eg debt, unemployment, housing problems, marital problems, alcohol, tobacco and drug misuse.
- This requires the practice knowing the relevant local third sector or statutory groups
- the local community context is thoroughly understood, local resources are mapped, and social prescribing resources and methods of signposting are created.

Mental health promotion and prevention in continuing professional development, using a knowledge, skills and attitudes framework, so that all front line health professionals are able to promote mental health and prevent ill health across the life span in all consultations, as well as to assess and manage mental disorders

- all health professionals in the practice receive regular training about the routine assessment and management of common mental disorders, including suicidal risk, and including assessment of social and physical risk factors which may precipitate and prolong illness unless addressed.
- all members of the practice are prepared for the usual mental health aspects of client contacts by in-practice education and role plays around various scenarios so that distressed clients are treated with dignity, respect and understanding, and speedy access to a health professional.
- all staff receive training in appropriate roles in breaking bad news about physical illness.
- all staff undertake mandatory Mental Health Promotion and Mental Health First Aid (MHFA) training and mindfulness training receive annual updates.
- Regular practice meetings of all practice staff to discuss practice improvements in mental health, practice policies about issues such as safeguarding, etc
- *Strengthen communication skills*, motivational interviewing skills, CBT skills for GPs and nurses

Consideration of their own physical and mental health promotion and self care as health professionals within their practice workplace practice and daily lives, conducting reflective practice and supporting a quality culture.

- Learn ways to encourage, experience and model a positive climate in workplace and balanced lifestyle; including staff environment supporting healthy diet, time for exercise, family time, congratulate successes
- Ask for and expect protected time to engage in local community development, serve on representative committees, attend CCG and other board meetings, leadership development
- Interact with media and professional groups to raise awareness of practice nurse role in primary care; learn to promote positive mental health and wellbeing in role as member of community
- Ask for and expect protected time for professional reflection and lifelong learning
- individuals can flourish, where there are opportunities for personal and professional growth, under supportive and inspirational leadership, and an enabling environment that supports shared learning amongst all.

Managing practice information systems and processes to support MH promotion

- Review of *modus operandi in primary care consultations* e.g. length of time slots to enable assessment and management of social risk factors as well as physical and psychological problems, more proactive consultations, regular review of social risk factors, biopsychosocial assessments and care plans. There are other useful techniques such as Living Life to the Full

Mental health promotion saves lives

- Consider how best to handle plethora of *NICE guidance* - does it also need simplifying to make it manageable and readable within the consultation?
- *Intersectoral committee at practice level* to drive service developments – see stepped care NICE guidance above on potential membership, but we would suggest: community nurses, including HVs; social workers, CPN if such exists; local third sector representative; local community worker.
- Can practices provide *online screening in waiting room* so more information available in the consultation, saving time
- *Computerised reminders* of issues to check/discuss.
- **Consider a practice audit to check**
 - How many people with various risk factors
 - Each practice provides speedy access to interventions to address risk factors including debt management, marital counselling, bereavement counselling, child abuse, housing problems etc.
 - How many people with severe mental illness, autism, learning disabilities
 - How many people with forensic problems
 - How many suicides and how many premature deaths.
 - Each practice provides speedy access to interventions to address resilience factors
 - Use of good practice guidelines on mental health promotion, prevention, treatment, rehabilitation, prevention of mortality
 - Effective support for people after suicide attempts
 - All practice staff well trained in assessment and management of suicidal risk

Practice Nurses Nurses have many important opportunities to support this work. They see large numbers of patients with both physical and mental health problems. They have often more time than GPs. And they often have particularly good long-term relationships with patients. Practice nurses are employed by GPs. This can be very helpful, but it can also inhibit their ability to train and take time out of routine work. Nurses in other key services such as sexual health will have many opportunities for MH promotion.

Generic medical and nurse education in mental health issues

Ideally, the content of basic generic medical and nurse education should include

- core concepts of mental health and illness,
- an outline of the social determinants of health
- how social networks enhance resilience
- The prevalence and consequences of disorder
- mental health promotion and prevention
- generic psychosocial skills
- a biopsychosocial approach to assessment, diagnosis and management
- cross cutting themes and intersectoral issues.
- online and in-person positive and effective communication skills for use with a variety of clients across the lifespan

Mental health promotion saves lives

As well as implementation in basic and postbasic medical and nursing education, continuing professional development is also important. Options for implementation include:

- cross training/shadow experiences in mental health settings including home visits, CAHMS, inpatient MH, including child and elderly populations
- Support to enable employers to release nurses and other practice staff for training.
- Use of appraisal and revalidation to support training
- Mentoring schemes
- identify a mental health promotion Practice Nurse champion in every practice diploma and degree (BSc/MSc) training programmes are available in health promotion for nurses and others in the local area.
- *Consider a train the trainers approach.* This is being done in Sheffield and in Ealing.

CLUSTERS OR NEIGHBOURHOODS OF PRACTICES

Clusters represent a population of about 30-50K people, a good size to align services and facilitate collaboration for good mental health promotion. Clusters of practices need to develop a leadership model that enables the following:

- Intersectoral work, for example with schools to help them implement the whole school approach to mental health, and offer talks to teachers on common childhood mental health problems and their management, thus strengthening the capacity of teachers to recognise mental health problems in children, support them within the classroom, and to use the referral pathway to primary care where necessary.
- leadership and support of community development and social action on health, including possible community development workers
- Integrated Nursing Teams
- Multidisciplinary opportunities and a hub of resources for education, training and support.

The information needs for a GP cluster to improve population/community mental well being

- Decide geographic boundaries of cluster-ie what practices are included in the cluster, and how it relates to local authority boundaries
- Map the context and resources of the local neighbourhood covered by the cluster
 - Sociodemography of Population, urban/rural, age structure, ethnicity/language/migration,
 - Services available –health, social care, education, youth and criminal justice services, NGO /voluntary sector
 - Community organisations
 - What staffing do they have
 - What are the current interagency boundaries and what can be done to enable closer working?
 - Find out what local data is available on mortality, morbidity, risk factors, resilience factors
 - If no local data, extrapolate with wisdom from national datasets.

Mental health promotion saves lives

- Draw up a list of key resilience factors that are locally relevant eg parenting classes, exercise classes, language classes for immigrants, whole school approach to mental health promotion.
- Draw up list of key risk factors that are relevant locally eg income disparity, debt, marital breakdown, substance abuse
- Work out what risk factors are crucial to address within the neighbourhood cluster eg access to debt counselling, housing advice, benefit advice, marriage guidance, people with problems with alcohol. It is very difficult to address income disparity but much can be done to help people in debt.
- Draw up list of local vulnerable groups eg looked after children, ex-prisoners, older isolated people, teenage gang members
- work with any local community development to make this process easier

CLINICAL COMMISSIONING GROUPS

CCGs are in a unique position to plan, design and buy mental health PPP and work in partnership with other organisations (e.g. local authorities). The evidence-based opportunities to engender mental health promotion and early intervention lie in developing local commissioning intentions.

