McPin Foundation | Transforming mental health research

WORKING IN COMMUNITY MENTAL HEALTH SYSTEMS SUPPORTING PEOPLE WITH SEVERE MENTAL ILLNESS

A briefing paper for all those putting practical steps in place in Integrated Care Systems and Primary Care Networks to better support people with schizophrenia, bipolar and other psychosis who are not under secondary care

Briefing paper   **June 2023**

Contents

> "PARTNERS research has revealed that while the Community Mental Health Framework provided further resource to fulfil NHS Plan ambitions to ensure all individuals with severe mental illness are provided with seamless, coordinated, person-centred care to improve wellbeing and address excess mortality, the steps for achieving this are, in most systems, not in place."
>
> *Richard Byng*
> *Professor in Primary Care Research, University of Plymouth*

Section 1: Introduction

This briefing paper is based upon the work of two linked pieces of research by a group spanning several universities, including teams at the University of Plymouth and the McPin Foundation. PARTNERS2 (2014–2021) and PARTNERS3 (2021–2022) were funded by the NIHR (National Institute of Health Research).

They report at a time when mental healthcare is undergoing a 'transformation' under the Community Mental Health Framework (CMHF) (2019) to better align mental health care, primary care and the voluntary sector provision in community settings for various groups including people with Severe Mental Illness (SMI).[1]

Our research was motivated by concern around the 'gap' in provision for people with SMI. People who can become lost in the system after discharge or remain sitting on psychiatric outpatient lists with limited contact from practitioners whilst experiencing chronic disability and a poor quality of life.

This 'gap' can impact on recovery and is inefficient for local systems. The definition of SMI varies, and in the PARTNERS studies it included people with a primary diagnosis of schizophrenia, bipolar or other psychosis.

There are some well-documented and significant concerns around outcomes and support for people with SMI:

- Higher rates of morbidity with premature mortality rates of approximately 20 years[2]

- Social isolation and loneliness impacting recovery[3]

- Difficulties with medication – including adverse side effects[4]

Additionally, there are specific concerns over safeguards within the Mental Health Act, and over representation of people from minority communities whose contact with mental health services involves coercion, particularly people identifying as Black or Black British.[5]

Despite the success for early intervention in psychosis services, delivered for up to three years to individuals, outcomes for those with long-term mental health needs supported in primary care or other secondary care services continues to be concerning.

> *Discharge to Primary Care has not provided the support that people with severe mental illness need."*

MARY NETTLE, LEAP MEMBER

[1] National Collaborating Centre for Mental health (2019) The community mental health framework for adults and older adults: https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

[2] See: https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi

[3] Wang J, Mann F, Lloyd-Evans B, Ma R, Johnson S. Associations between loneliness and perceived social support and outcomes of mental health problems: a systematic review. BMC psychiatry. 2018 Dec;18(1):1-6.

[4] Morant N, Azam K, Johnson S, Moncrieff J. The least worst option: user experiences of antipsychotic medication and lack of involvement in medication decisions in a UK community sample. Journal of Mental Health. 2018 Jul 4;27(4):322-8.

[5] Centre for Mental health (2019) Reforming the mental health act: The implications of the NIHR Mental Health Policy Research Unit's work for the Independent review: https://www.centreformentalhealth.org.uk/sites/default/files/2019-04/Reforming%20the%20Mental%20Health%20Act.pdf `

> *I've found that people's quality of life suffers and they end up forgotten and isolated. Their lives and the impact of their struggles on their loved ones matters, as does the fact many people with severe mental illness die earlier than they would, had they received the right medical help."*

DEB SMITH, LEAP MEMBER

The CMHF includes investment for new roles including peer support workers, community connectors and mental health professionals across community teams.

Alongside this the ARRS (Additional Roles Reimbursement Scheme) includes the option to employ mental health workers in primary care [6] and there is also a focus on addressing health inequalities for people with SMI.[7]

The role of social care is recognized as fundamental to good quality integrated mental health care systems.[8]

In specialist care there is a new national audit of early intervention in psychosis services from Healthcare Quality Improvement Partnership (HQIP) and National Health Service England (NHSE) to [9] support improvements in care.

Findings from the PARTNERS studies and the recommendations for action complement these initiatives by supporting systems to address the needs of those with SMI not under secondary care.

We report on the development and evaluation of a new system of support for people with SMI in primary care, and then translation of findings to the new context of CMHF transformation work across Integrated Care Systems in England.

Key insights gained from working across the community mental health system include:

- The kind of relationship and support that is valued by individuals with SMI is often not provided by specialist mental health or primary care teams

- Support for practitioners to deliver flexible person–centred coaching approaches that is often not in place

- The importance of leaders across mental health, Voluntary Community and Social Enterprise (VCSEs) and primary care actively engaging in collaborative approaches to make their systems work better for people with SMI

[6] Additional Roles Reimbursement Scheme introduced in 2019: https://www.england.nhs.uk/gp/expanding-our-workforce/

[7] NHS Long Term Plan 2019: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/our-approach-to-reducing-healthcare-inequalities/

[8] Dunthrone, E., 2022 Mental health social work: What it is, why and how it matters for integrated care. https://amhp.org.uk/mental-health-social-care-what-it-is-why-and-how-it-matters-for-integrated-care/

[9] The 2022-2025 audit will be delivered by the College Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists: https://www.hqip.org.uk/a-z-of-nca/national-clinical-audit-of-psychosis/#.ZGKLU3bMJPY

Section 2: The PARTNERS model of care

We know that care for people with SMI is fragmented. Many individuals are discharged to primary care and do not receive specialist mental health support.

In 2012, 31% had no contact with secondary care [10] and rates of discharge appear to have increased since then. We developed and piloted a primary care–based Collaborative Care model (PARTNERS) designed to improve quality of life for people with diagnoses of schizophrenia, bipolar or other psychosis.

We had three Lived Experience Advisory Panels (LEAPs) as part of the research team, with 19 service users and carers sharing their expertise, linked to three areas of the country: Devon and the South West; Birmingham; and Lancashire.

