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The Centre for Mental Health Services Development

Mental Health Priorities for Primary Care

Essential steps for practices and primary care groups

Angela Greatley
Edward Peck

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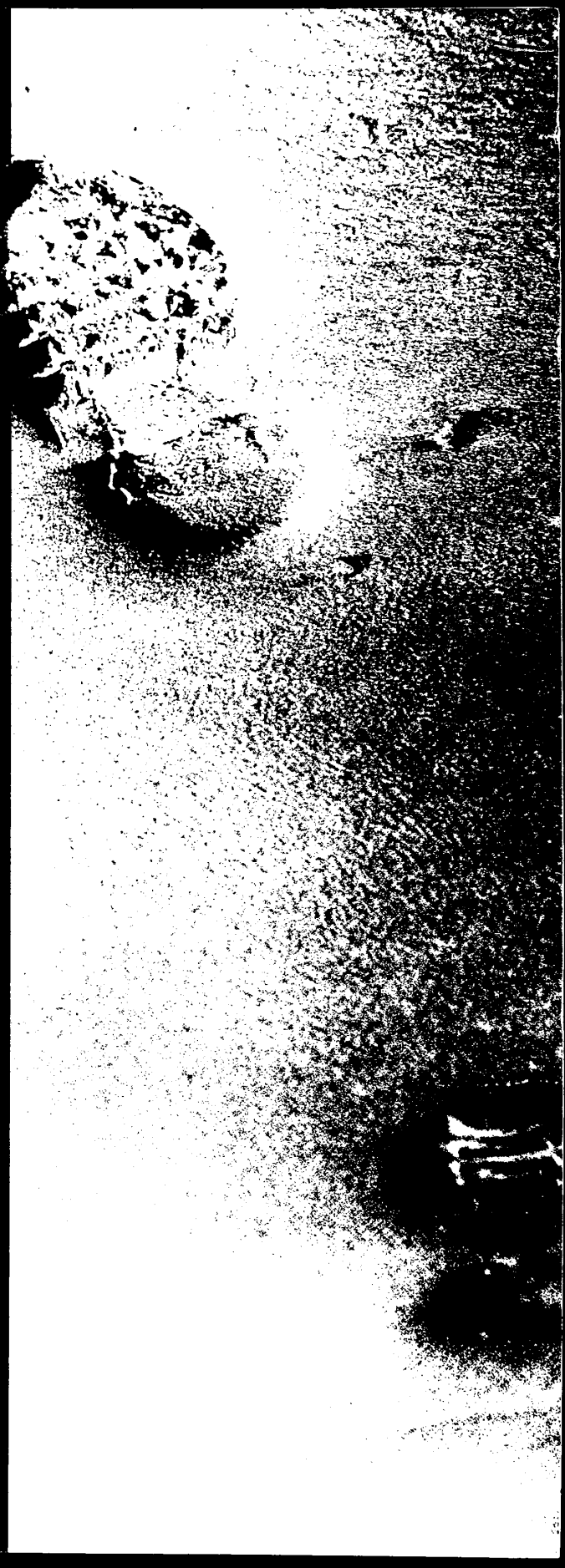

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Service users.

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Summary of findings and implications from the primary care and mental health development initiative

Introduction

Policy changes in health and social care present new opportunities for primary care to work in partnership with others to improve provision for people with mental health problems. Policy connections between mental health services, primary and community care were not always made effectively in the past and attention to implementation has been patchy. It is important to exploit the opportunities for planning and investment strategies presented by the new environment but it remains important that local service providers work together to connect practice and deliver integrated treatment, care and support. Both general practices and primary care groups could benefit from the lessons learned in the course of a King's Fund and Centre For Mental Health Services Development initiative, based in London. This development initiative brought together primary health care, health and local authority providers and commissioners with some user groups, to identify their concerns about primary care and mental health and to agree action plans to address shortcomings in local provision. The practical lessons learned can be used by practices, primary care groups and other health and social care agencies as they work together to plan and deliver integrated mental health care.

Findings

1. General practitioners in the project acknowledged the need to improve commissioning skills and to increase the range and quality of provision in primary care and in specialist mental health services. They saw the importance of collaboration with statutory agencies and the voluntary sector in order to deliver integrated care.

2. General practitioners and primary health care teams were willing to engage in developing better practice and more integrated care and support when they were able to influence the development agenda. General practitioners and community teams gained maximum benefit by focusing both on known and longstanding difficulties, as well as new opportunities for development.

3. Engaging all relevant stakeholders in the development process proved to be time-consuming even though there was considerable interest in the issues. The project team relied heavily on

the health authorities and social services departments to make early contact with GPs and practice staff but the agencies were not in a position to agree to proceed on behalf of the GPs and primary care practices. Consultation with locality / commissioning groups of GPs was important to tell us of the many initiatives that had gone before and warn us of issues that were well known but where progress had been patchy. They also described clearly the time pressures on local practitioners. However, direct discussion with practitioners and their teams was needed to explain the potential gains from the work and to tailor the precise arrangements to fit local circumstances.

4. A range of methods was used to obtain user views about primary care and about the relationship between primary care and specialist mental health care. The methods included discussions with local groups of service users and, in addition, a brief survey of both published and unpublished material which was undertaken by the project user consultant. It was found that, with more time, more could have been done to engage local patients of primary care who do not use specialist services.

5. People with mental health problems value primary care highly. However, staff attitudes and administrative arrangements could be changed to help them to get most from the services and to build their views into the planning process. We were told that because primary care is close at hand it is accessible to the many people who do not have cars or money for transport to more specialist services. Patients did not find it stigmatising to use the services in primary care because the door is not labelled "psychiatry". They suggested ways in which information and communication between the patient and the surgery might be improved.

