This report was developed in conjunction with and funded by the Pharmaceutical Schizophrenia Initiative whose members are: AstraZeneca, Bristol-Myers Squibb, Lilly and Janssen Cilag. The views expressed in this report are not necessarily those of the individual PSI member companies.
Executive Summary

Primary Concerns: A consensus paper on primary care mental health care by the Mental Health Foundation and the Pharmaceutical Schizophrenia Initiative

Despite recent developments in primary care, including the nGMS contract and the introduction of Practice Based Commissioning, mental health is in danger of being left behind as opportunities to improve primary mental health care have not been fully grasped.

The Mental Health Foundation and the Pharmaceutical Schizophrenia Initiative held an event in 2006 which identified six key areas which need to be addressed to ensure primary care mental health services not only keep pace with the wider agenda, but also offer the accessible, inclusive services which people experiencing mental health problems need and want.

1. Practice Based Commissioning for Mental Health

There is no national tariff system for mental health, and this causes problems in providing the range of services required to allow the choice in treatment which people need. GPs and other primary care staff are not yet adequately trained to carry out the commissioning role expected of them.

2. Age and mental health

Primary care services must be age-inclusive, and must specifically cater better for the mental health needs of younger and older people.

3. Physical and mental health

People with mental health problems should receive the same level of treatment for their physical health needs as others, but this is often not their experience currently. Practice Based Commissioning and the NGMS contract offer opportunities to redress this inequality.

4. Primary care workforce

Education and training for provision of mental health services in primary care is lagging behind the pressure on staff to provide increasing levels of support in primary care. Enhanced mental health education and training is needed for all primary care staff including GPs, practice nurses, administrative staff and counsellors.

5. Health promotion and community involvement in PBC

Health promotion and illness prevention need to be included in the commissioning agenda. Governance arrangements should be developed to support Practice Based Commissioning to ensure that communities are fully involved in the process.
6. Choice in primary care mental health

Both the nGMS contract and Practice Based Commissioning can enhance real choice, and this opportunity should not be missed. The primary care Personal Medical Services contract could also be used to develop flexible, imaginative and innovative services.

The ways in which each of these areas could contribute to a better, more person-centred primary care service for people experiencing mental health problems are explored in the following paper.

Workshop Participants:

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Prof David Taylor – Chair, Camden/Islington Mental Health Trust
The policy agenda for primary care is changing rapidly, fuelled by the recent White Paper *Our Health, our care, our say*, and the earlier nGMS contract and its review in April 2005. Practice Based Commissioning (PBC) appears as a continuous theme in the White Paper and is intended as a driver for service re-design and the movement of patients (and hence resources) from hospital into the community.

Despite these developments mental health is not always well served within the primary care agenda, and opportunities to improve primary mental health care have not been fully grasped.

In 2006 the Mental Health Foundation and Pharmaceutical Schizophrenia Initiative (PSI) jointly sponsored a Round Table discussion on primary care mental health. Key initiatives were identified which could improve the care currently being provided for people with all types of mental health problems. This paper explores potential solutions for a productive way forward in relation to the following key themes:

1. Practice Based Commissioning for mental health
2. Age and mental health
3. Physical and mental health
4. Primary care workforce
5. Health promotion and community involvement in PBC
6. Choice in primary care mental health

**INTRODUCTION**
1. PRACTICE BASED COMMISSIONING

Practice Based Commissioning (PBC) was announced by the government in 2004 and is currently being implemented throughout the NHS. It enables primary care practices to develop innovative care pathways and save money by directly providing certain hospital services rather than using (and paying for) secondary care services. Practices can also be innovative by designing patient centred care models. Any savings practices make by providing services at a lower cost than the nationally agreed ‘tariff’ price charged by hospitals can be reinvested to provide additional primary care services for their own patients.

While PBC offers several opportunities to institute change in care pathways, in mental health, there are limitations which need to be addressed.

• There is no national tariff for any form of mental health service. This means a primary care practice cannot save money by providing a mental health service more cheaply than the local hospital. There is therefore little incentive for primary care practices to provide their own mental health services. Without a tariff system, mental health services will lag behind the rest of the NHS and the opportunities which PBC provides will not be exploited.

The development of a national tariff for mental health which accommodates the complexity of mental health service provision is therefore a priority.

• PBC will require a change in focus on the part of GPs. They will need to move from considering the needs of the individual to creating a balance between the needs of the individual and those of the practice population. Currently GP training is centred on the needs of the individual rather than on what is needed for the whole community.

The training agenda for GPs needs to reflect the new tasks associated with PBC.

