



## BRIEFING 19

# Primary Solutions

An independent policy review on the development of primary care mental health services

The Sainsbury Centre for Mental Health is a registered charity, working to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services, through a coordinated programme of research, training and development. SCMH is affiliated to King's College London.

Copies of *Primary Solutions* are available from SCMH at £12 plus 10% p&p. Contact 020 7827 8352 (Publications), 134-138 Borough High Street, London SE1 1LB, [www.scmh.org.uk](http://www.scmh.org.uk)

## An Executive Briefing on primary care mental health services

**P** RIMARY CARE plays a fundamental role in caring for people with mental health problems. Further, by acting as a gatekeeper to specialist services, primary care also plays an important role in determining the way in which secondary care resources are utilised. Yet, despite the fundamental role of primary care in addressing mental health problems, there is no clear and comprehensive national policy framework on primary care mental health. The statistics on the involvement of primary care services are well known:

- ❖ 80 per cent of all contacts in the NHS take place in primary care, which receives 20 per cent of NHS resources.
- ❖ 90 per cent of people with mental health problems are cared for entirely within primary care, but use less than 10 per cent of the total expenditure spent on mental health.
- ❖ Around 30 per cent of people who see their GP have a mental health component to their illness.
- ❖ One in four people in the community has a mental health problem.

The report, *Primary Solutions*, sets out the policy background, and some of the issues, that from a primary care perspective might influence the development of such a comprehensive policy. The NHS Alliance and the Sainsbury Centre for Mental Health (SCMH) have combined their resources to produce this report. They understand the central role that primary care services play in delivering comprehensive and safe health care.

The structural and policy context, which crucially includes the development of primary care trusts (PCTs) and the continuation of the policy of a primary care led NHS, highlights the need for a clear framework.

Primary care mental health is central to the provision of both mental health and primary care services. To have no clear policy, no direction, for the large number of people with common mental health problems, managed in primary care, minimises their suffering, and diverts attention from their needs.

## The policy background

The National Service Framework (NSF) for Mental Health (1999) was the first of a series of National Service Frameworks designed to provide consistent clinical standards of care in England. It was followed a year later by the NHS Plan, which introduced several new types of workers to improve the services for people with mental health problems in primary care.

In 2001 the Workforce Action Team (WAT), a sub-group of the NSF Implementation Team, published a special report on primary care. It is these three publications that together form the framework for a primary care mental health service.

Standard Two of the NSF for Mental Health requires that any service user who contacts their primary health care team with a common mental health problem should:

- ❖ have their mental health needs identified and assessed;
- ❖ be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Few primary care professionals would dispute these objectives. But, as *Primary Solutions* describes in detail, identifying people with mental health problems in primary care is not just about better training.

Research shows that some 250 people in every 1,000 have some sort of mental health problem. Most of these, some 230 people per 1,000, attend their GP surgery. However, only 130 people per 1,000 are identified as suffering from a mental health problem.

Primary care professionals should not be embarrassed by this data – there are many reasons as to why not all cases are identified at consultation. The correct identification of people with a mental health problem is a complex mixture of social characteristics, consulting technique, age,

and sex of both patient and GP, and the presence or absence of physical symptoms. Further, a considerable proportion of those whose mental health problems go unrecognised recover without the need of medication or intervention from the GP, and they prefer it to be so. Given such factors, it is unrealistic to believe that ‘better training’ and ‘guidelines’ will solve the problem of low identification.

The NHS Plan proposed major changes to the way that mental health services are delivered. It described the development of 500 extra secure beds, 320 24-hour staffed beds, 170 assertive outreach teams, and access 24 hours a day, seven days per week for all those with complex mental health needs. The priority was to ensure that those with severe and enduring mental health problems receive services that are more responsive to their needs. This was to be resourced by £300m of new funding.

The NHS Plan also described the changes proposed for primary care mental health services: it acknowledged that most people (up to 90 per cent) with mental health problems are managed entirely in primary care. It proposed the development of a new post of ‘graduate primary care mental health worker’ to offer brief therapies of proven effectiveness.

