UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

Primary care for mental health for disadvantaged communities in London

Case summary

This example from the United Kingdom demonstrates how primary care can be used to provide an integrated health service for disadvantaged population groups. A primary care practice in east London developed an innovative way to include and mainstream disadvantaged populations, leading to improved holistic primary care for mental health and physical health needs, early identification of illness and comorbidity, reduced stigma, and social inclusion. A key feature of this best practice is the close link that it has developed with secondary level health and community services, as well as a range of organizations and services dealing with employment, housing and legal issues.

1. National context

The United Kingdom of Great Britain and Northern Ireland is a constitutional monarchy[1] made up of four constituent countries: England (84% of the population), Scotland (8%), Wales (5%) and Northern Ireland (3%).[2] Its population is mainly urban[3, 4] and growing slowly.[4, 5] The most striking demographic feature of the country is the increasing proportion of elderly people.[6] The official and main language used in the country is English.

The United Kingdom is the fifth-largest economy in the world and the second-largest in Europe.[7] Its main sectors of employment and revenue are services and industry.[8] Compared with similar European countries,[4] overall unemployment is low[9] but distribution of wealth is uneven.[10] An antipoverty strategy has led to relative improvements. In 2002–2003, the number of low-income households was lower than at any time during the 1990s, although it was still much higher than in the early 1980s.[4, 11] Since 2002, progress on poverty has stalled.[12] Disability is a major factor leading to poverty in the United Kingdom and, among the 2.2 million poor people who are sick or disabled, the largest category (almost half: nearly one million) are people with mental or behavioural disorders.[12] Additional information about the United Kingdom is provided in Table 2.35.

Table 2.35 United Kingdom: national context at a glance
Population: 60 million (90% urban) [a]
Annual population growth rate: 0.3% [a]
Fertility rate: 1.7 per woman[a]
Adult literacy rate: 99% [d]
Gross national income per capita: Purchasing Power Parity International $: 33 650 [e]
Population living on less than US$ 1 per day: data not available or not applicable [a]
World Bank income group: high-income economy [b]
Human Development Index: 0.946; rank 16/177 countries [c]

Sources:

[a] World Health Statistics 2007, World Health Organization (http://www.who.int/whosis/whostat2007/en/index.html, accessed 13 June 2008).

[b] Country groups. http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html, accessed 13 June 2008).

[c] The Human Development Index (HDI) is an indicator, developed by the United Nations Development Programme, combining three dimensions of development: a long and healthy life, knowledge, and a decent standard of living. See Statistics of the Human Development report. United Nations Development Programme (http://hdr.undp.org/en/statistics/, accessed 13 June 2008).

[d] CIA fact book, 2003 estimates (https://www.cia.gov/library/publications/the-world-factbook/print/uk.html, accessed 13 June 2008).

[e] World Bank, 2006. GNI per capita 2006, Atlas method and PPP (http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf, accessed 13 June 2008).

2. Health context

The United Kingdom's health context is summarized in Table 2.36.

People in the United Kingdom are living longer but have more years of unhealthy life, compared with similar European countries.[4]

Noncommunicable conditions cause 84% of all deaths in the United Kingdom. Cardiovascular diseases account for 37% of total deaths; cancer, 28%; and external causes (intentional and unintentional injuries), 4%. Ischaemic heart disease is the single most important killer, accounting for almost one out of every five deaths. The country's rate of premature death from the disease in people aged 25–64 is among the highest in comparable European countries.[4] The United Kingdom also has higher death rates from respiratory diseases and cancer (in particular, oesophageal cancer).[4]

Table 2.36 United Kingdom: health context at a glance
Life expectancy at birth: 77 years for males/81 years for females
Total expenditure on health per capita (International $, 2005): 2597
Total expenditure on health as a percentage of GDP (2005): 8.2%

Source: World Health Statistics 2008, World Health Organization.

The United Kingdom's National Health Service (NHS) is the country's publicly funded health care system, and celebrates its 60th anniversary in 2008.[13] It is a comprehensive health service that is available to the entire population, free-of-charge at the point of use.[1] Across the country, public funds represent 87% of total health expenditures.[14]

The Department of Health is responsible for setting policies and directions for the organization.[1] The United Kingdom has devolved responsibility for health care to its constituent countries since 1997.[15] This devolution is increasingly associated with reform taking quite different directions across the United Kingdom[4] and considerable differences exist now between the different NHS systems.[16]

One major characteristic of NHS England is the gate-keeping role of general practitioners for referral to specialists. Approximately 90% of patients' contacts with the NHS are with general practitioners, who provide 24-hour access.[1] Access to and sustainability of services in remote and rural areas are problematic, as most of the population is concentrated in urban areas and skilled health workers are in short supply.[4]

The NHS has gone through two major reforms in the United Kingdom in the last 20 years.