We propose that CCGs:

Expect mental health promotion and prevention to be included in all commissioning contracts and in all service provision by prompting mental health promotion, prevention, a biopsychosocial perspective and addressing comorbidities.

Undertake joint commissioning of evidence-based interventions such as:

- Parenting classes in schools
- Parenting classes for parents of all age groups
- a whole school approach to mental health promotion in schools
- MH First Aid training across all depts./sectors
- Community development and integrated joint community-based work
- Addressing major social risk factors such as personal debt, both in people with existing mental health problems, and in all routine clients.
- Expect research centres to support local efforts for good mental health
- Expect educational initiatives to support local efforts for good mental health

Promote integration of care, whole systems development and multidisciplinary team working within the community

- In ways that are equitable across the CCG i.e. not one lucky general practice receiving frequent specialist visits, and other general practices receiving none; but rather solutions that are practicable for all general practices in both rural and urban areas.
- This means that the CCG needs a map of its PHCs and its specialists, and to work out an equitable framework for supportive visits, content of visits e.g. educational sessions, seeing difficult clients together, planning joint work or joint care plans etc.
- Also map what specialist input is made into practices now as it may be very inequitable across the practices, and may also not be tailored to distribution of needs.

Mental health promotion saves lives

- Focus on early detection and early interventions for all disorders, especially childhood disorders (eg dyslexia, ADHD, emotional and conduct disorders, autism), depression and psychosis

Promote IT systems that support

- Interactions between primary and secondary care; Patient online record access <http://www.england.nhs.uk/ourwork/pe/patient-online/>
- Intersectoral working between health, education, social care, criminal justice;
- Good practice guidelines , simple enough to be used within the consultation;
- Clinical Audit and service improvements
- Monitoring risk factors at individual and community levels
- Data sharing within practices, between practices, across CCG, between Primary and Secondary Care, and local authority public health planning

Integrate mental health promotion into all care pathways for people with physical and/or mental illness.

Intersectoral (multi-sectoral) committee at commissioning level to monitor community level risk factors, evaluate service improvements and drive service developments

- **Area Audit** to find distribution of risk factors and of clients needing sub-speciality services e.g. forensic.
- **Equality impact assessments of work of Secondary Care Trusts.**
- **Equality impact assessments of work of Primary Care.**

HEALTH & WELLBEING BOARDS

The HWB should have a mental health champion, and should prioritise action on mental health . Health and Wellbeing Boards are important vehicles for engaging multiple sectors in achieving mental health.

Use JSNA documents to

- map mental health promotion needs accordingly
- informing strategy, priorities and improving outcomes in mental wellbeing.
- agree cross cutting priorities

Consider a Joint Needs and Assets Assessment.

This would explore local community assets, taking a positive approach to the community rather than focusing exclusively on deficits. These could include people, places, and skills. An example can be found here:

The JHWS is an opportunity to strengthen the development of intersectoral relationships to make linkages with the community and implement good practice and influence commissioning.

Ensure there is a Mental Health Champion on the HWB to serve as links to all sectors, most importantly the community. A mental health champion at HWB level can advocate for this challenging agenda across intersectoral working.

Mental health promotion saves lives

Agree and ensure implementation of multi agency priorities within the JHWS eg

- Suicide and self harm risk reduction
- Debt and related issues
- Whole school programmes for mental health promotion
- Ensure community wide mental health first aid – saving lives just CPR training

Model the Healthy Workplace agenda and prioritise it across organisations

This supports the mental health and wellbeing of workers, reduces sickness absence and increases productivity and has been shown to be cost effective.

Ensure member organisations utilize and enforce equality and diversity obligations to empower mental health promotion in all work streams .This statutory legislation **ref** provides opportunities to support mental health by, for instance, reducing stigma and discrimination and promoting healthy work practices that which impact on mental health and wellbeing.

The health sector to collaborate with social care to provide local access to interventions for

- Debt management
- Marital breakdown
- Parenting skills
- Domestic violence
- Child abuse
- Violence
- Street children and gang cultures
- Looked after children-multi axial care plans while in care, and after leaving care.
- Lonely older people and young mothers-social network enhancement
- Housing and benefit problems

The Health sector to link with education to provide local access to interventions for

- Whole School Approach to mental health promotion-security, trust, communication and positive regard.
- Bullying and cyber-bullying
- Detection, assessment and management of childhood disorders
- Looked after children

The health sector to link with criminal justice to provide local access for those people in touch with police, probation and prisons, supporting interventions on

- Dyslexia and educational failure
- Conduct disorder
- ADHD
- CMD
- Psychosis
- suicidality
- Multi-axial Care plans and pathways established prior to leaving prison, so no gaps as person moves into community.

ii Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

The Definition has not been amended since 1948.

ii Fair Society, Healthy Lives Strategic Review of Health Inequalities in England post 2010 p139 The Marmot Review February 2010 © The Marmot Review ISBN 978-0-9564870-0-1

iii <http://www.nice.org.uk/guidance/ph9/resources/guidance-community-engagement-pdf>

iv <http://www.radcliffehealth.com/ljpc/article/health-and-wellbeing-boards-new-public-health>

ETHICS PROPOSALS AT LIFE COURSE LEVEL FOR PRIMARY CARE.

The ETHICS think tank proposes the following interventions by primary care at each stage of the life course.

PRECONCEPTION

Mental health promotion and prevention topics relevant for primary care

General health promotion

- Give information about general life style issues of nutrition, exercise, and contraception
- Dialogue about contraception for young people when they become sexually active- who can they go to
- Discussion of sexual relationships and sexual problems
- Debt reduction before pregnancy, as personal unmanageable debt is a major risk factor for mental disorders.

Reproductive health promotion

- Education about preconception, pregnancy, parenting, babyhood and childhood needs to be improved in schools.
- It is important to support young women to have choice and to be able to make considered decisions about sexual behaviour, sexual health and pregnancy,
- Pregnancy planning for men and women important. Important not to use the baby to repair an inadequate relationship. Action for men concerned about fertility, reducing stress to improve sperm count.
- Infertility – increase emotional support throughout experience .Consider the cultural and individual consequences of infertility.
- Be aware of and understand impact of mental illness and associated medication on pregnancy/parenting

- Have information available in the consulting room.

Prevention

- Avoid unplanned pregnancies. The UK has a high teenage pregnancy rate which is associated with subsequent mental disorders in mothers and children..

