King's Fund

Working paper

FEBRUARY 2003

Mental Health Services in Primary Care

A review of recent developments in London

Rebecca Rosen and Clare Jenkins

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This is one of a series of papers being produced in 2002/03 as part of the King's Fund Mental Health Inquiry. The Inquiry aims to assess whether London mental health and mental health services have improved over the last five years. In 1997 the King's Fund produced a report entitled *London's Mental Health*, describing services in inner London 'that cannot be sustained'. The current Inquiry asks what, if anything, has changed since then, as well as tackling some new questions.

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Published by
King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
www.kingsfund.org.uk

Charity registration number: 207401

First published 2003

Edited by Eleanor Stanley
Typeset by Kita George

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Executive summary

This working paper aims to revisit findings from the 1997 King's Fund Inquiry on Mental Health and to examine the extent to which primary care mental health services have developed in line with recommendations made at that time. It takes a narrow view of 'primary care' as relating to general practice. Other community-based mental health services are addressed in other papers being produced as part of the Inquiry. The main focus of this paper is on general practice-based services for people with common mental health problems, and the role of PCTs in developing them.

Findings are presented from a postal questionnaire of a 20% sample of London GP practices and a telephone survey of mental health leads in London PCTs.

The postal questionnaire

This explored the following issues:

- recent exposure to education and training for mental health
- access to counselling and other psychological therapies
- involvement with the mental health National Service Framework
- overall quality of local mental health services
- quality and availability of services for selected patient groups

Key findings

- One-third of responding practices had organised some kind of in-practice training on mental health. (*See* ***Education and training in mental health***, p 19).

- The majority (80%) of all responding practices had access to counsellors in their own or a neighbouring practice. However, two-thirds of counsellors were available for only one to two hours each week, and access to other psychological therapists was more variable. (*See* ***Access to counsellors and other specialist mental health professionals***, p 21).

- Approximately one-third of responding practices were involved in some way with National Service Framework (NSF) implementation. The most common areas of involvement were:

  - guideline implementation
  - audit of clinical practice against NSF-linked standards
  - data collection to monitor progress with the NSF
  - education and training activities (*See* ***Implementation of the National Service Framework***, p 24).

- Opinion was mixed about overall progress with improving mental health services: 42% of respondents felt services were a little or much better than they were three to five years ago, while 29% felt they were a little or much worse. Just under half (46%) of all

respondents felt communication and liaison between primary care and specialist mental health services was a little or much better than it was three to five years ago, while 28% felt communication and liaison were a little or much worse (*See **Overall quality of mental health services***, p 25).

The telephone survey

This survey explored the following areas:

- resources available for mental health commissioning
- implementation of the National Service Framework
- involvement in education and training for primary care professionals
- integration in mental health services
- special services for selected care groups
- general progress with developing mental health services.

Key findings

- Policy-making for mental health services is universally based in multi-professional groups with representatives from health and social care. Respondents' experiences of partnership working varied from excellent working relationships that underpinned progress to poor or deteriorating relationships that were constraining change.

- The amount of dedicated management time available for mental health commissioning and service development varies considerably. The mental health leads surveyed had been in post (in their current or a precursor organisation) for between two weeks and five years and dedicated between 0.5 and 10 sessions a week to mental health commissioning. All but one of those with multiple areas of responsibility were assisted by one or more additional staff members.

- Data on earmarked budgets for mental health are very patchy. Only 16 of the 27 London PCTs involved in the survey had an earmarked development budget for mental health services, and these varied from £250,000 to £1.2 million.

- NSF implementation priorities are focused more on developing services for people with severe mental illness than on primary care mental health. Only nine PCTs surveyed included primary care services among their development priorities.

- Progress with implementing NSF primary care standards is patchy, with only one-third of the PCTs included in the study having completed the evidence-based guidelines required by the NSF, and far fewer working to implement these or to audit their impact. Less than one-third of the PCTs surveyed were involved in education and development activities aimed at GPs. Only seven PCTs were working with NHS Direct.

- Many PCT leads cited joint work with mental health trusts and social services to establish integrated community mental health teams as being among their greatest recent achievements. Other recent achievements (in some PCTs) included:

  - building good working relationships with partner organisations
  - improvements in primary care/secondary care interfaces
  - improvements in inpatient facilities
  - improvements in planning and policy-making mechanisms.

- The main constraints to service development identified by mental health leads were:

  - limited resources (financial and other)
  - problems with recruiting and retaining a skilled workforce
  - ongoing organisational change, resulting in high staff turnover and disrupted working relationships.

The next steps – conclusions and recommendations

There is evidence of some improvements in the overall quality of mental health services since the last Inquiry, as reported by the GPs referring patients into these services. However, these improvements are not equally evident in all areas of London. With integrated community mental health teams now established across the whole of London, GPs also reported improvements in liaison and communication between primary care and specialist mental health services. Some of the constraints on further service improvements are those that affect the whole NHS, namely:

- recruitment and retention problems
- organisational turbulence in PCTs and disruption of their relationships with other organisations
- limited managerial capacity in PCTs
- limited or absent development funds.

Other perceived barriers to the development of primary care mental health services include:

- limited capacity among primary care clinicians to cope with more mental health work
- the dissipation of effort across too many mental health development priorities
- limited co-ordination and integration of different types of mental health development work.

The NSF is focusing more attention on developing mental health services than had previously been the case. However, the following remain true:

- PCT work to implement the NSF is largely directed towards services for people with severe mental illness.
- Less work is underway to develop general practice-based services for people with common mental health problems.
- GP involvement with NSF implementation is limited.

In the light of these findings, recommendations are made in relation to the following issues, which are explained in detail below:

- service development capacity in PCTs
- promoting a primary care focus

- funding
- primary care mental health services
- improving clinical care.

Service development capacity in PCTs

There are significant shortfalls in the capacity to commission and develop mental health services in general practice settings and to provide adequate clinical services.

- PCTs should improve their capacity to commission mental health care. For many PCTs, this will require an identifiable development budget, increased numbers of commissioning staff and better systems for integrating diverse activities relating to mental health service.

- PCTs should focus on only two or three development priorities, paying particular attention to the integration and co-ordination of multiple streams of work required to achieve and monitor changes in practice.

Promoting a primary care focus

With most current work focused on severe mental illness, there is scope to explore how primary care staff can contribute appropriately to the care of this client group. However, there is an urgent need to attribute greater priority to primary care mental health services for common mental health problems.

- A primary care mental health champion is urgently needed in each PCT to lead developments in general practice settings. This post will need to be funded for several sessions per week if it is to have real impact on primary care services.

- Current shared care activity for people with severe mental illness should be mapped and evidence reviewed on effective roles that might be developed for general practice in the care of people with severe mental illness.

Funding

In the absence of earmarked funding for mental health, a shortage of growth money is a problem for many PCTs. Few have the resources they need to fulfil their mental health development priorities.

- More funds should be identified at a national level for mental health services. They should be distributed through local implementation teams to support local development priorities, with clarity locally about these funds and how they are to be spent.

- All PCTs should identify a budget for mental health services to support the implementation of priority developments. Primary care should feature in the top two or three priorities identified in every primary care trust.

Primary care mental health services

Access to counselling and psychological therapies has increased, but questions remain as to the long-term effectiveness of GP counselling. A key challenge remains to ensure that each patient is referred to the most appropriate form of psychological therapy.

Despite considerable effort to develop evidence-based guidelines for common mental health problems, this work does not necessarily result in better services. There was little evidence of the co-ordination and integration of guideline development, implementation work and primary care team education that is required to achieve changes in clinical practice.

The postal questionnaire did not provide conclusive results about groups of the population that were particularly poorly served. However, the majority of responding GPs raised concerns about three groups: asylum seekers, homeless people and people with addictions. These groups are particularly vulnerable to mental health problems, and there is scope to combine physical and mental health assessments in primary care settings.

- Current work on referral guidelines for GP counselling should be integrated with similar work on other psychological therapies to improve the appropriateness of referrals to all therapies.

- Work to develop local guidelines should be focused on two or three key areas, ideally for which there should be evidence of high local morbidity and local GP interest. This should be closely integrated with work to implement and monitor the guidelines and with related education and training and service developments.

- Each PCT should consider the extent to which their local population contains groups that are vulnerable to mental health problems and establish whether primary care providers can identify and manage the physical and psychological needs of those at risk (or refer to appropriate services).

Improving clinical care

This study identified limited educational activity to improve the clinical knowledge and skills of primary care clinicians in relation to mental health. The need to co-ordinate and integrate different strands of development work (see above) is also relevant here. The forthcoming cadre of primary care mental health workers will have an important role to play in such work.

- Education and training should be integrated with other related PCT mental health development work, in order to maximise the likelihood of changing clinical practice.

- Attention should be paid to identifying clear roles for the forthcoming cadre of primary care mental health workers. Their potential contribution to developing clinical skills in primary care team members and implementing local development initiatives at practice level should be harnessed wherever possible.

Introduction

This working paper aims to investigate the extent to which the deficiencies in primary care mental health services that were identified in the 1997 King's Fund Inquiry (Johnson 1997) have been addressed in the intervening five years. Its main focus is on primary care services available to people with common mental health problems, although it also touches upon the role of primary care in managing people with severe mental illness.

There has not been a systematic review of the developments in primary care mental health services in London since 1997. Information about service innovations, quality improvement, good practice, education and training, National Service Framework implementation and organisational change remains patchy. In order to provide an overview of progress in London, the author conducted a postal survey of 20% of London GP practices and a phone survey of mental health leads in London primary care trusts.

First, this paper summarises findings from the 1997 Inquiry. It then outlines key changes in primary care policy and practice, highlighting changes in the overall primary care context against which developments in primary care mental health services are occurring. Following a brief description of methods, the paper presents results from the postal questionnaire and from the telephone survey of London PCT leads. There then follows a critical commentary about the impact of recent policy and service developments in London. Finally it outlines further changes that are needed to ensure that the quality of primary care mental health services in the capital continues to improve.

Terminology

The term 'primary care' is usually taken to include a wide array of community-based, first-point-of-contact health services, including general practice, community nursing, minor injury and illness services, community-based therapies and sometimes also accident and emergency (A&E) services. As such, some of the work of community mental health teams could be considered as 'primary care' – particularly that of community psychiatric nurses.

To avoid confusion with other sections of this Inquiry on specialised mental health services, in this paper, the meaning of 'primary care' will be limited to services provided in general practice (for example, by GPs, practice nurses or practice-based counsellors). It will also review progress in primary care trusts, which act both as commissioners of care and providers of some primary care services that may be linked with general practice (such as health visitors and district nurses).

However, it is important to note that this focus on general practice precludes examination of the work of community-based specialist staff, such as community psychiatric nurses and the community mental health teams that are run by mental health trusts. Nevertheless, the central role of these mental health trusts in developing community mental health services outside of general practice is acknowledged.

Findings from the 1997 Inquiry

The 1997 King's Fund Inquiry highlighted several major areas of concern about mental health services in primary care:

- Many general practitioners (GPs) and practice nurses were argued to lack the necessary skills to diagnose and manage mental ill health.

- Counsellors and clinical psychologists were distributed inequitably around the capital, with limited professional links between them.

- Examples of good practice in primary care, such as shared care arrangements or use of case registers, were identified but were rarely in widespread use, and implementation of evidence-based clinical guidelines was patchy.

- Organisationally, different administrative boundaries for health and social care were seen to hinder service development and limit communication and liaison between primary and secondary providers, and between the health and social care sectors.

All of these deficiencies were argued to exist within a problematic wider primary care context. London had a higher proportion of sub-standard GP premises than the national average, a higher proportion of single-handed GPs, and a higher proportion of GPs achieving low coverage in markers of quality such as immunisation rates. London GPs made less use of practice nurses than elsewhere, and there was patchy provision of counsellors and brief psychological therapies within primary care.