• Mental health care does not just relate to which medication is prescribed or how quickly patients are referred, but also to effective day services, support in the community, support to gain or remain in employment etc. These are vital but there is no current arrangement as to how PBC can commission a joint health and social care package. The commitment to deliver on this is made explicit in the White Paper, and the introduction of individualised budgets make this a more feasible process, but we are still some years away from being able to do this effectively.

The White Paper commitment to develop joint commissioning by practices needs to be implemented rapidly.

• There is little opportunity for service users, carers or the voluntary sector to influence PBC commissioning plans, which are currently agreed by a PCT professional executive committee. PCTs need to support practices to commission innovative services, for example joint services with sexual health clinics in a local youth café, or accessible non-stigmatising mental health support and advice within local prisons. PBC in its current format will probably not enable staff to make the connections and invest the time in this sort of innovative development.

A governance structure is needed to:

• Address the needs of the population, using a transparent process to ensure that representatives of the whole community are involved in the commissioning process.

• Allow the development of innovative and imaginative projects to improve access to services.

• Allow access to public health data and public health consultants for practices undertaking PBC to meet the needs of the population as well as those of the individual.
2. AGE AND MENTAL HEALTH IN PRIMARY CARE

The provision of primary care services for older people and for children and young people with mental health problems are more problematic than for people of working age. In both cases, problems relate to access to services, the quality and quantity of services, and appropriateness of the way services are delivered.

Older people

Older people use health services more than other groups. However the organisational division between mental health services for adults of working age and older people has resulted in the development of an inequitable system. Out-of-hours services and crisis management for older people, for example, are not as well developed as those for adults of working age. All aspects of mental health services for older people need to improve including:

• person-centred care
• age equality in access to services
• treating people with dignity and respect
• holistic care in mainstream services
• a whole systems approach to the commissioning of integrated mental health services for older people

Good progress has been made in some areas but a number of the National Service Framework (NSF) for Older People standards have not yet been met. In addition, access to medication is not equitable. For example, older people with schizophrenia are less likely to receive newer atypical antipsychotic medication. Action should be taken to address this, including implementing the Department of Health’s recently published Older People Mental Health Service Development Guide.

A further area of concern is that the Improving Access to Psychological Therapies Programme focuses exclusively on adults of working age. This fails to acknowledge the contribution older adults make to communities, and economic analyses should include this when examining the cost-effectiveness of this type of intervention. Failure to include older adults in this programme is unethical and discriminatory.

The recent introduction into the nGMS Quality Outcomes Framework (QOF) of a clinical domain for dementia will begin to raise the awareness of this condition and how it can best be managed.
Young people

Early detection and consequent treatment improves long-term outcomes for people with mental health problems, but several factors combine to make this challenging in young people.

Young people are the group least likely to attend their GP for a variety of reasons; they may be attending college and living away from home, they may find it difficult to relate to doctors, they may not believe that the doctor could understand the symptoms and problems associated with adolescence, and the surgery environment may not be perceived as conducive to talking about emotional issues.

Often the mental health of young people is mixed up with other health concerns, such as sexual health, criminal justice and substance misuse, which make the situation even more complex. A number of PCTs are experimenting, with some success, by setting up centres aimed at this age group, where health education and appropriate treatment can be provided in a more culturally sensitive and less stigmatising environment.

Recommendations for future policy development

nGMS does not currently promote age-inclusive services. However, the structure of the nGMS contract can evolve and change. We recommend the development of a new domain within the contract to reflect other aspects of the GP’s role, such as joint commissioning across social care, and compliance with National Service Frameworks and NICE guidelines. PBC could be used to commission an age-inclusive service by:

- PCTs monitoring commissioning plans to ensure that the NSF for Older People is implemented effectively
- Establishing appropriate governance processes, which include the public and service users, within each PCT to ensure that targets and standards are being met
- Ensuring that disadvantaged groups actively benefit from the potential advantages offered by PBC
- Developing systems which deliver improved primary care access for young people

It may be appropriate to establish pilots to investigate how PBC can be used to develop different models for delivering age-inclusive mental health services. Potential pilots could include:

- Ensuring that the provision of out-of-hours services for older people is comparable to those for people of working age. The pilot could test whether the extra resource to fund this is balanced by the savings in emergency admissions and length of stay.
- An integrated intermediate care team for older people could potentially make significant gains in preventing admission, reducing length of stay, and hence saving resource.
- Services for young people could include involving school nurses in education about mental health promotion, or links between the criminal justice system, substance misuse services and accessible mental health care.
The relationships between mental and physical ill-health are well known. Primary care practices are now incentivised to identify patients with depression who also have diabetes or ischemic heart disease. There is also an evidence base for a link between mental ill health and people with chronic pain, people who have experienced stroke, and people using palliative care. There is some evidence to show that improving the mental health of people with long term physical conditions reduces the use of health resources.