The 1991, reforms embodied in the *NHS and Community Care Act 1990* introduced an internal or quasi market, which separated the responsibility for purchasing (or commissioning) services from the responsibility for providing them.[1] Trusts were expected to compete for contracts from district health authorities and general practitioners for the provision of clinical services. By 1998, all acute hospitals, community health service providers, and ambulance services had acquired trust status.

With the election of a Labour government in 1997, priorities changed and a new reform of the health system was designed to shift emphasis away from market-based processes to planning, collaboration and partnership. This strategy was defined in the white paper *The New NHS: modern, dependable* (1997), supported by the Health Act 1999.[1] This reform abolished general practitioners' fund-holding and created larger groupings: Primary Care Groups, which later became Primary Care Trusts (PCTs),[1] and covered populations ranging from 50 000 to 250 000 people. PCTs were expected to work more closely with local government social services departments. Devolution continued in 2001 with the White Paper *Shifting the Balance of Power – Securing Delivery*[17], which transferred the bulk of prior health authority functions to PCTs and conferred more power and responsibilities to front line staff, working with both patients and the public, within the NHS.

Mental health

Mental disorders account for the largest share of the burden of disease in the United Kingdom.[4] Despite the fact that mental disorders are common, public awareness and knowledge is generally poor.[18]

The National Psychiatric Morbidity Surveys of Great Britain, published in 1995, showed an overall 1-week prevalence of neurotic disorder as high as 12.3% in males and 19.5% in females aged 16–64 years.[19] A very small proportion of the population (less than 1%) had a psychotic disorder such as schizophrenia. Social factors correlated with higher prevalence of

neurotic disorders included being single, unemployed, and living in an urban setting. Twelve-month prevalence of alcohol dependence was 47/1000 population, while drug dependence was 22/1000 population. Both were considerably more prevalent in men, particularly young men.

Alcohol consumption per person in the United Kingdom has been fairly constant over the last 20 years. Binge drinking is common, comprising about 40% of all drinking occasions for men and about 22% for women. Surveys in 1998 and 2002 found binge drinking among women to have increased from 8% to 10% of those surveyed, and from 24% to 28% of those aged 16–24 years. The number of deaths due to chronic liver cirrhosis, an indicator of excessive use of alcohol, is rising in the United Kingdom.[4]

Although there are still over 4000 deaths from suicide each year in England, the overall rate of suicide (and undetermined deaths) has fallen more than 12%.[18, 20] This trend has been recently confirmed among British and Welsh young men.[21]

The Mental Health National Service Framework[22] was published in September 1999, and included major reforms in mental health service provision. Since 2001, the Framework has been implemented by local teams, with the support of a national implementation team[18] and implementation guidelines.[23] It focuses on the mental health of working-age adults, and covers both health and social services.[18] It includes all aspects of health care, health promotion, assessment, diagnosis, treatment, rehabilitation and care, as well as support to caregivers.

The Framework encompasses primary and specialist care and the role of partner agencies through seven standards set in the following five areas:

- mental health promotion;
- primary care and access to services;
- effective services for people with severe mental disorders;
- caring about carers;
- suicide prevention.[22, 24]

3. Primary care and integration of mental health

Until the mid-1980s, primary care received little attention from NHS policy-makers. In the 1990s, following the introduction of a new contract that increased general practitioners' accountability to health authorities, primary care-based purchasing became a central element of the NHS.[1] Payments systems were transformed to offer incentives for improved performance and to encourage general practitioners to be responsive to patients' needs.[1]

PCTs are the main purchasers of health services. They plan the delivery of all primary health care and in many cases, community health services at local level.[25] Most services are commissioned from National Health Service Trusts, which provide both acute and specialist hospital-based care.[25] PCTs' choice of NHS Trusts, including mental health trusts, is driven by considerations of quality and cost-effectiveness.

Monitoring of services is conducted by the PCTs but the Strategic Health Authority has overall responsibility for assessing services provided.