Despite these problems, the 1997 Inquiry highlighted some areas of development and innovation in primary care mental health. For example, the Defeat Depression campaign, launched in the early 1990s, raised the profile of mental health problems in primary care and provided new information and training opportunities for GPs. Another example was the London Implementation Zone (LIZ), established to develop primary care services in the areas of greatest health need in London. Some of the LIZ money was used to pump prime new mental health services, and the Inquiry noted an 11% increase in the overall number of counsellors in primary care (from 72 to 80%) across the whole of London between 1992 and 1995. Other good practice developments, such as the use of case registers and evidence-based guidelines, were occurring but were described as the exception rather than the rule.

Since the 1997 Inquiry, change in primary care has continued apace. A combination of drug developments, clinical service innovations, workforce trends, national policy priorities and NHS reorganisation are reshaping all aspects of primary care. The opportunities and constraints generated by these changes are briefly reviewed here in order to describe the primary care context in which the questionnaire and phone survey were conducted.

The policy and practice context

General practice largely avoided the turbulence of NHS policy developments until the 1990s. Since then, the role of GPs and their focus as the main entry point into health care has been increasingly under discussion. General practice is now seen as only one part of a wider primary care service that also includes community nursing and therapies, minor injury and minor illness units, walk-in centres, NHS Direct and primary care facilities in A&E departments. People with mental health problems may present to any of these services as their first point of contact with health services, and will increasingly use a mixture of GP, nursing and other services for their ongoing care.

Current pressures on primary care that are driving changes in policy and practice include:

- poor access to services
- problems with staff recruitment and retention
- increasing public demand and expectation
- shifts in the interface between secondary and primary care
- cost containment in secondary care.

The following are of specific relevance to mental health services in primary care:

- the continuing pressure on community mental health teams to focus on patients with severe mental illness
- standards in the Mental Health NSF aiming to promote high quality primary care services for people with mental health problems.

There have been a number of important recent changes in the clinical, professional, organisational, financial and policy contexts in which primary care mental health services are provided. Combined together, these will shape the extent to which initiatives to develop and improve services are successful. The most important of these are now briefly reviewed.

Changes in the clinical context

Recent policy has encouraged community mental health teams to focus on severe mental illness. In the mid-1990s, Department of Health guidance on the care programme approach required community mental health teams to develop systems to screen, prioritise and 'gatekeep' access, redirecting patients with less severe problems back to general practice (Department of Health 1995). This pressure has continued to intensify.

Goldberg and Huxley (1992) estimate that 90% of people who present to their GP with psychological symptoms will be managed within primary care and only 10% – perceived by GPs as having more severe problems – will be referred to specialist mental health services. However, of those referred patients, typically only a small proportion – Harrison (2000) estimates 20% – have severe illness. The remainder suffer from milder depressive and anxiety disorders, and many are referred back to their GP.

If community mental health teams succeed in targeting people classified as having severe mental illness, increasing the intensity and quality of service they receive, then a higher proportion of patients will have to be managed in primary care. Patients who are referred by their GP to the community mental health team are likely to have more severe symptoms than those who are not referred. If they are then redirected back to general practice, they could increase the overall severity of the GP mental health case-mix.

In practice, evidence is limited as to the extent to which these changes in case-mix have actually occurred. Harrison (2000) reports that the reorganisation of a community mental health team to focus on severe mental illness has resulted in reduced GP referrals for less serious mental health problems, implying that more patients were being managed in primary care. However, King (2001) explores the ambiguity of the term 'serious and enduring mental illness' and highlights variability in the way it is interpreted. Onyett *et al* (2002) find that the proportion of patients who could be classified as having severe mental illness varies from 33% to 100% in different community mental health teams.

Within primary care, the actual prevalence of mental illness in the patients of an individual GP practice varies, and typically reflects characteristics of the local area (for example, if it includes a shelter for homeless people or supported accommodation for people with mental health problems) and characteristics of the practice itself. Practices that include GPs with a particular interest in mental health are likely to attract affected patients, leading to a skewed spread of morbidity. In one part of central London, 32% of psychiatric service users with the most severe illness were registered with 4% of the GPs (Kensington, Chelsea and Westminster Health Authority 1998).

Cohen (2002) notes that approximately one-third of GP consultations have a mental health component, but that between 30% and 50% of people with mental health problems are not acknowledged as having such a problem at their GP consultation. Some of this deficit can be argued to be due to inadequate clinical skill in GPs. However, another explanation is that the ongoing relationship between GPs and their patients makes it fairly common to make a clinical assessment over three or four visits, as a stronger relationship develops between patient and doctor. Cohen argues that the accuracy of diagnosis increases to approximately 90% over three or four consultations. Despite this observation, the challenge still remains to ensure that, once identified, these patients receive appropriate treatment and, where necessary, specialist referral.

Data on the prevalence of mental health problems in primary care are very limited, partly due to the often complex process of diagnosing such conditions and partly due to problems with coding and collecting data. However, data from two national surveys of psychiatric morbidity in adults (OPCS 1994, ONS 2001) can be used to estimate the caseload for selected conditions among patients of a 'typical GP'. These figures are summarised in Table 1 and suggest a 13% increase in the overall prevalence of neurotic disorders among patients of a typical GP between 1993 and 2000.

Table 1 Population and estimated GP prevalence of mental disorder 1993 and 2000

Diagnosis	1993		2000	
	Weekly prevalence per 1,000 adults aged 16–64	No. of patients on GP list of 1,800 adults aged 16–64*	Weekly prevalence per 1,000 adults aged 16–64	No. of patients on GP list of 1,800 adults aged 16–64*
Mixed anxiety and depression	78	88	92	104
Generalised anxiety	46	52	47	53
Depressive episode	23	26	28	32
All phobias	19	22	19	22
OCD (obsessive-compulsive disorder)	17	19	12	14
Panic disorder	10	10	7	8
All neuroses	163	184	173	196
Functional psychoses	4	4–5	4	4–5

* Assumes 63% of GP list is aged 16–64

Source: Statistics taken from two national surveys of psychiatric morbidity (OPCS 1994 and ONS 2001)

An additional (also limited) source of information is the *Key Health Statistics from General Practice 1998* (ONS 2000), which includes data on the prevalence of treated schizophrenia, depression and anxiety in GP consultations. Table 2 summarises these data and suggests an upward trend in treated anxiety and depression both in men and women in 1994–98.

This increase cannot be explained adequately by changes in community mental health team caseload, since it started before relevant policy and largely pre-dates policy implementation. Other possible explanations include an overall increase in population prevalence, increased rates of diagnosis and increased rates of treatment for depression and anxiety (perhaps due to prescribing guidelines).

Table 2 Prevalence of treated mental illness per 1,000 GP patients

	1994	1995	1996	1997	1998
Prevalence of treated schizophrenia Men	1.9	2.0	2.0	2.0	2.0
Prevalence of treated schizophrenia Women	1.7	1.7	1.7	1.6	1.7
Prevalence of treated Depression Men	19.9	22.3	25	27.2	29
Prevalence of treated depression Women	50.5	55.9	60.8	67	70.1
Prevalence of treated anxiety Men	17.8	19.2	20.9	22.2	23.8
Prevalence of treated anxiety Women	41.7	44.6	47.4	51.4	54.4

Source: *Key Health Statistics for General Practice 1994–98* (ONS 2000)

Changes in professional roles

Several forces are driving changes in professional roles in primary care. A combination of GP retirements and difficulties in recruiting and retaining new GPs are resulting in areas of under-provision (Gray 2002). Growth in consumer demand and stringent access targets requiring GPs to provide routine appointments within 48 hours, coupled with low GP numbers, have triggered the development of a variety of nurse-led primary care services. Key among these are nurse-practitioners' clinics within general practice and new access routes to primary care through NHS Direct and nurse-led walk-in centres.

As the primary care skill-mix evolves, important questions remain about the competence of practitioners to assess, diagnose and manage mental illness. Various authors have commented on the skills deficit in GPs and assessed missed diagnoses of mental health problems (see, for example, Freeling *et al* 2002 and Thompson *et al* 2000). Little data is available on the numbers of nurse practitioners and practice nurses running clinics in general practice, nor on their skills and levels of training in mental health. A small study by Plummer *et al* (2000) identified only modest concordance between nurse assessments of psychological morbidity and symptom assessment using the general health questionnaire. Two other small studies of nurse-led interventions (Mynors-Wallis *et al* 1997, Mann *et al* 1998) for patients with emotional disorders showed no difference in clinical outcome measures compared to conventional care.

A recent study of an NHS Direct call centre showed that 3% of all calls were about mental health problems (Payne *et al* 2002). However, levels of mental health experience among NHS Direct nurses varied greatly, ranging from 8% of nurses with no formal training at all to some who had trained as registered mental nurses. Exactly half of NHS Direct nurses had received some additional training after taking up their current post. Although NHS Direct consultations are guided by computerised protocols, these are not foolproof, and this relatively low level of mental health experience could result in missed diagnoses or inappropriate advice.

Two further national policies will increase access to professionals skilled in mental health in general practice settings. The NHS Plan has a target to introduce 1,000 GP specialists by 2004 (Department of Health 2000). Jones and Bartholomew (2001) found that psychiatry was the eighth most common speciality practised by GPs with a special interest. These GPs may work within the general practice or as a clinical assistant in a mental health trust or an acute trust.

The policy to introduce a cadre of graduate mental health workers is still under development and will add to the evolving skill-mix of primary care professionals in mental health. In addition, a new cadre of 1,000 'gateway' workers are planned to liaise between specialist mental health services and primary care (Department of Health 2000).

The changing organisational context

The key change since the 1997 Mental Health Inquiry has been the launch of primary care groups (PCGs) and their evolution into primary care trusts (PCTs). These are now the administrative organisations responsible for providing primary care and commissioning

hospital and specialist services. PCT activity in relation to mental health services was explored in the telephone survey of mental health leads, presented in the following section.

Early surveys of PCGs and PCTs highlighted opportunities to develop mental health services, revealing that almost one-third of PCGs had identified mental health as an early priority for health improvement (Wilkin *et al* 2000) and 40% had increased the amount of counselling services they commissioned (Wilkin *et al* 2001). There were also examples of improved partnership working between community health and social care practitioners, and developments in joint investment for mental health services.

However, surveys of PCGs and PCTs have also highlighted major constraints on their work. These include limited resources, limited management and IT infrastructure, (Audit Commission 2000) and limited time and experience among mental health commissioning leads (Cohen 2002). With the universal transition to PCT status in April 2002, there remains a need for rapid organisational development in order to fulfil their service development roles effectively.

Alongside the launch of PCTs, London has seen widespread introduction of personal medical services contracts, linking primary care development to local health needs and allowing more flexible working patterns than the traditional GP contract. Some personal medical services pilots are focused on under-privileged areas and deprived social groups, in which there is a higher-than-average prevalence of mental health problems.

The changing financial context

In the absence of an annual NHS reporting system for mental health expenditure, trends in available resources are not easily identifiable. Glover (1999) developed a methodology to estimate how much of each health authority's per capita health funding was weighted for mental health and learning difficulties. He then attempted to compare this with estimated spend on mental health. While he identified wide variations in the ratio of weighted allocation to estimated spend, the methodological problems associated with the work make it only a rough guide to the overall figures. In the absence of national data on overall income and spend, it is extremely difficult to estimate what proportion of the mental health budget flows into primary care services.

Furthermore, little of the additional £700 million of mental health funding announced in 1999 (to be spread over three years) is likely to reach primary care services. Key early priorities for this funding were more beds (in hostels and secure units). With the NHS Plan came priorities for service development, including:

- crisis intervention, outreach teams and 24-hour access
- new treatments, including atypical neuroleptics
- staff training.

