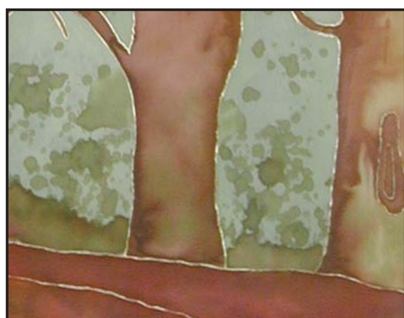
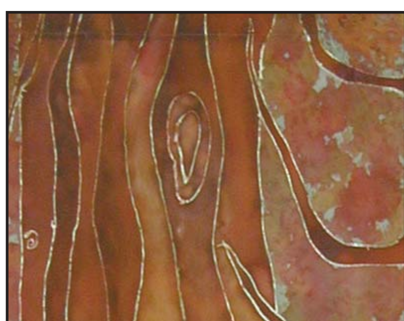
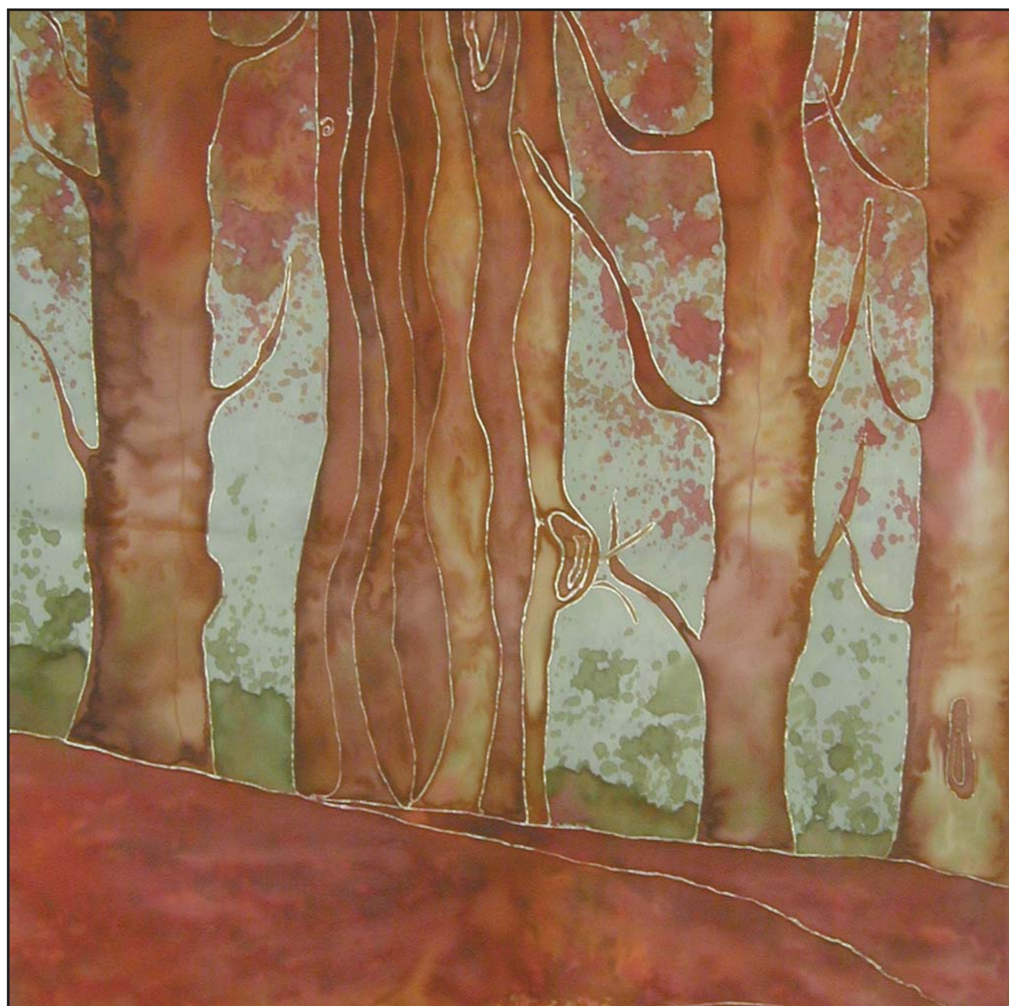
NHS

National Institute for
Mental Health in England

Cases for Change

Primary Care



mental health questions? **ask NIMHE**

Cases for Change

Mental health services in England are experiencing a period of unprecedented change. The pace of this change is potentially matched only by the pace at which information about both effective and less effective practice in mental health care is emerging. Over the past five years an incredible wealth of published literature has continued to remind all those engaged in developing mental health services of the reasons why fundamental change is necessary and of how services might be improved to better meet the needs of service users.

In addition to the evidence emerging from the research literature, it is important to recognise the role that publications appearing beyond the peer-reviewed journals have also had in informing the many cases for change that exist in adult mental health care today. These include publications reporting non-research based service reviews and the expert opinion of groups and organisations representing the interests of mental health service users, carers and professionals.

For those engaged daily in supporting change in local mental health services it can be difficult to feel well informed of the context of evidence and opinion within which current mental health policy has been established. With this in mind, in late 2001 the National Institute for Mental Health in England (NIMHE) commissioned a review of recent literature on adult mental health services with a view to producing an accessible summary of the emerging cases for change.

Cases for Change comprises ten booklets.

- **Introduction:** describes the background and methodology of the review and also summarises the findings and suggests areas for future research/policy development.
- **Policy Context:** describes the context of the review with an overview of recent mental health policy.

The following seven booklets each consider a different aspect of mental health service provision:

- **Primary Care**
- **Community Services**
- **Hospital Services**
- **Forensic Mental Health Services**
- **Partnership Working Across Health & Social Care**
- **User Involvement**
- **Anti-discriminatory Practice**
- **Emerging Areas of Service Provision:** reviews the literature that does not fit neatly into any of the previous topics.

The review collates evidence from over 650 documents published between January 1997 and February 2002 concerning adult mental health service delivery and/or policy in England. With the information collected synthesised into a number of key themes or issues, the review aims to describe how we got to where we are today and sets out the cases for change from the evidence base.