We used a combination of expert interviews, literature reviews, database analyses and focus groups to build a theoretical model which we then tested in practice. [11] [12] [13]

> I think the role in itself encompasses how we used to work many years ago, when we didn't have targets to meet and that became the focus, if you like, of a lot of our work.
>
> So my experience of being a Care Partner has been very much about getting to know people, their circumstances, their family, their relationships and what is important to them, mainly."
>
> *Grace, Care Partner, PARTNERS2*

[10] Reilly S, Planner C, Hann M, Reeves D, Nazareth I, Lester H. The role of primary care in service provision for people with severe mental illness in the United Kingdom. PloS one. 2012 May 15;7(5):e36468.

[11] Gwernan-Jones R, Britten N, Allard J, Baker E, Gill L, Lloyd H, Rawcliffe T, Sayers R, Plappert H, Gibson J, Clark M. A worked example of initial theory-building: PARTNERS2 collaborative care for people who have experienced psychosis in England. Evaluation. 2020 Jan;26(1):6–26.

[12] Baker E, Gwernan-Jones R, Britten N, McCabe C, Gill L, Byng R, Gask L. Using interpersonal process recall to understand empowerment processes in a collaborative care intervention for people with a diagnosis of psychosis. Psychosis. 2019 Oct 2;11(4):350–61.

[13] Baker E, Gwernan-Jones R, Britten N, Cox M, McCabe C, Retzer A, Gill L, Plappert H, Reilly S, Pinfold V, Gask L. Refining a model of collaborative care for people with a diagnosis of bipolar, schizophrenia or other psychoses in England: a qualitative formative evaluation. BMC psychiatry. 2019 Dec;19(1):1–7.

The PARTNERS model has several key components:

- Person-centred, strengths-based approach with emphasis on collaboration between the service user and a Care Partner (normally an experienced Band 4 or 5 worker). This relationship is crucial, and building trust is essential. The model is underpinned by a coaching approach. Coaching is used by the Care Partner to agree shared goals to work on together. These may be related to physical, psychological or social needs.

- Proactive engagement and support, so that the Care Partner meets with the service user regularly, reviewing progress and setting new goals. There is flexibility about the mode of delivery. The Care Partner operates as part of the extended primary care team and is supervised by an experienced mental health worker. Supervision is vital in the model.

- Care Partners take a proactive, coordinating role to link service users to the right support. This means actively working across system boundaries linking with primary care, voluntary sector providers, social care and secondary mental health services.

This model of care is based upon collaborative care for people with depression and anxiety.
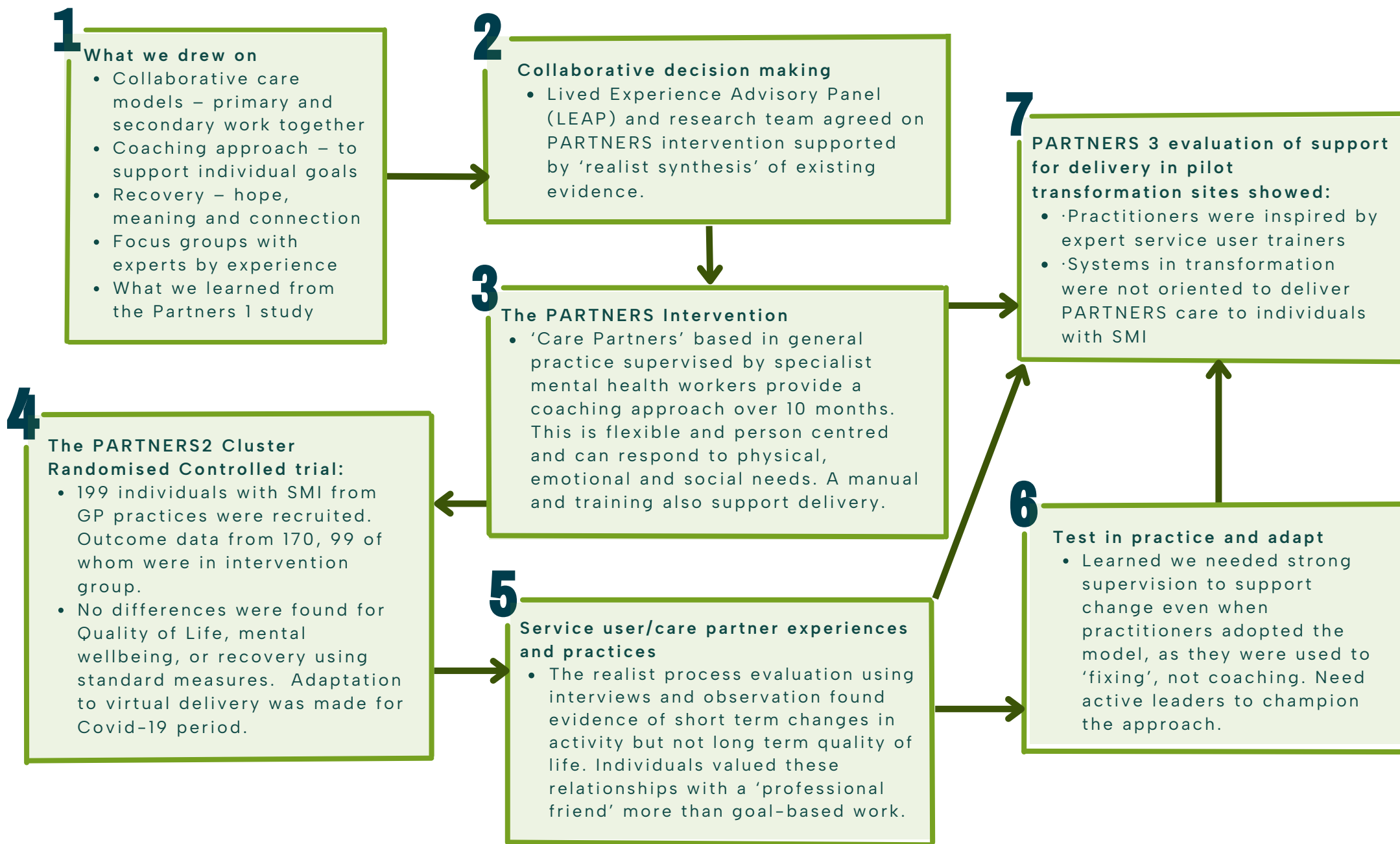
All three elements are important for addressing both mental and physical health needs among people with SMI, underpinned by partnership and a strong therapeutic alliance, pro-activity and outreach work.