How to implement:

- Conversations need to happen in schools, communities and practices
 - Schools can provide teaching about the responsibilities of sexual behaviour, pregnancy and parenting, but some religious groups create barriers to this provision in schools.
 - PHC consultations can provide information about sexual health, contraception, preconception issues
- Practice outreach can provide education to boys' groups, youth clubs, looked after children and young people with learning disabilities
- Community Education Provider Network
- Professionals need training to deal with these issues
- Have information available in the consulting room and electronically to help build resilience

PREGNANCY - MENTAL HEALTH PROMOTION RELEVANT FOR PRIMARY CARE

Build community connections and social networks during pregnancy, e.g. around advice about breastfeeding, healthy lifestyle, delivery etc

Raise awareness of

- impact of being a parent
- parenting skills
- environmental issues and green space
- social networks
- possibility of baby blues
- Epigenetics-cumulative stress is transmitted intergenerationally. Pregnancy stress bad for baby

Recognise and address impact of miscarriage and pregnancy termination

Strengthen social networks and relationships.

- Find out who is at home.
- Group support during pregnancy – community and NHS based
- Internet support eg Mumsnet

Prevention relevant for primary care

Target support to vulnerable groups eg

- people with existing mental or physical health problems,
- people with learning disabilities,
- TOPS,
- infertility,
- multiple births

How to implement**Get to know neighbourhood and community**

- Need joint meetings and co-education with schools, employers, community, third sector, faith communities etc to share knowledge and link resources (not just during crises)
- Employers – offer an education programme so that employers support pregnancy
- Social marketing research to learn how to reach different communities
- Use community based communication strategies and media to reach hard-to-reach populations.
- Have focused information available to both young and mature mothers/fathers families

Parenting classes-preferably multidisciplinary

Look for opportunistic “teaching moments” for people who are hard to reach

- Use pregnancy, baby immunization, infections, cervical smears, sexual health consultations, family planning consultations as “teachable moments”, taking biopsychosocial approach with the parents. Every contact counts-very important for mental health, listening, asking questions and giving information
- Explore the important contributions of male support to his partner during pregnancy and the importance of joint parenting.

Case-finding in pregnancy eg Edinburgh depression scale, and Interventions for stress and depression

- Midwife mental health awareness
- Use home visitors as community mental health workers
- Use pregnancy as an excuse for a home visit
- Identify high risk families and consider intergenerational effects
- Consider vulnerable and difficult to reach communities in your area
- Consider vulnerable groups eg people with learning disabilities, multiple births, people with physical health conditions.
- Discuss sleep hygiene and stress management tips for after the baby arrives

-
- Assess and manage Domestic Violence

Dialogue and action about these issues within the practice, with clients and with the community.

- Map what is already there in other sectors and make best use of resources
- Signposting in the practice
- Can amplify reach of general practice by
 - using community health workers to get better outreach
 - Partner with midwifery to support screening and healthy lifestyles
 - Improve education of nurses, midwives, health visitors, school nurses re: prenatal, postnatal, infancy, babyhood.
 - Health Visitors in particular often have poor training in mental health and mainly focus now on safeguarding rather than on broader proactive health promotion and prevention work. Safeguarding is of course crucial as child abuse is such a high risk factor for subsequent childhood and adult illness, but this focus should not be to the exclusion of wider issues.
- Making sure there are enough skilled nurses, GPs and others available onsite to enable good consultations when mental health promotion opportunities and red flags occur.
- Providing enough time during consultations for mental health promotion.

Information technology

- Can assist wide and appropriate implementation of mental health promotion, prevention, assessment and management guidelines
- help practitioners recognise women at risk
- short film clips give powerful messages.
- apps to deliver health messages. eg Emma's diary and baby buddy
- Patients having access to own clinical records
- Collate the conversations and information around the person, so that the team can pool and share information.
 - Consider use of a shared clinical record with patient consent. Such a shared record would need guidelines about data sharing and data protection issues to deal with the handling of sensitive information such as heroin abuse, family violence, financial information, and any subtle concerns raised by staff or relatives

BABYHOOD - MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS RELEVANT FOR PRIMARY CARE.
Parenting

- Maternity and Paternity leave encouraged to build family strength and parent baby bonding
- Employer supporting parenting and community involvement in child activities
- Give parenting tips during all consultations, immunisations etc
- Parenting skill training and support especially for 1st babies
- Fathers' role with babies
- Love and attention to emotional and physical needs.
- Family stability

Parental health

- Screen for "baby blues" during baby visits
- Be alert to depressed mothers and give information on sleep deprivation, nap when baby is asleep, eating well, permission to pace oneself, good enough mothering
- Sleep hygiene and stress management after baby born

Meeting baby's practical needs

- nutrition, especially poor families,
- education and support re breast feeding and weaning,
- avoiding allergies;
- cultural issues about weaning
- green space and fresh air

Social networks provide important social support and can buffer against the risk of depression; Moving house risks losing social networks

- Local parent and baby groups
- National Childbirth Trust meetings
- Local libraries
- Local swimming pools

Childcare issues

- Do childminders affect babies' MH? Should they have MH training?
- Nurseries?
- Grandparents (GrandparentsPlus <http://www.grandparentsplus.org.uk>)
- Family Nurse Partnership
- Looked after children-avoiding institutionalisation if possible

How to implement

- Use what is already available eg websites and apps, other settings eg places of worship

-
- Proactive case finding
 - Practices already often good at recognising families at risk, so need to take a proactive approach to communicating risk to the multidisciplinary team within the practice and the multisectoral team in the community, in order to align resources to support parenting, child and family in a sustained way.
 - ? risk register in the practice to assist regular review of families at risk
 - Child protection issues
 - Education for all sectors.