The articles highlighted at the beginning of each booklet as The Nature of the Evidence are those that are particularly relevant to the cases for change cited in the booklet concerned. Each document within the review has been classified using the "hierarchy of evidence" adopted in the *National Service Framework for Mental Health (NSF)* (Department of Health, 1999a):

- Type 1 evidence represents at least one good systematic review, including at least one randomised controlled trial.
- Type 2 evidence represents at least one good randomised controlled trial.
- Type 3 evidence represents at least one well-designed intervention study without randomisation.
- Type 4 evidence represents at least one well-designed observational study.
- Type 5 evidence represents expert opinion, including the opinion of services users and carers.

At the end of each of the main booklets, there are critical commentaries by service users and practitioners/managers/policy analysts from across England. These commentaries are intended to emphasise that different groups of people have different priorities and identify different cases for change. All contributors have been encouraged to be as challenging as possible and, where they disagree with interpretations, to say so.

Each booklet can be read independently or alongside one another to bring together a full picture of the development of mental health services. We hope this will be helpful in enhancing our understanding of the history as well as emphasising the need to develop future individual services within the context of an integrated system of care and support.

Cases for Change should be seen as a starting point and as a means to an end rather than an end in itself. By summarising the key issues that have emerged from the literature and by emphasising the diversity of opinion that exists within mental health services, Cases for Change may help to encourage debate about the best way forward and the way in which different view points can be balanced to achieve mutually beneficial outcomes.

Cases for Change has been written by a multi-disciplinary research team based at the University of Birmingham with the active support and encouragement of Susannah Rix at NIMHE Eastern, the guidance of the Expert Panel, and service users and practitioners who have provided written commentaries for the main sections of the review. Our thanks also to colleagues in the mental health group at the Department of Health for their editorial input to help finalise the publication.

The research team comprised:

- Jon Glasby, a qualified social worker and a lecturer at the Health Services Management Centre.
- Helen Lester, a GP, national primary care career scientist and Co-Director of the University of Birmingham's Interdisciplinary Centre for Mental Health.
- James Briscoe, a consultant psychiatrist and senior lecturer in the University of Birmingham's Department of Primary Care.
- Marion Clark, a former teacher who worked on this study as a user consultant.
- Steve Rose, Library and Information Services Manager at the Health Services Management Centre at the time of this review and now Health Care Libraries Manager, University of Oxford.
- Liz England, a clinical research fellow in the University of Birmingham's Department of Primary Care.

Four Seasons

These original artworks were designed and painted by a team at The Hollies in Ipswich, Suffolk. Working together the group generates ideas, energy and input. The community spirit engendered provides a platform that allows creativity to shine through. The group experience builds confidence and develops a sense of esteem. *"This kind of work may not cure our problems, but this is the first year I have not been admitted to hospital".*

The Hollies is a Social Enterprise developing meaningful work opportunities for people who have used mental health services. Social Enterprise can and does create real jobs. The pictures illustrate a theme of constant change and renewal in nature. They reflect the changes that can evolve through Social Enterprise and working together.

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The Nature of the Evidence

	Number of Articles
Type I	8
Type II	14
Type III	7
Type IV	17
Type V	55

"The cardinal requirement for mental health services in this country is not a large expansion and proliferation of psychiatric agencies but rather a strengthening of the family doctor in his/her therapeutic role." (Shepherd et al., 1966)

Background

Primary care is now arguably a key partner in developing mental health services, with PCTs driving change in service structure, delivery and outcomes.

Primary care is a free, universal, voluntary, demand led system working with whole populations and not just small percentages requiring intensive resources. It is part of many complex adaptive systems (Plsek and Greenhalgh, 2001; Wilson et al., 2001) and has developed some of the most sophisticated methodologies for working with uncertainty and complexity. Problems are undifferentiated, and people are often seen for short times but over long periods. Primary care is delivered by specialists in generalism – defined by Willis (1995) as taking an interest in whatever is of interest to its clients. It occupies an important space at the interface of users, families, communities and professional worlds, negotiating meaning around health, illness and disease. As a setting it is also generally preferred by mental health users and carers (Pilgrim and Rogers, 1993).

Ninety per cent of all patients with mental health problems (including 30 to 50 per cent of all those with serious mental illness) only use primary care services (Department of Health, 1999a; Kendrick et al., 2000). Mental health concerns which affect an individual's or family's functioning are present in 30 to 60 per cent of all primary care consultations, and a mental health problem is identified as the main issue in 30 per cent (Strathdee and Jenkins, 1996). A consultation inevitably involves exploring beliefs and feelings, and thus it could be argued that all consultations are, at least in part, concerned with mental health.

Despite this, there is evidence to suggest that users are not always offered good quality patient-centred care. Although a dimensional approach to assessing the severity of depression can improve detection rates (Thompson et al., 2000), up to 60 per cent of cases of depression go undetected (Docherty, 1997). This rate increases to 77 per cent for practice nurse consultations (Plummer, 1997). Many GPs prescribe older tricyclic antidepressants at doses below those recommended by consensus guidelines (Donoghue and Tylee, 1996) and prescribe all classes of antidepressant drug for a shorter periods than recommended.

The quality of care for users with serious mental illness is particularly variable. Standardised mortality ratios for people with schizophrenia are more than double the population norms partly due to suicide and accidents and but also from doubled cardiovascular and respiratory disorder mortality rates (Brown, 1997). Health problems often remain undetected, despite the fact that users have higher consultation rates than the general population (Nazareth and King, 1992). Evidence also suggests that people with serious mental illness are more likely than the general population to have poorer diets, be obese, take no exercise and smoke (Brown et al., 1999). Although these risk factors are well documented in primary care records, it appears there is often little effort made by primary care health professionals to intervene or modify them (Kendrick, 1996). The uncertainty amongst health professionals about who is responsible for the physical health care of people with serious mental illness may also contribute to their poorer physical health care (Bindman et al., 1997).