The new posts are to be funded with £25m. This is the first time in the history of the NHS that funding has been identified for primary care mental health. It is welcomed both as an acknowledgement of the problem, and the fact that it underlines the role that primary care mental health plays in a comprehensive mental health service. Further details of these posts are given in *Primary Solutions*.

From a primary care perspective these proposals provide some contradictions. People with severe and enduring mental health problems are vulnerable. It is appropriate that specialist mental health services concentrate their skills and experience at providing the best possible care for them.

However, a vast proportion of the GP workload centres on people with multiple problems of chronic physical disability, mental health problems, and social and economic disadvantage. This group of people, through no fault of their own, can be heavy consumers of NHS resources.

It has been estimated that 56 per cent of consecutive attendees at a medical outpatient clinic had unexplained symptoms. This group of people, who have complex health care problems that span physical, mental health and social care, are poorly served by the changes proposed.

Significant changes are being made to the services offered for people with severe and enduring mental health problems, and appropriately

so, but the proposals offered for a much larger proportion of people with mental health needs seem limited in both imagination and resource.

## Structural solutions

Since the publication of the NSF for Mental Health and the NHS Plan, many sites throughout England have experimented with different models of care for people who to date have not been managed successfully by primary care, but who do not need the more intensive care of a community mental health team (CMHT). Some of these models are described in the report, *Primary Solutions*.

Although graduate primary care mental health workers are welcome, it seems unlikely that they will be able to have the desired impact that is needed. Further work is needed to develop successful models of care, the role of these workers and other professionals such as GPs with a special interest, counsellors and primary care psychologists.

Primary care and mental health services suffer from a lack of sufficient human resources to meet the expectations of both Government and service users. The use of the Modernisation Agency to help develop new ways of working and the success of the Advanced Access projects in primary care are welcome.

However, it is unlikely that these changes alone will manage the capacity problem. Most primary health care teams feel that they are struggling to manage current workload without taking on the new responsibilities of the NSF for Mental Health. The current policy framework documents make little of the need to increase the primary care workforce but rather suggest that the current workforce be trained to do more. Capacity in mental health services cannot be managed by transferring care to primary care services.

Mental health users of primary care services frequently state that they would like their GP to spend more time with them, but understand they are under extreme pressure and not able to do so. GPs feel the same. They are interested in mental health (and indeed care of people with mental health problems takes up 30 per cent of their time) and would like to offer longer appointments. But the pressures on their time are such that they are unable to do more – a longer appointment for one person means someone else has to wait longer or gets less time with the GP.

The consequence of this increasing expectation, from both the politicians and the public set against an inability to provide what is needed, and what GPs would like to provide, results inevitably in a

deterioration in the mental well being of the workforce itself.

Primary Care Mental Health Education (PRiMHE) and its director Dr Chris Manning have worked tirelessly to try and raise the awareness of mental health problems in the primary care workforce. His work needs to be supported more formally by the Department of Health.

SCMH and the NHS Alliance are committed to improving the services for all people with mental health needs, not just those with severe and enduring mental health problems.

It is clear that there are several basic questions that have not been answered. SCMH and the NHS Alliance therefore propose to undertake an in-depth investigation to answer the following questions:

- ❖ What sort of models of care are appropriate and effective in primary care/general practice and between primary care and CMHTs, and what are the characteristics that make them effective?
- ❖ What impact will implementing such models of care have on the capacity of the primary care workforce to deliver and how will the inevitable gaps be bridged in the short and longer term?
- ❖ What impact will such models of care have on the health of the workforce particularly in the short term?
- ❖ What are the most appropriate and effective primary care models for groups with specific needs, such as minority ethnic groups or asylum seekers?

## Workforce issues

Any discussion of workforce numbers, roles and skill mix in relation to a single aspect of primary care is problematic. Tasks and roles in primary care are fluid: the needs demanded of primary care in inner city London are different from the needs of the community in rural Shropshire.