CHILDHOOD - MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS RELEVANT FOR PRIMARY CARE

General health promotion

- Nutrition
- Exercise
- Communication skills, Trust and sense of security are the components of the whole school approach to mental health promotion
- Develop resilience
- Coping with attachment issues so they don't prevent some children from full participation in school

High risk groups to address through targeted prevention

- Characteristics of the child
 - Child abuse: 18 x increased risk of emotional or conduct disorder
 - Physical health problems
 - Children with learning disability: 6.5 x rate of disorder
 - Looked after children (e.g. orphanages): 5 x rate of disorder
- Characteristics of the family
 - Lone parenthood: 2x increased risk of emotional or conduct disorder
 - Reconstituted families
 - Poor educational levels
 - Unemployment: 2-3 x increased risk of childhood emotional or conduct disorder
 - Low income: 3 x increased risk in lowest socioeconomic class
- Family functioning characteristics
 - Psychological distress among mothers and family discord
 - Poor parental mental health: 4-5 x increased risk of childhood emotional or conduct disorder

-
- Stressful life events
 - Separation of parents
 - Parents in trouble with the police
 -
 - Neighbourhood characteristics
 - Deprivation
 - Lack of social cohesion

Factors also noted by the think tank include

- Rented Housing, poor housing, overcrowding, garden sheds,
- History of previous poor parenting
- Extreme poverty and family debt
- Domestic violence,
- drug and alcohol in parents
- Children in brothels
- Mobile population

How to implement

Webs of Care:

- **how can HC professionals participate in, and help create webs of care in the consulting room, practice, cluster , and other social, voluntary and education sector agency?**
- **Schools and practices** often work in parallel rather than communicating and collaborating.
- How can we share information/concerns at school/practice level? Data Protection issues so best at informal level but important to develop links organically as required and felt to be of value.
- Liaison between School nurse, PHCT and CAMHS.

CAMHS liaison

- To enable early detection and intervention for conduct disorder, ADHD and other disorders – follow NICE guidelines , referring to CAMHS as appropriate
- To help practices to provide better care for patients (advisory/consulting service) and help easy referral for more complex cases.
- To provide formal outreach and Inreach? Psychotherapist/psychologist goes to practice, GP goes to school. Etc. Parallel with successful NWLondon 'Connecting Care4Children'

GP link with community work – feed issues into the community eg housing..

- Write letters eg to housing department (? Effective)
- Parenting: giving books, Triple P, **what is this?** picking up child protection issues
- Child protection issues – raise alarm!!
- school based interventions for conduct disorders
- Training eg with schools

Dialogue between practices and CCG

- narratives – problems at wider than practice level eg schools, neighbourhoods
- advocacy at all levels.
 - practice – bring challenging stories eg child protection problems ,
 - cluster – help collate/engage between CCG and practice,
 - CCG work with local authority for solutions.
 - national context eg local authorities cash strapped even for child protection
- Commission/make case for a community development worker local authority/CCG.
- Give examples of best practice for community development workers
- Leadership training for CCG boards to make the case for different things eg
- CCG boards should have insurance policy

HWB to encourage evidence based school based interventions

- social and emotional learning programmes to prevent conduct disorders;
- interventions to reduce bullying
- whole school approach to develop resilience through security, trust and communication.

HWB board includes representative with expertise in mental health**ADOLESCENCE - MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS RELEVANT FOR PRIMARY CARE.****General health promotion**

- Nutrition, exercise, movement, avoidance of alcohol, tobacco and drugs
- Nutrition problems often linked to poverty
- Breakfast before school
- Get rid of caffeine and food additives in schools
- Green space

Help schools to design and deliver whole school approach to mental health promotion

- Helping YP to develop resilience through a school atmosphere and linkages between the school, parents and the community that support a sense of security, trust and communication
 - Partnership between school and parents
 - Partnership between school and community bus conductors, shop keepers etc to empower local community to take an interest in this age group

-
- Address bullying, self esteem, and racism as early as possible
 - Ensure early recognition of dyslexia and dyspraxia, and appropriate long term management by teacher, parent, support teacher and educational psychologist.
 - Help teachers identify common MH problems, eg ADHD, autism, emotional and conduct disorders, how to manage and when to refer to GP
 - Ensure inclusion of faith-based schools
 - Make use of school events, After school clubs, religious festivals, art lessons

Encourage social connectedness,

- gives a sense of possibilities to young people that they have something to give
- Engender hope especially post recession
- Mutually beneficial intergenerational work eg Young people teaching IT skills to older people (and getting to understand each other in process)

Signpost online directory of resources

- eg. Well informed.org.uk,
- guidance.com for counselling and CBT.
- <http://www.sheffieldhelpyourself.org.uk/>

Encourage pathways to employment

- Role models esp disadvantaged and minority groups
- Volunteering as pathway to employment + sense of worth (vs exploitation)
- Developing leadership skills / intergenerational work / role models
- Teaching and mentoring skills. Start young as long as appropriate support

Target vulnerable individuals who are at risk

- See childhood risk factors
- Those living with long term conditions to avoid biopsychosocial crises
- 15-17 year old male prisoners have 18 x increased rate of suicide,
- Gang membership
- Alcohol and drug use
- carers
- Learning disability

How to implement***Establish opportunities for community education of adolescents***

- eg Youth workers, community development officers talking about sex, drugs, R+R in many settings, eg barbers and train community groups in mental health first aid.
- Identify individuals vulnerable to radicalisation, and establish early interventions and care pathways - ? need further discussion – prejudices etc Parents and schools want help outside the criminal justice system.

Train clinicians to talk with young people

Use opportunistic adolescent consultations eg for contraception, cervical screening, STIs, depression and anxiety to

- Ask about suicidal risk
- Check for eating disorders
- Ask about oral sex when a YP presents with a sore throat

Establish dedicated adolescent drop in clinics

- link with local community intelligence eg newsagents and bus conductors to encourage young people to use drop-in clinics tailored to young people (see Newham)
- to address contraception needs, depression and anxiety, alcohol and drugs

young people sexual health project working with in particular gender /sexual issues-

Develop drug support- on line or one to one

Develop practice based risk lists

- Long term register for Learning Disability and the effectiveness of this in Sheffield, which helps identify patients.
- adolescents who have a number of risk issues – need systematic assessment and support using a sympathetic GP instead of criminal justice system

Develop case finding roles eg in school nurses, social workers, prison nurses

Create innovative links between primary care, specialist care and community care eg in roving police cars

Care navigation for individuals with complex issues

- especially with respect to physical and mental health need. 'Stepped care'
- Mind pathways service
- CAMS IAPT- use as a recourse for disseminating info into community

Primary care signposting of interventions to support mental health

- Big White Wall
- Social marketing, theatre groups, media, social media
- 24HR Helpline
- Headspace

Primary care partnership with schools

- Teachers spotting sleep deprivation in school
- Teachers spotting nutrition deprivation in school –no breakfast
- Difficult children observed by teachers on patrol outside the school gates, bus conductors, local businesses, newsagents
- Teachers and neighbours spotting young carers
- Empower the local communities to speak up and ‘feel safe’
- Dialogue and advocacy with teachers to ensure sustained life long support to young people with dyslexia, ADHD, autism, and learning difficulties with careful systematic handover between age groups and agencies.