Mental health is not a neat high ground of clear definitions and well-demarcated pathways, but a messy swamp of symptoms that are often hard to disentangle and rarely conform to case definitions (Schon, 1983). Health professionals also vary in their "psychological mindedness" and abilities to elicit symptoms of mental illness (Goldberg et al., 1993). Detection is also affected by the way users present their problems. Many people are reluctant to talk about their mental health symptoms and worried about the stigma of mental illness. Symptoms such as tiredness and disrupted sleep may not be seen as possibly indicative of mental illness, or are normalised and minimised and therefore not mentioned to the primary care team (Kessler et al., 1999).

Many members of the primary health care team treat people with both common mental health problems and serious mental illness with little appropriate training or supervision. Fewer than 40 per cent of GPs have any postgraduate training in psychiatry and those that do are often exposed to hospital based psychiatry with little relevance to their work in primary care. Fewer than 35 per cent of GPs have undertaken any continuing education relevant to primary mental health (Kerwick et al., 1997). Fewer than 2 per cent of practice nurses have specific mental health training, although 89 per cent are regularly seeing patients with mental health problems (Crosland and Kai, 1998). This suggests both a need to review the role of the practice nurse in providing primary care mental health and the availability of education and learning opportunities for the wider primary health care team (see later in this booklet).

With the rise of community care, primary care has begun to shift from being simply a filter or referral pathway to specialist care to being a site of specialist mental health activity itself. This has been reinforced by national policy during the last decade, significantly altering the role of primary care as a lead commissioner and, increasingly, a provider of mental health services. Counselling, for example, is now available in approximately half of GP surgeries (Mellor-Clarke, 2000a) although there are issues around standards, education and training and risks associated with counsellors in primary care working in isolation from other providers of "talking treatments" (see later in this booklet).

All these changes have also meant adjustments in the way primary care conceptualises itself, and also how other parts of the health and social care sector respond to it. For example, four models of care have been identified which are broadly designed to support primary mental health care but are largely premised on a specialist care view of the world (Gask et al., 1997):

1. Community mental health teams which provide increased liaison and crisis intervention.

2. The shifted outpatient clinic where psychiatrists operate clinics within health centres.

3. Attached mental health workers, usually

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CPNs, designated to work with those with mental health problems in a primary care setting.

4. The consultation liaison model where primary care teams are provided with advice and skills from specialist mental health services.

However, each of these models has particular strengths and weaknesses. For example:

- Evidence suggests that the development of community mental health teams often brings about a major increase in the rates of new patients referred but that the new clientele consists largely of patients with common mental health problems who might otherwise have been managed by their GP alone (Gask et al., 1997). Some of these problems have been demonstrated in the recent Clinical Standards Advisory Group (CSAG) report on depression (see figure 1).
- Limited evidence suggests that the shifted outpatient model attracts referrals similar to those seen in the hospital setting (Murray, 1998).
- The impact of attached mental health professionals on referral patterns is also still unclear. A systematic review of controlled trials in primary care found that the effect of on site mental health professionals on consultation rates was inconsistent (Bower and Sibbald, 2002). Referral to a mental health professional reduces the likelihood of a patient receiving a prescription for psychotropic drugs or being referred to specialist care, but the effects are not consistent and are restricted to patients directly under the care of the mental health professional. Roles and responsibilities are also unclear with consequent less efficient working patterns (Corney, 1999).
- The Cochrane review of the effect of on site mental health workers in primary care concluded that consultation liaison interventions may cause changes in psychotropic prescribing, but that these are short term and limited to patients under the direct care of the mental health worker (Bower and Sibbald, 2002).

Figure 1 Joint Working across Primary Care and Specialist Services

CSAG (1999, p.33) field visits looking at the treatment of people with depression in primary care found that joint working and interagency communication were generally poor:

- There was little evidence of any shared care arrangements within the primary health care team.
- There was little evidence of any shared care arrangements in operation between primary care and specialist services.
- The majority of GPs reported that they did not know the consultant well enough to telephone him for advice.
- Most of the primary health care teams visited reported that no regular link working system was in place.
- Very few community mental health teams had a clear strategy for communication with primary care.

An increasing case for change is now being made for developing alternative primary care-focused models of mental health delivery that do not rely on approaches premised on specialist service models of care but that are commissioned by and grounded in the culture of primary care (see later in this booklet).

Cases for Change

Against this background, many of the Cases for Change documents reinforce key messages from the wider literature about:

- New ways of integrated working.
- The role of the practice nurse.
- The role of counselling in primary care.
- The provision of care for people with serious mental illness.
- The commissioning and provision of mental health services.
- New ways of learning together.

New ways of integrated working:

The notion of integrated primary mental health care has been on the agenda for some time (see also figure 2). However, the roles and responsibilities of specialist mental health services have often mitigated against closer working with primary care. Community mental health teams have sometimes struggled with the introduction of CPA and care management. It is unsurprising therefore that the emergence of a primary care agenda for integration of mental health service delivery has sometimes been seen more as a problem than an opportunity (Peck, 1997). Whether new models of primary care-focused integrated working succeed will depend on a number of changes in the culture and service delivery of care including:

- A commitment from primary care to mental health as an issue.
- The ability of specialists to shift into instead of trying to exercise control over

Figure 2 Integrated Primary Care Mental Health

Blount (1998, p.6), one of the foremost commentators on integrated primary care in the area of mental health, gives nine reasons why integration is worthwhile:

1. Integrated primary care (IPC) reflects the way that the majority of patients present their distress in primary care. Their problems are not either biological or psychological; they are both, presenting in an undifferentiated form.
2. For problems that are clearly psychological or psychiatric in nature, such as depression and anxiety, primary care medical settings are the predominant locus of treatment.
3. When primary care services are a better fit for the way patients present, there is a better adherence to treatment regimes which leads to better outcomes.
4. Even when trained in psychiatry and counselling, primary care physicians cannot be expected to address the array of psychological/ psychiatric problems present in primary care, and referral out is often a poor alternative.
5. IPC is the best way of potentiating the skills of primary care providers in dealing with the psychosocial aspects of care.
6. Primary care providers are happier with their work in integrated settings.
7. Patients are more satisfied with care in integrated settings.
8. It appears to be a break even or cost saving move in the long run.
9. IPC settings are the best laboratories for the further development and refinement of primary care medical services.

primary care working (Peck and Greatley, 1999).