The Mental Health National Service Framework and Quality and Outcomes Framework

Although primary care has been central to mental health improvement in the country for many years, the Mental Health National Service Framework[22] and the Quality Outcome Framework for primary care[26] have provided a particular impetus for improvement of mental health within primary care services.

The Mental Health National Service Framework has strengthened mental health services within general primary practice. As a result of Standard 2 (primary care and access to services),[22] service users presenting with a common mental health problem are assessed by their primary care team. Where feasible and appropriate, they are offered effective treatments within the primary care setting. If required, they are referred to specialist services for further assessment, treatment and care. Depending on the type of primary care practice, other standards of the Mental Health National Service Framework may also form an integral part of primary health services. For example, select practices provide mental health promotion (Standard 1), crisis anticipation (Standard 4), caring for carers (Standard 6), and suicide prevention programmes (Standard 7).

The Quality and Outcomes Framework was introduced in England in 2003 and was aimed specifically at general practitioners. Practices began to be rewarded for high-quality services for many long-term conditions, including mental disorders. Specific targets are set every two years, against which practices are benchmarked and rewarded.

The five indicators on which mental health services are assessed for quality are as follows:

- the practice can produce a register of people with severe long-term mental health problems who require and have agreed to receive regular follow-up;
- the percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of coordination arrangements with secondary care;
- the percentage of patients on lithium therapy with a record of lithium levels checked within the previous 6 months;
- the percentage of patients on lithium therapy with a record of serum creatinine and thyroid stimulating hormone in the preceding 15 months; and
- the percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months.

The Framework is updated regularly and supported by a Quality Management and Analysis System.[27]

4. Best practice

Local context

Waltham Forest PCT was established in 2003 to serve the north-east London Borough of Waltham Forest. It commissions health services for a population of 245 000. It is the 10th most

ethnically diverse PCT in London, with approximately 44% of its residents from a minority ethnic background. This figure rises to 65% for children of school age. The population is relatively young compared with the country's average. Over one third of residents are under 25 years, and approximately 35% are aged between 25 and 44 years.[28, 29]

The south of the borough contains some of the most deprived communities in England with ethnically diverse groups, high unemployment, childhood poverty, marked population growth, and rising rates of migration.[29]

The PCT has made good progress towards improving the health of its residents; however life expectancy is still lower than elsewhere in London and England. Cardiovascular disease causes more deaths in Waltham Forest than any other illness, followed by cancer.[29] Rates of tuberculosis, mental disorders, and other chronic conditions are higher than in other parts of England.[29]

The estimated number of people with a mental disorder in Waltham Forest is shown in Table 2.37.[29]

Table 2.37 Waltham Forest: estimated number of people with a mental disorder[29]

Depressive and anxiety disorders	32 312	18.6% of local population
Psychotic disorders	1 161	0.7% of local population
Dementia	2 516	1.4% of local population
Alcohol dependence	15 233	8.7% of local population

Needs are particularly high in the south of the borough, with some areas estimated to have nearly twice the average national rate of mental disorders. People with comorbid mental disorders and harmful substance use problems are of increasing concern for health and social services.[29]

In Waltham Forest, the model of care for people with mental health problems or disorders is guided by NHS England. Patients see a general practitioner, who either manages the problem or refers the patient to a specialist service in secondary or tertiary care.

Treatment and care for common mental disorders are generally conducted within general practices. The Waltham Forest PCT commissions the majority of hospital- and community-based services (over 70%) from one provider – the North East London Mental Health Trust.[29] Inpatient care is provided in four units across the borough, and links with a range of community-based services, including an assertive outreach team; a community rehabilitation team; a community drug and alcohol team; two community mental health teams; three units providing day services; an early intervention team; a psychotherapy clinic; a home treatment team; a personality disorders service; a psychiatric liaison team based at the acute trust; a primary care team; and cross-cultural services.

In addition, the PCT has smaller contracts with other mental health trusts, as well as private and voluntary services. Specialist commissioning, for example, for forensic and maternal-child mental health services, is conducted on behalf of the PCT by a specialist commissioning team, who procure specialized and tertiary services.

Overall, the primary care infrastructure has been moving from a high number of singlehanded practices to groups of larger practices; over the last three years, the number of practices has moved from 75 to around 50 practices.

Description of services offered

In Waltham Forest PCT, two practices have been contracted to provide an integrated primary health care service to vulnerable groups such as asylum seekers, refugees, and homeless people. They provide similar services; however the practice based in Walthamstow is presented in this example to illustrate the programme. The Walthamstow practice has 10 general practitioners (of whom two are trainees) and four practice nurses.