Although developed before the NHS Long Term Plan and the CMHF both published in 2019, the ethos and practical arrangements have an excellent match with both.

After the PARTNERS model was developed and field tested it was formally evaluated in a trial and then further tested in the context of the CMHF transformation.

Figure 1 (next page) summarises the research programme as a whole.

Figure 1: PARTNERS 2 and 3: A programme of research to inform service and care redesign for individuals with SMI

1

What we drew on
- Collaborative care models – primary and secondary work together
- Coaching approach – to support individual goals
- Recovery – hope, meaning and connection
- Focus groups with experts by experience
- What we learned from the Partners 1 study

2

Collaborative decision making
- Lived Experience Advisory Panel (LEAP) and research team agreed on PARTNERS intervention supported by 'realist synthesis' of existing evidence.

3

The PARTNERS Intervention
- 'Care Partners' based in general practice supervised by specialist mental health workers provide a coaching approach over 10 months. This is flexible and person centred and can respond to physical, emotional and social needs. A manual and training also support delivery.

4

The PARTNERS2 Cluster Randomised Controlled trial:
- 199 individuals with SMI from GP practices were recruited. Outcome data from 170, 99 of whom were in intervention group.
- No differences were found for Quality of Life, mental wellbeing, or recovery using standard measures. Adaptation to virtual delivery was made for Covid-19 period.

5

Service user/care partner experiences and practices
- The realist process evaluation using interviews and observation found evidence of short term changes in activity but not long term quality of life. Individuals valued these relationships with a 'professional friend' more than goal-based work.

6

Test in practice and adapt
- Learned we needed strong supervision to support change even when practitioners adopted the model, as they were used to 'fixing', not coaching. Need active leaders to champion the approach.

7

PARTNERS 3 evaluation of support for delivery in pilot transformation sites showed:
- ·Practitioners were inspired by expert service user trainers
- ·Systems in transformation were not oriented to deliver PARTNERS care to individuals with SMI

A significant part of the development of PARTNERS2 was lived experience expertise from service user and carer members in our LEAPs.

In the case study below we hear from a LEAP member reflecting on a recent admission to hospital and why for them, the PARTNERS2 approach remains so important.

My care experience

I was hospitalised for two months last year after losing a lot of weight and becoming delusional.

That had come about due to severe depression and withdrawal. I was taken to A&E by my daughter.

My discharge was delayed by a week because the staff were concerned about my wellbeing for various reasons. Many things were promised but still no support worker has transpired for me.

I have not seen any psychiatrist since discharge, only a non-medical prescriber that I'd been seeing previously. I had liked the psychiatrist I had in hospital because he took my personal considerations into account and always consulted with me before making changes to my medication.

The non-medical prescriber seems less able to accommodate my personal preferences and simply lets things stay on hold until I agree with her, it seems.

I think the Mindfulness Based Cognitive Therapy (MBCT) is helping somewhat and I am taking various forms of exercise, like bike riding and aqua fit as well as eating healthily again. I am also being socially interactive most days.

Obviously I did not have the benefit of a Care Partner and my GPs are inconsistent due to the size of the practice and an awkward appointment system.

Aftercare has always been lacking, with too much emphasis or dependency on medication rather than human understanding/interaction which is the key to psychological wellness that PARTNERS2 sought to offer.

LEAP member, June 2023

Section 3: The PARTNERS2 trial and process evaluation

The PARTNERS2 cluster randomised controlled trial had 198 participants from 39 practices and produced a neutral result.[14]

Key outcomes

People's quality of life, wellbeing and mental health symptoms – were no worse or no better as a result of receiving primary care based collaborative care for 10 months (see figure 2).

However, people receiving a Care Partner reported really valuing their relationship with the Care Partner, and found the coaching helped them start to think about making changes to their lives, achieve small goals, and it improved their confidence.

In interviews, service users described the benefits of working with a Care Partner, viewed as a 'professional friend'.

These included both support to achieve practical goals as well as for some emotional support.

We had not measured this in the standard service user reported outcome collection.

We found this was especially important for service users who do not have existing supportive relationships provided elsewhere from professionals or family or friends.

[14] Byng R, Creanor S, Jones B, Hosking J, Plappert H, Bevan S, Britten N, Clark M, Davies L, Frost J, Gask L. The effectiveness of a primary care-based collaborative care model to improve quality of life in people with severe mental illness: PARTNERS2 cluster randomised controlled trial. The British Journal of Psychiatry. 2023 Jun;222(6):246-56.

"I couldn't class her as a friend, 'cos you've got to go on a professional – but that's how she talks to me, it's like I've known her for some time. It's like a – she puts you at ease when you're talking to her, there's no, how can I put it, there's no awkwardness or if there's a break in the conversation she'll bring it back round or yeah, I don't really feel, like, anxious, you can be yourself when you're talking to her."

KEITH, PARTNERS 2 SERVICE USER INTERVIEW

They're [the Care Partner] more understanding about my illness. They've obviously read reports that I've suffered from what I've suffered, and it's them giving me a little bit of hope, if you like, a little bit of belief that I can go out and accomplish a silly thing like getting a sausage roll and milk and tea and stuff like that. They give me that little push, it gives me that little bit of confidence that I so much need, you know."

ANDREW, PARTNERS 2 SERVICE USER INTERVIEW

This demonstrates, that despite the neutral trial result, the PARTNERS intervention has potential to improve the care provided to people with SMI.