6. Many people in the project were frustrated that little had been done to address systematically a range of longstanding difficulties in the relationship between primary and specialist mental health care. These difficulties will not surprise those who are familiar with the literature. Despite the diversity of GP practices and community teams involved in the project, common problems were identified including:

   - Speedy and effective information exchange
   - Operation of the Care Programme Approach (CPA)
   - Understanding and working with diverse organisational cultures

- Quality and accessibility of primary care services
- Configuration and availability of specialist services

7. Ideas agreed for addressing these shortcomings included:
   - using up-to-date technology and developing protocols for communication on referrals, discharges and case summaries
   - agreeing what is essential CPA information, improving the timing of meetings, agreeing how best to involve GPs when it is necessary and establishing or re-establishing GP / Consultant links
   - developing and agreeing a common approach to liaison / linkage between primary and specialist care
   - introducing 'booked' telephone consultations and nurse hotlines in primary care
   - finding ways to introduce advocacy / interpreting into primary care
   - GPs and community teams working together to influence the configuration of a range of specialist services

8. People identified problems with the size and complexity of the mental health system. Communication can be as difficult between different levels and professions within an organisation as it is between the primary care teams and other health and social care agencies. It was helpful to identify these problems at the mapping stage.

9. Some of the development issues identified could not be resolved by GPs and health & social care practitioners working on their own. Commitment from health and social care agencies was needed for progress to be made in resources and service configuration. However, for change to be effective senior managers have to be informed by the experience of GPs, primary care teams and community teams concerned with local service delivery.

10. Participants were enthusiastic and willing to tackle change, provided that they felt all agencies were committed to working on longstanding problems.

Implications for primary care groups

Expectations of primary care groups (PCGs) are high and there was real concern that mental health will not be given priority as organisational turbulence absorbs all the energy of local stakeholders. However, there are matters that, if addressed early on, will establish a firm foundation for future work. PCGs and practices can take practical steps to begin planning better provision for the local population building on the experiences of practices who participated in this project.

1. PCGs might consider adopting the development process discussed in this report for use by local practices and teams. Participating practices and community mental health teams found that it was helpful to work with different stakeholders, to adopt a four stage action planning programme and to have support / facilitation for the work involved. Evaluation showed that participants found these approaches helpful in tackling longstanding problems and agreeing action plans.

2. PCG Boards can make a useful start in tackling mental health issues by agreeing who will lead for the PCG and what are their most important early tasks. A useful early start might be made on the following tasks which are set out in greater detail later in this report:
   - Getting to grips with the people and the area – summarising what is known about local needs, services and investment
   - Building on the practical experiences and achievements of practices within the PCG patch that have tackled some of the issues identified in this project
   - Progressing aims and objectives already agreed in strategies and investment plans, by both building on existing agreements and drawing on what is know to be effective practice

3. PCGs will find that they will make faster progress if they work in partnership with others. Participating practices in this project agreed it was important to work with:
   - health authority commissioners
   - local authority planners / commissioners in social services and housing

- service users and local voluntary groups, including users of primary care mental health services
- mental health interest groups in neighbouring PCGs
- managers and team co-ordinators in trusts and other significant mental health providers

Introduction and the changing policy environment

Background

During 1997 and 1998 the King's Fund and the Centre for Mental Health Services Development (CMHSD) worked on a project designed to explore how primary care practitioners could work with other health and social care agencies to improve services for people with mental health problems. We were concerned both at the difficulties experienced by mental health service users in accessing appropriate care and by the frustration demonstrated by commissioners, providers and primary health care professionals as they attempted to offer co-ordinated services. We identified shortcomings in policy and practice and considered ways of resolving difficulties. This report sets out findings from the project and examines the implications for primary care working in partnership with health and social care.

The policy environment

The theme of government mental health policy for almost the last thirty years has been that of closing large institutions and creating community based services. However, institutional closure has offered only a limited mental health policy framework and has itself rarely received consistent attention, either nationally or from health and social care agencies at regional and local level. Equally, whilst programmes of institutional closure have generated some innovative service responses, the development of fully integrated community based services has been patchy. Whilst there have been many policy statements relating to mental health issued over the last few years, these have often appeared as exhortation - with little attention to implementation issues or discussion of how mental health fits within the broader national community care agenda.

During the same period, increasing priority has been given to extending the scope of primary health care and to improving its quality. Throughout the 1980s and 1990s there was a growing emphasis on the importance of primary health care services and particularly on the role of general practice in primary care. This focus became central to government policy in the early 90s, when fundholding was seen as a key element in bringing about change in the national healthcare system. However, there was little attention to the creation of a coherent community/mental health/primary care policy framework and limited discussion of implementation issues. It is

therefore not surprising that it has proved very difficult to create a consistent and coherent approach to primary and community based mental health treatment, care and support.

The factors set out above have, amongst others, played a significant part in creating the patchwork of policies and service responses that exist in mental health care and in its relationship with primary care in the late 1990s. Despite examples where services have been created that are responsive to user voices and agreed need, both policy and implementation have often been hampered by confusion and ambiguity about interpretation, and the sharing of responsibilities between specialist mental health, primary health and social care. Continuing financial constraints in health and local government and tensions concerning possible cost shifting, especially between health and social care, have exacerbated both the policy and practice difficulties. There has also been an increase in public disquiet about mental health services, a growing professional unease at the inability of services to respond adequately and a consistent user voice articulating deficits.

The importance of primary care services for people with mental health problems

Creating a coherent primary care response and a well managed inter-face between primary and specialist secondary care is critical to the development of an adequate mental health service system and to the delivery of high quality care. Most mental ill health is seen and treated in general practice primary health care teams (PHCTs). It is estimated that up to a fifth or even a quarter of patients consulting their GP may be experiencing some mental health problem and that over 90% of those seen with mental health difficulties will never be referred to specialist services. It is therefore particularly important that GPs and their teams deliver high quality care and are given appropriate support to do so. Equally, those people who need more specialist help rely on good collaboration between primary care, specialist health services and social care to provide an effective and co-ordinated response to their more serious mental illnesses.

The urban environment

Achieving a clear local policy framework and delivering an agreed set of service responses has been particularly difficult in the cities. It is in cities where a number of factors combine to create conditions in which communities and individuals live in mentally unhealthy situations, and it is in cities that the highest rates of diagnosed mental illness are to be seen. It is also in cities that primary care may be under greatest pressure and is often less well equipped to respond.