Mental health problems vary from severe disabling chronic conditions to mild adjustment disorders. Physical health problems similarly vary from acute life threatening conditions to mild illnesses, which will pass in time. Service users vary in age from before the cradle through to the grave. Trying to manage this enormous range of problems, and to meet the competing pressures of the NSFs for other conditions, has placed considerable pressure on the primary care workforce.

## Gaps

A recent survey indicated that there is a shortfall in GPs of around a third (out of 33,000 GPs). This shortfall has happened because of changing work practices: more GPs work part time and are taking different career pathways.

To this changing pattern is added the shift in care from secondary and long term residential and hospital care to primary and community care. Hospital admissions are shorter, discharges quicker, and community teams for all aspects of care have proliferated.

While the educational needs for newly trained GPs have been described by the Joint Committee for Postgraduate Training in General Practice (JCPTGP), there is no similar curriculum for GPs working now. When this fact is placed alongside the move towards re-validation, and other recently introduced methods to ensure the quality of care provided by GPs, it is clear that work is needed to describe the skills that are needed to provide high quality care.

One route to achieve this might be to introduce quality measures within the GP contract that is currently being negotiated. The management of common mental health problems needs to be given the same level of quality payments as GPs gain for undertaking specific improved aspects of care in certain clinical areas such as coronary heart disease.

## GPs with a special interest

The NHS Plan describes the development of GPs with a special interest. This development is welcomed but does require more work to ensure that there is consistency of qualifications and training to become eligible, and that the presence and role of GPs with a special interest is matched to local need.

## Nursing

There are some 18,000 practice nurses, most of whom work part time. Only two per cent of practice nurses have received formal mental health training. The role of practice nurses is changing rapidly and this is described in more detail in *Primary Solutions*. To allow nurses to maximise their potential, an increase in both numbers and their skills are required.

The number of available community nurses has been put under pressure by the development of 'first contact' services such as NHS Direct, and walk-in centres. We welcome the recently announced pilot to develop mental health services within these centres but fear that this development might put

further workforce pressure on both specialist mental health and primary care nursing staff.

## Practice receptionists and administrative staff

Reception and clerical staff are usually recruited from the local community and play a vital role in primary care. They are frequently the first point of contact for the service user and are sometimes required to work with people who are distressed, frightened, and occasionally abusive.

Absolute numbers of receptionists and clerical staff are unclear, but changes in the proposed GP contract in relation to staff pay are welcomed, as is the opportunity for the staff to benefit from the NHS superannuation scheme, and become much more part of the NHS family.

## Counsellors

The number of practice counsellors has grown rapidly over the last ten years, and they are now an integral part of a significant minority of primary care practices.

Counsellors are supported by a strong professional organisation, the Association of Counsellors and Psychotherapists in Primary Care (CPC). But it is necessary to ensure that all counsellors are covered by some form of professional support to ensure consistent levels of care.

## Primary care mental health workers

The NHS Plan proposed the development of 1,000 new workers to provide evidence-based psychological therapies for people with common mental health problems. SCMH and the NHS Alliance strongly support the development of these new posts and welcome the fact that primary care mental health services are at last receiving some of the resources that they so desperately need.

However, the strong support for these posts is tempered by the experience of SCMH and the NHS Alliance at introducing new models of care. It is important there is clarity as to the role and capacity of these new workers, that their introduction is evaluated and assessed as well as ensuring that they are appropriately supported.

In particular, there should be a clear distinction between the role of link worker and the new posts; the former is a mental health professional, usually part of a CMHT, who takes on the role of improving communication between the primary health care team (PHCT) and the CMHT. Primary care mental health workers offer a tremendous

opportunity that must not be wasted through confused and ill considered plans that raise expectations unrealistically.

### Gateway workers

Five hundred gateway workers were also introduced in the NHS Plan, and similar support is offered by the NHS Alliance and SCMh to this development. However, we place similar riders on this support – there needs to be clarity about their role, and expectations should be realistic for what is a new and as yet unclear post.

### Recommendations

- ❖ The effect of implementing the NSF for Mental Health in primary care should be investigated, and the conclusions inform workforce development.