Primary care partnership with employment sector

- Liaison with local job centres about programmes taking adolescents into volunteering and semi training?
- Establishing employment pathways – establishing work experience and internship tracks in place so that working class adolescents are as supported into employment as middle class adolescents
- social enterprise employment advice for people with mental health problems.
- Ensure positive role models for children of single parent (of opposite sex to single parent)?
- Provide mentoring via youth workers–

Primary care partnership with voluntary provision

- Voluntary and Community groups .
- Faith groups- existing charities (hard to reach communities)-
- Samaritans
- Boost social networks through Community Development
- Radio-media- TV specialist channels for certain communities- Somali radio (Acton based for young Somali kids)
- Places of worship- eg Mosque- Gurdwaras (young people club) – Hindu Temple – classical dance classes
- Use pubs, youth clubs, shop keepers, faith leaders for disseminating mental health promotion
- Mental health young people advisors
- Use festivals and events for promotion and platforms for key messages/information delivery
- Use media for addressing issues eg Somali – Sunrise – Desi Radio

Other Primary care linkages with

- Prison-based nurses
- Ensure support to young people going into prison and wrap around support on leaving prison

Identifying the champions both statutory and community organisations- way in-joint levers- what is it that we can offer each other to work

How to implement

- Up skilling staff in both statutory and community groups in a two way process-
- Share existing links and good practice across health networks
- Identify gaps collectively, gather data , information about good practice to make a business case, and move from a pilot project to a systematized , sustainable established service
- MDT example Villages Central London CCG-social care, environmental health etc- Care Navigator role- social prescribing
- Using parents as volunteers in schools
- Parent pupil teacher agreements
- Close liaison across Interfaces between primary care and CAMHS.s
- Find out through your council who your local community development workers are, and where they are.

WORKING ADULTS - MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS RELEVANT FOR PRIMARY CARE

General health promotion activities

- Understand the meaning of work (purpose, respect, status, income), what it can mean to fail at work, what it takes to be a good employer, mindfulness at work
- Within the consultation – when are the potential teachable moments? GP can ask open questions re mental well being–
 - how is work? how is home? Are you feeling stressed?
- Offer lifestyle support within the practice
 - Diet/Exercise/Stop smoking/Alcohol and sensible drinking/Sexual health
 - Provided by practice nurse/health care assistant
 - Refer to lifestyle programmes which need to be culturally sensitive
 - Consider activities like cooking and meal preparation classes – based within the practice, or that can be accessed by GP referrals, or can be sign-posted by GPs and practice teams
- Consider co-location of debt & employment adviser services either at a practice or cluster level. Likely latter will be more cost effective
- Advertise services of debt advisers/career/employment advisers in the practice.
 - Consider using text and multiple media (i.e TV screens in practices) as well.

-
- Housing adviser at a cluster level – source of stress for many adults
 - May reduce the need for requests to write supporting letters for housing
 - Information recorded within the notes on –
 - Follow up after deaths – immediate and possibly after a month with partners
 - Use new patient checks to ask open ended questions about well being
 - Create a list of resources at the cluster/CCG level – available to all practices of contact details of community services in the locality, voluntary groups and community groups and faith groups

Targeted prevention to high risk groups

Be aware that Ethnic minorities have 3 x increased rate of psychosis and 3 x increased rate of suicide, and Prisoners have 20x psychosis rate and (5x for men and 20x for women) suicide rates.

- Use new patient checks as an opportunity to identify patients at high risk and perhaps establish a re-call system via text e.g. 3 months after they have registered etc..
 - Is there anything that I can help with
- Check social domains of marriage, family, work, housing, money and leisure for stresses and supports.
- Use IT to flag up clients with multiple social and physical risk factors
- Identify fat folder patients, assess for depression and anxiety, and treat if present. Invest now to save multiple somatic consultations later.

How to implement.

Case finding within consultations

- Look for patients that have depressive symptoms

Mental health promotion for people with established mental health problems

- Outreach work to other sectors e.g. workplace, community groups and faith groups

Linkages between the practice and the employment sector

- a. How do we help those who fall out of work through unemployment or long term sickness?
- b. How do we help those who are ill but still at work
- c. Understanding good employment practice
- d. Working for free - as investment (internship) - as expected (artists, often) Integration of immigrants into workforce; Issues of race, and racial and other diversity
- e. Signposting, offering realistic advice in appropriate manner (viz. Dr's own experience of employment issues)

OLDER PEOPLE - MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS RELEVANT FOR PRIMARY CARE

General health promotion

- Understanding meaning and purposefulness of life in older age
- Strengthen existing settings and develop new settings for
 - for exercise, movement. Exercise and Movement prevents dementia, immobility, and pain and promoting wellbeing (also music, singing, other joyful activities)
 - social networks
 - lifelong learning eg a language
- At home , ensure
 - Pets and Plants!
 - Proper nutrition
 - Keep good heating; fuel poverty associated with mental and physical morbidity and mortality.
 - address social isolation by strengthening social networks, Befriending, and Intergenerational visits
 - Doing volunteering themselves
 - Access to transport
 - access to services incl primary care

Targeted health promotion and prevention

- Signpost Debt and finance advice services
- Carers support, information and discussion
- Acknowledging uncomfortable issues – extended families don't always care – older people scared/ashamed to share any mental health issues
- Signposting other support (beware digital exclusion!),
- Adult Safeguarding
- Social Isolation huge issue, major determinant of mental and physical morbidity and mortality. Need to work with CCG LA H&WBB, voluntary sector incl AgeUK, Alzheimer's.
- Strengthen social networks through community development and other interventions in people who are lonely, excluded, stuck indoors,, have low self esteem, feel superfluous
- Check for fuel poverty (cold is bad for the brain)
- Check for podiatry needs, to maintain mobility.
- Check for comorbidity, long term health conditions,
- Check for asset rich, income poor in case nutrition and heating etc compromised.
- Education/Training needs around Frailty

Opportunistic Action in routine consultations

- Encourage exercise by enabling access to community organisations eg Older people exercise in Day Centres. Walks for older people. Maintain mobility in care homes.
- Encourage healthy eating for people who are on low incomes by signposting to low cost, healthy cooking classes
- Facilitate befriending services
- Liaise with Churches and other faith groups

- Important to be around other older people (club society shared activities) and lived environment (live with others, access to transport etc).
- value of intergenerational experience (family, voluntary sector and other organised activities). Having a sense of value in family and community
- proactive approach to high prevalence of physical morbidity, which is a major risk factor for depression
- older people are often uncomplaining
- proactive approach to assessment of depression and suicidal risk..older people are a high risk cohort.