There are a number of reasons for our mixed results:

- Difficulties in recruiting, retaining, and replacing Care Partners (which reflected wider NHS pressures) meant that some people did not receive a full 10 month intervention. We found on average participants had nine interactions with a Care Partner lasting 10 minutes or more (telephone or face to face including virtually). However, 9% received no recorded Care Partner input.
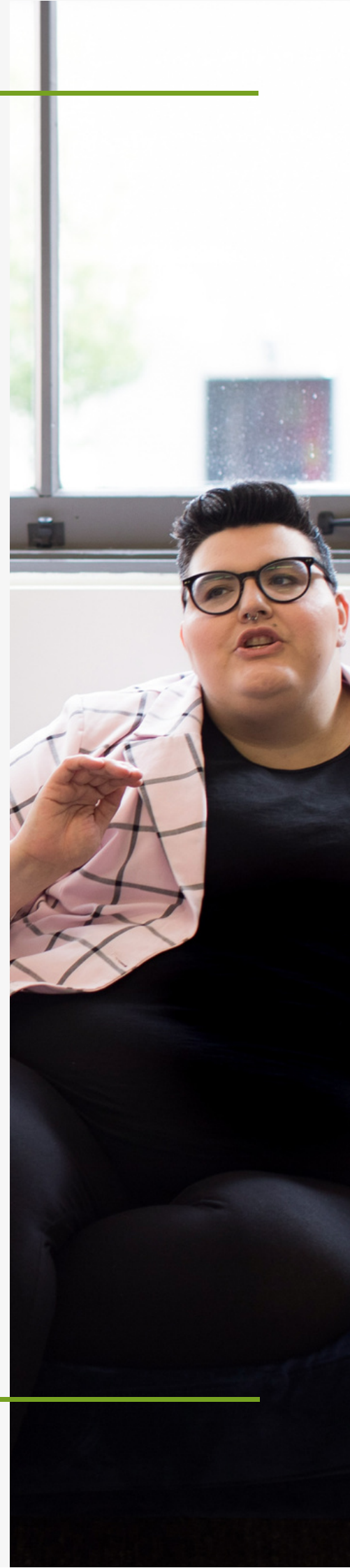
- The outcome measures were not sensitive enough to capture the individualised and subtle positive changes that people experienced as a result of the intervention. For example, realising things could be different, achieving goals that were big to them but maybe small to others, improvements to confidence.

- Adaptation to virtual (telephone or video) working during the COVID-19 pandemic.

Overall, we conclude that the relatively low intensity PARTNERS intervention did not show improvements in standard outcome measures over 10 months; however, some steps towards recovery were evidenced.

The subtleness of these changes and the individual circumstances of the people receiving the intervention suggest that an intervention of longer than 10 months might be needed to improve quality of life.

Arguably this may be the case for many individuals with complex needs as there have been other recent neutral results in well run trials.[15]