**Lead:** National Institute of Mental Health for England (NIMHE).

### Primary care mental health workers

That the role of the new mental health workers is clearly limited to providing explicit evidence-based forms of psychological interventions to individuals suffering from specific mental health disorders.

- ❖ That there is a clear distinction between this role of providing specific talking therapy treatments, and the much wider role of link-working that requires different skills and experience.
- ❖ That there is a mechanism for support and training for these new post holders in place.
- ❖ That these posts are evaluated, and that the results be widely distributed.
- ❖ That the role of this new post is seen as an integral part of a comprehensive mental health service, and that it is embedded within an overall strategy of how services are provided, not added as an afterthought.
- ❖ That clear referral and discharge guidelines are in place to ensure that the maximum benefit is derived from what will be a scarce resource. Case mix and workload need to be reviewed on a regular basis to ensure that the guidelines are appropriate and effective.

**Lead:** PCT clinical champions (clinical governance leads and commissioning managers).

### GPs

- ❖ There is a need to develop an approach for GPs with a special interest in mental health, so there is national consistency of care standards and qualifications, but matched to local need.

**Lead:** Royal College of General Practitioners (RCGP) in partnership with NIMHE and National Primary and Care Trust Development Team (NaPaCT).

### Counsellors

- ❖ Specify employment policy for primary care counsellors, which include supervision and professional development standards.

**Lead:** CPC in partnership with NIMHE.

### Gateway workers

- ❖ Their role and skills should be clarified, and their impact on care evaluated.

**Lead:** NIMHE and regional development centres.

## Education and training

The workforce needs appropriate education and training to provide a modern, safe and effective primary care mental health service. This needs to be put in the context of both the national mental health agenda, described in the NSF for Mental Health, and the national primary care agenda.

SCMH and the NHS Alliance agree that there needs to be a national primary care mental health training strategy that will bring together the training needs of the various professional groups, and provide a strategic direction to that training. We look to NIMHE to take this work forward.

### GPs

Doctors have to undergo a three-year postgraduate training course to become eligible to become GPs. *Primary Solutions* makes a number of recommendations based on a specially commissioned piece of work by the Department of Health (DoH) in 1999. This consisted of a national survey of GP postgraduate courses to assess the education and training that is provided on primary care mental health. The recommendations are wide ranging, but fit well with other proposals in this document and the proposed national strategy.

### Community nurses

Only two per cent of practice nurses have a mental health qualification. District nurses, health visitors and community midwives are expected to identify and manage complex mental health problems such as bereavement, post natal depression and the depression and anxiety that is often associated with chronic physical disability.

Further, some 25 per cent of people with severe mental health problems are managed entirely by primary care services; and a significant proportion of this group are maintained on depot phenothiazine injections that are administered by practice or community nurses. There are clear educational needs for these nurses, which can be met through a national strategy.

### Clerks and receptionists

All receptionists should be trained in managing people who are distressed and confused. We suggest that the skills required to be a receptionist in primary care are little different to those of a receptionist in a mental health service and that multi-agency training should be provided.

### Recommendations

- ❖ A national primary care mental health training strategy is developed to identify the needs and co-ordinate the training of all staff working in primary care.

**Lead:** NIMHE in partnership with RCGP, Royal College of Nursing (RCN) and NaPaCT.

### Training for GPs

The development of innovative posts involving community/primary care experience either through liaison psychiatry or as devolved clinic work for senior house officers (SHOs) or registrars.

- ❖ Study leave release to specific courses in primary care mental health on the same basis as release to Child Health Surveillance and Family Planning courses should be encouraged for SHOs and registrars.
- ❖ Examples of mental health curricula should be widely distributed to course organisers and registrars. Where courses are 'learner led', the learners need some guidance as to what is available to make informed choices for their education.
- ❖ Day release courses offer the opportunity for inter- and multi-disciplinary working at registrar level.

- ❖ Awareness of currently available teaching materials needs to be raised for course organisers.