Only the last two of these three categories directly affect primary care (Marshall 1999).

At a local level, uncertainty over the value of earmarking funds for mental health contributes to variable budgetary arrangements in different PCTs. Thus, some PCTs have a single identifiable mental health budget, while others draw on different budgets (such as children's services, older people's services and adult services) to fund different services (such as mental health services for children and adolescents, or for adults and older people). Whatever the budgetary arrangements, the majority of PCTs are facing several challenges to their ability to direct additional mental health funding into service developments. These include:

- financial pressures in acute trusts that are draining PCT growth monies into the hospital sector
- long-standing understaffing, pulling new funding into staff recruitment rather than service development
- the requirement to bring inpatient facilities up to modern standards.

In addition, the high cost of atypical anti-psychotic drugs, which are covered by the general medical services budget rather than the mental health budget, are creating a cost pressure that affects primary care. A fuller review of mental health expenditure will be presented in another paper to be published as part of the King's Fund Mental Health Inquiry.

The changing policy context

Several important policy developments have occurred since the 1997 King's Fund Inquiry. In *Modernising Mental Health Services* (Department of Health 1998) came early commitments to ensure 24-hour access, improve community-based mental health services and promote the use of functional teams, such as crisis intervention and home treatment teams. These ideas were further developed in the Mental Health NSF (Department of Health 1999) and later in the NHS Plan, which heralded the launch of more than 300 crisis intervention teams for people with mental health problems and pledged to improve assertive out reach and community based services.

In relation to primary care mental health in London, the NSF establishes clear priorities for developments in mental health services in specialist providers, primary care settings and at the interface between primary and specialist care. Standards Two and Three of the NSF specifically address primary care with a focus on effective assessment, diagnosis and treatment within primary care. They stress the importance of appropriate referral to specialist services where necessary, 24-hour access to services and increased use of NHS Direct as a first contact point for advice and for 're-routing' patients to specialist providers.

Proposed models for achieving these aims resonate closely with recommendations made in the 1997 King's Fund Inquiry. Systematic use of evidence-based guidelines, managed referrals to specialists, liaison between specialist and primary care services and improved support and information for patients and carers are all proposed within the NSF. NSF supporters and critics alike seem to agree that it will serve to focus attention on to mental health services in a way that has not happened until now. Findings from the postal questionnaire and London PCT telephone survey presented here will provide further evidence through which to assess progress in implementation.

Another important policy development has been the introduction of flexible financial arrangements between health and local authorities, allowed through the 1999 Health Act. These flexibilities were introduced to support the development of coherent, co-ordinated services appropriate for people whose care needs span health and social services. The Act created opportunities for lead commissioning, pooled budgets for joint services and greater integration of selected health and social services.

Partnership working between health and social care is a central tenet of modern mental health care, and the Health Act flexibilities created theoretical opportunities to generate seamless services focused on client groups rather than disjointed by the requirements of accountability to different agencies. In practice, such changes have not always taken place, despite the growth of partnership working between health and social services.

A recent review of partnership working (Banks 2002) argued that while such arrangements are now widespread and widely accepted, their effectiveness is hindered by various factors. These include financial pressures on participating organisations, and ongoing change, both in the participating organisations and in the roles of their frontline workers. Despite these limitations, the Health Act and additional opportunities arising from the introduction of care trusts will continue to allow innovation in the design of services at the interface between health and social care.

General developments in primary care

In addition to the developments noted above, there have been numerous other changes in primary care in the capital. There has been further investment in GP premises and more funding for GP education: most practices are now computerised, and there are a number of innovative practices and PCTs using electronic data collection to improve service quality (Mundy 2002).

Yet despite all these changes, primary care in London remains problematic, with continued difficulty in recruiting GPs, a higher-than-average prevalence of single-handed GPs and poor premises, and lower scores on quality measures than elsewhere. There has been change and improvement in London's primary care, but the context against which we review mental health services remains far from ideal.

Methods

Data for this working paper has been gathered through a postal questionnaire sent to a 20% sample of London GP practices (stratified by the size of the practice) and a telephone survey of the mental health lead in London PCTs. The postal questionnaire and the interview schedule were designed to explore issues highlighted in the 1997 King's Fund Inquiry.

Both the questionnaire and the phone survey had to obtain an appropriate balance between breadth and depth. Neither could be so long as to discourage potential respondents. Yet in aiming to address the range of issues raised in the 1997 Inquiry, each was necessarily broad in the range of questions included. This resulted in survey instruments that would produce broad description of current practice with little opportunity for detailed exploration of the nature of the activities identified, nor of their impact.

Findings from the questionnaire and phone survey were presented to an expert advisory group (*see p 57 for a list of its members*). The group was made up of primary care clinicians with a particular interest in mental health, PCT mental health leads and senior managers and clinicians from mental health trusts. Participants were asked to comment on the factual accuracy of the report and the extent to which findings and recommendations resonated with their own experiences of mental health services in primary care. Discussion of the study findings, conclusions and recommendations were revised in the light of comments from the expert group and relevant published literature.

Postal questionnaire

The postal questionnaire was sent to a 20% sample of London GP practices, selected from six of the former London health authority areas: Barnet; Ealing, Hammersmith and Hounslow; East London and the City; Kensington, Chelsea and Westminster; Merton, Sutton and Wandsworth; and Bromley. These health authorities were selected to be representative of London as a whole, including inner, intermediate and outer London areas. This sampling method has been used previously by other researchers, including Campbell *et al* (2001).

GP practices in each health authority were stratified into the following groups:

- single-handed
- two or three partners
- four to six partners
- more than six partners.

Exactly half of the practices in each category were randomly selected to receive a questionnaire.

The sample frame was based on former health authorities rather than PCTs because the only available database of GP practices (www.binleysonline.com) was grouped by health authority. However, the borders of most London PCTs are co-terminus with health authority boundaries (in north-east London, three PCTs cover the two boroughs of Redbridge and Waltham Forest), so the results can largely be mapped onto current administrative areas.

The questionnaire was designed to include questions about the key issues identified in the 1997 Mental Health Inquiry Report. It included sections on:

- characteristics of the practice, and of the staff who worked there
- education and training in mental health
- access to counselling and other mental health services within the practice, and in neighbouring practices
- implementation of the National Service Framework for Mental Health
- the quality of local mental health services.

The questionnaire was piloted on one practice nurse, one practice manager and five GPs with a history of involvement in mental health service development. It was then revised and piloted on a further three GPs. Some minor revisions resulted, but no further piloting was undertaken. Two reminders were sent to all non-responding practices. A third reminder offering respondents free entry into a draw for a £25 gift token was sent to practices in City and East London and Ealing, Hammersmith and Hounslow since after two reminders, they still had particularly low response rates.

Telephone survey

A draft interview schedule was developed covering themes identified in the 1997 Inquiry with additional questions on progress with implementing the NSF. Thus, the following topics were addressed:

- resources available for mental health commissioning
- implementation of the National Service Framework
- involvement in education and training for primary care professionals
- integration in mental health services
- special services for selected care groups
- general progress with developing mental health services.

Modifications were made in response to comments from the project steering group and questions were piloted on two non-lead mental health specialists in London PCTs. Their comments resulted in changes both in the wording of specific questions, and in the range of questions included.

Postal questionnaire – results

The overall response rate from all six areas sampled was 48.6%, with the response rate for each individual area varying from 36 to 56%. Response rates are summarised in Table 3. The third reminder to practices in Ealing, Hammersmith and Hounslow and East London and City resulted in 13 additional responses (seven from Ealing, Hammersmith and Hounslow and six from East London and City), increasing their response rates from 28% and 36% to 36% and 43% respectively. The origin of 15 questionnaires was unknown because they were returned with the (coded) front cover missing.

It is important to note that the findings presented here represented respondents' own perceptions of their current activity. Their views do not necessarily conform to standard descriptions of particular activities.

Table 3 Response rate by health authority area

Health authority area	Total sent out	Total returned	Response rate
Barnet	20	11	55.0%
Bromley	23	12	52.2%
Ealing, Hounslow and Hammersmith	89	32	36.0%
East London and City	84	36	42.8%
Kensington Chelsea and Westminster	50	28	56.0%
Merton, Sutton and Wandsworth	59	24	40.7%
Health authority area not known		15	9.5%
Overall response rate	325	158	48.6%

Source: King's Fund (2003)

The response rate from single-handed practices was 41%, from practices with two or three partners it was 46% and practices with four or more partners had a 58% response rate. Nearly a quarter of respondents (24%) were from training practices. Table 4 compares the proportion of responding practices of each size with those in the sample frame.

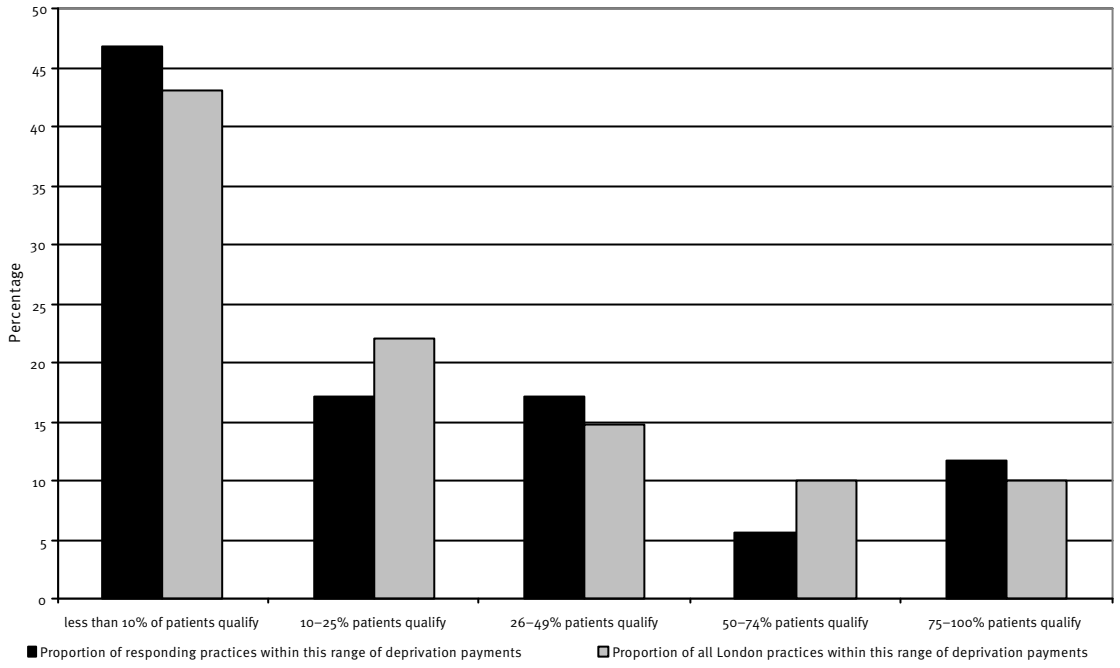
Table 4 Percentage of respondents from different-sized practices compared to percentage in sample frame, by area

Health authority area	1 partner		2–3 partners		4+ partners		No. of ptnrs not recorded	Total % returned
	No. sampled	No. (%) returned	No. sampled	No. (%) returned	No. sampled	No. (%) returned		
Barnet	9	5 (56)	8	5 (63)	3	1 (33)		55
Bromley	8	3 (38)	7	5 (63)	8	4 (50)		52
East London and City	30	10 (33)	26	7(27)	28	19 (68)		43
Ealing, Hammersmith and Hounslow	39	9 (23)	39	15 (38)	11	5 (45)	2	36
Kensington, Chelsea and Westminster	19	7 (37)	25	14 (56)	6	6 (100)	1	56
Merton, Sutton and Wandsworth	15	5 (33)	23	11 (48)	21	8 (38)	1	41
Health authority not known		10		2		2	1	
TOTAL	**120**	**49 (41)**	**128**	**59 (46)**	**77**	**45 (58)**	**5**	**49**

Source: King's Fund (2003)

Of those practices that provided information about patients qualifying for deprivation payments (128 out of the total 158), just under half (47%) had less than 10% of patients qualifying for deprivation payments, 34% of practices had 10–49% of qualifying patients, 7% of practices had 50–74% of qualifying patients and 12% of practices had more than three-quarters of the patients eligible for deprivation payments. The range of deprivation scores across responding practices is presented in Figure 1, which shows comparative figures for London as a whole, illustrating that the spread across London is broadly comparable with survey respondents.