Casefinding, assessment and treatment

- Use the biopsychosocial model
 - Assess and manage physical health problems. Two or more long term conditions increase the risk of depression seven times; deafness can induce paranoid ideas
 - Assess and address social problems eg debt, fuel poverty, housebound
 - Assess and manage psychological problems- Proactive detection and management of depression.
 - Look for pre-existing mental health problems; depression, psychotic illness, learning disabilities
 - Treat depression related to bereavement if it hasn't resolved in 3 months,
 - Suicidal risk assessment-if depression present, always assess suicidal risk
 - Use the whole PHC team eg District nurses who can do assessment and motivational interviewing while they treat leg ulcers
 - Be alert to vulnerable groups eg People with learning difficulties are now living longer, but often can't tell you what the matter is. Any sudden change in behaviour often indicates physical pain.
 - Ensure staff trained in accurate detection and diagnosis of depression/Delirium/Dementia.
 - Importance of assessing Functioning (activities of daily living).
- Falls, incontinence, decreasing mobility, confusion are often presentations which need addressing directly and which also point to underlying disease.
- Early detection of dementia – exercise, Rx
- Anti depressants - does this cause more alarm in this age group?- discussion with peers within community group sessions

General ethical issues

- Therapeutic nihilism vs. heroism.
- Conflicts in Dr, patient, carer.
- Importance of Care Plan discussed, shared, updated. A dynamic document. Again (see adults), issues of subjective vs objective approach (we need to employ both and move seamlessly between the two)
- Compassion, respect. A frail, confused old lady has had a rich life with many stories to tell, if she could. How would I treat her if a friend or relative? What can I do to relieve suffering and return her to functioning? Or how can I accept her impending death and support her and her carers in her transition?

Understanding role transitions

- Different roles have different meanings to us. Important to articulate and help people in times of transition, as we lose some roles and take on new ones.
- Retirement as loss of skills and status, but also release from pressures and responsibilities
- Loss of friends as they die or move away
- New roles include Grandparenthood (grandparents plus website), Travel opportunities, Hobbies and volunteering, Downsizing and moving house
- Pressure from others eg. Children - babysitting, property, money
- Family reconciliation
- Good things of getting old – wisdom
- Status, identity, planning for change
- Isolation, death, bereavement, Long term conditions
- Need to extend working life
- Helping reminiscence; discover new interests, reconcile old differences.
- Discuss power of attorney and living wills as we go along
- Develop/facilitate meaning and purpose of life

Understanding changed body image:

- perception of and relationship to our bodies changes eg. Pain and poor mobility suggests an alienation, even an enemy. Beauty and what it means now, Experience of living in an ageing body.
- Adjustment to disability and death .

Nursing homes-

- Ensuring culturally competent – recruit from reflective communities so that mental health promotion can be in community languages – if not possible bring vol sector gps into the nursing home
- Carers- supporting carers and using them as a recourse for mental health promotion
- Places of worship – often a central part of older peoples live

END OF LIFE - MENTAL HEALTH PROMOTION AND PREVENTION INTERVENTIONS RELEVANT FOR PRIMARY CARE**General mental health promotion**

- Use a Biopsychosocialspiritual model
- Support family, carers, and relatives including their own health.
- Coping with long term physical conditions; actively address pain and mobility.
- Communication skills important as dialogue may be very difficult. Importance of supportive reminiscence.
- Making accurate biopsychosocial assessment , diagnosis, and management
- Making useful estimates of prognosis

- Coping with different patient and family styles of acceptance and non-acceptance
- Sometimes death is anticipated, sometimes it is a surprise eg chest infection in hospital can change the situation suddenly. This impacts on everyone. Supporting the transition to a new situation
- Consider other bereavements

GP and whole team in practice can

- Use a Biopsychosocialspiritual model
- Treat depression which can also improve pain management
- Facilitate dialogue, addressing Guilt and Relief on behalf of dying person as well as the carer
- Tell older people they are loved
- Consider telling people that the dying person will meet their friends and relatives after death if this gives comfort
- Improve skills for discussing prognosis and breaking bad news
- Train for competence in talking with patients about their death

Advanced directives

- should include MH
- Choice of place of death
-

Hospices

- Do a good job
- Can teach primary care and volunteers

Community Compassion

- Bringing volunteers into hospices
- Making a conversation with the community

Bereavement of carer

- An opportunity for MH promotion
- Bereavement counselling where needed
- Follow up after deaths – immediate and possibly after a month with partners, and look for continuing depressive symptoms, and treat if they don't clear up in 3 months.

Training for competence in Communications skills about death

- Facilitation of dialogue
- Guilt
- Relief on behalf of dying person as well as the carer
- Telling older relatives that they are loved
- Quiet
- Frequent conversations
- A problem for the clinician if they know the patient well
- Prognosis and breaking bad news
- Biopsychosocialspiritual model
- Family, carers, relatives – inc their health. Dialogue may be very difficult. Importance of supportive reminiscence. GPs can facilitate.

Anticipate and ask yourself

- Would you be surprised if this person died in 6m?
- Should we talk to the family or our patient before anyone is even at risk of dying?
- Part of care planning?

A biopsychosocial approach to end of life

CONCEPTUAL GOAL / BASIS	PRACTICAL RECOMMENDATION
value personhood	<ol style="list-style-type: none"> 1. Support making own choices eg. pain control, food, activity, positioning, medications, housing etc 2. Meet the client where they are; Listen and hear. 3. support narrative unity, memory and reminiscence, helping see individual as star in own movie 4. provide and enable love, respect and compassion

normalize stage of life	<ol style="list-style-type: none"> 1. recognize transitions within the end of life (changeable conditions) 2. provide preparation and anticipatory guidance for individual and family experiencing death, dying, bereavement and end of life 3. address physical, mental and spiritual needs as they arise 4. avoid unnecessary medicalization
support friends/family	<ol style="list-style-type: none"> 1. address family dynamics 2. acknowledge monetary, financial and legal concerns; POA etc. 3. advance directives planned earlier in life 4. acknowledge issues regarding funeral planning 5. keep in touch and screen for poor coping (eg. drug or alcohol misuse) inappropriate grief, anxiety or depression 6. recognize caregiver burden and make referrals to appropriate support system 7. acknowledge cultural and/or faith community support system
support staff and the clinical system	<ol style="list-style-type: none"> 1. acknowledge grief and loss experienced by staff during all transitions 2. ensure coordination of care with identified coordinator role for good communication (seamless not disjointed) 3. promote full experience of hospice services, use of palliative services and appropriate home care (avoid last minute referrals or delays)

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Case studies

Title: Incorporating MH Promotion & EI into **every** secondary care commissioned Physical Health Contract

Author(s): Steve Thomas & NHS Sheffield Mental Health Commissioning Portfolio Team

Location: Sheffield

System Level(s): DH/NHSE / Government / CCGs / LAs

Life Course Approach: whole life – could be applied in any contractual situation

Contact details (for more information on this project): me!