Emerging policies

National policies are being re-shaped rapidly, with welcome attention to the problems created by past fragmentation of health and social care. The following have significant implications for mental health and primary care:

- the new approach to public health which focuses on inequalities and takes a more community based approach,
- tackling social exclusion which has a particular impact on mentally ill people - their life chances, work opportunities, housing and involvement in the life of the community,
- changes in health policy - health action zones, the establishment of primary care groups, emphasis on quality improvement, effectiveness and reformed clinical governance,
- the duty of partnership between health and social care,
- opportunities presented by alliances with drugs action teams, education action zones, criminal justice initiatives and expanded work opportunities.

Emerging opportunities

In the new climate it may be possible to challenge policy and practice difficulties more effectively. There is renewed interest in tackling the problems experienced by socially excluded people living in cities. The introduction of a national service framework is a welcome development offering a fresh opportunity to take a more holistic approach to health and social care for people with mental health problems.

However it remains important that local commissioners, including primary care groups, and providers continue to work in collaboration to develop practical approaches that can lead to better services. This report concentrates on how local health and social care practitioners working with PCGs and other commissioners may improve both the implementation of local policy and the delivery of co-ordinated treatment, care and support services. It seeks to identify those areas where attention to long standing problems may contribute to improved practice and to developing shared confidence in working together.

Developing the primary care and mental health initiative

Background

The King's Fund and CMHSD mounted a joint development initiative in 1997 and 1998, to explore the primary care/mental health agenda with GPs, primary health care teams, health and social care agencies. This followed early work for the King's Fund London Commission on "London's Mental Health" which had indicated that the position for the capital's mental health services remained serious despite some examples of good work and innovation, including, in primary care, schemes promoted through the London Initiative Zone. It showed that the inter-face between mental health and primary care was particularly problematic.

Building GP interest in mental health services development

The first phase of the initiative began with two preliminary workshops in 1996, which explored the level of interest amongst GPs and agreed ideas for a new development initiative. In depth consultations were then held with GPs in three London health districts to explore their concerns. Discussions were held with practitioners and local medical committees in the three districts - Camden & Islington, Bexley & Greenwich and Redbridge & Waltham Forest. A wide variety of concerns and potential development issues were identified during the workshops and consultations.

GP concerns and areas identified for improvement

The following key concerns were identified:

- concerning commissioning - general practice requires support to develop skills in needs assessment at practice level and to devise comprehensive mental health strategies, plus training in commissioning if practitioners and teams are to take a proper role in the process,
- concerning providing - general practice needs support to improve the quality and range of its provision, to improve collaboration between primary and specialist service providers, to agree service outcomes, to facilitate all agency working (health, housing, social care and voluntary sector) and to give GPs a real say in the shared management of serious mental illness,
- concerning collaboration – shared commitment, dedicated time and input is required to facilitate shifts in culture and in the management of change: to improve team communication, agree roles and responsibilities and provide appropriate skills development within and between specialist and primary care services.

The GPs suggested that a development project should proceed in three areas of London. Given the nature of London's primary care provision, they felt that the approach taken should enable small practices as well as larger teams to participate.

Partnership between the King's Fund and CMHSD

The King's Fund and CMHSD agreed to work jointly to take forward the initiative. Both organisations wished to explore the problems and possible solutions, and by working together could offer a broad range of skills and experience to project participants. It was clear that it would not be possible to address all of the issues set out by practitioners and particular aspects of the agenda were therefore selected. These were primarily concerned with identifying the most critical inter-agency problems and testing-out ways of developing collaboration to improve services. In order to support the initiative a project team and an advisory group were established. Grant aid was obtained, through the Department of Health "Building Partnership for Success" programme.

Project aims

The following aims were agreed:

- to identify the most important health and social care issues relating to primary care and mental health
- to establish ways of identifying and agreeing local priorities for change
- to create multi-agency approaches to negotiating joint action plans setting out agreements for improvements in local services

Diversity of areas and practices involved

Building on the 1996 discussion, the following criteria were agreed for site selection:

- three development sites were to be identified with different population characteristics, e.g. – social deprivation, ethnicity
- the general practice/primary teams should have different characteristics e.g. not all fundholding, some small, some large but the overall population served should not exceed 20,000
- all statutory agencies had to agree to participate, but no development work could go forward without the explicit commitment of specific GP practices/teams

initial contact was to be made with health/local authorities, trusts and GP commissioning/locality groups but explicit practitioner commitment from specific GP practices was seen to be key to success.

Stakeholders

For this initiative the primary care team was defined as including both core and non-core staff: with general practitioners, students, trainees and practice staff, plus any attached nursing, therapy or social care staff who had clear and regular contact with the team and who also served the practice population. However, this did not include staff from specialist teams with a more general remit for liaison with a number of general practices.

Other main stakeholders were the community based specialist mental health care providers: specifically the community mental health teams, including mental health social workers, either as full team members or in associated social work teams.

The locality and/or mental health commissioners in both health and social services were also involved, as were provider managers.

Users views were also sought. More information about the approach taken to obtaining their views is set out later in this report.

The Approach

The team produced a development package for discussion with primary care and statutory agencies in London. The package divided the project into four phases providing a flexible framework within which appropriate local arrangements could be negotiated.

This framework allowed agencies/teams to discuss issues and develop views within their own professional / work groups. Meeting in their teams was important for groups to share perspectives, "vent" frustrations and move to formulating ideas and issues for later joint discussion, with action planning based on the agenda derived from these meetings.