Figure 1 Percentage of patients in responding practices and across London as a whole who qualify for deprivation payments



Source: King's Fund (2003)

The majority (89%) of the 158 respondents were GPs, with 4% of forms completed by practice nurses, 2% by practice managers and 5% by other members of practice staff. A quarter of the 158 respondents declared a special interest in mental health and a further 20% reported that another GP in their practice had a special interest in mental health. Of those reporting a special interest in mental health, two were GPs with a special clinical interest and eight were involved in strategy and policy development or NSF implementation. The remainder with a special interest did not specify how this was enacted.

Education and training in mental health

- One-third of responding practices had organised some kind of in-practice training on mental health and 9% had undertaken a mental health training needs assessment for their staff.
- The types of educational activity reported included case-note review, critical incident analysis, talks from visiting speakers, and sending staff on courses.

Fourteen of the 158 responding practices (9%) had undertaken a mental health training-needs assessment. Almost one-fifth (18%) of practices had arranged training for their practice nurses and 13% for the receptionists. One-third of the 158 practices had organised at least one form of in-practice mental health training. Table 6 summarises the percentage of respondents who themselves had had different types of training. Table 7 presents

the percentage of practices that had organised various forms of educational input for practice staff.

The proportion of responding practices that had organised training varied between sample sites. Only 20% of the 31 responding practices from the former Ealing, Hammersmith and Hounslow health authority had organised training, while 38% of responding practices from East London and City and Barnet had organised training and just over 40% of practices from Bromley and Merton, Sutton and Wandsworth had done so. In Kensington, Chelsea and Westminster, the equivalent figure was 32%.

Table 6 Mental health training received by individual respondents during the last 5 years

Type of training	Number responding to this question	Number (%) who have had this training	% of all respondents* who have had this training
Mental health awareness	144	86 (60)	54.4
Anxiety	142	78 (55)	49.3
Depression	148	99 (67)	62.7
Post-natal depression	136	58 (43)	36.7
Schizophrenia	134	50 (37)	31.6
Dementia	136	60 (44)	38
Suicide and self-harm	132	42 (32)	26.6
Counselling skills	131	32 (24)	20.3
Cognitive strategies	131	21 (16)	13.3
Motivational interviewing	117	7 (6)	4.4
Drug or alcohol misuse	138	73 (53)	6.0
Eating disorders	132	35 (27)	22.2

*n = 158

Source: King's Fund (2003)

Table 7 Percentage of responding practices that had carried out different types of training activity

Type of educational or training activity	No. responding to this question	Yes Number (%)	No Number (%)
Case note review	64	21 (33)	43 (67)
Critical incident review	66	31 (47)	35 (53)
Expert speaker visiting the practice	67	29 (43)	38 (57)
Talk from drug representative	60	21(35)	39 (65)
Staff on mental health courses	61	24 (39)	37 (61)

Source: King's Fund (2003)

In addition, 12 practices overall reported that they had organised other types of training. These included visits to external mental health projects, regular meetings with a local consultant psychiatrist, and in-house meetings between practice staff and psychotherapists or counsellors.

Access to counsellors and other specialist mental health professionals

- The majority (80%) of all responding practices had access to counsellors in their own or a neighbouring practice. However, two-thirds of counsellors were available for only one to two hours each week.
- A high proportion of practices (70–80%) also had access to other cognitive and brief psychological therapies, bereavement and stress counselling and eating disorder groups.

The questionnaire explored the proportion of practices that had access to various psychological therapists – either in-house, or in a neighbouring practice. Counselling is available in two-thirds of responding practices, with a further 14% having access to a counsellor in a neighbouring practice. Response rates to questions on access to other mental health professionals were low so findings may be unreliable. However, of those who responded, 40% reported access to within-practice community psychiatric nurses and 41% reported access to a psychologist. Table 8 summarises the percentage of practices with access to different types of mental health professional in their own or a neighbouring practice.

Table 8 Percentage of responding practices with access to mental health professionals on site or in a neighbouring practice

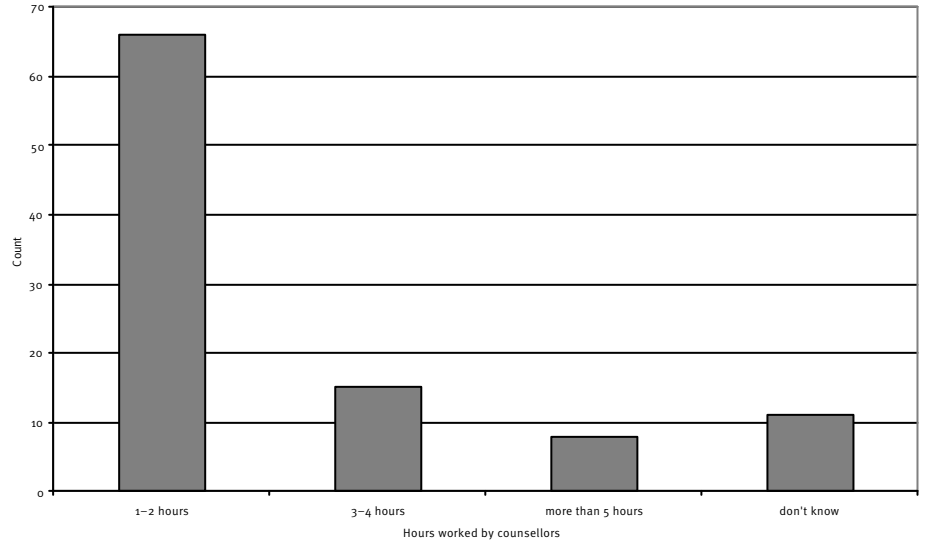
Type of staff	No. responding to this question	No. with access to this member of staff in their own practice	No. with access to this member of staff in a neighbouring practice	% of all respondents* with access to counsellors or other therapists
Counsellor	125	106	19	79.1
Psychologist	66	48	18	41.8
Community psychiatric nurse	63	39	24	39.9
Psychiatrist	46	26	20	29.1
Psychiatric social worker	27	7	20	17.1
Psychotherapist	29	16	13	18.4
Child psychologist	30	13	17	19.0

*n = 158

Source: King's Fund (2003)

For those practices with a counsellor, two-thirds (66%) had access to one-to-two hours of counselling per week, 15% had three-to-four hours per week, 8% had more than five hours per week and 11% did not know for how many hours the counsellors worked. Although respondents were also asked about the hours of work of other mental health professionals, there was too much missing data to allow for meaningful analysis of responses.

Figure 2 Histogram showing total number of hours worked by counsellors* reported by responding practices



*n = 117

Source: King's Fund (2003)

A total of 92 respondents said that they had either referral criteria/guidelines or a referral proforma for their counsellors. A total of 17 practices had both. The questionnaire also explored the availability of mental health services within GP practices or surrounding organisations. A high proportion (more than 80%) of practices had access to cognitive and other brief psychological therapies, bereavement counselling and stress counselling. Nearly three-quarters (70%) of practices also had access to an eating disorder group. Among practices with access to specialist mental health services, few made referrals on the basis of guidelines/criteria or used a special proforma to refer patients.

Table 9 Availability of selected mental health services within GP practices and other organisations

Type of service available	No. responding to this question	No. with service available in own or neighbouring practice	No. with service available in another organisation*	No. not knowing whether they had access to this service	% of all** respondents with access to this service
Cognitive therapies	136	40	83	13	86.1
Brief psychological therapies	130	54	66	10	82.3
Bereavement counselling	137	45	83	9	86.7
Stress management	127	40	72	15	80.4
Eating disorder group	109	3	85	21	70.0
Other mental health services	42	3	27	12	26.5

*'Another organisation' includes mental health trusts, other NHS trusts and voluntary organisations. GPs may or may not have direct access to these services.

**n = 158

Source: King's Fund (2003)

Use of mental health guidelines

Just over a quarter of all practices reported using guidelines for the management of at least one mental health condition. Among those that used guidelines, a very small proportion audited their use.

Overall, 42 respondents (27% of all respondents) reported the use of a practice-wide policy of using guidelines for the management of at least one mental health condition. Just over two-thirds (67%) reported that they did not use guidelines and 6% did not respond to the question. Among those practices that used guidelines, only a small proportion had audited their use. Data on use and audit of guidelines/criteria are summarised in Table 10.

Table 10 Use and audit of guidelines for selected mental health conditions

	No. of practices with a policy of using guidelines for the following conditions	% of all respondents* using guidelines	Number of practices with a policy of auditing use of guidelines
Anxiety	22	14	4
Depression	33	21	8
Post-natal depression	14	9	4
Schizophrenia	12	8	3
Dementia	8	5	?
Suicide and self-harm	9	6	0
Drug or alcohol misuse	16	10	2
Eating disorders	7	4	2
Other	1	1	0

*n = 158

Source: King's Fund (2003)

Implementation of the National Service Framework

- Approximately one-third of responding practices were involved in some way with National Service Framework (NSF) implementation. The most common areas of involvement were:
  - guideline implementation
  - audit of clinical practice against NSF-linked standards
  - data collection to monitor progress with the NSF
  - education and training activities.

Staff in 51 practices (34% of the 149 practices that responded to this question) had some involvement in implementing the National Service Framework for Mental Health. In 33 of the 51 practices involved with the NSF, this work was being carried out by a GP and in one it was being carried out by a nurse. Seventeen respondents did not record who was working on the NSF. The main areas of work in progress were:

- implementing clinical guidelines
- auditing clinical practice against NSF standards
- collecting data to monitor NSF implementation
- education and training.

Table 11 summarises the number of practices involved in each type of work.

Table 11 Key areas of work in practices involved in implementation of the National Service Framework

	Yes	No	Don't know or missing data	Total
Implementing clinical guidelines	28	5	18	51
Auditing clinical practice against NSF standards	28	3	20	51
Collecting data to monitor NSF implementation	30	2	19	51
Education and training	14	8	29	51

Source: King's Fund (2003)

Three people reported that they were taking part in other work around NSF implementation – one in 'ensuring 24-hour accessibility', one in 'locally organised courses' and the other in a 'care discussion group run by a family therapist'.

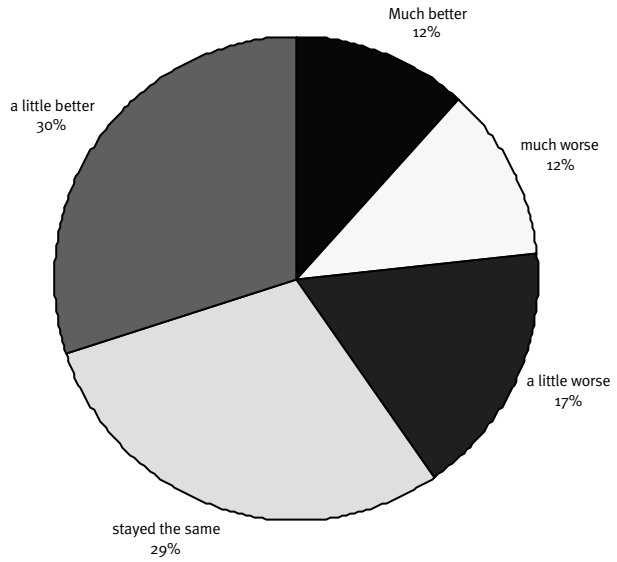
Overall quality of mental health services

- Opinion was mixed about the overall change in the quality of mental health services. Less than half (42%) of respondents felt that services were a little or much better than three to five years ago, while 29% felt they were a little or much worse.
- Just under half (46%) of respondents felt communication and liaison between primary care and specialist mental health services was a little or much better than three to five years ago, while 28% felt communication and liaison were a little or much worse.