**Lead:** JCPTGP in partnership with NIMHE.

- ❖ Contract negotiations to include a quality standard for the management of common mental health problems, such as depression.

**Lead:** British Medical Association and DoH.

### Community nursing

The National Primary Care Mental Health Training Strategy should develop curricula that allow:

- ❖ All nurses to receive training to understand how mental health problems can present and influence physical illness.
- ❖ Practice nurses to receive specific training in the administration of depot phenothiazines that include symptom recognition and elicitation of signs of mental health problems.
- ❖ Health visitors to receive specific training to identify and manage post natal depression.
- ❖ District nurses to receive specific training on the identification and management of bereaved people as part of their training on the care of the dying.

**Lead:** RCN in partnership with NIMHE.

- ❖ Educational consortia should ensure that such courses are commissioned and provided locally based on the national curricula.

**Lead:** PCT training officers.

### Clerical staff

- ❖ Multi-disciplinary training should be developed for clerical staff from all sectors to address the care of service users who are distressed and/or violent.

**Lead:** GPs as direct employers but facilitated by PCT training officers.

## Modern information systems

The NSF for Mental Health proposed the development of electronic mental health records and electronic Care Programme Approach records. Primary care, however, has been using electronic records for some years, and the challenge is to find a way of sharing information between specialist mental health services and primary care services. The NHS Information Authority is leading this work nationally and it is important that primary care is a full partner in this.

The National Service Framework for Mental Health (Standards Two and Three) details how primary care should develop shared care guidelines and audit them for six mental health conditions. SCMH and the NHS Alliance recommend that the initial work in primary care mental health informatics (the science of information, often computer based) is directed at completing these guidelines and ensuring that the data can be shared between primary and specialist mental health services.

The National Institute for Clinical Excellence (NICE) is developing national guidelines in these six areas. We recommend that a parallel programme of work that produces the electronic data, codes and programmes needed to implement the guidelines locally, accompany these guidelines.

### Recommendations

- ❖ We would recommend that primary care informatics focus on the areas described in Standard Two and Three of the NSF for Mental Health in the first instance. Lessons learned will be transferable to all other areas at a later date.

**Lead:** PCT information leads and primary health care team clinicians.

- ❖ We recommend that as NICE guidelines are produced covering these clinical areas, so the health informatics and clinical codes needed for this process are developed and published in a parallel programme.

**Lead:** NICE and Mental Health Information Strategy working party.

## Caring for people with severe mental health problems

Primary care plays a vital role in caring for people with severe mental health problems. It provides the only point of contact for 30 per cent of this group, and for the remainder, provides shared care in one form or another with the specialist mental health team. Primary care is also responsible for providing physical health care to the whole of this vulnerable group.

This subject is dealt with in more detail in SCMH's publication, *A general practitioner's guide to managing severe mental illness* (Cohen and Singh, 2001).

The NSF for Mental Health and the NHS Plan introduced a number of specialist mental health teams to complement the work undertaken by CMHTs. Understanding how these teams work is vital for primary care, so that it can access and use them appropriately.

### Early intervention in psychosis

These teams serve a population of about one million and will aim to reduce the time taken to identify people in their first episode of psychosis.

Research evidence suggests that reducing the duration of unidentified psychosis significantly improves prognosis, and reduces both frequency and duration of admission to hospital. However, the symptoms and signs of early psychosis are nebulous and difficult to identify. The average GP is likely to see one new case of first episode psychosis once every five years.

SCMH and the NHS Alliance recommend that a training programme be developed as part of a national strategy to improve the awareness of primary care clinicians of the early stages of psychosis. Also that a screening tool be developed to enable GPs to be more specific about clinical concerns they may have about an individual.

### Crisis resolution/home treatment teams

These teams each serve a population of around 150,000 and are designed to provide a crisis service to the service user at home, 24 hours per day, seven days per week, until the crisis has resolved. Such a service is obviously a great resource, but the links to other out-of-hours services need to be carefully planned to stop a plethora of 'emergency' telephone numbers developing.