FIGURE 2: SUMMARY OF PARTNERS2 TRIAL NEUTRAL FINDINGS
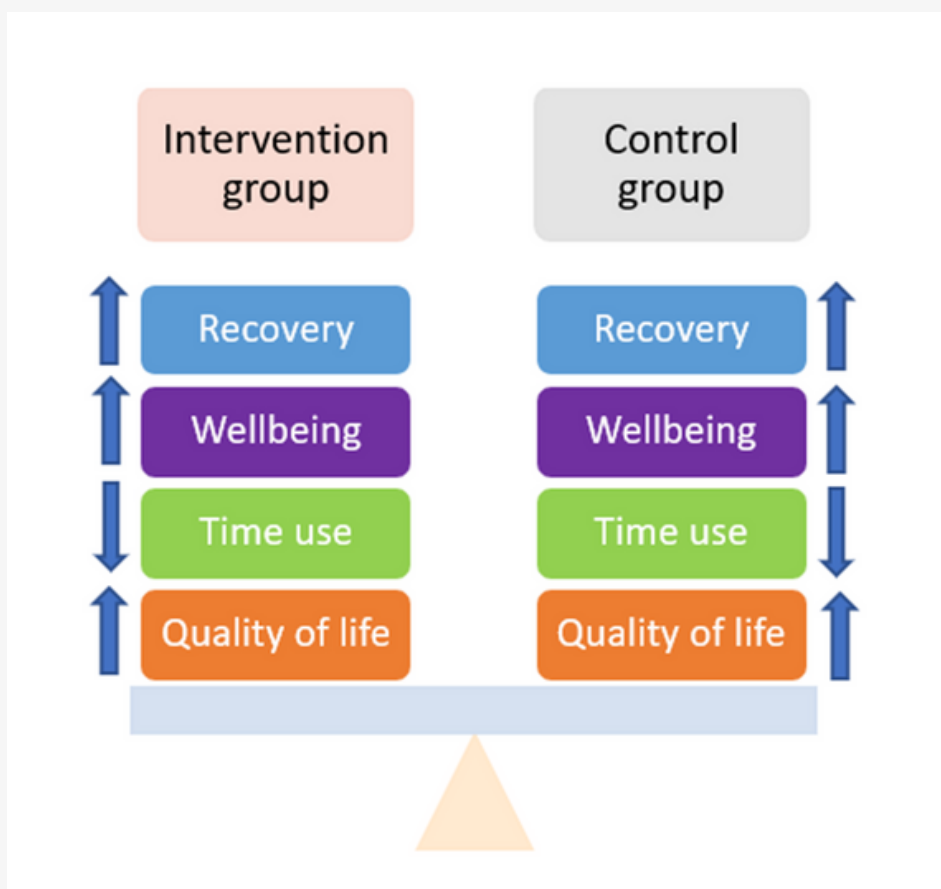
[15] Salisbury C, Man MS, Bower P, Guthrie B, Chaplin K, Gaunt DM, Brookes S, Fitzpatrick B, Gardner C, Hollinghurst S, Lee V. Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach. The Lancet. 2018 Jul 7;392(10141):41-50.
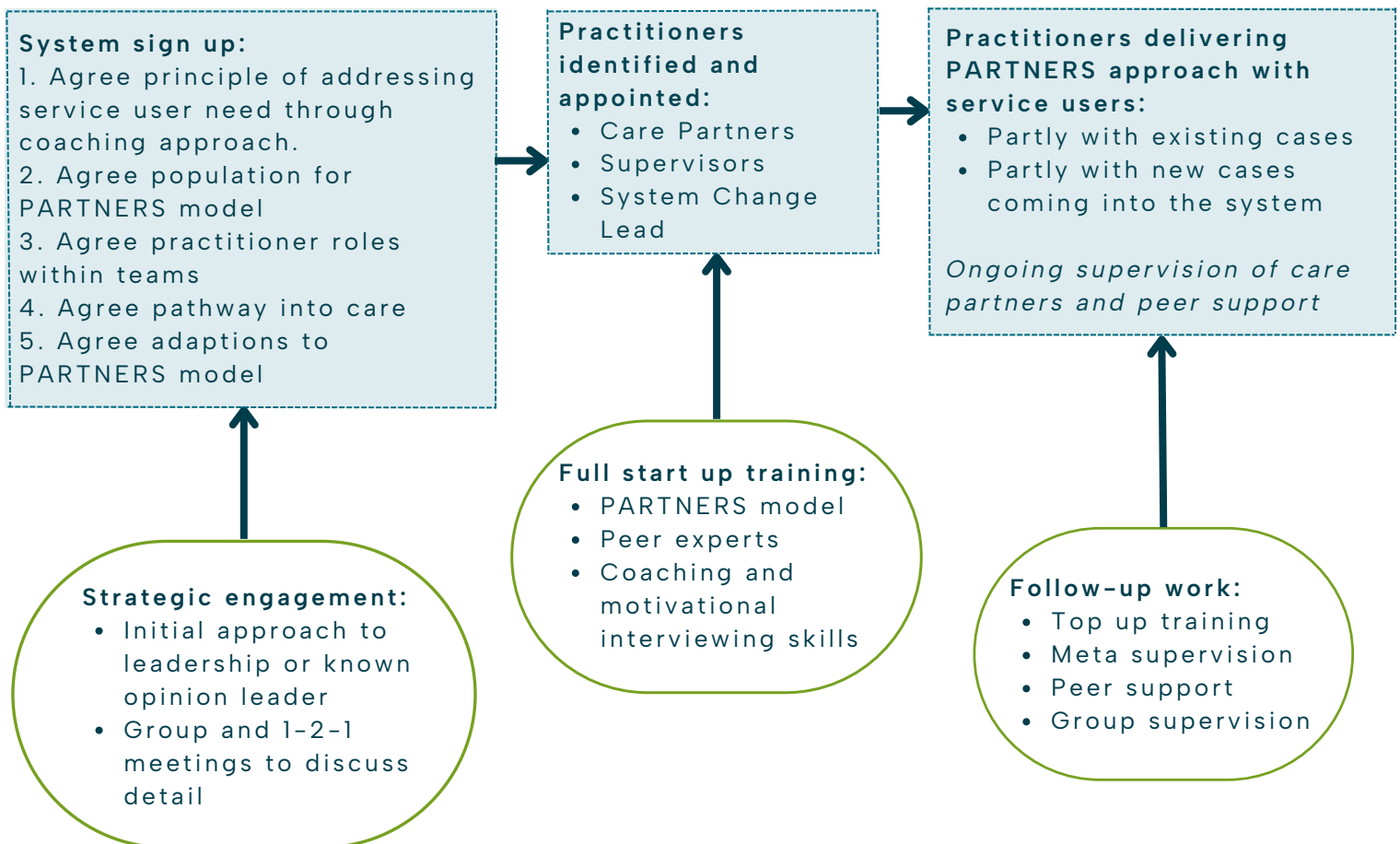
Section 4: Further testing in Community Mental Health Framework pilot sites (PARTNERS3)

Due to the positive response from Care Partners and service users receiving the intervention, and because PARTNERS aligns well with current mental health policy regarding person–centred and place–based care, we continued to test and develop the approach.

PARTNERS3 explored how PARTNERS might be delivered in two further areas wanting to address gaps for people with SMI. Our study team supported system leaders over the period June 2021 to June 2022 to identify suitable workers to take on the roles of Care Partner and supervisor.[16]

We provided training, support, and meta supervision as shown in figure 3.

FIGURE 3: COLLABORATIVE OPTIMISATION: PATHWAY TO IMPLEMENTATION OF PARTNERS APPROACH IN NEW SETTINGS

System sign up:
1. Agree principle of addressing service user need through coaching approach.
2. Agree population for PARTNERS model
3. Agree practitioner roles within teams
4. Agree pathway into care
5. Agree adaptions to PARTNERS model

Practitioners identified and appointed:
- Care Partners
- Supervisors
- System Change Lead

Practitioners delivering PARTNERS approach with service users:
- Partly with existing cases
- Partly with new cases coming into the system

Ongoing supervision of care partners and peer support

Strategic engagement:
- Initial approach to leadership or known opinion leader
- Group and 1–2–1 meetings to discuss detail

Full start up training:
- PARTNERS model
- Peer experts
- Coaching and motivational interviewing skills

Follow–up work:
- Top up training
- Meta supervision
- Peer support
- Group supervision

[16] Byng R, Frost J, Richards D, Gibson J, Stirzaker A, Day J, Dave S, Pinfold V. 2023. National Institute for Health Research Policy Research Programme Project: Optimising key components of the community mental health policy through implementation of the PARTNERS intervention: learning about personalisation, integration and team–based supervision. NIHR reference number: NIHR202090
https://www.plymouth.ac.uk/research/primarycare/mental-health/partners3

Staff found the structured training helpful in understanding why and how to create changes to practice. We found that the role of lived experience team members in co-delivering training was seen as particularly motivating, providing additional authority for shifts in practice.

Having a person in each Trust to lead change at a system level was also a vital role; this championing of the PARTNERS approach meant that others saw it as a strategic priority and something worth finding out more about, particularly in systems that were stressed by COVID and other NHS pressures. Care Partners and supervisors described PARTNERS as useful, and something that was possible to incorporate into existing their role.

For me I need to have structure and know why I'm doing something and the reason for doing it. I was a bit apprehensive because I felt like it was a new thing that I had to learn, a new process and how am I gonna time this thing with everything else that I've got to do on a daily basis. But after having our training...but also listening to the people that are supporting the project, so [Researcher2] and people like that who have their own lived experience, that for me resonated so because of [Researcher2] involvement as well, that give me more incentive that yes it will work."

