

Development and policy

Rediscovering primary care mental health: experience from Waltham Forest in East London

Shahid Dadabhoy

to come

Christa Drennan

to come

Nick McNulty

to come

Introduction

The great 'undiscovered country' of health in our mind has been primary care mental health (PCMH). Twenty five per cent of routine general practitioner (GP) appointments are for people with a mental health problem, and around 90% of mental health-care is provided solely by primary care.¹ The range of clinical material presenting to GPs is quite wide, from mild affective disorders to profound psychosis. The fact that we frequently look after not just the individuals but their families and their social context, often over significant periods of their lifespan makes mental health problems complex, multi-factorial and enduring. Yet those working in primary care receive scant recognition for their efforts.

This represents a rather personal account of my involvement in major mental health redesign and restructuring work within Waltham Forest Primary Care Trust (WFPCT) in East London. Our major partners are North East London Mental Health Trust (NELMHT) and the London Borough of Waltham Forest (LBWF).

Our perspectives are those of a clinical lead for mental health and those of two mental health managers for WFPCT working with a close-knit, hardworking and dedicated team of enthusiasts and allies who span WFPCT, NELMHT, LBWF and many other key stakeholders. We hope that this article approaches a fitting tribute for over two years of ongoing work.

The challenges

National issues

In England mental health services have been undergoing quite seismic changes over the last few years, with a growing body of evidence as to best practice emerging from the Department of Health (DOH), Social Exclusion Unit (SEU), National Institute for Clinical Excellence (NICE) and National Institute for Mental Health in England (NIMHE). Some readers of this journal will undoubtedly be familiar with these themes. These include:

- *patient choice*: a greater emphasis of more personalised, individual and bespoke care²
- *self care* including the Expert Patient Programme (EPP): a drive towards empowering patients to take control of their own care, mutually supported by a clinical team³
- *black and minority ethnic (BME) service users*: this is encapsulated in the DOH report *Delivering Race Equality*⁴
- *social exclusion*: the SEU publication *Action on Mental Health* is a multiperspective attempt to promote inclusion for those suffering from mental health problems⁵
- *new workers in the mental health landscape*: examples include the new gateway and graduate workers
- *new roles for community pharmacies*: the DOH vision of pharmacies to be recognised as an integral part of patient self-care and medicines management⁶

- *practice based commissioning*: the possibility that practices and localities could commission services from a wider range of providers⁷
- *National Institute for Clinical Excellence (NICE) guidance*: this of course does not just include prescribed medication but also psychological interventions and self-help such as bibliotherapy⁸
- *the new GP contract (nGMS)*: offers possibilities for locally designed services matching need to be commissioned, in addition to the limited scope of the Serious Mental Illness register.

Local issues

In addition to these drivers at the National level, it is primarily at the local level that there are profound imperatives making modernisation mandatory. These can be roughly divided into two sets of factors, though these are hardly mutually exclusive.

Demographics and their effect on mental health need

Waltham Forest is an outer London borough with a population recorded at around 220 000 people with high levels of deprivation, high levels of ethnicity and significant numbers of refugees.⁹ The most recent public health report included a mental health needs assessment which included morbidity data.¹⁰ This is outlined in Table 1.

Waltham Forest needs are higher than the average for England, with deprivation and ethnicity impacting quite heavily on the figures. Some electoral wards in the southern parts of the borough are estimated to have almost twice the national rates of mental illness.

In addition, rates for admission with those diagnosed for schizophrenia are much higher than would be expected. Paradoxically, the corresponding rates for neurotic disorders are much lower. Overall inpatient bed numbers are higher than would be expected and the issue of dual mental health and

concurrent substance misuse are a growing challenge to existing services within Waltham Forest.

The inadequacy of current primary care mental health (PCMH) provision

In our opening paragraph of this article we demonstrated that there is a significant burden of mental health in primary care. What has been more alarming is the mismatch to resources. In 2004/2005 WFPCT and LBWF combined spent approximately £32.5 million on mental health, of which only a minuscule 1.3% was spent on PCMH.