Respondents were asked whether they felt that overall, during the last three to five years, services had become much worse, a little worse, stayed the same, become a little better or become much better. They were asked the same question about communication and liaison with staff from local mental health services. The most frequent responses were that services and communication and liaison alike had become either much better or a little better. Less than one-third of respondents stated they thought that services and communication and liaison had got worse.

Responses about the overall quality of services are presented in Figure 3, which shows that 42% of respondents felt that services have become a little or much better, 29% felt it had stayed the same and 29% felt that it had become either a little or much worse.

Figure 3 Respondents' opinions of changes in the overall quality of mental health services in the past 3–5 years



Source: King's Fund (2003)

Results are also presented by former health authority area (Table 12) where they have been clustered into three groups ('worse', 'stayed the same' or 'better') for each sample site, due to the small numbers in each group. The majority of respondents in the former Kensington, Chelsea and Westminster and Merton, Sutton and Wandsworth health authorities reported that services had improved. In Bromley, eight out of 12 respondents felt that services had become worse, and in Barnet six out of 11 respondents felt the standard had remained the same. There was no majority opinion in respondents from East London and City or Ealing, Hammersmith and Hounslow.

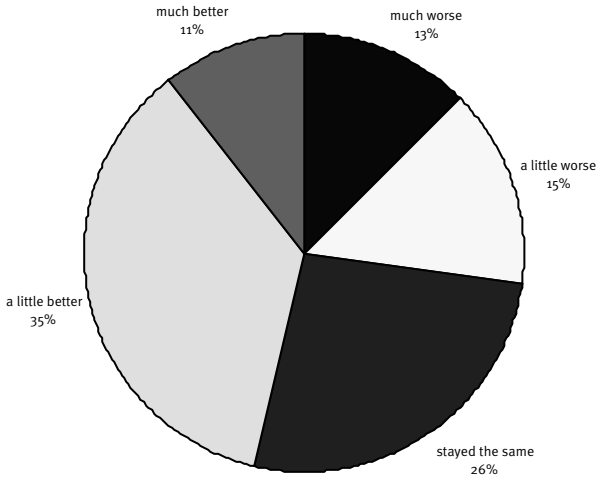
Table 12 Reported overall change in quality of mental health services over last 3–5 years, by area

	Worse	Stayed the same	Better	Missing data	Total
Barnet	6	1	3	1	11
Bromley	8	3	1		12
Ealing, Hammersmith and Hounslow	7	13	10	1	31
East London and City	12	8	15	1	36
Kensington, Chelsea and Westminster	3	6	19		28
Merton, Sutton and Wandsworth	5	10	10		25
Health authority not known	3	5	6	1	15
Total	**44**	**46**	**64**	**4**	**158**

Source: Kings Fund (2003)

Responses to questions about changes in the quality of communication and liaison with staff in local mental health services are presented in Figure 4. Overall, 46% of respondents felt that communication and liaison between primary care and specialist mental health services had improved, 26% felt they had stated the same and 28% thought they were worse.

Figure 4 Respondents' opinions of how communication and liaison with staff from local mental health services had developed in the past 3–5 years



Source: King's Fund (2003)

Views on liaison and communication by former health authority are presented in Table 13, in which they have again been clustered into three groups. These responses mirrored the views

on overall change in quality, with a majority reporting improvements in Kensington, Chelsea and Westminster and Merton, Sutton and Wandsworth, no clear view in Barnet, East London and City Health Authority or Ealing, Hammersmith and Hounslow and a majority describing worse communication and liaison in Bromley.

Table 13 Reported overall change in quality of liaison and communication with mental health services over last 3–5 years, by area

	Worse	Stayed the same	Better	Missing data	Total
Barnet	4	2	4	1	11
Bromley	7	3	2		12
Ealing, Hammersmith and Hounslow	9	10	9	3	31
East London and City	13	5	17	1	36
Kensington, Chelsea and Westminster	5	8	15		28
Merton, Sutton and Wandsworth	2	8	15		25
Health authority not known	1	4	8	2	15
Total	**41**	**40**	**70**	**7**	**158**

Source: King's Fund (2003)

Problematic services

Asked about the most problematic characteristics of local services, the bulk of responses fell into broad categories relating to:

- staffing and the availability of specialists
- problems with liaison and communication
- problems with access to services, particularly in emergencies
- inadequate resources.

Some respondents cited problems with specific services (particularly drug and alcohol and child and adolescent services) and a cluster of miscellaneous problems were also identified, including housing, patient behaviour and inpatient facilities. Some of the most common responses were:

- not enough consultants and other specialist staff
- long delays in access to specialist services, even when urgent assessment was requested
- inadequate access to counselling and other psychological therapies
- deficits in services for specific care groups (such as drug and alcohol users, children and adolescents
- difficulty arranging emergency admissions and rapid assessment.

The most commonly cited factors that would contribute most to improving mental health services were:

- more staff, with clearer roles and reduced levels of staff turnover
- better liaison and communication between GPs and mental health specialists
- faster access to specialist services
- easier emergency admissions
- improving co-ordination of services through schemes such as rapid assessment clinics and care pathways.

In addition, respondents were asked whether they thought specific patient groups were particularly poorly served by local mental health services. Table 14 summarises their responses in relation to different population groups.

Table 14 GP opinion on whether patient groups are poorly served by current mental health services

	Yes	No	Respondents did not know or missing data	Total
Elderly people	51	54	53	158
Children	54	46	58	158
Adults	33	49	76	158
Homeless people	56	20	82	158
Refugees	55	25	78	158
People with addictions	68	29	61	158
People from black and minorities ethnic groups	31	32	95	158
Other	9	9	140	158

Source: King's Fund (2003)

Other groups identified as particularly poorly served at present included victims of sexual abuse, people with eating disorders and non-English speaking patients.

There was no clear consensus about which services were good and which were bad – most attracted an equal balance of critics and enthusiasts. The greatest differences in opinion that were observed related to services for homeless people, refugees and people with addictions, where a majority of respondents felt there were significant problems.

Telephone survey – results

Telephone interviews were conducted with mental health leads in 27 of London's 32 PCTs. Interviews lasted between 25 and 50 minutes. The first part of the survey focused on the infrastructure for commissioning and developing mental health services. Questions addressed issues such as staffing complement, levels of experience and available budgets for mental health.

Infrastructure of primary care trusts

- The amount of dedicated management time available for mental health commissioning and service development varies considerably. The mental health leads surveyed had been in post (in their current or a precursor organisation) for between two weeks and five years, and dedicated between 0.5 and 10 sessions a week to mental health commissioning.
- All but one of those with few sessions dedicated to mental health and multiple areas of responsibility were assisted by one or more additional staff members.
- Only one PCT reported having a full-time employee dedicated to primary care mental health services. Other PCTs were supporting the development of primary care services in a variety of ways, including commissioning sessional support from audit facilitators, development community psychiatric nurses, lead GPs and others.

The job titles allocated to mental health leads reflected both the variability of their roles and the amount of time they had available for work on mental health. Some leads were PCT directors of commissioning and partnership whose role spans all commissioning or partnership working, across adult, child and mental health services. Others had responsibility only for mental health services.

Input into mental health commissioning and development varied from 0.5 to 10 sessions per week. This variation was partly due to some new organisations not yet having all staff in post, with more senior staff covering the mental health lead role until the posts are filled. For the nine leads with lower input (0.5 to four sessions per week), all but one had at least one other member of staff to assist with commissioning. Six had made joint health/local authority appointments, two posts were PCT-based, and one was vacant.

The mental health leads interviewed had been in their current (or equivalent post in the precursor PCG) for between two weeks and five years, with five in post for eight months or less. They came from various professional backgrounds, with 11 having some form of mental health training. Five were former psychiatric social workers, one was a public health doctor, two had experience of clinical psychology and two were registered mental nurses.

In addition to full- or part-time managerial staff involved in commissioning, one PCT had a full-time development worker dedicated to primary care mental health services, and one had a part-time facilitator. Three PCTs were involved in commissioning networks of community

psychiatric nurses to liaise closely with primary care clinicians, and take on a developmental role. Six had identified local GPs with a special interest in mental health who carried out development work with other GPs on a sessional basis, four had general primary care development facilitators whose remit included mental health and three had development facilitators whose role in mental health was not defined.

In four PCTs, the managerial lead devoted some sessions to development work with practices. A small number of PCTs were developing collaborative arrangements, such as lead commissioning or shared development of evidence-based guidelines.

Decision-making groups and processes

- Policy-making for mental health services is universally based in multi-professional groups with representatives from health and social care. (Group names vary but they are typically local implementation teams for the NSF or partnership boards.)
- Respondents' experiences of partnership working varied from excellent working relationships that underpinned progress to poor or deteriorating relationships that were constraining change.

In 14 PCTs, the local implementation team was the main decision-making group for local mental health policies and developments. In two of these, a pre-existing joint working group or partnership board had evolved to fill the local implementation team role. In 13 PCTs, the main decision-making body was a joint PCT/local authority/mental health trust partnership board. In these cases, either the decision-making body fulfilled the role of the local implementation team, or the team existed as a subgroup of the decision-making body. Three PCTs also had an additional, more operational, mental health implementation group to implement decisions made by the local implementation team.

In every PCT, membership of these groups included representatives of the PCT, the local authority and the local mental health trust and, typically, voluntary organisation members representing patients and carers. Local implementation teams and partnership boards with wider membership typically included a representative from housing services, a wider selection of voluntary organisations representing specific conditions (such as schizophrenia) and individual patients or carers. Four included representatives from the police, criminal justice or probation service. Nineteen PCTs had a primary care lead on the local implementation team, though three reported that this person had so many other responsibilities that they could not act as a real 'champion' for mental health services in primary care.

Three PCTs also identified GP leads, who were involved with mental health service development across all local practices. One had a community psychiatric nurse lead for each practice, each of which communicated with a PCT-wide lead community practice nurse. Three informants did not know whether there was a GP lead and 16 did not have one.

Available budget

- Data on earmarked budgets for mental health are very patchy. Only 16 of the 27 London PCTs involved in the survey had an earmarked development budget for mental health services, and these varied from £250,000 to £1.2 million.
- The majority of development priorities related to specialist services for people with severe mental illness and only nine PCTs included primary care development plans among their stated priorities.
- Many PCTs had also obtained additional external funding from a variety of sources, including single regeneration bids, neighbourhood renewal funds, health action zone initiatives, Sure Start, the European Social Fund and the New Deal for Communities initiative.

The quality of information about earmarked mental health budgets was generally poor. Some PCTs had a single budget head for mental health, while others had funds spread across several service areas such as elderly mentally infirm services, child and adolescent mental health services and adult services.

Information about the availability of development funds was more useful. Sixteen reported having earmarked development funds for mental health. Development budgets range from £250,000 to £1.2 million. The mean budget across all 16 PCTs was £445,000. Typically, though, this money must cover cost pressures, such as correcting long-standing staff shortages or bringing inpatient facilities up to standard. This was in addition to fulfilling NSF and local development priorities. For the nine PCTs with no mental health development funds, the reasons given were that the PCT was trying to manage a significant overspend or that all development money had been sucked into acute sector priorities. Two PCTs had planned to have development funds for mental health but this had 'disappeared' due to cost pressures in other areas.