The following four phases were offered:

- the 'diagnostic' phase in which GP practice/primary care teams and community mental health teams (CMHTs) - including both health and social care staff – worked in their own groups to 'map' their particular views of the challenges and opportunities in local mental health care
- the action planning phase in which stakeholders each of in the three sites met to share their perspectives, to agree shared priorities and to negotiate local action plans for change
- the third phase in which representatives from the three sites met to share learning and consider a joint agenda for wider dissemination
- the fourth phase in which the King's Fund and CMHSD disseminated findings

GPs and PHCTs were offered different options for the 'diagnostic' phase. In the first option, based on an approach developed by CMHSD, practices undertook a one week survey of patients who showed any type of mental health problem and who saw any member of the PHCT during the nominated week. This information provided a practice 'map' of mental health issues. Alternatively, primary teams worked in a focus group meeting to map concerns. The community mental health teams undertook their mapping exercises in focus groups. Both approaches provided a snapshot of concerns in that week; neither attempted to provide an in depth analysis of problems over a longer period. Practices in two sites met in focus groups and in the third, GPs and PHCTs completed the one week survey. The survey is particularly helpful in demonstrating to the PHCT itself how it dealt with mental health matters. Action planning was offered to each site through two linked sessions or over one full day. All group work and action planning was facilitated by the project team, who also undertook analysis of the survey.

(Further information on the mental health questionnaire used may be obtained through CMHSD).

Setting up the evaluation

Delivering improved mental health services is likely to be a medium to long term task and we thought it unlikely that our time-limited project would see significant and demonstrated change "on the ground". However, we could assess the views of participants both about the importance of issues raised, their relative priority and about the best way for primary care and other agencies to work together to tackle those issues. Therefore the evaluation was designed to assess how far the project had raised key policy and practice lessons and to test out participant views on the effectiveness of the processes used. Further information is set out in a later section of this report.

About the three sites

Hackney

- an inner city area in north London
- East London and the City Health Authority works with three boroughs and the City of London – the project involved the London Borough of Hackney
- the provider trust is the City & Hackney NHS Community Services NHS Trust
- participating practices were two in north Hackney: they are fund-holders and make up a Total Purchasing Pilot (TPP) serving a total population of approximately 22,000 people

Hounslow

- an outer urban area in west London
- Ealing, Hammersmith and Hounslow Health Authority works with three boroughs – the project involved the London Borough of Hounslow
- participating practices were two: one non-fundholding serving a population of 5,500, the second, also non-fundholding, serving a population of 6,500
- the provider trust is the Hounslow and Spelthorne Community and Mental Health Services NHS Trust

Islington

- an inner city area in north London
- Camden and Islington Health Authority works with two boroughs – the project involved the London Borough of Islington
- Participating practices were two: one non-fundholding serving a population of a little under 11,000 the second (a new non-fundholding practice being established in an area of high deprivation) serving a population of approximately 2,000
- The provider trust is the Camden & Islington Community Health Services NHS Trust

Significant issues in designing the development initiative

We found that primary care practices needed to shape the agenda. Some primary care development work is derived chiefly from a commissioning agency or a provider perspective. We found that only the early engagement of GPs and practice teams could ensure that the agenda was based on the direct experience of GPs and primary care. Issues of concern to and potential solutions from commissioning agencies were of great importance and we worked on them, but

they could not be used to 'substitute' for issues raised by primary care. Practices in all areas voiced their frustration at past experience of dialogue with commissioners and providers, they often felt that primary care's concerns had been articulated clearly but had met with, at best, only a partial response. This concern was mirrored by some feeling amongst commissioners and providers that, whilst some GPs were interested in mental health, it always proved hard to gain commitment to a development programme.

The team found that the process of engaging GPs, and to some degree other PHCT members, proved time consuming. It was important to gain the interest of lead GPs involved in commissioning – both through localities and fundholding. However, there was no substitute for the direct discussion with practices in which the team could demonstrate the potential gains from any development work. PCG Boards will want to consider how best to engage practices when they advance plans for development initiatives.

What people with mental health problems want from primary care

Background

Flexible, responsive, needs led services will only be developed with the input of users. In our project we were therefore concerned to find out firstly, what people with mental problems want from primary care and secondly, what they want from primary care working in collaboration with specialist mental health services.

We recognised that there are differences between the needs of those who use only primary care services and those who use specialist mental health services as well as primary care. There are differences between those who suffer a mental health problem of limited length or severity at some time in their lives and those diagnosed as having a serious and long term difficulty. However, all users have common requirements: (a) to receive the full range of general primary care provision in a way that is appropriate to their own needs, (b) to receive elements of mental health treatment in primary care as needed, and (c) to access specialist mental health care if required.

The importance of primary care

People who report mental distress or ill health to their GP may be treated quickly and effectively suffering no recurrence of their difficulties. Their characteristics may, in respect of general health, be no different from others in the practice population and their treatment and care will be provided by GP and PHCT for both their mental and physical health difficulties. However, some people with mental illness and particularly those for whom it is more serious and prolonged are likely to have higher levels of physical ill health in addition to continuing mental health problems. We did not consider formally the prevalence of co-morbid mental and physical illnesses within this study. However, informal estimates from general practitioners suggested that perhaps a third of those who suffer with chronic physical ill health also experience mental health problems. CMHT staff thought that perhaps a third of their clients suffered from some long term physical disability or condition.

Mentally ill people often live in poorer circumstances. For example, they may have dietary difficulties associated with a lack of money. They may find it very difficult to use ordinary sport and leisure facilities, some may suffer the effects of a lack of exercise. Taken together with an

increased propensity to smoke and the physiological effects of prescribed medication, then a higher level of need should be expected for all primary care services. As more users with serious mental illness live in the community they will rely more on the GP, dental and pharmacy services. Additionally, those who have been in psychiatric hospital for prolonged periods in the past may find that their general health deteriorated in that time.

User involvement in the development initiative

The project team took two approaches to gain user views. Firstly, the project manager approached user groups in the three project sites to gain local opinion. Secondly, the project's user consultant provided a brief review of published and unpublished user material on primary care. Using this material and the specific local information we were able to summarise both the difficulties experienced and some approaches that might be taken to improving services. We fed these views into the action planning process.