People with severe and enduring mental health problems have worse physical health outcomes, and are less likely to remain in employment than other groups. Health and social care services are only now beginning to address these issues. PCTs are responsible for the health of their entire population, and should address this area of health inequality as a matter of priority.

Bringing these disparate sets of evidence into a single programme that will benefit those who have complex needs, lies at the heart of a desire to deliver “whole person” care.

Current Policy Implementation:

Little policy exists to address the needs of people who fall into the groups described above. The specific QOF indicator for mental health now demands a review every 15 months, including routine health promotion and prevention advice, but this only applies to those with a diagnosis of schizophrenia, bipolar disorder or other psychoses. No such elements are included in the indicators for dementia or depression.

Whilst the QOF makes some progress towards improvement, there remain some areas that have not been addressed. Specifically:

- It fails to specify the physical health outcomes that could be assessed, such as screening for diabetes, respiratory conditions, and ischaemic heart disease. All of these are currently QOF clinical domains, and setting up a cross analysis (in the same way that has been done for depression) would be relatively simple.

- It fails to assess specific physical health promotion activities offered to this group, such as obesity (relevant considering the potential side effects of atypical antipsychotic medication and the sedentary life styles of people with severe mental illness) and smoking status. Again, both of these are measured as specific QOF domains elsewhere.

Routes which might allow the link between mental and physical ill health to be implemented effectively need consideration. PBC could also be an effective way to manage the redesign of the service for those who are frequently referred to hospital, but have medically unexplained symptoms.
One possible route forward is the development of management plans for the relatively small number of people who have been referred several times, have no identified physical cause for their symptoms, and have scored positively on a validated screening questionnaire for somatisation. Two interventions are recommended:

- referral to an experienced therapist and CBT as appropriate
- regular GP consultations to monitor and provide reassurance that physical symptoms are being taken seriously, with appropriate referral

The resource to provide extra talking therapy services for those identified, could in the long term, be funded by the reduction in use of other services from which these patients/users are diverted.

Recommendations for future policy development

- People with mental health problems should receive the same level of treatment for their physical health needs as others. The quality of this care should be assessed and recorded as part of the QOF.
- The findings of the Disability Rights Commission’s “Equal Treatment” Formal Inquiry into health inequalities experienced by people with mental health problems should be considered and action taken to address this issue.
- PCTs, in partnership with the local authority, should be required to run equity audits that actively look for variation in health outcomes. This should form part of the Local Area Agreement.
Primary care workers are being asked to undertake an increasing number of mental health care roles, including both the provision and commissioning of services. However, training programmes do not yet reflect this changing agenda. The Royal College of General Practitioners (RCGP) Position Statement on Mental Health and Primary Care recommends that the training and educational needs of all primary care clinicians regarding mental health are met.

Current arrangements for training and education for primary care staff as providers of care

Undergraduate training for doctors includes a mandatory psychiatry element, and undergraduate nurses likewise, receive some training in this clinical area. The RCGP curriculum for mental health makes no mention of continuing training or development. The current appraisal system for qualified and practicing GPs does not require them to demonstrate specific skills in managing mental illness, nor risk assessment. Currently the only mandatory clinical skill for all GPs to demonstrate is resuscitation skills.

There is no national support for the development of practitioners with a special interest in mental health, despite several years of lobbying. Workforce development directorates have consistently failed to invest in this training. There is no defined set of knowledge, skills, attitudes or competencies that are required of practice staff, nurses, community nursing staff or administrative staff, although NIMHE is developing some of these data sets. Only 2% of practice nurses have received any mental health training.

Counsellors that work in primary care will, following the White Paper Our Health Our Care Our Say, be required to register on a list of providers. However it is not yet clear what qualifications will be required to allow a counsellor to be officially registered or how this will be regulated.

Graduate mental health workers in some areas of the country have been successful, whilst in others the funds have been diverted to other clinical areas. Nationally, only 600 of the 1000 target are in place. Training programmes have been successful in some areas of the country, where they have been based in a primary care setting.

Education and training for provision of mental health services in primary care is lagging behind the pressure on staff to provide increasing levels of care for increasingly complex patients in primary care.

Recommendations for future policy development

General Practitioners

- The mental health curriculum for training GPs should be reviewed with consultation with service users.

- The MRCGP examination should contain sufficient questions on mental health issues to adequately test the knowledge of aspiring GPs, including one question on suicidal risk assessment.