Primary care has extensive experience of setting up out-of-hours services, and this experience should be tapped to ensure that there is a close

link between the out-of-hours services run by the mental health trust and that run for primary care. It should also provide a link to local NHS Direct and walk-in centres, so that there becomes a single number that accesses all forms of emergency care.

### Assertive outreach teams

These teams each serve a population of around 250,000 people and are designed to reach the relatively small number of people with severe mental health problems who find it difficult to engage with mental health services and who are significantly disabled by their illness. These teams have a relatively small caseload which is managed intensively by highly trained clinicians. It is likely that most GPs will only have one or two of these clients. Protocols on follow up and medication supervision are frequently different to those of the CMHT, and GPs need to know where their responsibilities lie.

### Community mental health teams (CMHTs)

The recently published Policy Implementation Guide (PIG) describes the relationship between primary care and CMHTs. SCMH and the NHS Alliance welcome the document. The Guide sets out the need for both an active relationship between the CMHT and the primary health care team (PHCT), in the form of regular meetings, or the allocation of a member of the CMHT to each PHCT, and the need for clarity on referral and discharge processes.

This will be supported by the development of a register of people with severe mental health problems held at practice level, which can be used to provide pro-active care to users that covers both their physical and mental health needs. SCMH and the NHS Alliance support these recommendations.

### Physical health care

The NSF for Mental Health makes the point that the physical health of people with severe health problems is a major concern. Indeed the standardised mortality ratio (SMR) – the rate at which a group of people die compared to a ‘normal’ population is significantly raised. People with severe mental health problems are four times more likely to die from cardiovascular disease and respiratory disease (90 per cent of people with schizophrenia smoke), are five times more likely to suffer from diabetes, and up to ten times more likely to acquire Hepatitis C than the average population.

These facts put people with severe mental health problems at significant risk of physical ill health, and SCMH and the NHS Alliance believe it is the responsibility of primary care to take a pro-active stance to improving their physical health care.

SCMH and the NHS Alliance believe that people with severe mental health problems should be offered pro-active health screening including protection against influenza by vaccination on an annual basis and that this group should be included in the ‘at risk’ groups identified by the DoH.

### Recommendations

- ❖ Training for primary care clinicians on signs and symptoms of early psychosis and relapse, mental state examination, risk assessment, and psychopharmacology is developed as part of the National Training Strategy.

**Lead:** PCTs in partnership with Mental Health Trusts.

- ❖ A screening tool for primary care needs to be developed to assist clinicians in making appropriate referrals.

**Lead:** NIMHE.

- ❖ The crisis resolution team should be accessed through the existing out-of-hours services that are managed by primary care, such as Co-ops (which provide out-of-hours care) etc. There will also be links into the crisis resolution team from NHS Direct and walk-in centres, as well hospital A&E departments.

**Lead:** PCTs and Mental Health Trusts.

- ❖ It is recommended that the role of the assertive outreach team should be clarified, as it may be different from the care model provided by other mental health teams such as the CMHT.

**Lead:** PCTs and Mental Health Trusts.

- ❖ Local agreement on explicit referral criteria for generic and specialist teams needs to be obtained, and shared widely with all professionals.

**Lead:** CMHTs and PHCTs.

- ❖ Discharge plans and after-care arrangements should identify key roles and responsibilities of primary and secondary care, with written details of contact points.

**Lead:** CMHTs and PHCTs.

- ❖ An agreed system for ensuring consistent and structured communication between primary and secondary care needs to be developed including care programme approach reviews, out-of-hours access, and crisis care.

**Lead:** PCTs and Mental Health Trusts.

- ❖ Developing case registers of those with severe mental health problems supports shared care and should be promoted.

**Lead:** PHCTs and CMHTs.

- ❖ Local arrangements for regular liaison between primary and secondary care need to be in place.

**Lead:** PHCTs and CMHTs.

- ❖ PCTs and specialist mental health services should jointly develop protocols for identifying and monitoring physical health of people with a severe mental illness by undertaking regular reviews, either opportunistically or at special clinics.