In one area the teams approached a group of users of specialist services. We held a meeting at which we explored their views of GPs and primary care, and of the primary care/specialist services relationship. This meeting was focused through use of a semi-structured questionnaire and the results were fed into the action planning process. Voluntary sector representatives were also involved in action planning.

In a second area, users were already involved in a major consultation process being led by the Health Authority. The project team participated in the series of workshops at which users (and other stakeholders), gave their perspectives on local primary care services and the relationship between primary and secondary mental health care. Again, this was fed into the action planning process.

The timescale of work in the third site did not allow for any new initiative and existing material and local information was drawn into action planning.

The team found that the project design was weak in respect of user input. Although the views of members of user groups were of great importance, they were users of specialist services. It would have been helpful to have been able to engage patients from the specific practice populations to comment on the kind of service they would wish to see. However it would be time-consuming

and difficult, to identify those within a practice population who experience mental health problems but who are not necessarily known to specialist services. The time available within this initiative did not allow the team to set up groups of practice patients with direct experience of using only primary care mental health provision. Future development initiatives might look to tackle this gap and PCGs will need to consider how best to address this issue.

User's views on some problems and possible solutions

Users were keen to offer their own views on their experiences of using GP services and to bring forward information passed to them by other users. They concentrated on their experiences of GP services and practice staff, but also identified shortcomings in the relationship between primary care and specialist services.

A summary of user views

We found that primary Care is highly valued by users: it is geographically accessible – many users do not have access to, or money for, transport - and it is a door that is open to the whole community, with the potential to avoid the stigma associated with specialist mental health services.

Some problems

- long waiting times for appointments and limited surgery hours
- reception and other support staff who are not fully prepared to assist people with mental health problems
- lack of printed material in waiting rooms – this was seen as being of potential help to carers as much as users
- length of consultation – often too short and inflexible
- insufficient attention by staff to physical symptoms as well as mental health problems
- limited knowledge, amongst GPs and PHCT members, of other local voluntary and social care services
- lack of information for GPs on the up-to-date position of any individual's case when that individual is also being treated by specialist services
- lack of 'expert' knowledge – users are not troubled by this if primary care is open about the limits of knowledge
- relatively poor arrangements for access to records and/or for making complaints
- some evidence of high charges for 'sick' notes and referral letters to other agencies

Possible solutions

- systems which offer more flexible length of appointments and trust the users to indicate when they may need more time
- telephone consultations with practice or other nurses, which may be more appropriate than GP calls for some issues, plus the possibility of talking to the GP if this is appropriate
- availability of clear written material in the waiting room for carers and families as well as users
- practice staff to receive mental health 'awareness' training
- regular liaison/CPA arrangements to ensure the practice is up-to-date on individual plans and on the general arrangements for users to access specialist care
- proper attention to the physical ill-health of people with mental health problems
- specialist support to primary care which gives up-to-date advice on medication and on the full range of other therapies available
- information on the voluntary sector, for GPs and PHCT members

We found that some of these suggestions are already in place in some practices.

Identification of local problems and some solutions in mental health care

Common concerns

The three sites share many typical urban characteristics. However, there are also marked differences between them, including intensity of local need, characteristics of the local population and the patterns of service that have arisen in response to perceived local needs. Issues particular to London's different ethnic groups were also identified.

Despite the differences between areas, the project team found that 'core' concerns were very similar across all stakeholders in all sites. Variation was principally in the order in which concerns were ranked or the degree to which they presented.

The project team had carefully established a process by which participant stakeholder groups were able to explore and develop their own issues separately, prior to inter-agency action planning. The initial meetings included discussions on the views that might be held by other stakeholders - a process which provoked much helpful discussion and allowed for the airing of (sometimes) uncomfortable perceptions and prejudices prior to action planning. The process therefore helped in sharing differing perspectives, including those of users, prior to the action planning days. All teams began to acknowledge that they might be a part of the problem if they were not prepared to work to become part of the solution.

Some problems and some potential solutions

All agencies, teams and individuals that we met raised issues that could be grouped as follows:

- Practical problems about provision of information and information exchange
- Specific difficulties in achieving effective operation of the Care Programme Approach (C.P.A.)
- Difficulties in sharing and understanding team languages, cultures and diverse organisational arrangements
- Developing effective primary care responses to user concerns and the concerns of partner agencies

- Issues requiring attention at an multi-organisational level and over a timescale outside the scope of our participants

The solutions and possible development options varied in size and complexity:

- There were difficulties which might be improved with careful team-to-team working and very little additional resource
- There were matters requiring change-management support and skill-sharing over a sustained period
- There were problems of service deficit or inappropriate service configuration requiring sustained inter-agency development programmes between primary care, statutory and voluntary agencies, incorporating the views of users.

Providing and exchanging information – are you there and are you listening?

The following matters cause ongoing practical problems. Solutions may be achieved with some investment of time but with very little new financial resource. Changes would lead to considerable improvement and failure to address these real and practical problems stands in the way of achieving more significant change.

- the variable and sometimes poor quality of referrals to secondary care and the need to improve the timeliness, speed and quality of response to them
- variable and often poor arrangements for exchange of information between secondary and primary care when a patient is receiving a specialist service
- inadequate arrangements for involving the GP/PHCT in the discharge of patients and their return to primary care, including patchy provision of summaries of treatment, medication and of care plans
- poor arrangements for dealing with crises for patients who are living in the community and who are known to the secondary care services

May be improved by

- developing shared protocols for handling referral, discharge etc., including pro-formas for written information
- using up to date and appropriate technologies to exchange information - e.g. pagers, faxes, email
- working towards bringing IT systems closer together
- providing clear information on crisis services and ensuring there is a response - not a further crisis assessment - in emergencies

CPA and the SMI - systematic arrangement or bureaucratic nightmare?

Working together on the CPA and gaining the right kind of primary care involvement causes some of the most acute difficulties in day to day working. These included complaints of:

- lack of concern by specialist teams about what happens in the community and lack of interest in CPA participation from GPs
- lack of CMHT knowledge about patients, their families and other carers
- specialist teams only responding to hospital cultures and GPs not responding to CMHTs
- too much paper and too many meetings

Practical improvements that may be achieved for little new financial investment.