- Appraisal of GPs should ensure that the learning programme agreed by the peer review process includes aspects of mental health management and identification.

- In line with the requirement that every GP updates his/her resuscitation skills every three years, a GP should be required to update his/her skills in suicide risk assessment every three years.
Practitioners with a Special Interest (PwSI):

- Workforce development directorates should undertake to fund and commission appropriate training courses to develop these new roles.

- A development programme to review the skills knowledge and competencies of PwSI is needed to ensure that it fits with the changing provision of services.

Practice administrative and nursing staff

- Practice nurses and nurse practitioner training should include a compulsory module on mental health.
- Administrative staff, as part of their continuing training should learn about how to manage distressed people, including those experiencing mental health problems. Providing appropriate training for reception staff was also highlighted in the RCGP report.
- NIMHE should continue to develop the competency framework for primary care staff, and to ensure it is both accessible and practical.

Counsellors

- A formal registration scheme is needed which will ensure appropriate skill levels and regulation.
- Employment of counsellors should only be allowed if they are appropriately registered and receive regular supervision.

Current training for primary care staff as commissioners of care:

The other major new role for GPs and practice staff is the commissioning of care. There is no current requirement for commissioners (practice based or PCT based) to be able to demonstrate the competencies, skills and knowledge required to commission effectively. It seems extraordinary that billions of pounds of NHS resource are being spent by people who are not trained in any way to ensure the most effective outcome for the resources utilised and more importantly for the user of the service.

GPs are trained to understand the relationships and problems that occur in individuals – that is the essence of general practice. Public health medicine is about understanding the relationships and problems that occur in population groups. For GPs to be able to commission for a population group, rather than for individuals, much greater attention needs to be given to the public health agenda in their training and development.

Recommendations for future policy development

- All commissioners of health care services, including mental health services, need to demonstrate that they are “fit for purpose”; either through a recognised commissioning qualification or a period of practical training and experience.
- GP training should contain a specific module on practice based commissioning, including understanding the public health agenda.
- As PBC develops and other primary care professionals take on this task, they too should be able to demonstrate the skills and competencies needed to commission mental health services effectively.
5. HEALTH PROMOTION AND COMMUNITY INVOLVEMENT IN PBC

Health promotion and illness prevention needs to be included in the commissioning agenda, and this will be more effectively achieved if a wide range of community stakeholders are involved in the process.

For PBC to be effective at addressing the needs of vulnerable groups, it is likely that skills associated with community development will be needed, including working in partnership and allowing the lead to come from social care organisations or the voluntary sector. Most GPs are unlikely to have gained this experience through their clinical career and are likely to need support in order to develop these skills.

Local Area Agreements exist on a much wider population base than most PBC clusters, usually covering the area of one or more local authorities. These focus on several goals across a range of services and can relate to either national or local priorities. It may be useful for PCTs to adopt a similar structure for implementing practice based commissioning for mental health.
6. CHOICE

Although widely used, the term choice often has limited meaning in primary care mental health. However, involving patients in decision making can improve outcomes, and offering patients a choice of intervention increases patient satisfaction. These aspects of patient choice should be incentivised to increase uptake.

The current nGMS contract incentivises the use of the Choose and Book system for referrals to acute care, where the emphasis is on the patient choosing a convenient out-patient appointment. Choice of the type of intervention offered for a mental health condition is a much more significant advance in quality of care than choosing the time of an out patient appointment, and this is not supported by current systems. As stated in the IPPR report, A Good Choice for Mental Health’, people have the right to choose their treatment. The key to making that choice is having the right information and patients should receive details on different treatment options, such as medication and its side effects.

Choice of service

Unlike physical health services, an inequitable situation exists where mental health service users must use the NHS service to which they are allocated, regardless of their preferences. Mental Health Trusts do not publish the comparative outcomes of different Community Mental Health Teams (CMHT) or inpatient units, and they have no incentive to do so whilst this lack of patient choice remains.

Part of this deficiency reflects that contestability, the internal market, and national tariffs have yet to be applied to mental health trusts. Although ways to introduce Payment by Results (PbR) in mental health trusts are being sought, this work is far from ready for implementation, and it is unclear if it will be possible at all. It also reflects the lack of consensus on the definition of a successful outcome in mental health treatment.

This situation, where acute trusts are establishing systems based on PbR, leaving mental health trusts behind in an outmoded system still based on block contracts, needs to be addressed. If PbR is not suitable for mental health, a system where choice can be facilitated, making full use of the outcomes which service users themselves define as being successful, should be developed as a matter of urgency.