**Lead:** PCTs and Mental Health Trusts.

## Summary

SCMH and the NHS Alliance take seriously the care provided by primary care services to people with mental health problems. To do otherwise for 30 per cent of people who consult their GPs for a group of conditions that affects one in four people each year, would be folly.

SCMH and the NHS Alliance have in this executive briefing and in more detail in the *Primary Solutions* report, posed questions on policy, resource allocation, and development issues.

Together we will:

- ❖ investigate the allocation of resources to primary care mental health services, so that a case can be made to increase the proportion allocated within primary care services;
- ❖ undertake an investigation of different models of care that both bridge the gap between primary care and specialist mental health services, as well as looking at how primary care services can more effectively provide care to groups of people with special needs.

Questions or comments on this briefing should be directed to Alan Cohen at SCMH ([alan.cohen@scmh.org.uk](mailto:alan.cohen@scmh.org.uk))

# New Publications from The Sainsbury Centre for Mental Health

## Primary Solutions

*An independent policy review on the development of primary care mental health services*

Price: £12

This publication published in association with the NHS Alliance reviews the development of mental health services in primary care. It looks at the different structures for how primary and secondary care work together and the skills required by the workforce to meet these challenges. Topics include: the role of primary care in managing the care of people with severe mental health problems; the information systems available to support this; and the future role of primary care trusts in providing specialist services.

## Breaking the Circles of Fear

*A review of the relationship between mental health services and African and Caribbean Communities*

Price: £15 (£7.50 for users, carers and smaller voluntary organisations)

Black people mistrust and often fear services, and staff are often wary of the Black community, fearing criticism and not knowing how to respond. This cycle is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism. SCMH's major policy review of 2002 documents these 'circles of fear' and the impediments to change which lead to poorer treatment and care of African and African Caribbean adults. Its groundbreaking recommendations chart a programme of reform aimed at 'Breaking the Circles of Fear' and delivering mental health services which meet their needs and aspirations.

## Working for Inclusion

*Making social inclusion a reality for people with severe mental health problems*

Price: £25 (£15 for users, carers and smaller voluntary organisations)

Everyone has the right to fulfil positive social roles and contribute to their local community including people with mental health problems. This publication provides the first in-depth analysis, with examples, of how mental health and other agencies can support people with mental health problems to engage in a full life in the community. Case studies include schemes in the fields of education, employment, primary care, mental health promotion, police and local government. (A4 ring-bound file, 270 pp)

## Setting the Standard

*The new agenda for primary care organisations commissioning mental health services*

Price: £10

This report proposes a new set of standards for primary care organisations commissioning mental health services to ensure that they meet local needs. It details eleven standards that can be used by primary care trusts as a self-assessment tool to assess their own fitness to commission mental health services. The standards were developed by an expert group of psychiatrists, GPs, chief executives and public health specialists.

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The Sainsbury Centre  
for Mental Health

# Primary Care Advice Unit

## Developing integrated mental health services

The Primary Care Advice Unit is a joint project of the Royal College of General Practitioners and the Sainsbury Centre for Mental Health. We support primary care organisations in meeting the challenges of providing integrated mental health services and achieving the performance targets set by the National Service Framework (NSF) for Mental Health, NHS Plan and local strategies.

### Bespoke training programmes

Our innovative training programmes are designed to meet each organisation's needs. Previous work has included practice-based training, and the development of programmes for primary care trusts and community mental health teams, on such topics as:

- ❖ guideline development and implementation
- ❖ caring for people with a severe mental illness in primary care
- ❖ caring for young black psychotic men in primary care
- ❖ commissioning mental health services
- ❖ leadership skills for mental health leads in PCTs

We cater for a diverse range of professions and backgrounds including GPs, nurses, administrative staff, psychiatrists, mental health professionals and NSF local implementation teams.

Our approach ranges from classroom-based training, to small group work and portfolio learning. We work closely with those who commission the training to ensure that the most appropriate approach is used. Our aim is to enable the organisation to develop its own programmes in the future.

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