The overall service provides treatment and care to people with mild- to moderate- mental disorders, as well as to those with more complex mental and psychosocial needs. In particular, the service seeks to reach people not normally in contact with health services and people from minority ethnic groups.

This service offers a four-step approach to deliver holistic integrated services in primary care (see below).

During step I, general practices provide written and verbal information to patients about mental disorders as well as how to access more specialized mental health care services, housing, employment, and social services. Patients are also directed to local libraries with collections of written and video materials related to mental health issues. Further assistance, guidance and support are provided by an individual, usually a mental health service user, who has the specific responsibility of promoting self-help and social inclusion among patients.

During step II, the primary care practices undertake mental health and psychosocial assessments of their patients, sometimes using standardized screening and assessment instruments. Depending on the complexity of the problem, patients are either managed in the practice or are referred to appropriate secondary-level and community-based services within the PCT. Psychological therapies, including cognitive-behavioural therapy, are provided within the general practice by a counsellor; however depending on the degree to which long-term counselling is required, patients are sometimes referred to more specialized services outside the practice.

In relation to step III, patients are referred to organizations or institutions that can assist them with economic and social problems. This support is crucial in ensuring that people are able to manage employment, housing, and family issues, thus preventing further isolation and possible deterioration of their mental health.

Step IV relates to people who previously have been acutely ill, but are now stable. These patients are meant to receive holistic mental and physical health care within the primary care setting, while at the same time reducing the load on secondary level services. However to date, this step has not been well-implemented in this practice.

In addition to treatment and support of people with mental disorders, the practice also attempts to promote good mental health through its approach to health care in general. For example, the practice communicates carefully with migrants and people who do not speak English, and

offers telephone interpretation services to all in need. Similarly, practitioners strive to remain non-judgemental and to assist all vulnerable groups, including homeless people. They also attend to the cultural background of each patient and interact in an appropriate and acceptable manner. The practice hence not only specializes in managing people with mental disorders, but also promotes the mental health of all its patients.

The process of integration

In 2001, the Waltham Forest PCT recognized that, due to the disadvantaged nature of patients from the area, there was a higher prevalence of a number of health problems, including mental disorders, compared with other areas. They also recognized that these groups had more difficulty accessing health services.

In response, the PCT established in 2003 a directly-managed general practice aimed at addressing the needs of marginalized communities, including hard-to-reach groups such as refugees, asylum seekers, and the homeless.

This service, although initially popular with patients, was later closed because of concerns that it was increasing stigmatization and inhibiting social inclusion. The PCT decided that the best way forward was to fully integrate vulnerable groups into general primary care services. Following consultation, the PCT advertised the patient list to general practitioners, after which two practices came forward to fulfil this role.

To ensure that the practices were able to continue to deliver high-quality care to their existing patients, while also addressing the needs of the new patients, many of whom had complex needs, contracts for an Enhanced Service were formulated. An additional payment was made to these practices, to reflect the greater workload associated with the patient list, and to enable them to offer an appropriate level of service for this disadvantaged group.

After receiving the contract from the PCT, the practice invited all patients for a full health check at a clinic run by the practice nurse. Patients were sent and asked to complete two questionnaires: the Patient Health Questionnaire (PHQ9) and the Hospital Anxiety and Depression (HAD) scale prior to their first appointment. During the clinic session, the practice nurse took a psychosocial history (covering housing, employment, social and legal issues) and conducted a full physical examination. Based on the results of the assessment, a comprehensive medical treatment and psychosocial care plan was devised for each patient. Treatment, counselling and referrals were made as indicated, and planned follow-up appointments were organized. Patients were also provided with practical assistance. For example, it was recognized that "referral" means more than telling a patient where to go; when dealing with vulnerable groups, it was often necessary to write or telephone agencies on behalf of patients, organize appointments, and provide directions and public transport information on how to get to the referral centre.

One of the key aspects of the practice, enabled by the negotiated contract with the PCT, was that longer appointment times could be offered compared with mainstream general practice. This allowed more time to work with patients on some of the important psychosocial issues described above.

Support from other levels of the health system

The practice has established linkages with community mental health teams, hospitals, acute psychiatric services, local pharmacies, social care advisers, legal services, the voluntary sector, service user groups, and community groups. It interacts with each group on a regular basis to ensure that a seamless service is offered to patients. For example, quarterly meetings are held with psychiatrists who provide secondary-level services. Patients are discussed and joint action plans are developed. Regular meetings are also held with service user groups. These are usually two-way information sharing sessions. Professionals from the service provide information around self-care and treatment options, while service users can explain their needs so that health professionals can respond to their requirements.