- The development of a reciprocal culture that recognises that practices differ between sectors and that each can be appropriate in different circumstances (Peck and Greatley, 1999). Such working practices are however dependent on knowledge of each setting's strengths and weaknesses and the creation of a culture of mutual respect.
- Good communication across the interface particularly focusing on criteria for referral and discharge, agreed guidelines and mutual support (WHO, 2000).
- The development of a culture where primary care and specialist services can work together to develop service structures appropriate to local morbidity and resource levels and to negotiate and manage the necessary changes within a feasible implementation timeframe (Jenkins and Strathdee, 2000).
- The ability of PCTs to commission services that encourage and enable better integration between services.

The Cases for Change literature has highlighted a number of examples, often in single sites, that offer guidance in developing more integrated services, although rigorous evaluation is required before such services can be reliably disseminated (see figure 3).

The NHS Plan (Department of Health, 2000d) heralded the introduction of 1,000 new primary mental health workers and 500 gateway workers by 2004. The role of the primary mental health workers includes infrastructure building and referrals facilitation. It also incorporates some face to face client work appropriate to the skills of newly qualified graduates with some mental health training (see Further Information). While these new workers will have a potentially important role in facilitating more integrated primary care and providing a bridge between practice nurses and CPNs, the evidence base to develop their role is currently lacking. Previous work suggests that cost effectiveness data will be required if the true value of these new workers is to be assessed appropriately. Additional workers by themselves may also be insufficient to create a cultural shift, but could prove a useful additional resource in developing integrated user focused mental health services.

The role of the practice nurse:

Practice nurses interact with people who have mental health problems on a regular basis, yet have a relatively limited role in their care. Few practice nurses have specific training in mental health issues. Indeed the evidence suggests that up to 70 per cent of practice nurses have received no mental health training in the last five years (Gray et al., 1999) and that in some areas only 8 per cent have attended a study day that includes a mental health component (Nolan et al., 1999). It is therefore perhaps not surprising that many practice nurses report a lack of confidence in their ability to talk to and treat people with mental health problems (Armstrong, 1997; Crosland and Kai, 1998; Millar et al., 1999).

The limited evidence base on the role of the practice nurse in mental health suggests that between 13 and 43 per cent of practice nurses include identification of anxiety and depression as a routine part of their role (Thomas and Corney, 1993). Practice nurses also work with people with chronic physical illnesses who are often at particularly high risk of developing mental health problems (Rimington et al., 2001). Many practice nurses are also increasingly involved with people with serious mental illness (Kendrick et al., 1998). Thus, a recent national survey of practice nurse involvement in mental health interventions (Gray et al., 1999) found that:

- 51 per cent were administering depot medication at least once a month.
- 33 per cent were involved in ensuring compliance with anti-psychotic medication.
- 30 per cent were monitoring side effects of medication.

Against this background, the Cases for Change literature has suggested a number of ways forward in increasing the involvement of practice nurses in primary care mental health. Integrated rather than devolved working practices, structured care with follow up along chronic disease model lines and linking role changes to service organisation and delivery appear to be key factors in developing practice nurse roles in primary care mental health. Some of the most effective interventions, particularly telephone follow up (Hunkler et al., 2000) and self-help interventions (Bower et al., 2001), appear to be relatively inexpensive in terms of time and money (see figure 4).

Appropriate education and learning strategies, discussion with other professions about skill mix and a supervisory framework are also required to underpin

Figure 3 Examples of Innovations in Integrated Working

Tummey (2001) and colleagues describe a nurse led quick response service which enables liaison between primary care and specialist services for urgent referrals. The service had the advantage of a clear referral pathway, speedy access, good interface communication and a focus on reduction of suicide and self-harm.

Challenger et al (1998) describe the roles and responsibilities of the primary care based psychiatric social worker in a GP practice in Manchester. They found that the accessibility and low stigma of the setting meant that patients were happy to see the social worker and that the surgery was able to provide more holistic care. The service was also valued by other health professionals in the practice.

Bruce et al (1999) describe a primary care based CPN service dedicated to the care of the long term mentally ill. The service promoted a slow transfer of care from institutionalised care to a community setting and was welcomed by staff and carers although the evaluation found little impact on users' quality of life scores.

The Workforce Action Team (Department of Health, 2001j) describes a fully integrated primary care liaison service in North Birmingham. The service helped to empower GPs to recognise and treat psychiatric illness, jointly manage patients, screen urgent referrals and disseminate information about other non-statutory agencies. The service however also demonstrates the difficulty of sustaining new ways of working when a product champion leaves and of imprinting on the fabric of service delivery in a climate that does not value integrated working practices.

the case for change in practice nurse roles and responsibilities in primary care mental health.

The role of counselling in primary care:

There has been a rapid increase in the number of counsellors in primary care in the last decade. In 1993, 31 per cent of practices had access to a counsellor but by 2001 this figure had risen to 51 per cent (Mellor-Clarke, 2000a; NHS Centre for Reviews and Dissemination, 2001). This growth may reflect increasing consumerism within the NHS and patient preference for non-pharmacological options for mental distress (Chilvers et al., 2001; Hemmings, 2000) which may also account for high levels of patient satisfaction (Bower, 2000; Gordon and Wedge, 1998). The growth in counselling services also reflects the ability of primary care teams to purchase services through fund holding, total purchasing and, more recently, PCT commissioning roles.

Unfortunately, the evidence base for the effectiveness of primary care based counselling is relatively limited. Thus, two key systematic reviews on counselling in primary care report modest benefits associated with the treatment of mild to moderate depression by counselling in the short term, but less evidence of benefits in the long term (Bower and Sibbald, 2002; NHS Centre for Reviews and Dissemination, 2001). There is also little reliable evidence on the cost-effectiveness of counselling. At the same time, there is no strong national consensus on what constitutes a counselling service in primary care and services and availability can vary greatly across the country (White, 2000). There are also disputes over counsellors' roles and responsibilities (Hemmings, 2000), professional accountability and the minimum qualifications and training needed (Hudson-Allez, 2000).