CarePartner1 PARTNERS3 interview

What I really liked was despite how clearly overwhelmed both staff were with the volume of work that they have...They were still looking for opportunities as to where they could use...the approach, and recognise that actually they were doing something different...there were ways of doing things which just meant that they understood that person better, or got a very different response with very little change to what they, as practitioners, needed to do."

Supervisor1 PARTNERS3 interview

However, despite positive intentions, actually ensuring the model was delivered to the right people in a short timescale in a stressed system was not possible. Challenges included immature or weak links with general practices in the newly transformed systems and a lack of proactive pathways into care for people with SMI, due to prioritisation of short interventions for people requesting support.

Sites looking to implement PARTNERS will need to consider how to address these wider system-level changes alongside providing the appropriate training and support for Care Partners.

"My main observation from working on PARTNERS3 and being present in support sessions for the Care Partners where they talked about trying to work in different ways was how it took time for practitioners to adapt previous methods of working and move away from wanting to 'fix' people's lives.

They had to give themselves space to practise in a longer-term way, building up a shared understanding with the service user before employing a coaching approach.

Practitioners embraced the opportunity to work in this way, something we found on PARTNERS2 as well.

Real-world challenges made it hard to implement in practice despite practitioners feeling it was a common sense approach."

JOHN GIBSON, SERVICE USER RESEARCHER

It is also important to note there were limitations in the PARTNERS studies.

One was lack of diversity in the study sample for PARTNERS2, particularly when considering ethnicity. We know from other work that culturally appropriate care is vital.

For example, it is unclear about whether relational mechanisms of the 'professional friend', built into the PARTNERS model, along with training in cultural sensitivity would be sufficient to overcome any divides related to ethnicity as well as gender, age and class.

Future research needs to address sample diversity much more carefully and take steps built into the study design to do so.

Section 5: What have we learned?

System complexity

Innovation in providing support for people with SMI must work across, and take into account, three different levels of system complexity.

- First is the service user–practitioner 'level' where trust must be established and a strong therapeutic alliance needs to be present. Lack of continuity of care is a threat. There may also be challenges with low levels of motivation. Personalised care with individual goals based on individual needs at a particular time requires high level skills and a good knowledge of available local resources.

- Second is the team in which a Care Partner is a member. It needs to have a team culture that is supportive of new roles and open to ways of delivering care. People in new and adapting roles require supervision and support, including peer support from colleagues, to take on new ways of working. This will need to be personalised, at least in part, reflecting previous experience.

- Third is the system which needs to have a leadership culture that is supportive of change and innovation. New care programmes need committed champions in leadership roles who drive change in both values and practices.

Challenges to innovation likely need to be carefully navigated at all three levels. We propose that workforce development, an inclusive organisational culture and collaborative leadership approaches are all vital to ensure service users don't get 'lost' in the system. This can be a positive experience:

Well, it's been one of our very few good news stories over the last few months… I've been speaking to my manager about it, you know when it's all doom and gloom, in our leadership meetings I've put my hand up and said, or in clinical governance meetings and said, 'actually can I just give you an update about how [PARTNERS] is going because this is something that we've managed to keep going and it's really positive'.

So I've just come from supervision with my manager who has supported me to support this project all along and they're just really keen to engage with it and take it forward and celebrate it… and I think because it fits really well with community transformation, that really helps as well."

SYSTEM CHANGE LEAD1 INTERVIEW PARTNERS3

We explore some more specific points below:

Goal–based work and Care Partners as professional friends

PARTNERS encourages practitioners to develop a broad psychosocial understanding alongside the service user. This helps to develop a trusting relationship and a shared understanding of what is important to the service user.

This seems to be at the heart of being a professional friend. Collaborative identification between the practitioner and the service user of the goals on which the service user wishes to work is essential to developing an understanding of what is important to the service user and what is most likely to make a difference to them in their everyday lives.

Working with multiple organisations in different sectors

The challenges of implementing any change in large systems is evident to many who work within the NHS. The CMHF advocates delivery of person–centred care with little reference to how to go about delivering this.

PARTNERS offers a real opportunity to bring together multiple organisations to deliver a model of care which fits well within the philosophy of multiple organisations.

This relatively simple way of working with service users in a collaborative endeavour, fits well with the working practices of those in the voluntary sector as well as aligning with the clinical/diagnostic world of the NHS. PARTNERS uses a goals–based, coaching approach that allows for different sectors to have a shared approach to care, which all understand and can sign up to. When working well trust as well as goals can be shared across teams.

New roles – ideals and reality

The Care Partner role was co-designed with extensive input from practitioners, service users, carers and researchers drawing on existing evidence, clinical knowledge and lived experience expertise. It was a new stand-alone position developed at a time before the CMHF.

The Care Partner joined a general practice primary care team, with supervision from a specialist mental health practitioner in secondary care services. We worked with nine Care Partners in the trial and the two who were in the role the longest helped us understand both key attributes and their training and support needs.

One was a team leader and social worker, the other a support worker with experience of working in both secondary care and the voluntary sector. They brought different skills and experiences to the role but crucially they were open to doing things differently – unlearning old practices and embracing a coaching approach.

In the PARTNERS3 implementation study we trained staff from secondary care and the voluntary sector incorporating Care Partner responsibilities into existing new and adapted roles in the CMHF.

The PARTNERS collaborative care model for SMI can be incorporated into roles across sectors but needs strong supervision, training and support. We encouraged peer support between people taking on Care Partner roles.

However, few of those trained in PARTNERS3 were in a position to put the model into practice for people with SMI identified as needing proactive care. New roles need significant time for systems to oversee team and role selection, supervision, liaison with different part of the system including primary care, as well as pathways for care.

Proactivity

Historically, a significant proportion of service users have been seen infrequently in psychiatric outpatients or have been discharged from secondary mental health care services without proactive support to move on in their lives. If someone is struggling with poor motivation, is isolated and has little belief in their ability to make changes they will often struggle to make changes alone.