Alternative options for provision

Currently, there is no incentive for CMHTs to prevent admission to hospital other than bed availability. The flexibilities of nGMS offer an alternative route through the development of Personal Medical Services (PMS) contracts. Specialist PMS contracts only deliver one aspect of care and patients do not need to be registered with that team or practice to receive that care. For example, community nursing teams can have a budget to provide care for patients registered with a general practice, and can choose how to use that resource to deliver the most appropriate care. This allows flexibility, imagination and innovation in a similar way to PBC.

Applying the principle of specialist PMS, a CMHT’s budget could be used to purchase care and community support as an alternative to admission to hospital. The costs associated with admission are greater than community based care, which provides an incentive for change in the behaviour of the CMHT.

Recommendations for future policy development

• Further reviews of the nGMS contract should consider how practices can be incentivised to demonstrate real ‘choice’
• CMHTs should consider developing specialist PMS pilots so that alternatives to hospital admission are encouraged.
CONCLUSION

Mental health care has undergone many changes; whilst much of this is welcomed, many challenges lie ahead. The introduction of PBC and nGMS provide an opportunity to tackle many of these challenges if service development and redesign can be accommodated.

Two key factors underpin the initiatives recommended in this document:

- placing the service user at the centre of mental health care
- taking a holistic approach towards managing their overall well-being.

Doing this will ensure that the right services and resources are in the right place at the right time and meet the expectations we all have for improved primary mental health care.
1. **Practice Based Commissioning for Mental Health**

- The lack of a national tariff for mental health services needs to be addressed. Solutions which accommodate the complexity of mental health services and still facilitate choice are needed as a matter of priority.

- The training agenda for GPs must be changed to reflect the new tasks they are expected to undertake in practice based commissioning.

- The White Paper commitment to developing joint commissioning by primary care practices must be rapidly implemented.

- Governance structures for PBC must be developed to ensure that the needs of the population as a whole are addressed and that both public and voluntary sectors are involved in the commissioning process.

2. **Age and mental health**

- Commissioning plans must be monitored by the PCT to ensure that the NSF for Older People is implemented effectively.

- Appropriate governance processes, which include the public and service users, need to be established within each PCT to ensure that targets and standards are being met.

- Systems need to be developed which deliver improved primary care access for young people.

- Practice Based Commissioners must ensure that disadvantaged groups actively benefit from the potential advantages offered by PBC.

3. **Physical and mental health**

- The opportunities that PBC offers to redesign services and take a more holistic approach to health care are clearly significant, and need further investigation and development.

- People with mental health problems should receive the same level of treatment for their physical health needs as others. The quality of this care should be assessed and recorded as part of the QOF.

- The findings of the Disability Rights Commission’s “Equal Treatment” Formal Inquiry into health inequalities experienced by people with mental health problems should be considered and action taken to address this issue.

- PCTs should be required to run equity audits that actively look for variation in health outcomes. This should be in partnership with the local authority, and be a required function of Local Area Agreements, so that outcomes are considered across the health and social care horizon.
4. Primary care workforce

- Education and training for provision of mental health services in primary care is lagging behind the pressure on staff to provide increasing levels of care for increasingly complex patients in primary care. Enhanced mental health education and training is needed for all primary care staff including GPs, practice nurses, administrative staff and counsellors.

- GP training should be enhanced to include skills training in effective commissioning skills. Strategies to address this should include a recognised commissioning qualification and post-graduate training.

5. Health promotion and community involvement in PBC

- The governance arrangements that need to be developed to support PBC should ensure that health promotion and illness prevention are included in the commissioning agenda.

- To promote community involvement, it would be appropriate to consider a similar structure to a Local Area Agreement.

6. Choice in primary care mental health

- Further reviews of the nGMS contract should consider how practices can be incentivised to demonstrate real "choice".

- Community Mental Health Trusts should also consider developing specialist PMS pilots so that alternatives to hospital admission are encouraged. This allows flexibility, imagination and innovation in a similar way to PBC.
Primary Concerns: a better deal for mental health in primary care

REFERENCES


2 Further information about nGMS is available on the NHS Employers website at: www.nhsemployers.org/primary/primary-886.cfm.

3 Information about Practice Based Commissioning, the National Service Frameworks for Mental Health and for Older People and other government documents can be found on the Department of Health website at www.dh.gov.uk


About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy, and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by services users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and to promote mental well-being.

We also work to influence policy, including Government at the highest levels. And we use our knowledge to raise awareness and to help tackle the stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. To support our work, please visit our website or call our fundraising team on 020 7803 1121.

If you would like to find out more about our work, please contact us.

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