As a result, the Cases for Change literature suggests that a number of changes will be required to effectively develop counselling within primary care:

- There is as yet no single national body that oversees the development of primary care counselling services. A case can be made that such a body could argue for better pay, pensions, paid administrative time, professional development and more accredited training courses (Curtis Jenkins, 1995; Eatock, 2000; Foster, 2000). Such a body could also have a role in patient protection from counsellors whose practice falls below recognised standards.
- There is a need for better primary care team education about which patients are suitable for referral and when, and which type of counselling is needed, aided perhaps by the development of referral and treatment guidelines (Davidson, 2000). Good communication between counsellors and other members of the primary care team through regular team meetings and primary care team-counsellor review of the patients referred could also improve referrals and help promote the integration of counsellors into primary health care teams (Curtis Jenkins, 1995).
- Users' expectations of counselling also need to be realistic. User involvement in drawing up guidelines may help both to focus services on what is really wanted and needed and can be delivered.
- The considered development of options such as group work, self help material, self help assessment packs and one off advice clinics may also help to manage patient demand and provide cost effective alternatives to individual counselling (White, 2000).
- A case can also be made for altering the focus of research on the effectiveness and cost effectiveness of counselling as current research may fail both to reflect "real life" clinical practice and to focus on more subtle outcomes that impact on cost effectiveness such as improvements in problem solving and self-esteem (Churchill et al., 1999; Gordon and Wedge, 1998; Hemmings, 2000; King et al., 2000).

The provision of care for people with serious mental illness:

At least 30 per cent of people with serious mental illness are only in contact with primary care services (Kendrick et al., 2000). As mentioned earlier in this booklet, there is also considerable evidence to suggest that people with serious mental illness have poorer health

Figure 4 Evidence Base for Expanding the Roles and Responsibilities of Practice Nurses

Tele-health initiatives: Hunkler et al (2000) investigated a practice nurse based telephone follow up for patients starting antidepressant medication in a randomised trial comparing usual care, tele-health care and tele-health care plus peer support. The intervention involved ten 6-minute phone calls by practice nurses over four months. Patients in the intervention group were more likely to experience a 50 per cent improvement on depression rating scales at six weeks and six months, than patients under usual care. Patients were also more satisfied with their treatment. A similar randomised controlled trial in Seattle supports these findings (Simon et al., 2000).

Psychological therapies: A randomised controlled trial that involved practice nurses trained to deliver six sessions of problem solving in primary care for patients with depression showed significant improvements on depression rating scales at 12 weeks and this improvement was maintained at 52 week follow-up (Mynors Wallis et al., 2000).

Medication adherence: Practice nurses appear to have a positive role in improving adherence to antidepressant medication. A randomised controlled trial evaluating two different methods of improving adherence with antidepressant medication found that for people with major depression, counselling significantly improved adherence to medication from 50 to 66 per cent at 12 weeks with concomitant clinical benefits (Peveler et al., 1999). Improved adherence to medication was also demonstrated in a study comparing usual treatment of depression with an enhanced treatment intervention (Rost et al., 2001).

Structured care for users with serious mental illness: Burns (1998) examined the impact of a structured assessment on the process of care and clinical status of patients with schizophrenia by practice nurses who had received a one-day training course. Practice nurses were far more diligent in carrying out the assessments on the 150 patients who attended for their depot injections than the GP colleagues but there was no impact on treatment patterns or clinical outcomes.

than the general population and create a significant work load for primary care (Kai et al., 2000; Lang et al., 1997), but that GPs do not perceive themselves as being involved in the mental health care of users with serious mental illness (Bindman et al., 1997). This suggests a case for change in the structure and process of delivery of primary care for users in and out of contact with specialist mental health services.

In response, the Cases for Change and wider literature have suggested a number of ways forward. Thus, the feasibility of rapidly identifying and creating registers of users with serious mental illness in relatively organised and computerised general practices has been demonstrated (Kendrick et al., 1994) and the development of such registers has been strongly encouraged in recent National Institute for Clinical Excellence (NICE) guidelines on the use of atypical antipsychotic medication (NICE, 2002). In addition, the Primary Care Schizophrenia Consensus Group has published management guidelines which adopt a model based on structured care being offered to people with a chronic physical illness (see figure 5). Finally, Burns et al (1998) found that the most successful method of offering structured assessment is through a nurse-led specialist clinic, suggesting that expanding the role of the practice nurse (allied to the provision of appropriate training) may improve care.

Despite this, a number of limitations remain in terms of providing good quality primary care for people with serious mental illness:

Figure 5 Management Guidelines for Schizophrenia

1. Identify patients and organise a regular review.
2. Perform a comprehensive assessment to include:
   - social and environmental factors
   - mental state
   - physical problems
   - medication.
3. Provide information and advice for patients and carers.
4. Consider indications for involvement of specialist services.
5. Develop individual crisis management plans.

(Burns and Kendrick, 1997, p.517)

- Structured assessments by GPs may not be feasible in routine surgery largely because of time constraints (Kendrick et al., 1995).
- Burns and Cohen (1998) found that paying GPs an item of service payment of £85 per annum for "monitoring" people with serious mental illness was successful in ensuring GPs undertook the assessments. However, they did not demonstrate an improvement in health care.
- There are potential problems with the development of serious mental illness registers such as stigmatisation, indefinite registration and of a potentially benign development becoming a subtle form of control rather than care (Barr and Cotterill, 1999). As a result, any case for change in this area needs to be debated with users to ensure registers are an active and accurate resource for delivering good quality primary care and not an additional source of stress.
- Mechanisms to improve the shared care of people with schizophrenia may also include the provision of patient held records. Evidence to date suggests that they may be valued by users and improve communication across the interface with specialist services (a valuable outcome in its own right), but do not affect longer-term outcomes such as symptoms and satisfaction with care (Essex et al., 1990; Stafford and Laugharne, 1997).
- There is little explicit literature on the views of users with serious mental illness on primary care and existing evidence has produced conflicting findings (see figure 6), suggesting the need for further rigorous qualitative work in this area of health care.