- gaining appropriate primary care input to the CPA process by agreeing to seek involvement only at the right level and the right time e.g. - not inviting *every* GP to *every* meeting
- communicating necessary information in writing and by other means, but not sending *every item* on *every* occasion e.g. not sending a whole care plan with each letter
- offering other agency staff booked appointment slots with GPs, rather than using specially arranged meetings
- ensuring the right timing and location for necessary meetings / reviews
- developing shared registers and other shared care tools/material where there is a clear agreed purpose.

Developing communication and sharing cultures – what goes on in the black box?

There is a need to share the perspectives of different organisations in order to promote an increased awareness of organisational arrangements and cultures, to find and use the right language for communication and to share professional views.

Problems are characterised as:

- community mental health team staff change constantly, as do organisational arrangements
- 'they' don't respond to our enquiries and 'they' are never around when we are (from both primary and community team staff)
- we never really know what other professionals do
- we always have their problems 'dumped' on us (from both primary and community teams)

This may be improved by

- establishing and developing liaison and linkage systems between specialist and primary care - including which CMHT members from which disciplines should link with primary care, can they carry out sessional work within practices, how often should regular contact sessions be held and can a common understanding of overall process and procedure be developed?
- clarification of the relationship between the role of a liaison or linkworker attached to a practice and the keyworkers for particular patients of the practice - including consideration of the degree to which these functions can or should be carried out by the same workers
- agreeing the functions of consultant clinics in primary care to ensure that they provide treatment within the practice but also to allow for regular review, discussion and broader consultation between GPs and psychiatrists – primary care, when properly supported, does not refer lightly and is not looking for a 'take-away' service
- ensuring that GPs and primary care staff are given appropriate, flexible and differentiated responses, respecting the differing skills and interests available within practices
- agency boundaries drawn in a way that maximises the capacity for primary care liaison

Developing local services in primary care – improving a valued service

The following approaches were suggested to improve the quality and availability of both primary care and community based mental health care:

- skills exchange and training on issues of common interest, e.g. on medication, shared protocols, handling serious conditions to improve primary care knowledge and skills
- information and advice, e.g. up to date information on services, phone and fax numbers to be shared between PHCTs and CMHTs
- advocacy and support for primary care patients as well as secondary care patients
- support to practices with patients whose first language is not English, offering appropriate language and cultural support – often available in specialist teams but not in primary care

The following have been strongly supported by service users

- primary care innovation - booked 'phone consultations, nurse hotlines, flexible appointments
- provision of general and specific written information in the practice for patients and for carers
- specialist provision located in primary care; this is easier to access and may lead to less stigma
- mental health awareness training for practice staff

Major change and developments - looking to the future

Participants also developed an agenda of issues that have broad implications and will require significant and sustained inter-agency collaboration to achieve change, including team building and change management/support.

- specialist services need to develop communication methods appropriate to work with GPs and with each other, e.g. with and between specialist psychological treatment services, with and between substance misuse services and mental health teams,
- there should be a wider menu of specialist services, including bringing into the mainstream a variety of alternatives to conventional therapies
- language support is needed for patients whose first language is not English - we were told by most participants that primary care is regarded by many minority ethnic communities as the most acceptable location in which to receive care, yet language support is rarely available
- ensuring wide availability of culturally sensitive primary and specialist care services in response to users from a variety of cultures
- ensuring a range of alternatives service, e.g. day services, leisure, work opportunities to broaden choice/opportunity when referring primary care patients

Barriers to change

Participants found significant barriers to close collaborative working. For example, the sheer size and complexity of the mental health system tends to create difficulty and separation between the many stakeholders who need to work together. It was difficult for commissioners, managers, and practitioners to identify everyone whose contribution might lead to improved care and to forge good working relationships with them. Informal contact was also difficult with such a broad range of potential stakeholders and did not therefore support the formal working relationships.

There was difficulty in engaging people working at different levels within organisations, i.e. managers and clinicians, and there was difficulty in handling the varying perspectives that professional groups bring to assessment, treatment, care and support. These perspectives have often remained unexplored and unexplained: this was apparent both within and between statutory agencies as well as within and between agencies and primary care. Organisations themselves were often unclear about which staff and practitioners should relate to GPs, particularly when they needed to find the most appropriate way to meet both commissioning and provider agendas in primary care.

We also saw the potential for new divisions to arise within agencies. For example, social workers and social services managers involved in mental health care were working in a more and more integrated way with their health colleagues and, to a degree, with specialist housing workers. However, there was a danger that those mental health social workers and managers could become more separate from the mainstream of social services and housing staff who do not see mental health as central to their concerns. If this tendency grows the capacity of mental health staff to influence the mainstream planning of social care services may be reduced and a new gap created between social workers and managers with different backgrounds and skills, thus further complicating relationships with GPs.

Action Planning to overcome barriers and achieve change

Yet, despite these barriers, participants in action planning days were enthusiastic and willing to tackle issues of communication, liaison and linkage, shared care and, to differing degrees, education and skills sharing. Each site based group was very committed to achieving change on those issues that could be taken forward by local teams working together. Each felt that they had gained a great deal by working closely with those whom they saw rarely in everyday practice.

Stakeholders in each area agreed a variety of plans to address their concerns and to make practical improvements. These ranged from:

- tackling information problems by using the fax and pagers
- reducing CPA documentation to essential requirements, agreeing that a meeting was not necessary for every change in a care plan and agreeing more appropriate times for meetings when they were needed
- reviewing and re-establishing contact between GPs and consultant psychiatrists
- developing agreements on the nature of liaison schemes, agreeing which staff might be involved and clarifying the roles of keyworkers
- nurse hotlines
- developing / refining shared care registers

Participants were, however, equally aware that they were not in a position to make local agreements to tackle some major change, especially where additional resources were thought to be needed. Thus, a significant work programme remains for local agencies to take forward in collaboration with primary care. As the project proceeded it became apparent that change on these issues could be taken forward by working within and between Primary Care Groups (PCGs) and other agencies. The next section offers some early thoughts from project participants on how PCGs might tackle the mental health aspects of their agenda.