Waltham Forest, also typically for this part of London, still has a large number of single-handed GP practices working with largely part-time practice staff, with limited access to personal development and education. This, in addition to the demographic challenges already mentioned, conspires to increase the burden upon PCMH.

Historically, in the mid 1990s, there was a massive disinvestment from PCMH to the extent that effectively no service provision or resources were left. It is rather ironic that the disinvestment resulted from inadequate management of the financial risks of rolling out 'care in the community'. Effectively GPs and the extended primary care team were abandoned to manage on their own. Prescribing became the mainstay of PCMH.

Some valuable support grew out of the voluntary sector organisations working within Waltham Forest. In addition WFPCT supported (with funding from SRB and the New Opportunities Fund) a 'healthy living' centre called the Community Health Project, aimed predominately at groups like refugees and including a counselling service and highly commended complementary therapies such as homeopathy. However, this service was funded only for the more deprived sections of the borough.

In response, tentative efforts were made by GP fundholding practices to commission their own brief generic counselling services. While initially

Table 1 Mental health needs in Waltham Forest

Condition	Number	% of adult population
Anxiety, depression, phobias and other common mental health problems	32 312	18.6
Psychotic illness e.g. schizophrenia	1161	0.7
Alcohol dependence	15 233	8.7
Dementia	2516	1.4

popular, the model utilised could not cope with the complexity of PCMH presentations. This became more apparent when fundholding ended and these legacy services were rolled out to all GP practices in WFPCT. Very quickly this provision became over-subscribed and unable to match demand, incurring long waiting times as well as clinical risk.

Concurrently, with these inadequacies in mind, many GPs, either out of frustration, ignorance or desperation, attempted to refer patients with unmet need into the secondary care services within NELMHT. Overwhelmed, as the interface between primary and secondary care became more strained, the response from the latter was to tighten criteria for referral. These quickly degenerated over time, so that referral across the interface became for GPs a fairly Kafkaesque process with hostility, anger and a pernicious lack of communication being a salient feature.

Others, largely from resident BME and refugee communities where mental health was highly laden with stigma and frequently translated into somatisation behaviour, started to populate secondary care services with physical health problems.

Despite this, many of the most complex patients with mental health problems who do not meet the eligibility criteria for secondary care, remain, by a lack of resources, inadequately managed by their own GPs.

Finally, while it was exceptionally difficult to access NELMHT, it was practically unheard of to be an ex-patient of the secondary care services, creating an ever burgeoning financial burden and increasingly marginalising and socially excluding those with mental health problems.

The situation had become unsustainable by 2004, leading to a financial gap of £900 000, most of it earmarked for secondary care.

The solution: primary care mental health, a stepped approach

Service redesign and redressing the mismatch has become a priority in the light of these national and local forces. The solution would have to be systemic and integrative. Fire-fighting and further duplication of services were not to be tolerated. In addition, the model hopes to at least acknowledge existing best practice and the wider determinants of mental health. In the rest of this article we will concentrate on the solutions and developments aimed at primary care.

Two core values were established through consultation with stakeholders:

- 1 services that support people to manage their own health and build upon their strengths and skills to make a full life (recovery)
- 2 services that are able to respond to individual needs within the context of their communities (culturally capable).

Box 1 summarises the four key elements of the 'stepped care' approach strategy. The essence of our model in WFPCT is to change the focus back to supporting and ultimately adequately resourcing primary care to:

- 1 rehabilitate mental health as a chronic disease like asthma or hypertension, to destigmatise it and prevent social exclusion
- 2 tap into the considerable expertise of primary care to provide a patient-centred, holistic, continuity of care approach encompassing the complex interplay of mental and physical health as well as addressing the socio-economic context of health problems
- 3 provide an empowering venue where supported self-help and empowerment for service users, carers and their families can flourish
- 4 proactively offer mental health promotion.