Overall, therefore, the Cases for Change literature has demonstrated the clinical need for better structured and delivered primary care services for people with serious mental health problems. There are also a number of examples of good practice and a small but growing literature on users' views of what constitutes good primary care. The policy imperative (Department of Health, 1999a) and the evidence base now make a compelling case for change in this crucial area of primary care mental health.

The commissioning and provision of mental health services:

During the last ten years, primary care has had increasing organisational experience of both commissioning and providing mental health services. In the wake of the *NHS and Community Care Act 1990*, many GPs became budget holders and purchasers as well as providers of services. In the mid 1990s, total purchasing and fund holding arrangements permitted a general practice or groups of practices to hold delegated budgets with which to purchase specialist services. Between 1996 and 1998, 13 sites around the country also operated as mental health extended fund holding pilots with the ability to purchase inpatient mental health (Lee and Gask, 1998).

Following the rapid series of changes described in the Policy booklet, PCTs have been given specific responsibility for commissioning mental health services as part of their overall brief to improve the health of the community, secure the provision of high quality services and integrate health and social care locally. At the same time, PCTs are also increasingly providing as well as commissioning mental health services, often in partnership with a specialist provider for services such as those for people with eating disorders or child and adolescent care.

The policy case for change in commissioning therefore appears to have been operationalised with the expectation that this in itself will bring services closer to the user, reflect local issues and encourage partnership working across health and social care sectors. However, evidence from a postal questionnaire to the 481 PCGs in England in January and February 2000 from the Sainsbury Centre for Mental Health (2001a) suggests a number of barriers to implementing the expected changes in commissioning (see figure 7).

Potential ways forward in this area have been synthesised in a recent systematic review by Lester and Sorohan (2002) which addressed the organisational development needs of PCTs for commissioning and providing mental health services (see figure 8).

New ways of learning together - education and learning strategies in primary care mental health:

As discussed in the background, many GPs and members of the extended primary care team lack both confidence and competence in dealing with mental health issues because of limited training. As a result, many of the changes envisaged in primary care mental health rely on the development

and delivery of appropriate education and learning strategies.

Previous attempts to educate the primary care workforce in the area of mental health have met with mixed success:

- The Hampshire depression project found that education delivered to practice teams, although well received, did not deliver improvements in recognition of or recovery from depression (Thompson et al., 2000).
- A Randomised Control Trial (RCT) on the effectiveness of teaching general practitioners skills in brief cognitive behavioural therapy to treat patients with depression found that the training had no discernible impact on user outcomes (King et al., 2002).

There is, however, a growing evidence base, reflected in the Cases for Change literature, on the key features for devising and delivering complex interventions such as primary care mental health education (Campbell et al., 2000):

- Singelton and Tylee (1996) suggest that an overtly learner-centred approach to continuing medical education in mental illness is a more successful model than the traditional perceived pedagogic

Figure 6 Service Users' Views of Primary Care

Rogers and Pilgrim (1993) interviewed 326 service users from Mind across the UK and found that:

- 81% found GPs helpful.
- 63% felt GPs had a positive attitude towards them.
- However, 52% felt GPs did not explain or give sufficient information.
- GPs were also criticised for giving insufficient time, dismissing physical problems and not offering alternatives to medication.

Crosby and Barry's (1995) interviews with 24 long-term and new referrals to community services in Wales emphasised a perceived lack of respect from GPs and a lack of information provided during the consultation.

Nazareth et al (1995) interviewed 83 patients with schizophrenia and found that:

- 88% felt a continued need to see their GP.
- 40% were opposed to seeing the mental health team in the GP surgery.
- There was general resistance to a change from specialist to primary care-based mental health services.

Bailey's (1997) research with ten service users with serious mental illness in Birmingham found that:

- Overall satisfaction with primary care was low.
- 70% of the users did not feel listened to.
- There was a perceived need for more GP training.
- There was a perceived lack of information and explanation.
- There was a desire for more structure to care such as the introduction of registers and guidelines for care.

Bindman et al (1997) interviewed 90 people with serious mental illness in London and found that:

- 69% rated their GP's handling of physical health care as good/excellent.
- 43% rated their GP's handling of mental health problems as good/excellent.
- 42% said they did not discuss their mental health with the GP.
- 59% wanted their GP to have little involvement with their mental health.

Kendrick et al (2000) administered structured questionnaires to 102 people with serious mental illness in South London and found that the majority expressed satisfaction with their GP services.

In Faulkner's (2000) research, a user-administered semi-structured questionnaire with 76 mental health service users in 6 geographical areas across the UK emphasised:

- The need for more information about medication.
- That satisfaction was increased by longer consultations.
- That satisfaction was increased by a GP perceived as caring and who demonstrated respect for the patient's viewpoint.
- Access and continuity of care were important to service users.

Kai and Crosland's study (2001) involving in-depth interviews with 34 service users with enduring mental illness found that participants valued an empathetic and continuing therapeutic relationship with professionals and that fear of social stigma influenced engagement with services.

Figure 7 Primary Care Commissioning

Research conducted by the Sainsbury Centre for Mental Health (2001a) found that:

- Only one third of PCGs had a manager with some responsibility for mental health.
- All of the managers, with the exception of one, had other clinical areas to deal with as well as mental health.
- 73 PCGs believed that they were actively commissioning mental health services, yet only 66 PCGs had a commissioning manager, 90 per cent of whom spend less than 25 per cent of their time devoted to mental health.

Key barriers included:

- Time commitment for commissioning.
- Lack of specific commissioning knowledge.
- Lack of resources.
- Poor Information and Technology IT systems.
- The tension between providing services for the severely mentally ill and for those with common mental health problems.
- Lack of capacity of the PCG to manage the current change agenda.

approach (that is, that teaching should be based on local training in a learner-friendly environment rather than a hierarchical approach with a medical expert in a large lecture theatre).

- The Defeat Depression campaign, which ran for five years from 1992, demonstrated the importance of local initiatives in dissemination (Rix et al., 1999).
- Howe's (1996) work on detecting psychological distress in general practice demonstrated that self-directed educational approaches including reflection on one's own practice and basic audit principles can improve detection of psychological distress.