Only nine PCTs had prioritised developments in primary care mental health. The majority of these were in addition to priorities relating to severe mental illness. Where primary care priorities existed, they included development of psychological therapies and counselling (seven PCTs), shared-care protocol development, education and training (two PCTs), introduction of graduate mental health workers (two PCTs), and support for voluntary sector organisations and carer support groups (two PCTs).

The box opposite also lists other priorities. By far the majority of planned developments reflected NSF priorities for severe mental illness – particularly services in which the PCTs had been rated as 'red' (ie performing poorly) during their most recent NSF self assessment. Thus 12 PCTs had prioritised crisis resolution, with a further three developing home treatment teams or A&E liaison services to contribute to crisis resolution. Assertive outreach had been prioritised by eight PCTs and early intervention in psychosis by six.

Mental Health service development priorities in London PCTs

National Service Framework priorities (No. of PCTs with this priority)*	Locally determined priorities
• primary care-linked priorities (9), of which: – shared care protocols development (2) – counselling and therapies (7) – education and training for primary care staff (2) – supporting voluntary organisations (2) • gateway workers/primary care liaison workers (2) • crisis intervention/resolution (11) of which: – home treatment (2) – A&E liaison services • including home treatment (2) and A&E liaison services (1) • assertive outreach (8) • early intervention in psychosis (6) • improving community mental health teams (2) • user involvement and partnership (3) • mental health promotion (2) • care programme approach and case management work (1) • 24-hour access (1) • NSF self-assessment 'reds' (3) • improved inpatient wards and increased ward staff numbers (3) • increase in staffing levels in order to deliver the NSF (1) • suicide prevention (1)	• asylum-seekers and refugees • improved access for patients from black and minority ethnic groups • carer support and partnership • occupational therapy services • maintaining services from local voluntary organisations • decreasing out-of-area placements • increasing user involvement • stigma

* Most PCTs had more than one priority

Source: King's Fund (2003)

External sources of funding

In addition to core PCT and local authority social services funding, 20 PCTs had external sources of funding for some of their local mental health services. Most of these had one or two sources of external funding. Four had additional funding from three or more sources. Sources of additional funding are presented in Table 15. The most common were single regeneration bids, health action zone funding and neighbourhood renewal funds.

Table 15 Sources of additional mental health funding in London PCTs

Source of funding	No. of PCTs receiving or bidding for funding from this source
Health Action Zone	2
Single Regeneration Bid	4
Neighbourhood Renewal Funds	5 receiving funds 3 bids submitted
Children's Fund	1
New Deal for Communities	2
European Social Fund	1
Local Partnership Fund	1
Guys and St Thomas' Hospital Special Trustees	1
Special project funding from the Department of Health	1

Source: King's Fund (2003)

Implementation of the National Service Framework

- NSF implementation priorities are focused more on developing services for people with severe mental illness than on primary care mental health. Only nine of the PCTs surveyed included primary care services among their main development priorities.

- Progress with other areas of primary care NSF implementation is patchy, with only one-third of PCTs included in the study having completed the evidence-based guidelines required by the NSF, and far fewer working to implement these or to audit their impact. Less than one-third of the PCTs were involved in education and development activities focused at GPs. Seven were working with NHS Direct.

All the PCTs had an NSF plan, although these had been developed in various ways. Six PCTs had inherited plans. These had been developed following either a previous service review or strategy development work carried out prior to the NSF, or by a prior organisation (two by the former health authority, two from the preceding PCG/PCTs). In two of these PCTs, members of the local implementation team had worked closely with the health authority mental health group to ensure a sense of wide local ownership. Four had inherited a plan and were now revising it through the local implementation team in order to develop ownership.

The remaining PCTs developed their plans through their local implementation team or partnership board. Half of these reported involving users, carers and others through stakeholder events and other forms of consultation. Two PCTs described multi-agency development work to develop their NSF plan through an iterative process of discussion, consultation and revision of the plan.

Progress with implementation

In terms of progress with NSF primary care standards, 21 of the PCTs questioned had developed, or were in the process of developing, policies on access to counselling and/or psychological therapies, although some of these policies pre-dated the NSF. Five had no policy on counselling and two respondents were unsure whether policies existed.

All respondents reported that they had developed, or were developing, one or more of the primary care guidelines required by the NSF. Some of this work was being undertaken jointly, with five PCTs working together to develop common guidelines in one area and two developing shared guidelines in another.

Only nine PCTs had completed all the guidelines required by the NSF, although few had undertaken subsequent work to disseminate the guidelines, facilitate their implementation and audit change. Where implementation work was in progress, one PCT had commissioned audit support workers to assist with guideline implementation. In three PCTs, the managerial lead for mental health was responsible for implementation and three PCTs had GPs who were involved in implementation on a sessional basis. One informant reported that implementation of the prescribing guidelines was being led by the local prescribing group. Only one PCT had undertaken an audit of all their primary care guidelines, and two had audited one or two topics.

In a further seven PCTs, the guidelines required for the NSF were either completed or under development, but none reported having implemented the completed guideline. Where audits had been undertaken, these were focused on severe mental illness and the care programme approach. Table 16 summarises progress in guideline development across London PCTs.

Only 12 informants thought that at least one doctor in every practice would have seen the NSF document – or a summary of it. 'Guestimates' of the percentage of local GPs who would have some idea about the primary care standards ranged from 5 to 80%. The majority who were willing to estimate a figure (16 out of 27) said 30–50%.

In relation to the NSF standards for improving access to mental health services, 15 PCTs had introduced developments to support extended access to mental health services, with two more planning to do so. However, the majority were increasing access to services for severe mental illness (typically a 24-hour crisis resolution team). The remainder either did not have details of these developments or were focusing on primary care access through, for example, 24-hour telephone helplines or improved access via A&E. Only seven PCTs were working with NHS Direct to develop 24-hour access to telephone advice and assessment.

Table 16 Primary care guideline development across London PCTs

	Counselling	Anxiety	Depression	Schizophrenia	Drugs and alcohol	Prescribing benzo-diazepines	Prescribing anti-depressants	Prescribing anti-psychotics
Guidelines fully developed	16	15	16	15	9	14	13	13
Under-development	5	4	4	3	5	3	4	3
Not yet started	3			1	2			
Respondent did not know	3	3	3	3	5	5	6	6
Audits undertaken	13 PCTs reported undertaking some audit. Of these, three were auditing primary care mental health work. The remainder were conducting audits related to Stages 3 and 4 NSF self-assessments.							
No audits undertaken	10 PCTs had undertaken no audits							

Source: King's Fund (2003)

All the PCTs were using the NSF self-assessment process to monitor progress, and all but two were at 'red' in at least one area. In general, NSF implementation priorities for the coming year reflected areas where the PCT was 'at red' during the last self-assessment. However, some respondents noted that the several of the self-assessment measures were slightly different from last year, making it much harder to assess progress.

Less than half of the PCTs (12 out of 27) had set local mental health development targets in addition to those in the NSF. Two PCTs that had set local targets aimed to harmonise NSF-based developments with the requirements of other external agencies, such as the social services inspectorate. The standards set by different agencies were not always felt to be complementary, and this created difficulties in terms of incompatible development goals and priorities. In other PCTs, local targets reflected additional local priorities, including:

- developing a women-only crisis house
- developing services for refugees and asylum seekers
- prescribing quality
- managing violence.

Overall, two PCTs rated progress with implementing the NSF as 'excellent', although one of these described joint working and planning as excellent but stated the rate of change and development was only reasonable due to the lack of resources needed to implement policies. Seven rated progress as 'good', 13 as 'reasonable', two as 'poor', one as 'very poor' (due to lack of resources to fund change, although much effort had been made) and two were unable to say. The most common factors identified as helping NSF implementation were:

- improved multi-agency and partnership working
- development funding (where it existed)
- effective joint commissioning structures
- growing awareness about mental health among primary care team members
- constructive engagement of key stakeholders.

The most commonly mentioned barriers were:

- the repeated reorganisation of NHS organisations
- lack of money
- recruitment and retention problems
- lack of capacity for commissioning.

Three respondents stated that the NSF targets relating to severe mental illness were taking precedence over implementation in primary care.

Education and training

- Few of the PCTs surveyed were undertaking education and training on mental health topics for primary care staff.

- Only three PCTs surveyed had a dedicated budget for primary care mental health education and training. Four more had found money for education and training work from their mainstream mental health budget.

In addition to progress with NSF implementation, the survey explored PCT involvement in education and training around mental health. Eight PCTs had conducted needs assessments for mental health training in primary care. Four further needs assessments were planned, or were in progress. Where they had been completed, needs assessments had identified a wide range of priority areas for training, including:

- substance misuse
- training in relation to local guidelines
- mental health awareness
- risk assessment.

Five PCTs were targeting their education and training efforts at GPs, and eight of the remaining nine (not all of which had conducted needs assessments) were supporting training for the whole practice team. One was focusing mainly on staff in the mental health trust. Only three PCTs reported having a dedicated mental health training budget, although in four PCTs money from the wider mental health budget had been used to support educational and training. Where designated funding was not available, local consultants and GPs with a particular interest in mental health were providing some training to local staff.

Liaison with other organisations and services

- Many PCT leads cited joint work with mental health trusts and social services in establishing integrated community mental health teams as being among their greatest recent achievements.
- Several PCTs reported now employing staff jointly with the local authority. A few used shared patient records, but none yet used shared computer records.
- Other recent achievements (in some PCTs) included building good working relationships with partner organisations and improvements in primary care/secondary care interfaces.

All respondents reported that community mental health services were now provided jointly by health and social services. Although the development of integrated community mental health teams was started many years ago in some areas, their formation through ongoing joint work between mental health trusts, social services and PCTs (or their pre-cursors) was cited as a major development challenge. Several PCT leads reported their role in this process and the successful launch of their community mental health teams as being among their greatest recent local achievements.

Management arrangements varied, with five respondents stating that their integrated community services were jointly managed, two developing joint management, two being run by a care trust, one by a local authority, and 13 under health service management. In three PCTs, respondents explained that management responsibilities varied for different services. One respondent (new in post) was unsure where management responsibility was located.

Despite this relatively high level of integration, joint records were in use in only ten PCTs, and no PCTs had yet started using joint computer systems. Sixteen informants reported that in their opinion, all or part of the joint mental health services they had established could be considered as 'innovative' or unusual.

Key areas of innovation in integrated service organisation and provision were in:

- crisis resolution and assertive outreach
- home treatment teams
- implementation of the care programme approach
- systems for integrated health authority/local authority management of mental health services
- integrated complaints procedures
- involvement of voluntary organisations in mainstream services for severe mental illness
- systems for sharing information between health and local authority staff.

Special projects for specific patient groups

- Respondents described a wide range of projects that have been established for specific care groups across London.

A number of projects had been established for specific care groups, although not every PCT had established such projects (*see* **Table 17**). Across London, respondents described projects targeted at:

- people with a dual diagnosis of psychiatric illness and drug or alcohol addiction
- people from black and minority ethnic groups
- children and adolescents with mental health problems
- older people with mental health problems
- people with eating disorders.