How Primary Care Groups might begin to tackle the mental health agenda

Views emerging from the project

The project concluded with a meeting between participants from each of the three sites, in July 1998. As well as sharing perspectives on the findings emerging from each area – both problems and potential solutions - the meeting was asked to reflect on how learning from the project might inform the soon to be established Primary Care Groups (PCGs).

We explored two questions, firstly how PCGs might begin to establish priorities for change in mental health services in their areas and secondly, how PCGs might begin to forge appropriate relationships between statutory agencies, primary care, users and voluntary organisations.

Tackling first things first

Participants were aware that newly established PCGs would be primarily concerned with establishing themselves, with Board membership and staffing arrangements and they acknowledged that the business of organisational change would, as ever, absorb all the energy that is available – and then more. It seemed unlikely that specific care group interests would be at the top of the agenda. There was also, a lack of clarity about the role that primary care might be expected to play in commissioning mental health.

However, participants felt strongly that the importance of mental health needed to be established early on in the life of each PCG; mental health concerns many patients in any practice population and mental health spending is significant in any health district.

Taking these matters into account, we concentrated on tasks that would set the scene early on for PCGs to work effectively in years to come.

The following are the first ten tasks we feel that PCGs should tackle in order to begin work on the mental health agenda, five points concern what can be done and five identify other stakeholders - we called it "a starter for ten".

Mental Health priorities for PCGs - A "starter for 10"

What should we do?

- analysis of local demography and of known mental health needs; by beginning with an appreciation of what is already available from HA and LA sources, PCGs can avoid the search for the "holy grail" of new and perfect information. Data may be imperfect but can often be used to make a start. Importantly, PCGs will gain local ownership by using and developing available information on needs. This exercise should be one of "getting to grips with the people and the area" and must include information on culture and race.
- service mapping; again, beginning with what is already known, mapping will be helpful both in establishing a common baseline of knowledge and, perhaps more importantly, in learning about working together to agree information and to share perspectives.
- using HA contract material; agree how much money is being spent on secondary and tertiary mental health services for people in the PCG catchment population, and begin to collect information on identified mental health spending in primary care.
- establish which practices and community teams have already worked on the mental health agenda - how have they tackled this, what have they found works well and what works less well, what are the known gaps and difficulties, is there duplication? Practices will be re-assured to know that their work is to built upon and should be asked to share learning with their colleague practices. Work on pathways of care might be piloted by some practices and shared across the PCG. Similarly some practices might concentrate on developing information on evidence based mental health practice to share with others.
- establish working arrangements with the HA to collaborate in the production of Health Improvement Programmes (HImPs) as they relate to local mental health, bringing forward plans for changes that will improve the effectiveness of mental health services; and with public health contribute to addressing inequalities, for example in tackling the targets set out in "Our Healthier Nation"

Whom should we work with?

- with users and carers, by establishing a framework for consultation and feedback. The overall arrangement for lay involvement in PCG Boards may be useful but cannot substitute for a mechanism by which people who use particular services are directly involved. Their perspectives will be important for commissioning and to contribute quality improvement. Arrangements will need to be set in place to involve people who use primary care mental health services as well as those who use specialist care.
- with health authorities and neighbouring PCGs, forging working relationships to agree how best to commission the more specialist services: this is of considerable importance because specialist services may be dealing with the tip of an iceberg whose mass appears in primary care e.g. eating disorders.
- making contact with neighbouring PCGs, health authorities and trusts will be valuable for sharing information on the management of particular groups of patients who cause concern for both secondary and primary care e.g. people at high risk of violent behaviour and for improving the quality of services.
- establishing early links with a wide range of organisations outside the traditional health and social care boundaries, e.g. housing (departments and associations), planners in local government and later, links with education and employer interest groups, with Health Action Zones (HAZs) and Drug Action Teams (DATs) may be helpful - lessons may be learned from the way that they have worked, e.g. setting up reference groups (police, probation, council and other opinion leaders).
- working on "systems" issues, e.g. what a GP sees as a shortage of hospital beds may in fact be a lack of suitable supported housing accommodation which can be tackled by changes elsewhere in the system. These changes will require engagement of senior agency managers.

Contributing to development

Early attention to the issues set out above could make a real contribution to the ability of any PCG both to address its mental health agenda and to tackle the three major tasks set for Groups:

- improving health and addressing inequalities
- developing primary and community care
- playing a part in commissioning local specialist service

For those Groups choosing to prioritise mental health, these ten steps will provide a firm foundation for progress.

Evaluating the initiative

Our approach to evaluation

The project set out, firstly, to identify the most important local mental health / primary care issues and secondly, to establish a robust and effective multi-agency methodology for setting priorities and creating action plans to address these concerns. We were therefore keen to evaluate whether participants had been able to identify and share the most important issues and, how far the approach taken had assisted them to negotiate and agree plans to address problems.

Bearing in mind the short time frame and limited funding available for the project, the advisory group agreed that the following framework for evaluation would be appropriate:

- to use a developmental and evaluative process which would assess the work from the perspective of participants
- to record any interim outcomes
- to avoid the use of overly complex tools which would not be appropriate to project size and duration
- to incorporate the evaluative process into the work of the project rather than to use external evaluation at the end of the process.

Independent advice was provided by a CMHSD senior staff member who was not otherwise engaged in any aspect of the work.

Assessing views

Views of participants were sought twice during the project;

- firstly at the end of the site based action planning phase (dealing with phases one and two)
- secondly after representatives from sites had met and worked together on issues of common concern (phase three).

The team devised a short form – a single A4 sheet double-sided - which sought participant views offering a series of tick box options and inviting additional brief written comments. Members of PHCTs and CMHTs were asked to consider the questions, with commissioning and provider managers asked to complete a slightly amended version of the same questions. (A copy of the evaluation sheets used may be obtained through the King's Fund).