Aim of Project: This is not yet a 'projects' per se but is a contractual process that is moving through NHS Sheffield CCG.

Brief Description:

The NHS 'standard contract' is non-negotiable at a national level. Therefore there should be appropriate lobbying and recommendation at an NHSE/DH level to incorporate reasonable contract clauses to support MHP & EI in all physical health contracts.

Locally CCGs can within reason, put into contracts whatever they want.....there is in effect no restrictions as such. The key however, is getting providers to sign up to these requirements – which can be challenging when they fall under the 'local' category as opposed to the being 'nationally mandated' requirements. The latter is generally non-negotiable, the former however is nearly always open to negotiation. The key is clearly to sell this as something that is of benefit to the patient and provider, and where there are costs associated with implementation, it can be demonstrated that these costs can be offset elsewhere along the pathway.

A move towards outcomes based commissioning will clearly help – given providers generally speaking are paid for activity at present – meaning rather perversely they benefit from people coming and going from services (within the rules of course which means they still get paid). What is wanted is for mental health and mental wellbeing to be core components of more or less **every clinical intervention that happens in the NHS** – if not explicitly then certainly implicitly – through, for example, a better more informed workforce.

Some examples -

A requirement that all service literature, including clinical and corporate information is available in Easy Read format.

A requirement that all clinical staff receive Mental Health First Aid training (could consider utilising CQUIN to incentivise providers to do this).

The contract could ask all those bidding for new business (by way of a standard question) to provide us with evidence as to how the mental as well as the physical health of people using the service will be addressed.

As part of the Social Values Act the contract could specifically ask bidders to provide evidence as to how they will ensure a certain number of *provider posts* are allocated to those with a SMI or Learning Disability (positive discrimination).

The contract could ask to identify a mental health/dementia lead in the organisation – in the same way as confirmation is currently required on the safeguarding or Prevent lead. The contract could then engender target training and information resources to these individuals and a requirement to train & disseminate information.

The contract can ask that all providers are required to provide a plan for how they themselves intend to tackle the stigma attached to mental ill health – this could be incentivised via CQUIN.

The contract could ask providers to demonstrate how mental health is incorporated into the delivery of physical health care – through either the concurrent delivery of psychological services or through joint working with a local Mental Health Trust– again a possible idea for CQUIN.

We deliver a 'PLI type event' in 2016/17 but as part of the 2016/17 contract we make it compulsory that a certain % of each providers workforce need to attend. This should be aimed at lower level psychological interventions and a basic understanding of mental ill health and learning disabilities - how to 'spot' the symptoms and how to provide effective care.

Contracts issued to local Mental Health Trusts also includes a requirement for them to provide training and support to a certain % of the local physical health providers workforce (which was

the biggest area of success according to the RAID evaluation). This could be extended to primary care, 3rd sector providers and the independent/commercial sector.

Elements of the above to be done in partnership with the LA (via their contracts) so that social care providers and council run services (i.e. JC+, housing etc.) are included.

The contract requires a certain percentage of staff to be trained initially as 'trainers' in MH First Aid, and then to incrementally extend the percentage coverage.

Outcomes:

Increased knowledge and understanding and early recognition of mental distress, lack of well-being or overt mental illness in the physical health setting.

Destigmatisation.

Increasing awareness of the interplay between physical and mental non-wellbeing & MI and how the one significantly affects the other with regard to illness trajectory & recovery.

Long term conditions to be managed more effectively.

Increased 'parity of esteem'.

Signposting to appropriate self-help/3rd sector/early stepped care as appropriate recognition has taken place.

NHS Staff to be able to recognise and mitigate for their own mental wellbeing and mental health at an earlier stage because of their training.

Funders: N/A

Costs: unknown at present. There may be early risks as Providers will want to negotiate costs for training within the contract value BUT there are likely to be evolving savings in various parts of the system – the challenge will be to identify and track these and to see the value of EI/MHP outwork over a generation rather than 'in-year' savings.

Further Information: This approach is currently being debated/discussed within NHS Sheffield CCG. LA colleagues and Public Health are involved at this early stage with a view to developing a 'pilot' contract in maybe 2 or 3 areas.

There will be challenges in contract monitoring and 'enforcement' that need exploration and development by contract experts.

Title: Provision of IAPT Stepped Care for People with Long-term Conditions (LTCs) and Medically Unexplained Symptoms (MUS) – with coexistent Anxiety and/or Depression

Authors: Deborah Gamsu/Rebecca Haines, Primary Care Health and Medical Psychology, Toni Mank, Sheffield IAPT

Location: Sheffield

System Level(s): Primary Care, GP Practices – City-wide

Life Course Approach: Working and older adult

Brief Description:

The existing Sheffield IAPT stepped care model has been enhanced to better meet the needs of people with long-term conditions and persistent physical symptoms and co-morbid anxiety and depression. This has involved the alignment of Step 4 Clinical Psychology (Primary Care Health and Medical Psychology, PCHaMPs) with Sheffield IAPT. The clinical psychologists have expertise/experience of working with people with a broad range of physical health conditions and/or persistent physical symptoms.

PCHaMPs has worked in partnership with Sheffield IAPT to improve and enhance IAPT interventions for people with LTC/MUS – through the provision of training, consultation and supervision, further development of IAPT interventions for people with LTC/MUS, and Step 4 assessment and intervention.

Rather than being condition-specific the Sheffield IAPT model is a generic one – with a focus on improving IAPT staffs' and service users understanding of the impact of, and interplay between,

long-term conditions, psychological well-being and self-management: and applying IAPT interventions at the appropriate level in the model as needed.

Example Developments:

- Three day training programme for Step 2 and 3 IAPT staff – including the following:
 - Understanding the impact of, and interplay between physical and mental health.
 - Application of existing IAPT assessment and interventions for people with physical health issues – with specific reference to inclusion of physical health conditions/symptoms as part of the five areas assessment; engagement issues and psychoeducation
 - Development of new IAPT interventions – including motivational interviewing and pacing at Step 2; Acceptance and Commitment Therapy at Step 3.
- All IAPT staff have access to direct consultation with Step 4 Clinical Psychologists for advice about IAPT interventions, resources, signposting and stepping decisions for people with LTC/MUS
- Step 4 LTC/MUS Psychology supervision provided as part of monthly IAPT supervision groups
- Step 4 Clinical Psychology assessment and intervention can be accessed for people who have psychological issues specific to physical health and self-management – and where IAPT interventions at Step 2 and 3 are not appropriate or improvement/recovery not achieved.
- PCHaMPs and PWP development and delivery of Step 2 group interventions (see outline below) – Healthy Living Workshops and 6 week courses on ‘Living Well with Pain’ and ‘Living Well with Long-term Conditions’. Now delivered as part of IAPT rolling programme.
- PCHaMPs and CBT therapist development and delivery of Step 3 group intervention – Acceptance and Commitment Therapy approach for Long-term Conditions.
- Development of links and resources about specific conditions – including statutory and voluntary sector services.