Table 17 Special projects in place for specific patient groups

Project type	No. of PCTs reporting providing services targeted at specific care groups	Types of project in place
Dual diagnosis services	13 PCTs providing at least one service targeted at patients with dual diagnosis	**Education, training and research** • Staff from hospital-based service training community-based clinicians • Participating in a research-linked pilot to increase drug and alcohol expertise in primary care **Specialised workers or teams** • Nurse practitioners with a special interest • Dual-diagnosis workers or teams – either free-standing or based in community mental health or drug and alcohol teams **Specialist projects or services** • Dual-diagnosis centre covering part of a PCT • Assertive outreach and needle-exchange project • Newly established project team to review drug dependency
	3 PCTs planning developments	**Planned** • Funding allocated to provide a small team • Working group developing strategy for local services • Funding agreed for four dual diagnosis workers

Project type	Number of PCTs reporting providing services	Types of project in place
Services for people from black and minority groups	21 PCTs providing at least one service targeting patients from black and minority ethnic groups	**Voluntary organisations wholly or partly funded by the PCT (examples given below)** • black mental health consortium • mental health capacity within Bangladeshi and African communities • counselling services targeted at members of specific ethnic groups (eg Asian women) • helpline for Asian people • dedicated befriending service • women-only drop-in projects for Asian and for black Caribbean communities • antenna project for black youngsters aged 16–24 • day programme for black people **Specific groups targeted by health authority or local authority or local authority services** • Carer support groups • Advocacy services • Initiatives to expand the range of languages for which interpreters are available • Support services for refugees • Counselling, psychology or support service for patients from specific ethnic groups • Ethnic minority specialist in community mental health team • Advocacy service for people from black and minority ethnic groups • Ethnic minority mental health nurse team (two nurses) based in one community mental health team • Local authority-funded project for Asian women with mental health problems **Involvement in service planning/development** • User and adviser forums for service planning • Assessment and training in needs of Islamic people in hospital **Other** • Video for Bengali community • Project for Somali men with mental health problems

Project type	Number of PCTs reporting providing services	Types of project in place
Services for children and adolescents	12 PCTs providing at least one service targeting children and adolescents	**Specialist team established** • Conduct-disorder team planned • Adolescent mental health team – joint with social services • Early intervention service for younger people **Projects based in or linked to schools** • Early intervention project for secondary schools • Drug and alcohol projects for younger people • HART team **Special services targeting younger people** • Joint health and social care day centre • Joint work between PCT and Sure Start • Counsellors targeting young people • Family units **Specialist posts** • Primary care post for children and adolescents • Dedicated GP-based psychologist for young people **Voluntary organisations working with young people** • Youth counselling services • Project for young people in custody with no responsible adult • Drug projects targeted at younger people
	Two PCTs planning developments	**Work in progress** • Child and adolescent mental health services strategy under development in two PCTs
Services for older people with mental health problems	16 PCTs providing at least one service for older people with mental health problems	**Disease-based services** • Alzheimer's clinic • 'Memory lane' project – social services-funded café for people with dementia • Specialist dementia services, including outreach and home treatment (7 PCTs) **Specialist workers or teams** • Admiral nurses within mental health trust to support older people in the community • Multi-disciplinary community mental health team for older people (3 PCTs) • Psychiatric liaison service for older adults

Project type	Number of PCTs reporting providing services	Types of project in place
Services for older people with mental health problems *(continued from previous page)*		**Education and training** • HAZ initiative – education on dementia care for users and carers, and for staff in residential homes **Projects for patients and carers** • Funding for carer support • Advocacy projects provided by local voluntary organisations with funding from the PCT **Voluntary organisations in the community** • Lunch clubs • MIND day centres • Voluntary sector advocacy projects
Other special projects	12 PCTs providing at least one innovative project targeting other patient groups	**General practice disease registers for people with severe mental illness** • New service to assess physical health of people with mental health problems • Women-only mental health service • Joint physical and mental health project encouraging GPs to review both at same time • Services for gay and lesbian people • Prison mental health team • Employing a mental health service-user co-ordinator • Accommodation support for mental health service users • Learning sets for GPs • Cognitive behaviour therapy using computers • Electronic patient records for mental health • Extending day-care opportunities – shared social services and PCT resources for day care • System for developing and revising evidence-based protocols • Mental health promotion projects

Source: King's Fund (2003)

Achievements, opportunities and constraints on service development

- Important recent achievements (in some PCTs) included:
  - building good working relationships with partner organisations
  - improvements in primary care/secondary care interfaces
  - developments in inpatient facilities
  - improved planning and policy-making mechanisms.
- The main constraints to service development identified by mental health leads were:
  - limited resources (financial and other)
  - problems with recruiting and retaining a skilled workforce
  - ongoing organisational change resulting in high staff turnover and disrupted working relationships.

The final section of the questionnaire explored informants' views about:

- their greatest achievements in mental health service development over the last few years
- what would contribute most to improving mental health services in primary care
- what they considered to be the greatest constraints.

In terms of greatest achievements, the most common responses were:

- establishing effective and well integrated community mental health teams (eight PCTs)
- building good working relationships between local stakeholders (nine PCTs)
- innovative work on the primary/secondary interface in mental health, with more attention paid to primary care services and improved service provision (six PCTs)
- completing the re-provision of hospital services (four PCTs) and improving the quality of remaining hospital services (four PCTs). Two of these PCTs had also improved their community mental health facilities.
- improved service planning (four PCTs), including improving the evidence base and strategy development processes.

In addition to the above, three informants had made particular progress in working with service users, five reported good progress with establishing or developing a particular service (early intervention, assertive outreach, older people, child and adolescent mental health services, and asylum seekers and refugees), and three stated that their greatest achievement was merely surviving.

The most commonly identified factors that would contribute to improving services (the lack of which were seen as placing the greatest constraints on development), were:

- increased resources or the release of earmarked funds diverted to acute trusts
- improved staff recruitment and retention
- greater organisational stability within the PCT
- better management capacity

- better relationships between professional groups
- greater commitment to the development of primary care mental health services.

Many of the constraints on development that the informants identified mirrored the factors listed above. However, the following additional issues were raised:

- poor use of IT, and limited data and information availability
- poor or deteriorating relationships between stakeholders
- the high cost of forensic services and the care of mentally disordered offenders
- limited capacity in primary care staff to manage mental health problems.

Discussion

This paper has set out to examine the extent to which recent developments in mental health services have served to improve care within general practice. Key deficiencies in primary care mental health noted in the 1997 King's Fund Inquiry (and numerous other publications since) were:

- skills deficits in primary care clinicians
- limited resources for education and training
- problems with access to practice-based psychological therapies
- patchy application of good practice, such as case registers and evidence-based guidelines
- organisational problems relating to the administrative boundaries of health and social care
- inadequate liaison between primary and secondary providers and between health and social care sectors.

The single most significant development since the 1997 Inquiry has been the launch of the National Service Framework for Mental Health. If fully implemented, this framework could stimulate developments in primary care that would address many of the problems highlighted above. However, this is a problematic 'if', with several other NSFs competing for attention and limited resources, and ongoing organisational change affecting the capacity of PCTs to develop services.

Capacity and integration

A number of comments in the postal questionnaire and telephone survey, and made by the expert advisory group, related to two common themes: capacity and integration. Since neither was the subject of specific questions in the postal or telephone surveys, the volume of comments pertaining to these issues highlighted them as particularly important in the development of primary care mental health services. This section summarises the key points made by respondents and members of the expert advisory group relating to these two underpinning themes.

Limited capacity was problematic in clinical and managerial settings alike. Clinically, the GP survey identified that fewer than half the practices contacted contained a GP with a particular interest in mental health. The most common responses to questions on pressing problems related to:

- staffing and skills shortfalls within practices (GPs, counsellors and lack of practice-based community psychiatric nurses)
- unfilled consultant posts in mental health trusts
- lack of access to community psychiatric nurses and other specialist mental health workers
- slow access to services – particularly in emergencies.

Within PCTs, one key constraint on capacity was the limited funding available. The second was that mental health leads often lack the experience, knowledge and adequate support

staff to deal with commissioning and service development across the whole mental health agenda. While some PCTs outside London have tried to overcome these problems by establishing purchasing consortia, the situation is more complex within the capital. Mental health trusts have been merging into ever-larger organisations, while purchasers are becoming smaller, making consortium arrangements harder to establish. All of these issues are compounded by several rounds of organisational change, which have precipitated multiple staff changes and disrupted established relationships.

This point was raised repeatedly in the telephone survey and by the advisory group. A considerable proportion of the limited resources available for mental health commissioning and service development is currently focused on re-establishing the partnerships and trust required for effective commissioning and service development.

The expert advisory group highlighted a further area of concern that is particularly problematic, given the limited capacity described above. This is the amount of duplicated or unproductive effort driven partly by the NSF and partly by a lack of focus and co-ordination between different groups. For example, development of primary care guidelines in response to the NSF is often duplicated in multiple PCTs. It is also often divorced from education and training initiatives. Furthermore, many guidelines are developed in forms that are not user-friendly for clinicians (for example, thick documents), which minimises their impact. While the 1997 report recommended increased use of guidelines, it seems that more thought is needed about the best approach.

One proposed solution to these problems was to improve the integration of work to develop mental health services. In questionnaire and survey responses, and in advisory group comments, the theme of integration was evident at three key levels:

- clinical integration
- the importance of integrating development initiatives
- the need for organisational integration.

The questionnaire identified limited evidence of integrated clinical working. Despite mixed views on the value of guidelines, they can stimulate integrated clinical working between primary care and specialist services. Yet less than 20% of practices surveyed were working to implement them.

Evidence of improved communication and liaison was patchy, although many PCT respondents described special projects promoting joint work between health, local authority and voluntary sector services. However, only two PCTs reported work to develop shared care between GPs and mental health specialists (focusing on patients' physical health as well as their mental health needs), and just one reported work on shared electronic patient records. The expert group highlighted the potential contribution of case registers and shared care arrangements to improve the overall quality of care through a 'chronic disease management' approach to long-term mental illness.

In terms of service development, the expert group emphasised the importance of co-ordinating and integrating different domains of activity to ensure each was mutually supportive, and thus more likely to be effective. Examples given included linking efforts to expand the provision of counsellors and psychological therapists, and the development of referral protocols to promote the appropriate use of different therapies for different patients.

This work would also need to be linked to educational initiatives about psychological therapies.

Organisationally, the disruptive influence of recurrent PCT reorganisation was raised repeatedly. But the expert group highlighted another problematic trend. Health authorities have fragmented into PCTs and over the same period, mental health trusts in London have been merging into larger organisations, in line with policy espoused in *The New NHS* (Department of Health 1997). Commissioning with multiple PCTs can create inefficiency both for trusts and PCTs alike, and in some areas where several PCTs are aligned with a single county council, consortium commissioning arrangements are emerging. However, this is less likely to happen in London, where nearly all PCTs are aligned with a single local authority, and the potential benefits of close inter-agency working could be lost with consortia. Furthermore, where they do exist, consortium arrangements are still evolving, with details of levels of delegated authority and funding arrangements still being worked out. Consortium commissioning will struggle to effect change until such details have been agreed by all involved.

The impact of the National Service Framework

Among the PCT mental health leads interviewed, there was general consensus that the NSF has attracted a higher level of attention and resources towards mental health services than had existed previously. The bulk of implementation work is taking place at PCT level, with only one-third of GP practices reporting any involvement with the NSF – mainly in implementing guidelines, auditing and collecting data. While people expressed positive views about the NSF, some also noted that it was generating a lot of activity that was not focused on areas with the greatest chance of impact on service quality. The multitude of measures covered in the self-assessment process were thought by some to be dissipating effort in too many directions, reducing the effectiveness of any one single initiative.

The PCTs surveyed were universally working jointly with their co-terminus local authorities – through partnership boards and/or through local implementation teams that included health and local authority members. Perhaps unlike the former local authority/health authority joint planning groups, these groups and boards are now the central strategic planning mechanisms for mental health services. Yet several informants describe the constraining effect of repeated organisational change, high staff turnover and the need to rebuild teams and groups or generate ownership of policies developed by previous organisations.

