Joining the dots: a social model for mental health support

The national picture

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Who we help
Our clients’ circumstances

Most clients have experienced health issue(s) in the last year

- Physical health problem: 55%
- Stress, depression, anxiety: 71%
- Other mental health: 21%

Most clients sought support from health professional

Help from health professional for condition

- Other mental health: 97%
- Physical health: 92%
- All clients: 83%
- Stress, depression and anxiety: 82%
Housing clients with a mental health problem

- 100% Housing
- 47% Benefits & tax credits
- 29% Debt
- 8% Legal
- 13% Other
- 7% Health &
- 7% Financial
- 2% Other

- Relationships & family
- Health & community care
- Financial services & capability
- Utilities & communications
- Employment
- Discrimination
- Consumer goods & services
- Travel & transport
The links between mental health and practical problems
Monitoring client outcomes using WEMWBS
Of our clients with mental health problems:

- 3 in 4 felt less stressed, depressed or anxious after advice.
- 3 in 5 felt better able to manage their condition following advice.
- Over 2 in 5 had to seek help from health services less often after advice.
So what does this mean?
Health service time is spent on non-health matters.

- 39% Write letters for government or employers
- 34% Give budgeting or debt management support
- 7% Complete benefits forms
Patients don’t get the support they need

2 in 5 patients don’t get the practical help they need

Only 11% of IAPT staff feel able to help patients by themselves

96% of IAPT staff signpost patients to advice
... and their mental health suffers
And what should be done?
DEVELOPING A SOCIAL MODEL OF HEALTH

Dr Janet Bliss
Clinical director, Community Programme
Liverpool CCG
### Relative contribution of the determinants of health

<table>
<thead>
<tr>
<th>Health Behaviours</th>
<th>Socio-economic Factors</th>
<th>Clinical Care</th>
<th>Built environment</th>
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</thead>
<tbody>
<tr>
<td>30%</td>
<td>40%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Smoking 10%</td>
<td>Education 10%</td>
<td>Access to Care 10%</td>
<td>Environmental Quality 5%</td>
</tr>
<tr>
<td>Diet/Exercise 10%</td>
<td>Employment 10%</td>
<td>Quality of care 10%</td>
<td>Built Environment 5%</td>
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<tr>
<td>Alcohol use 5%</td>
<td>Income 10%</td>
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<tr>
<td>Poor sexual health 5%</td>
<td>Family/Social Support 5%</td>
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<td></td>
<td>Community Safety 5%</td>
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**Source:** Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status.
Design challenges

● The ‘inverse care law’ – those who need our support and care the most are typically least likely to access it

● Salutogenic theory-building a ‘sense of coherence’

● Our sense of coherence is based on our ability to understand the systems we live in, our perceived ability to influence them and a sense of purpose

● Asset-based approaches- culture change for commissioners

● The dual challenge for an effective social model of health is to make it accessible and relevant to those who need it most – this means vulnerable people – the beneficiaries, and front-line staff – the clients.

● We need to design something that avoids disempowering individuals and communities....too easy for health to default to a deficit model.....
Design principles

● Systematising Asset Based Community approaches via Neighbourhood Collaboratives

● Developing a framework for wellbeing services with trusted partners

● Developing and embedding ‘link workers’ within health services

● Reversing the Inverse Care Law
The current model

- Liverpool Advice on Prescription in Primary Care project (Liverpool APP) set up in 2014 in order to alleviate poverty and hardship among people with LTCs and/or co-morbid mental health problems.

- Provides a social treatment option for primary care teams in respect of: benefits, financial hardship and insecurity, homelessness, debt, relationship breakdown, bereavement, domestic abuse, unemployment, fuel poverty.

- 50 advice clinics in health settings every week
APP Outputs 2017/18

● 730 interventions pcm
● 75% of referrals are from GPs
● 40% of users were living on <£600 pcm
● 70% of people had one or more long-term physical or mental health condition
● 20% of clients with SMI
● 50% had not used an advice service before
● £6.7m secured in additional income for vulnerable patients
● £2.6m reduction in household debt
● 80% of users report increase in wellbeing
● But...no wellbeing offer
Activity: eg volunteering, gardening, allotments, city farms, woodwork, bowls, angling, bicycling for beginners, bicycling with a disability, yoga, tai chi, walking groups – different levels, active ageing

Resilience: eg income maximisation, debt, housing, financial management, confidence-building, adult skills and lifelong learning, Enterprise Hub

Creativity: eg arts and crafts, music, orchestra, pottery classes, knit and natter groups, acting, baking

Connecting eg lunch clubs, circles of support, acting classes, local history clubs, cookery and nutrition, intergenerational groups, walk and talk groups, bereavement support, peer support, Wheel Meet Again, Back to Life, Made up to Meet

Simple referral, initial assessment by phone call within 48 hours or sooner
Advice on Prescription Plus

• 5 link workers across city
• Links to general practice, mental health and social care
• Non-clinical
• Provides motivation and support
• Supports patient until social prescription activated
Informed by analysis of linked data-sets

Primary Care Data
- Health Conditions
- Health
- Prescribing
- Consultations

Secondary Care Data
- Emergency and elective admissions
- Outpatient attendances
- Accident & Emergency Department attendances

Community Care Data
- Contacts by Service
- Referral Source
- Discharge outcome

Social Care Data
- Contacts by package
- Assessments
- Social care need

Mental Health Data
- Contacts by service
- Mental health conditions
- Mental health need

Advice on Prescription Data
- Cases opened
- Case issues & activity
- Self reported health outcomes

Patient Level data link on common identifier in a secure environment

Patient level (but not identifiable) output available for analysis
Data Linkage Project

- Supported by the health foundation
- Linking health data with APP data
- Opportunity to link socio-economic data with health data at patient level
- Allows us to target services more effectively
- Pilot in respiratory service
- Early indications show 50% increase in income maximisation in this targeted group