The cases for change in education and learning have been highlighted in a number of recent policy reports. Thus, the Workforce Action Team (Department of Health, 2001j, p.6) included a separate report for primary care which considered "the action required to ensure the primary care workforce is equipped to deal with mental health problems." This report identified an "overwhelming case" for education and training programmes in primary care mental health to be strengthened and further developed (p.9). In particular:

- Suggested education and learning methodologies will need to be responsive to and embedded within the culture of primary care with a balance between context rich practice based learning, and protected time in an academic environment (Sainsbury Centre for Mental Health, 2001b).
- Training will need to have both uni- and multi-disciplinary components (to encourage integrated learning but also recognise the contributions of each constituent discipline) and will also need to be competence based, include time for reflection and enable unpredicted learning to occur (Department of Health, 2001j).

To date, there have been relatively few such training opportunities in mental health for primary care staff (see Department of Health, 2001j for further details). However a recent evaluation of an integrated primary care mental health training course in the West Midlands that incorporates many of these education and learning features (Brown et al., 2002) found that such training can have an impact on the delivery of mental health care both in primary care and across the interface with specialist services (see figure 9), and perhaps provides a way forward in learning together.

Overall, the cases for change in primary care mental health are now overwhelming, driven (perhaps at too quick a pace) by policy, but guided by an increasingly robust and varied evidence base of good practice. Primary care is now taking on extended responsibilities in commissioning and provision, embracing new mental health workers, re-evaluating the roles of current staff and responding to new education and learning opportunities in mental health. However, cultural shifts are needed on both sides of the primary care/specialist services interface with users' views accepted as central if such changes are to achieve valued, integrated primary care-focused services.

Further Information

For those wishing to explore these issues in greater depth, there are a number of useful resources:

- Jenkins et al (1998) provide a comprehensive overview of health promotion in primary care mental health, including topics such as theoretical frameworks for education in primary care, the use of guidelines and community education strategies.
- Byng and Single (1999) provide a general overview of how practices can develop services for people with long term mental illness and offer practical advice on interface working (including the development of specific shared care agreements).
- The World Health Organization's (2000) Guide to Mental Health and Primary Care provides practical advice and information about clinical management of patients with mental health problems presenting in primary care.
- Users' views on primary care mental health are well represented in a user-led research report into people's strategies for living with mental distress (Faulkner and Layzell, 2000; see also the User

Figure 8 Primary Care Commissioning: Ways Forward

Successful commissioning requires:

1. Engagement in a leadership programme.

2. Infrastructure changes such as good IT and achieving a critical mass of staff to achieve change.

3. Commissioning of a skills training programme that encompasses issues of needs assessment, contract management and use of outcome indicators to monitor care.

4. Partnership working at every level of the organisation and between organisations and crucially between health and social care professionals and users.

5. A workforce development programme that encompasses new roles such as primary mental health workers and gateway workers.

6. A research and development programme.

(Lester and Sorohan, 2002, pp.40-41)

Figure 9 The Impact of the Trailblazers Course

The Trailblazers course is designed to encourage leadership in primary care mental health and to promote integrated working across primary care and specialist services. Participants to date have included GPs, psychiatrists, psychologists, health visitors, community psychiatric nurses and practice nurses. An evaluation found that the course led to:

- The development of leadership skills.
- The cascading of learning to local colleagues. The 14 course participants felt they had used their learning to influence over 200 health professionals during the six months of the Trailblazers course.
- Increased integration between primary care and specialist services - pairs began work on developing local protocols across the interface, on the development of ideas for new mental health workers to work across the interface between primary and specialist services, and on developing joint educational initiatives.
- Participants addressing patient's needs more effectively through changes in their own practice and consequent effects on the wider team.

(Brown et al., 2002, pp.38-39)

Involvement booklet).

- The Sainsbury Centre for Mental Health's (2001a) Setting the Standard proposes a number of standards for PCTs commissioning mental health services to ensure that they meet local needs.
- The Sainsbury Centre for Mental Health's (2002a) Primary Solutions is a useful independent policy review of the development of primary care mental health services.
- Nolan and Badger (2002) provide further information on promoting collaboration in primary mental health care.
- Mind's My Choice campaign (launched February 2002) aims to increase the choices offered to people when they ask for help from primary care services. The project will include a survey for people to find out what services are available locally and whether people are being offered a choice as well as a campaign for improvements. For further details, see www.mind.org.uk/mychoice/index.asp
- The Department of Health and National Institute for Mental Health in England have published guidance on best practice to help PCTs implement the primary care mental health workforce targets in the Priorities and Planning Framework 2003/6. The aim is to appoint 1000 new graduate primary care workers and 500 'Gateway' workers by 2004 to support GPs in managing and treating people of all ages with common mental health problems. Training programmes are now being established across England to ensure that each graduate worker obtains one year of full time training at postgraduate certificate level. Access to training will then be extended to all members of primary care teams. Guidance is available from www.doh.gov.uk/mentalhealth or www.nimhe.org.uk

Critical Commentary

I was not surprised to read that in 30 per cent of consultations, a mental health problem is identified as the main issue. Nor surprised at the low percentage (35%) of GPs having undertaken any continuing education relevant to primary mental health. In my experience, GPs' willingness and ability to grapple with Schon's "messy swamp of symptoms" fluctuates alarmingly. This wouldn't be such a deep concern, except that, as the report highlights, 90 per cent of all patients with mental health problems including 30 to 50 per cent with serious mental illness, only use primary care services. Why don't they turn to specialist services? Because, I'd suggest, there's scant response from that quarter unless you've slashed your wrists. Not a personal experience, but not apocryphal, either. In essence, there's no treatment option between a sticking plaster and amputation.

So I welcome the shift from "referral pathway…to site of specialist activity." I believe that timely, well resourced primary care options delivered by trained practice nurses and GPs can heal the cut before it turns gangrenous - that is, treat mental distress before it demands long-term specialist intervention. Intervention which, sadly, still involves stigma, dislocation, and distress.