None of these four steps is intended to undermine, replace or supplant the work of GPs. Quite the contrary, the steps are intended to enhance GPs' role and support them. Neither are they intent on restricting access to secondary care. They are there to offer alternative treatment options and resources to rapidly, effectively and with clinical safety maintain patients in PCMH.

Box 1 The four levels of support in the 'stepped care' approach

- 1 Information and self-help
- 2 Assessment and brief intervention
- 3 Intermediate care
- 4 Chronic disease management: serious mental illness

Explanation of each step is necessary:

Step 1: information and self-help

This includes the distribution of assessment and referral guidelines, high-quality patient information leaflets, developing a resource centre with helplines promoting self-help and self-care, supporting self-help groups, developing an expert patient programme,

computerised cognitive behavioural therapy, bibliotherapy, and creating links in primary care to job retention services.

These comprehensive and varied services are all designed to empower people to help themselves and, by default, promote awareness of mental health issues. GP surgeries and other venues are to hold significant stocks of signposting material initially. There are significant opportunities to expand these already wide resources into several languages.

Step 2: assessment and brief intervention

The service provision is directed at people with common mental health issues. It involves a prompt (within a 1–2 week horizon) and comprehensive mental health assessment by highly qualified mental health professionals, followed by signposting and referral to appropriate services, including secondary care and the voluntary sectors.

Referral currently is prompted by the GP, but request forms are jointly filled in, allowing patients to prioritise their concerns. In addition referral forms record medical sickness certification issues and proactively police the impact of common mental health issues on employment. This step especially complements the clinical activity of GPs and is aimed at expanding treatment options, particularly ‘the talking cures’ to suit individual patients.

Step 3: intermediate care

With the support of the Sainsbury Centre for Mental Health, WFPCT is developing a pilot service for people with chronic complex mental health issues, compounded by physical illness and/or other issues (such housing, employment etc), and for whom a brief intervention is not appropriate, or indeed has failed to resolve their morbidity.

We feel there is considerable potential to address this group’s needs, as many of these people populate a range of health service resources, diminishing capacity while not providing any improvement to their wellbeing. Examples of the latter are as diverse as secondary care mental health services, but also include various chronic disease clinics in acute trusts.

This step is envisaged to be led by psychological therapies but will be backed up by a wide range of agencies spanning as many domains as the client needs. The plan is to get existing psychological therapy practitioners from both the NHS and independent sector organisations, who find such work

rewarding, to sign up to a ‘bank’ of sessions. Our other stakeholders particularly in employment have been very active and enthusiastic members of our development team. To achieve some form of recovery for even a small number of these patients would, we feel, make a significant impact on several parts of the health and social care micro-economy in Waltham Forest.

Step 4: Chronic disease management

This service supports the transfer of care of patients with stabilised serious mental illness to primary care, in partnership with specialist services. Our current estimates are that at least 25% of those receiving care within the NELMHT’s community mental health teams (CMHT) could do so, as or more effectively within primary care.

We envisage that a negotiated multipartite agreement between patients, their GPs, their current CMHT and other stakeholders would be essential. We plan to incorporate far more involvement from hitherto underutilised stakeholders such as the voluntary sector and community pharmacists, who are considerably strengthened by their evolving contract role.

There is a considerable need to bolster expertise ahead of this, particularly for GP practice staff. We see the role of the practice nurse being particularly important. Education and training specific to this role is planned to address this need.

GPs will be remunerated for this work through a nGMS locally enhanced service model. The current estimate rate is in the region of £200 per patient per annum.

The implementation process

As with most bright ideas the trick is in making it all work. We hope to highlight some of the activities undertaken so far. We apologise to those who may know infinitely more than us regarding this subject.

Mapping existing provision: ‘the undiscovered country’

Although painfully aware of the shortcomings, a large part of the initial work was indeed trying to map the current mental health landscape in Waltham Forest. Most of us found that we were rediscovering a whole range of services, competencies and skills

offered different practitioners, particularly within the voluntary sector, that we had been previously unaware of. Over the last few years, jointly with other stakeholders there had been the publication of a mental health directory listing services, their contact details and a brief description of what they did. It is our aspiration to continually update these and to have them available in electronic format both as a CD ROM and networked onto the WFPCT intranet.