Outcomes:

All IAPT staff have attended the introductory training, and ongoing PCHaMPs LTC/MUS consultation and supervision is embedded within the service. Healthy Living Workshops and Courses for 'Living well with Pain' and 'Living well with Long-term Conditions' are delivered by IAPT PWPs as part of the IAPT rolling programme of group interventions.

- Increased recognition of psychological co-morbidity associated with living with a long-term condition and/or persistent physical symptoms.
- Early intervention through access to primary-care based psychological interventions where IAPT staff have an understanding of the impact and interplay between physical and mental health.
- Direct access to a range of stepped care interventions within primary care that take in to account physical health: including psycho educational group interventions with a focus on improving understanding and management of the physical and psychological aspects of living with physical health conditions; guided self-help interventions including Motivational Interviewing and Pacing; and CBT and Counselling interventions.

Funded: Initial funding for pilot provided by National IAPT LTC/MUS Pathfinder Project; 2014/5 onwards funded by Sheffield Clinical Commissioning Group.

Evaluation: Evaluated as part of the IAPT National Pathfinder Pilots and local evaluation undertaken. Continuing to collect IAPT MDS supplemented with QoL and condition-specific measures where required; Group interventions continue to be evaluated.

Further Information:

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Sheffield IAPT Pain and LTC Courses and Healthy Living Workshops

PCHaMPs and IAPT Psychological Wellbeing Practitioners have worked together to develop and deliver psycho educational group interventions for people who have long-term conditions and/or persistent physical symptoms. The groups and courses are held in city centre venues and are now part of the IAPT rolling programme of courses.

Living Well with Pain – 6 week course (and/or an introductory half day Healthy Living Workshop)

Objectives: Improve understanding of persistent (chronic) pain

Improve confidence and ability to manage pain and associated difficulties

Content: Understanding chronic pain and the effects

Managing activities, Relaxation and breathing control for pain, Use of distraction methods

Introduction to Mindfulness, compassion and acceptance

5 areas with pain, managing mood

Communication and relationship issues, Managing sleep problems

Managing flare ups, Signposting – resources, websites etc

Evaluation: IAPT outcome measures and Pain Self-Efficacy Questionnaire

The workshops and courses have been positively evaluated. Service user feedback has highlighted – the best things about the course: Practical advice, strategies for living with pain; group experience; the facilitators – presentation and understanding.

‘I was a bit sceptical about attending the course but was pleasantly surprised by the content and those delivering it. I would certainly recommend the course to other people with pain as they would find something within the course to help them’

‘I started the sessions feeling very low but the course helped me to get through a bad time and has set me up going forward. I feel more positive now knowing I have the tools to help me cope with pain’

‘Helped me to understand and manage pain – enormously helpful’.

Living Well with a Long-term Condition – 6 week course (and/or an introductory half day Healthy Living Workshop)

Objectives: To provide people with a toolkit for managing their LTC(s)

To meet others living with an LTC

Content: Understanding long-term conditions, generating your own 'problem list'

What is self-management, Biopsychosocial approach, 5 areas and Goal Setting

Barriers to self-management, managing thoughts and feelings, Mindfulness, self-compassion and acceptance

Managing worry & rumination, Problem-solving, Relaxation

Sleep management and Pacing

Communication and relationship issues, managing set-backs, Signposting

Evaluation: IAPT outcome measures

The workshops and courses have been positively evaluated. Service user feedback has highlighted – the best things about the course: Meeting others, sharing experiences, learning self-management strategies.

'It was a worthwhile course and I would like to see it continue for others to gain the benefit from''

'Thank you for seeing the need, making moves to address it and moving mental health in to the 21st centurythe GP's will thank you!'

Title: Sheffield Physical Health and Psychological Wellbeing (IAPT) Project: A Health Education Yorkshire and the Humber Initiative

Authors: Moira Leahy, Sheffield Health and Social Care NHS Foundation Trust and Steven Kellett, University of Sheffield, on behalf of the Project Team

Location: Sheffield

System level: community, primary and secondary care

Life Course Approach: working adult, older adult and end of life

Brief Description: This Health Education Yorkshire and Humber regional initiative is testing an innovative way to integrate the delivery of mental and physical health interventions. We are seconding physical health practitioners to train as IAPT (Improving Access to Psychological Therapies) Psychological Wellbeing Practitioners (PWP). Once qualified, practitioners are supported to integrate their PWP knowledge and skills within their own physical health settings. Using a proof of concept approach as our starting point, we are

- | | | |
|----|--|---|
| 1. | esting whether this model improves access to talking therapies for people with physical health problems, who also have common mental health problems | T |
| 2. | xploring the contribution of IAPT PWP knowledge and interventions skills to the facilitation of self-management in people with long term conditions/physical health problems | E |
| 3. | ssessing the implications of the project for both pre and post registration training | A |

Outcomes: Twelve practitioners including district nurses, physiotherapists and occupational therapists (Band 4 to 8a) have been trained. Our project learning indicates that equipping physical health practitioners with IAPT PWP knowledge and skills has huge potential to:

- support delivery of truly integrated and holistic interventions S
- increase early recognition and assessment of anxiety, depression and suicide risk in people with physical health problems, including people who are housebound I
- increase access to talking therapies through delivery of low-intensity mental health interventions alongside physical health interventions I
- help practitioners, service users and carers untangle and understand the interplay between the mental and the physical, including addressing anxiety H
- facilitate engagement and timely interventions to facilitate self-management and recovery F
- enhance patient outcomes, patient and carer experience and practitioner satisfaction E
- reduce fragmentation in the patient's journey; reduce onward referral and make cost savings R

Integrating PWP skills into practice fit more readily within some roles/physical health settings than others; backfilled protected time has been necessary to enable testing in certain areas. All practitioners found the training challenging, highly relevant and applicable to their core roles, and value the IAPT clinical supervision and case management model.

Funders: Health Education Yorkshire and the Humber, Sheffield CCG, Sheffield Prime Ministers Challenge Fund Programme, NIHR CLAHRC Research Capability Funding plus core services.

Costs: Project delivered within funds available at any given time.

Has the project been evaluated? Yes. Further evaluation is underway within the NIHR CLAHRC Mental Health and Comorbidities Theme; includes exploring the contribution equipping physical health practitioners with IAPT PWP skills can make to delivering parity of esteem, and reducing barriers associated with the conceptual and organisational divisions between mental and physical health.