The PARTNERS approach encourages active engagement with those whose lives have often been constrained by disabling symptoms, overuse of medication or/and social disadvantage and inequality.
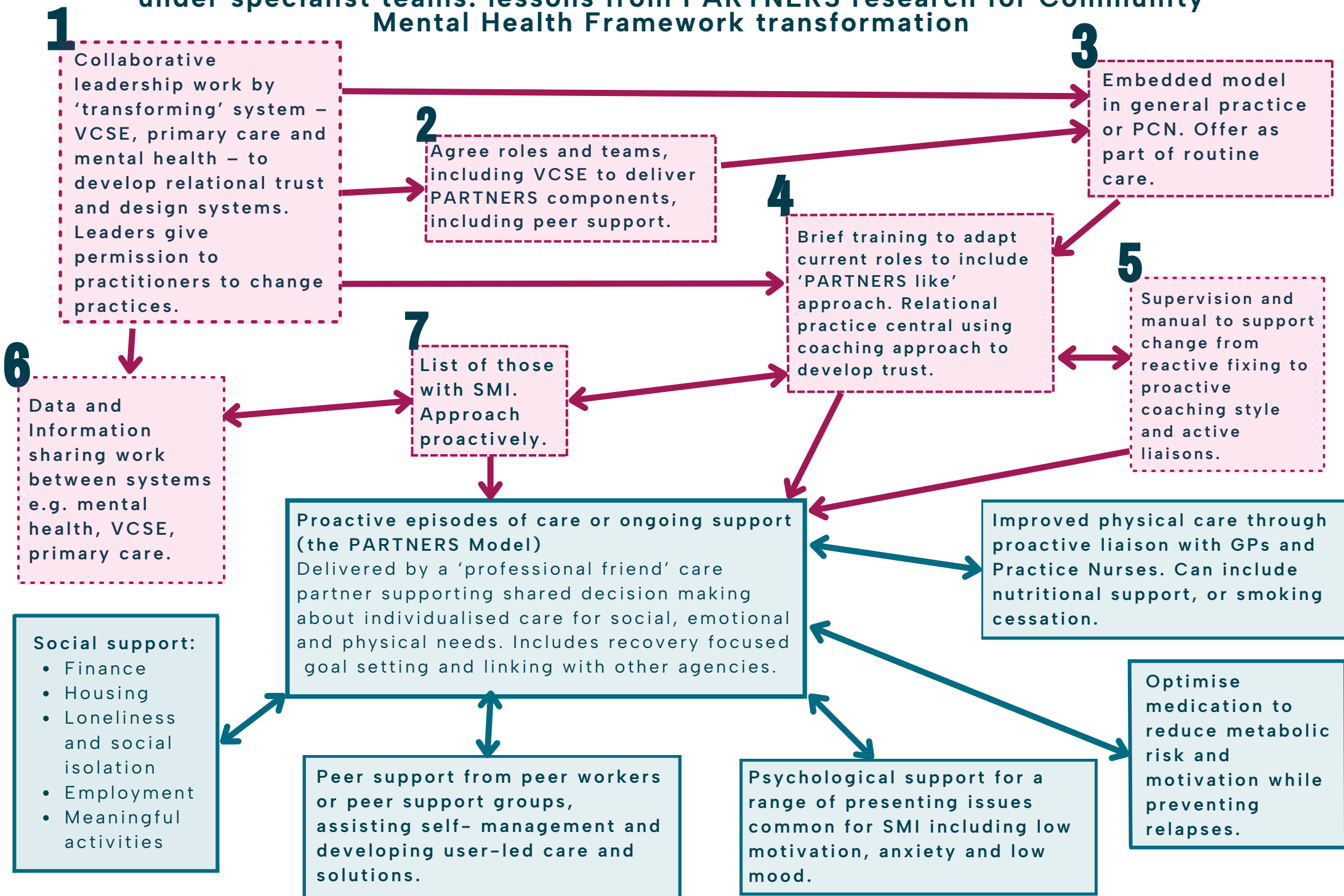
In its collaborative value-base to change, PARTNERS enables a non-judgmental approach which is adaptable to the needs and wishes of the service user in both intensity and content. We describe below the steps system leaders need to take to provide this flexible proactive care.

Section 6: Key ingredients for integration of a PARTNERS approach into transforming systems

Taking the learning from the two studies we propose that integrated care systems need to ensure the organisations in the system are working together with agreement about who provides proactive care for people with SMI along with a network of training and supervision support for practitioners, as shown in figure 4.

Figure 4: Ensuring delivery of care for individuals with SMI who are not under specialist teams: lessons from PARTNERS research for Community Mental Health Framework transformation

1 Collaborative leadership work by 'transforming' system – VCSE, primary care and mental health – to develop relational trust and design systems. Leaders give permission to practitioners to change practices.

2 Agree roles and teams, including VCSE to deliver PARTNERS components, including peer support.

3 Embedded model in general practice or PCN. Offer as part of routine care.

4 Brief training to adapt current roles to include 'PARTNERS like' approach. Relational practice central using coaching approach to develop trust.

5 Supervision and manual to support change from reactive fixing to proactive coaching style and active liaisons.

6 Data and Information sharing work between systems e.g. mental health, VCSE, primary care.

7 List of those with SMI. Approach proactively.

Proactive episodes of care or ongoing support (the PARTNERS Model)
Delivered by a 'professional friend' care partner supporting shared decision making about individualised care for social, emotional and physical needs. Includes recovery focused goal setting and linking with other agencies.

Improved physical care through proactive liaison with GPs and Practice Nurses. Can include nutritional support, or smoking cessation.

Social support:
- Finance
- Housing
- Loneliness and social isolation
- Employment
- Meaningful activities

Peer support from peer workers or peer support groups, assisting self–management and developing user–led care and solutions.

Psychological support for a range of presenting issues common for SMI including low motivation, anxiety and low mood.

Optimise medication to reduce metabolic risk and motivation while preventing relapses.

WE ALSO MAKE THE FOLLOWING OBSERVATIONS:

What kind of relationships and support is valued by individuals with SMI but often not provided by specialist mental health and primary care teams?