Options: The report highlights the growing availability of counselling in primary care. I would contend that the wider the range of treatment options, the better the chance of matching each patient with an option that works fast and works well. One-to-one counselling is just one of these options. Group sessions can be cost-and outcome effective, but so too can group yoga and tai chi sessions, where stress relaxation exercises taught can last a life-time. Many serious mental illness sufferers swear by specific nutritional supplements – selenium, Omega 3 - others by acupuncture. Awareness of the huge demand for these therapies is a starting point. Ask the experts – those with a mental health problem. For examples, read the Mental Health Foundation's published research, Strategies for Living (Faulkner and Layzell, 2000). Prescribe a complementary therapy at the request of your patient and "compliance" ceases to be a problem.

Well resourced: New treatment options must be taken seriously and funded at least to the same level as pharmacological therapies. Funds for three sessions of acupuncture for three patients a year makes a mockery of any attempt to give patient choice.

Timely intervention: By this I mean two things: first, training in diagnosing serious mental illness and other mental health problems; secondly, a rapid response to patients' requests for help. The latter includes giving them credit for knowing when a crisis is a crisis. A stitch in time saves time, money and, I'd contend, lives.

Trained GPs and nurses: As highlighted by the report, training is vital to the success of integration, but before training must come consultation. Service users and GPs in consultation need to work to a specific brief, be involved in the big picture, not just a fragment, be trained to communicate with each other and be given decent remuneration for their valuable time and expertise. Existing service user research on effective services is out there ready to be utilised: for example: The Mind Model for Choice in Primary Care (www.mind.org.uk/mychoice/index.asp). More must be undertaken at a local level to identify local needs.

After consultation, training. It must be continuous. It must not be funded by pharmaceutical companies. It must, crucially, involve current mental health service users who have valuable expertise, as well as experience of their illness to communicate. Who should be trained? In general awareness and sensitivity against stigmatising patients, everyone a patient comes into contact with, and that starts with the receptionist. If someone says they are in great need of seeing someone, they should be believed, even though they can't point to a part of their body and say "that's where it hurts."

The tele-nursing trial mentioned in the report serves as a springboard to explore potential pitfalls and successes of a new approach. Some would resent a nurse "checking up" on them: one man's "Man Friday" is another man's "Big Brother." Others would find this a lifeline. Another pitfall: this was a trial of limited duration. All good things come to an end, but did anyone think how uncomfortable, if not distressing the withdrawal of the phone calls would be? Treatments should preferably be offered "until you feel you no longer need it", or the duration made clear. Aims and expectations on both sides should be discussed. Surely, fewer, well-thought out, long-lasting initiatives do more good than flash-in-the-pan clinical gimmicks.

Rachel Hannah, mental health service user, Worcestershire Users and Carers Network

Critical Commentary

The chapter on primary care offers a very welcome and useful starting place. It summarises much of the evidence on primary care and the drivers for change. I found some things to be excited by, much to agree with, a few gaps and an occasional quibble.

The important epidemiology and service failings of mental health services in primary care, although seen and researched predominantly from medical and specialist perspectives, are well presented. There is no doubt that much mental distress is not identified, named or diagnosed, that there are inadequate skills, attitudes and provision and in some cases there is an unwillingness or inability to play a serious role in the care of many people with mental illness and distress. Likewise the chapter highlights many of the current weaknesses in the structures and relationships within our current care delivery system.

Much of the exciting new work around ways of working, the advent of new workers and developments around the roles of existing workers is here. However there are some gaps which only partly reflect the lack of research evidence.

There are critical new ways of working for General Practitioners – the excellent developments around advanced communication skills, patient centred consultation and practice, leadership and commissioning roles and the whole area of GPs and collaborative practice. Likewise, there is insufficient detail on specialist mental health workers such as CPNs and OTs working into and within primary care. Their roles in service development and extending the capacity of the primary care team need emphasising. The reason this has not been demonstrated in the research literature yet probably lies in the fact that service delivery models have not mandated or trained these workers to behave in a capacity building way.

One of the most exciting new developments is that of health technologies designed to enable people to deliver their own solutions. Early work on facilitated, computerised, telephone and manualised self-help is likely to be a key role for the new graduate mental health workers. This is not simply a 'holding procedure' while we train more therapists, but a development based on a radical rethink about power, knowledge, and competence in healthcare.

The section on commissioning and change management needs to make reference to some of the broader literature such as ScHARR's work on Learning from FACTS – a detailed analysis of how to work for change in primary care settings and the increasing importance of complexity science in understanding successful change in systems.

The call for a learning programme in primary care mental health as a change management and clinical governance intervention is timely. Courses such as Trailblazers and postgraduate learning programmes such as that being developed at Northumbria University, among others, are a critical first step. However it is important that these learning programmes are closely liked to both service and workforce development in order to achieve the right workforce with the right capabilities in the right services.

So there is much that is good in here AND it should go further. The call for integrated practice is to be welcomed, but the thinking is rather narrow. Integrated practice can usefully be defined as the practice of care that takes as its core value the inextricable and indivisible linkage between mind and body, between the physical and the psychological. The playing out of this core value occurs at the level of thinking, of language, of communication, of structure and organisational relations. The recipient and provider of care are partners in the construction of integrated practice. The implications of this are legion. Patients must be equal partners in the construction of care, specialists and generalists are only separated by their skills, not by bricks and mortar or by referral and responsibility. They are partners in the whole solution. The mental health of those with physical health diagnoses is as important as the physical health of those with mental health diagnoses and ultimately these artificial distinctions will disappear as we integrate language as well as practice.

Finally and perhaps inevitably, I would have preferred a report that integrated rather than split and dealt with solutions as much as it dealt with problems. A separate section on primary care makes little sense to a user who will navigate their life and its distress by calling on themselves, their family, community and environmental resources, generalists, specialists and many others. I recognise that this traditional organisation of the territory (primary, specialist etc) reflects current practice. But if we never change the words we will never change the thinking. Generalist contributions are inextricably linked with the contributions of other parts of this web of potential solutions. We will also all be served better if we focus as much on the strengths of the parts of this system as we so often do on its weaknesses. These may prove to be more potent drivers for further change and improvement.

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GP with a special interest in Primary Care Mental Health, Northumbria

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