Establishing commonality with stakeholders

One of the most difficult tasks has been to agree commonality with different stakeholders. The most important of these is to agree a common shared vision and values. We are particularly keen to encourage the same guidelines, policies and protocols being respected and agreed by all parties involved. The devil, as they say, is in the detail, and when it comes down to practicalities divergent views start to emerge. The consultative process is well underway from June 2005.

That being said, so far we have made a substantial amount of progress in Steps 1 to 3 with most stakeholders. This is largely because of the fact that there is little current provision, and effectively we are ploughing virgin soil. The response from stakeholders has been very encouraging.

Progress at Step 4 is currently dependent on our secondary care partner NELMHT which has larger internal re-organisation and cultural issues, and these may impact on our own service development. However a tentative target date of December 2005 has been set.

Finally, whilst we are aiming for a lifespan service, true to the ethos of primary care, development at the ends of the lifespan is proceeding at a far slower pace.

Timing

The redesign is still very much work in progress, but substantive services are already in place. What has been achieved so far?

Step 1 has been implemented fully by June 2005 and we have three graduate workers in place with responsibility to oversee this element. An evaluation is of course mandatory after a reasonable length of time since going 'live'.

Step 2 has been piloted in two GP practices in vastly different geographical and demographically areas of WFPCT for just under a year. It has proved popular with patients and GPs alike. Both are keen

on the rapidity of access, and GPs feel more confident about offering a more comprehensive service. Patients from BME populations like the service, particularly the option of possible complementary therapies. Step 2 is due to be rolled out to all GPs in WFPCT by October 2005, and recruitment is underway.

Similarly, Step 3 is also due to be online by October 2005. Current activity is mainly centred on building the 'bank' of sessional psychotherapists and strengthening the governance and personal development infrastructure.

Step 4 is likely to be delayed beyond our predicted December 2005 horizon. We are partly waiting for developments within NELMHT and sanction from organisations representing GPs. The rate-limiting step is likely to be the complex negotiations, assessments and infrastructure that will be needed ahead of implementation.

Conclusions

We feel that we in Waltham Forest have a sound model that addresses not only many national themes, but also local priorities. The model buttresses primary care to complement the work of hard-pressed GPs. It mainstreams and rehabilitates mental health into the wider community, acknowledging BME and refugee communities as well as others who by default have become socially excluded. The strategy is integrative, establishing linkages that we aspire to be clinically and managerially safe. We like to think that the patient experience will improve considerably by the intrinsic features of choice and bespoke treatment options.

We are always willing to learn whose ideas are better than ours. We therefore actively invite feedback and inquiries. Contact us through Heather Jordan, tel: +44 (0)208928 2411 or email: heather.jordan@wf-pct.nhs.uk.

REFERENCES

- 1 Department of Health. *National Service Framework for Mental Health* London: Department of Health, 1999, p. 29.
- 2 Department of Health. *NHS Improvement Plan: putting people at the heart of public services*. London: Department of Health, 2004.
- 3 Department of Health. *Self Care: a real choice*. London: Department of Health, 2005.
- 4 Department of Health. *Delivering Race Equality: a framework for action*. London: Department of Health, 2004.

- 5 Social Exclusion Unit (SEU). *Action on Mental Health*.
- 6 Department of Health. *Dawn of a New Era For Pharmacy*. (John Reid, press release, April 2005) www.dh.gov.uk (accessed 12 September 2005).
- 7 PCB
- 8 National Institute for Clinical Excellence (NICE)
- 9 Waltham Forest Primary Care Trust. *Waltham Forest Annual Public Health Report 2004-5*. London: Waltham Forest Primary Care Trust, 2005.
- 10 Datta P. *Mental Health Needs Assessment, Outer North East London*. ??????, 2004.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Received ??????

Accepted ????????