Responses from site based work

An evaluation sheet was sent to each participant in the site action planning process. We were interested in views of both phases one and two i.e. both mapping and action planning. We distributed the evaluation sheets five days after the action planning events to avoid, as far as possible, collecting only the immediate reactions to the day itself.

The response rate was:

- Hackney 14 forms sent out — 5 were returned
- Hounslow 17 forms sent out — 11 were returned
- South Islington 16 forms sent out — 7 were returned
- From a total 47 forms sent out — 23 were returned – a little under 50%.

Summary of views

We asked how helpful the work had been:

- 19 respondents found the mapping exercise and the action planning process either of great help or of some help in identifying the most important issues and agreeing priorities for change.
- 4 respondents found the mapping exercise and the action planning process had no effect or was unhelpful

We also asked whether participants thought their work was likely to lead to improved services:

- 21 respondents thought the work was likely to have a positive effect
- 2 respondents thought that it would have no effect
- none thought it would be unhelpful

Additional comments

We invited participants to write in their own comments on why the work had been helpful, and their responses may be grouped as follows:

- it helped (CMHT) staff see the GP perspective
- it helped GPs and PHCTs to understand more about the operation of community mental health services
- it helped all front line staff see the importance of health and social care relationships
- it helped by providing up-to-date local information

- it provided a forum for improving communication – improving communication was thought to be difficult without external facilitation
- it assisted with the process of drawing psychiatrists into a discussion of the issues
- the process provided a good structure for the systematic examination of existing services and offered potential for a more user centred approach to those services.

The following were identified as potential limitations on progress

- 2 respondents were very concerned about the funding available to mental health care
- there is a historical tension at the interfaces between primary, secondary and social care which, whilst helped by the process, is deep seated and long standing
- the process helped to identify issues but there was doubt about the willingness of senior managers and clinicians to act upon the priorities
- the project did not include follow-up to provide a stock-take of changes made and this was identified as a weakness in the design
- 1 respondent thought that the mapping exercise was inadequate and that the structure of the action planning day was poor

The team has been advised that, to date, two specific developments have been further discussed in one area with a view to implementing changes agreed in action planning.

Responses from multi-site meeting

At the end of the project, in September 1998, a final evaluation sheet was sent, again seeking views on the prospects for change and the helpfulness of the process.

The response rate was:

- 25 forms sent out to participants in all sites 11 returned

Summary of views

We asked how useful the process had been:

- all respondents felt that it had been of use

We asked people to reflect on their action plan and indicate whether it was likely to lead to improved services:

- All respondents said it was likely to have a positive effect

Issues likely to have an impact on future mental health services

We asked participants to identify the issues likely to have an impact on primary care and mental health over the next three years (items at the top of this list were the most frequently mentioned):

- availability of beds and alternative types of provision e.g. supervised accommodation
- primary care groups commissioning specialist services
- the nature and quality of primary care / specialist care liaison, including with psychiatrists
- the importance that specialist services afford to primary care concerns
- willingness to work on the information and communication agenda (issues set out on pages 14 and 15)
- relationships with the local authority commissioning social care and housing
- making primary care groups accountable
- community treatment orders
- funding.

What did evaluation show?

- careful facilitation proved effective in tackling long standing problems
- the process was helpful both in identifying priorities and in negotiating action plans
- action plans need to be revisited regularly
- issues thought likely to impact on primary care / mental health over the next three years were raised commonly in the three sites
- there were issues that needed strategic attention and there were concerns about the willingness of "people at the top" to listen and respond.

Responses to our evaluation did not vary between sites, with similar comments made.

Conclusions

The project demonstrated that with careful design and facilitation it is feasible to engage GPs and primary health care teams, secondary care providers, users and commissioners in a programme to agree mental health priorities and produce action plans for change. Participants told us that they had been able to identify the most important local concerns and had found that the process had helped them to work together. They had gained a better understanding of each others' perspectives and had been able to develop a shared commitment to tackle some long standing problems. There was however some doubt about senior commitment to see though the changes and to provide new funding where needed.

There can be no doubt that people with mental health problems want to see improvements in primary care. Those whose difficulties are more serious and prolonged also want to see improved collaboration between primary and secondary care and good primary care provision remains important to users of specialist mental health services. Policy guidance requiring mental health services to concentrate on the "needs of the seriously mentally ill" was intended to ensure that resources were targeted to meeting those needs. However, implementation of this guidance seems to have created an unhelpful divide between primary and secondary care and does not assist primary care to work effectively with people with mental health problems.

Health, local authorities and GPs also wish to see improvements in primary care and better integration between primary and specialist care. However, the difficulties in achieving such change are long standing and have proved daunting. Participants found it difficult to commit time and were perhaps unwilling to do so unless they were convinced that the work might be of real benefit both to working relationships and to longer term investment strategies. They needed to see that the perspectives of all stakeholders would be respected.

We saw that local action can be powerful in identifying potential solutions to some of these problems, especially in areas of practice development, delivery of services and in commitment to training together to meet service demands. The process we employed helped people to identify those issues that are within their power to tackle, by brokering relationships and smoothing a path to "win win" negotiations. However, we also saw the limitations of project interventions where there is no capacity for local follow-up.

The project also created an agenda of issues that are not within the power of GPs and their immediate partners to tackle. We saw how action – or inaction – in one part of the system affects other elements of care and real joint commissioning at a senior level is needed to address these systems issues. This is where strategic partnerships need to act but their actions must be informed by the knowledge and priorities of those working face to face with people with mental health problems.

Looking to the future, PCGs have considerable potential to acknowledge some of the historical divides and to devise plans to bridge them as well as addressing emerging issues creatively. There are already examples of primary care working well with their social care and housing partners to address the fragmentation of services. The challenge is to build on these examples to plan strategic change, without losing the first hand knowledge that primary care offers, and to avoid reliance on practitioners, PHCTs and other community based teams to resolve problems that require senior commitment to bring about change.

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