Another frequently highlighted problem with NSF implementation is the limited development and commissioning capacity within PCTs and within general practice. Only half of the mental health leads surveyed worked full-time in this role, and just over half had earmarked budgets for mental health development. Many PCTs involved additional people (such as local GPs, audit support workers and liaison community psychiatric nurses) in primary care-based work, but very few had an employed staff member whose role was to champion the development of primary care mental health.

Several informants voiced concerns about the clinical capacity of primary care clinicians to manage more patients with mental health problems. Despite this, there was a sense of slow but steady progress, with only three PCTs describing NSF implementation as ‘poor’ or ‘very poor’ and 20 saying progress was ‘reasonable’ or ‘good’. Furthermore, there was a growing

range of advice to support this work in PCTs (including guidance documents from the Department of Health, the National Primary Care Research and Development Centre and the Sainsbury Centre). Such resources will be of particular value to those mental health leads who are newest in post.

Progress with the National Service Framework primary care standards

In relation to the two primary care specific NSF standards, the questionnaire and telephone survey revealed variable progress across the necessary services and areas of clinical practice.

Of the 27 PCTs contacted, only 20 were working on guidelines for depression, 21 on guidelines for referral to a counsellor, and between 14 and 19 (50–70%) were working on guidelines for other diseases. Furthermore, where guidelines had been developed, not all PCTs were working actively to implement them, and only three reported having undertaken audits. Only one-third of GP practices described having been involved in guideline implementation, and estimates by PCT leads of the proportion of GPs who were aware of the NSF standards ranged from five to 80%.

These data highlight that work on primary care implementation is not universal, and that there is minimal work in progress to monitor implementation and change. The data also show patchy work to develop 24-hour access to mental health advice through NHS Direct, with only seven PCTs tackling this. The majority are placing priority on extending the hours of access to services for people with severe mental health problems.

This last observation is consistent with other priorities within PCTs. A significant majority of NSF priorities relate to crisis intervention, early intervention and assertive outreach projects for people with severe mental illness. In line with the general policy thrust of the NSF, PCTs are focusing the majority of their time and resources on severe mental illness. This is slowing the development of primary care mental health services and channelling the bulk of resources towards specialist services. Despite this, however, a range of activities – not necessarily related to the NSF – are underway, and these will contribute to the gradual development of mental health capacity in primary care.

Education and training

In relation to developing the mental health skills and capacity of primary care clinicians, the picture is sketchy. Several PCT mental health leads identified limited capacity as one of the main barriers to developing services, so development of skills is urgently needed.

One-quarter of the PCTs surveyed had undertaken a needs assessment for mental health education and training, although only three had an earmarked budget for education and training, and four more have funded training programmes out of the wider mental health budget. Although fewer than 10% of practices had undertaken a needs assessment, one-third had organised mental health training, including case-note review, critical incident

review and talks by external speakers. One-fifth had provided training for practice nurses and/or receptionists. Furthermore, eight London PCTs were using primary care mental health facilitators or lead GPs to work with directly practices to implement primary care guidelines and support further training.

Although still far from universal, this work was going on against a background of improving resources for mental health education and training. The charity Primary Care Mental Health Education 2002 (www.primhe.org) provides a focus for these activities and a forum for sharing resources and experiences. Other resources include a resource-sharing website run by Virtuall (www.virtuall.org) and a World Health Organisation response for primary care mental health (www.whoguidemhpcuk.org).

Access to psychological therapies

Both the postal questionnaire and the survey of PCT leads provide evidence of limited improvement in access to counselling and other psychological therapies. A very high proportion of practices surveyed (80%) reported having access to practice-based counselling and 40% have access to a psychologist. This is in line with reports of the early intentions of many PCTs to improve access to counselling identified soon after they formed (Wilkin *et al* 2000) and confirmed by responses to the current survey. But the volume of service remained very limited, with three-quarters of practices receiving only one-to-two hours of counselling time per week.

This suggests that while problems of inequitable access between practices may be resolving, the volume is still insufficient to meet demand. Furthermore, as community mental health teams focus increasingly on severe mental illness, redirecting people with less serious illness back to general practice, the demand for practice-based psychological therapies is likely to grow faster than the rate of increase in their provision.

It is important to remember that evidence for the effectiveness of practice-based counselling is equivocal. Evidence is stronger for the effectiveness of more structured, brief psychological therapies such as cognitive behavioural therapy and the survey shows that between 17% and 40% of practices have access to other therapies. Nevertheless, resources remain extremely limited for what is likely to be a growing pool of patients.

Liaison and communication

The 1997 King's Fund Inquiry highlighted poor liaison and communication between primary care and specialist services as a major problem. It identified a range of different organisational arrangements through which to improve services. These included:

- 'shifted outpatients', where mental health outpatient clinics are held in general practice premises
- transient support for GP practices from attached multi-disciplinary mental health teams, which train and develop skills, and then move on when the primary care team is confident in its skills

- an integrated care model, based on care registers shared by primary care and specialist services
- the use of liaison key workers (such as community psychiatric nurses) to work closely with individual practices.

Although this paper has not explored this issue in depth, the GP questionnaire provided an overview of opinion about changes in the quality of liaison and communication. It found that almost half of respondents felt the situation had improved, about one-quarter felt it had stayed the same and approximately one quarter felt it had worsened.

Three of the PCTs had established special projects through which community psychiatric nurses were linked to GP practices, providing liaison with the community mental health team. Two further PCTs had worked to improve liaison in other ways, citing this work as among their best achievements of the past few years.

Also relevant here is the work that is underway in most PCTs to develop guidelines for common mental health problems. Typically, these guidelines address referrals between primary and specialist services and should help to clarify the roles of different professionals, and to improve communication between them. However, as noted above, little of this work has been audited, so its effects are unclear.

The next steps – conclusions and recommendations

GPs reported some overall improvements in the services available to people with mental health problems whose care is provided mainly within general practice. With integrated community mental health teams now established across London, GPs also reported improved liaison and communication between general practice and specialist mental health services. However, improvements were not equally evident in all areas.

There is a general belief that the NSF is focusing more positive attention on to developing mental health services than had previously been the case. However, while most PCTs reported reasonable or good progress with implementation, the majority of this work was aimed at people with severe mental illness, with less work underway on primary care mental health services. This is resulting in slow progress for the 90% of patients with mental health problems who are managed entirely within primary care.

Progress in improving mental health services is also hindered by a number of generic problems that are affecting all parts of the NHS. These include:

- staff recruitment and retention problems
- the disruptive effects of organisational change at PCT level
- difficulties establishing the inter-organisational relationships required for successful developments
- extremely limited development budgets within PCTs.

A range of more specific constraints are also inhibiting progress in developing primary care mental health services, and recommendations for change are made in respect of the following issues, which are described in further detail below:

- service development capacity in PCTs
- promoting a primary care focus
- funding
- primary care mental health services
- improving clinical care.

Service development capacity in PCTs

There are significant shortfalls in the capacity to commission and develop mental health services in general practice settings and to provide adequate clinical services. Limited funding and management capacity is exacerbated by a lack of co-ordination and integration between different areas of work in progress resulting in duplication, dissipation of effort and lessened impact of initiatives that are underway. Furthermore, the NSF has generated a large number of competing development priorities, with very limited funding available to support implementation. In these circumstances, the greatest opportunities for service improvement are likely to arise if local implementation teams agree on a limited number of top priorities and focus on achieving these before moving on.

Recommendations

- PCTs should improve their capacity to commission mental health care. This will require an identifiable development budget, more commissioning staff and better systems for integrating diverse activities relating to mental health service.

- PCTs should focus on only two or three development priorities, paying particular attention to the integration and co-ordination of multiple streams of work required to achieve and monitor changes in practice.

Promoting a primary care focus

As noted above, most NSF implementation work is currently focused on services for people with severe mental illness. From a primary care perspective, there is scope to assess the implications for general practice of proposed developments for people with severe mental illness and to assess how primary care staff can contribute appropriately to their care. Although this paper does not explicitly examine primary care work in this area, it did identify a small number of innovative shared-care projects that might act as models for future developments.

However, greater priority needs to be attached to primary care mental health services for common mental health problems if significant improvements are to be achieved. This requires effective leadership in the development and improvement of primary care mental health services. Key challenges include:

- developing the knowledge and skills of primary care clinicians
- appropriately using counselling services and psychological therapies
- ensuring that any guideline development work is carefully targeted on to areas where changes in practice are most likely.

Many PCTs have general practice or primary care mental health leads, but they typically devote only a tiny part of their working week to this role. This is insufficient to achieve significant change in primary care.

Recommendations

- A primary care mental health champion is urgently needed in each PCT to lead developments in general practice settings. This post will need to be funded for several sessions per week if it is to have real impact on primary care services.

- Current shared care activity for people with severe mental illness should be mapped and evidence reviewed on effective roles for general practice in the care of people with severe mental illness.

Funding

In the absence of earmarked funding for mental health, the shortage of growth money is a problem for many PCTs. Many do not have the resources they need to fulfil their mental health development priorities.

Recommendations

- More funds for mental health development should be identified at a national level. They should be distributed through local implementation teams to support local development priorities, with clarity locally about these funds and how they are to be spent.

- All PCTs should identify a budget for mental health services to support the implementation of priority developments. Primary care priorities should be among those identified in every primary care trust.

Primary care mental health services

Access to counselling and psychological therapies has increased, but the volume of provision is limited. There remain questions about the long-term effectiveness of GP counselling. A key challenge remains to ensure each patient is referred to the most appropriate form of psychological therapy. Furthermore, despite considerable effort to develop evidence-based guidelines for common mental health problems this does not necessarily result in better services.

There was little evidence of the co-ordination and integration between guideline development, implementation and primary care team education that is required to achieve changes in clinical practice.

Regarding the level of service provision for different population groups, the postal questionnaire did not provide conclusive results about poorly served groups. However, the groups for which the majority of responding GPs raised concerns were asylum seekers, homeless people and people with addictions. These groups are particularly vulnerable to mental health problems, and there is scope to combine physical and mental health assessments in primary care settings.

Recommendations

- Current work on referral guidelines for GP counselling should be integrated with similar work on other psychological therapies to improve the appropriateness of referrals to all therapies.

- Work to develop local guidelines should be focused on two or three key areas – ideally for which there should be evidence of high local morbidity and local GP interest. This

should be closely integrated with work to implement and monitor the guidelines and with related education, training and service developments.

- Each PCT should consider the extent to which their local population contains groups that are vulnerable to mental health problems and should establish whether primary care providers can identify and manage the physical and psychological needs (or refer to appropriate services) those at risk.

Improving clinical care

The study identified limited educational activity to improve the clinical knowledge and skills of primary care clinicians in relation to mental health. The need to co-ordinate and integrate different strands of development work (see above) is also relevant here. The forthcoming cadre of primary care mental health workers will have an important role to play in such work.

Recommendations

- Education and training should be integrated with other related PCT work streams in order to maximise the likelihood of changing clinical practice.

- Attention should be paid to identifying clear roles for the forthcoming cadre of primary care mental health workers. Their potential contribution to developing clinical skills in primary care team members and implementing local development initiatives at practice level should be harnessed wherever possible.

- Where local capacity allows, efforts should be made to develop primary care involvement in the shared care of people with severe mental health problems.

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Acknowledgements

Particular thanks are due to Suji Ramakrishnan, who provided extensive administrative support for this project and also helped with the telephone survey. Thanks also to Angela Greatley, Janice Robinson and Steve Gillam, who provided advice and helpful comments on the project design and early drafts of the questionnaire and interview schedule.

We are extremely grateful to the many GPs and primary care staff across London who took time out of their busy lives to complete the postal survey and to the mental health leads in London primary care trusts who participated in the telephone survey.