- A relationship as a professional friend in creating collaborative partnerships, practitioner skills and experience are more important than seniority or previous job titles in Care Partner roles. This relational practice with a Care Partner was also valued by some more than goal based work.

- Support underpinned by the value of relational work – the ongoing relational aspect of the intervention may be of particular use to those service users who are isolated and do not have existing supportive relationships provided elsewhere by family or friends, which made up the majority of those the intervention was offered to in our studies.

- Continuity and time – the need for longer period of contact with a Care Partner for some, or a more intensive type of input from the Care Partner, to influence quality of life is likely to be necessary. As well as agency, hope and self-confidence – all things eroded over time when living with enduring mental health issues.

- Choices – the need to take into account service user choice, including whom they work with therapeutically. Some of the service user and practitioner pairings in our study showed clear signs of poor alignment or 'therapeutic fit' which seemed to be due to interactional style. Providing choice over which Care Partner to work with was not offered in our research, but we recommend this would be useful to explore in practice.

We need care systems to do more to promote the right of individuals with SMI. This includes opening up opportunities and actively encouraging people to ask for care related to social, psychological, physical, nutritional and medication needs when required, as well as to be offered these options without asking.

Care systems should provide training (such as assertiveness, building self-confidence and motivation, self-management, SMI psycho-education courses) to support for individuals with SMI to use information and peer support to help establish and manage collaborative relationships with practitioners.

How can we better support practitioners to deliver flexible person-centred coaching approaches?

- **Supervision is vital** and is often hard to secure as senior staff tend to be very stretched. We found frontline staff coping for large periods without supervision and the research team having to step in to provide this support – which is not an option in ordinary routine care. Lack of supervision undermines the collaborative care model so must be prioritised and seen as an integral part to service delivery.

- **Help practitioners to unlearn previous practices** and be supported to do so. Encourage peer support with other practitioners who are likeminded, re-establishing confidence in using person centred approaches from previous professional training.

- **Give time for the new model or care to feel natural** and part of everyday practice. Particularly coaching skills, which people often take time to learn and feel confident in using.

- **Practitioners require the personal skills to build 'professional friend' relationships** with service users. Finding the right way is likely to be very individual to the practitioner. It is also important to build the confidence to liaise across hierarchies; mental health work experience alone is not sufficient.

- **Create a team culture** that models coaching approaches in how it operates as a unit with practitioners working together across the system. Encourage peer to peer support in the team, prioritising workplace wellbeing and being open to innovation.

- Do **get to know local resources** and people in your area who can support your work to provide integrated and joined up mental health care.

We need care systems to create learning and support spaces for practitioners to deliver new models of care for people with SMI, emerging out of a growing bio-psycho-social evidence base.

Joining up physical and mental health care is everyone's responsibility, as is ensuring people are not left in the 'gap' though working across teams as one system. It shouldn't be this difficult, but it seems to be so. We need active promotion of this way of working from system leaders and a learning approach so we overcome difficulties along the way.

How can leaders across mental health, Voluntary Community and Social Enterprise (VCSEs) and primary care more actively engage in collaborative approaches to make their systems work for people with SMI?

- System leaders from primary care, mental health and VCSEs have to actively forge positive trusting relationships with each other. Agreeing that together they will ensure individuals with SMI receive holistic, person-centred care and people are not excluded due to diagnosis.

- Appoint champions from across VCSE, primary care and mental health services to ensure PARTNERS type care is provided. This might have a different name but is based upon collaborative care and person-centred principles.

- Decide which team(s) and practitioners take on the 'Care Partner' role of shared decision making about goals and the coaching approach; they will also make the proactive approaches to engage individuals in care.

- Ensure supervisors are trained and in place, potentially from a different team to the 'Care Partner', but with clear communication in place to enable joined up working.

- There needs to be a system in place to identify individuals with SMI who have been discharged from secondary care and are in the 'gap'. For example matching specialist team caseloads with Quality Outcomes Framework (QOF) list in practices. This might need to be linked to clear incentives.

- Decisions need to be made about which teams and practitioners will provide the different types of support and interventions across teams in the system. Together this can provide a network of care: e.g. general practices providing physical health advice/support/monitoring and reviewing medication; e.g. Care Partners themselves or community connectors or social prescribing link workers supporting connection to social interventions; e.g. psychological support for symptoms of anxiety or low mood.

- Information sharing across different electronic care records needs to be in place for practitioners across teams to work together effectively. This is a challenge for integration in all systems and there will be opportunities for the interests of those with SMI to be promoted as part of this ongoing work which is required for all those with complex care needs.

- Actively foster a proactive collaborative person-focussed approach to care based on flexible delivery including considerations for culture, gender and age. Emphasise the importance of a strengths-based approach to care moving away from a diagnostically driven deficits-based understanding of psychosis. Encourage people with SMI to work within healthcare systems as 'patient leaders' and peer support workers, while recognise some individuals will need ongoing support to have basic needs of housing, company and good nutrition met.

We need system leadership to be visible and vocal about proactive, person-centred, collaborative approaches for working with people with SMI and their families. It will require champions to walk alongside those changing the way they work, to give permission and support for this way of working.

Despite the CMHF alignment with the PARTNERS approach in terms of ambition and value base, in the short term there were many barriers to implementation. Long-term systems change and commitment will be required, including investment in the workforce's training and supervision.

Section 7: Next steps

We would like to hear from any community mental health system that is interested in the PARTNERS model, with a view to exploring implementation or conversations about how this work aligns with other roles such as social prescribers, community connectors and peer support workers.

We can deliver facilitated local discussions or talks including lived experience experts, for those wanting to take on the PARTNERS model.

We also welcome feedback on this briefing paper and are interested to hear about your experiences of the community mental health transformation programme.

PLEASE DO GET IN TOUCH VIA CONTACT@MCPIN.ORG OR PRIMARYCARE@PLYMOUTH.AC.UK

Acknowledgements

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Faculty of Health

Find out more about our work

www.plymouth.ac.uk/research/primarycare

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