Human resource development for mental health

To work effectively in this primary care practice, knowledge and skills are required for the identification and management of mental disorders, as well as for working with different vulnerable populations.

Three of the ten practitioners already had specialized training in psychiatry. One of the four practice nurses was provided with special mental health training, focusing on culture and issues of concern to the main vulnerable groups reached by the clinic.

All practitioners are encouraged to continuously improve their mental health skills. The primary care practice holds in-service training and case presentations on a weekly basis, which provide an important learning experience for all practice staff. Cultural competency, including the cultural presentation of physical and mental health problems, has been a specific area of focus for in-service training. In addition, training has dealt with how patients' ethnicity and religion can affect consultations. Practitioners are also encouraged to improve their mental health skills through professional development courses, which are offered on an ongoing basis in England.

5. Evaluation/outcomes

This project has demonstrated that, with appropriate support, disenfranchised population groups can be managed within primary health care. Since its establishment, the majority of the programme's patients with a mental disorder have been treated in primary care. The number of patients with a severe mental disorder recorded on patient registers has increased, with the suggestion of increased active management of these patients by the general practitioners.[29]

At the end of the project's first year, the practice submitted a report that outlined progress and described future plans. A monitoring visit was undertaken by PCT staff and a local ethnic minority community group representative, during which the report was discussed in greater detail. The visit revealed the genuine commitment of the practice to the programme. An audit showed that the population of refugees and asylum seekers voluntarily coming to register for medical care had increased. At the outset of the project, the practice had a total of 150 patients registered as vulnerable; currently, it has a total of 215 people in this category.

The practice also demonstrated that it was successful in reaching those in need of mental health services. Among programme patients, there was a 5.9% prevalence of severe mental disorders,

compared with 0.9% in the rest of the practice population, 0.8% in the East London area, and 0.9% for the London area.[26] Most patients are treated within the practice or referred to other services within the PCT.[29, 30]

The practice also showed significant progress in assisting patients with psychosocial rehabilitation.[29] Within a 12-month period, for example:

- The practice referred 3761 patients for assessment and brief intervention, and 105 patients for intermediate therapy.
- 327 patients were placed in capital volunteering projects, and 54% of these were from minority ethnic backgrounds. As well as providing volunteering opportunities and work experience for people with mental disorders, the scheme also encouraged participation of the wider community, thereby improving community members' understanding of mental disorders and reducing stigma.
- A mental health service directory was provided to patients to facilitate access to specialized services. One thousand hard copies and 100 CDs were produced, and the information was also made available on the Waltham Forest PCT website.
- 117 patients participated in a computerized cognitive-behavioural therapy course.
- 40 patients participated in a course entitled "staying well for service users".
- 80 caregivers participated in a course entitled "staying well for carers".
- 40 people participated in a course entitled "staying well for people in work".
- Nine mental health support groups were conducted, including groups for people hearing voices, people with bipolar disorder, work preparation, self-management, and groups focusing on women's and men's issues.
- 74 patients were accommodated in a job retention programme.
- 180 patients were provided with guided self-help interventions.

6. Conclusion

This example shows that it is possible to integrate disadvantaged and marginalized patients into mainstream primary health care while respecting their diversity. Patients are helped within a broad-based biopsychosocial framework, with due attention to their physical health, mental health, and social needs. Because the practice is aware of the high prevalence of mental disorders in this population, problems are identified at an early stage, thus preventing deterioration and the need for more specialized treatments.

Key lessons learnt

- Refugees, the homeless and asylum seekers are disadvantaged populations who, despite having higher rates of mental disorders, can be successfully managed within primary health care.
- The primary health care approach promotes social inclusion and improves access to health and social care services.
- The Mental Health National Service Framework and the Quality Outcomes Framework have helped to promote mental health access and integration of mental health into primary care throughout the United Kingdom.
- Mainstreaming mental health service delivery for special populations is feasible and affordable.

- Attention to mental health issues within a general practice helps ensure that people with mental disorders are treated, but also that all patients receive mental health promotion services.
- Attention to problems that go well beyond medical interventions – to include social, psychological, economic and cultural issues – requires engagement and intensive interaction with a number of formal and voluntary community services.

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