



**DISMANTLING THE BERLIN WALL:
THE IMPACT OF A PRIMARY CARE TRUST'S INTEGRATED HEALTH AND
SOCIAL CARE SERVICES UPON ADULT MENTAL
HEALTH SERVICES IN PLYMOUTH**

EXECUTIVE SUMMARY

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The Purpose and Scope of this Study

For many years, service users have demanded (i) the effective and empowering delivery of services, irrespective of the provider agency, and (ii) holistic treatment and care, rather than an emphasis on symptom management, that addresses the 'whole person' as part of a 'whole systems approach' to service provision.

Given their centrality in mental health services, it is assumed that effective integration between health and social care is an essential precursor to addressing these demands. However, both have traditionally been divided by a 'Berlin Wall' constructed of differing cultures, practices, models of care and budgetary arrangements. The flexibilities needed to achieve their effective integration and to dismantle the 'Berlin Wall' were introduced in the 1999 Health Act (Section 31), which offered the opportunity to pool existing health and social care budgets, thereby facilitating more integrated partnership working by affording the opportunity for joint service commissioning and provision.

However, a number of structural models exist (e.g. specialist mental health provider trusts) under which these integrated arrangements can be operationalised, and health and social care commissioned and provided. One such model is the Primary Care Trust (PCT). The extent to which PCTs can deliver integrated mental health services effectively is, however, debated. Central to this debate is the government's citizenship and social inclusion agenda; in particular, are mental health needs best met by specialist mental health trusts or by organisations that provide simultaneously for the health needs of the general population?

Established in April 2001, Plymouth PCT aims to enhance equity at service level, and improve the responsiveness of community services across the city using the freedoms and opportunities offered by joint commissioning. Minimal work has been undertaken to examine the impact of these organisational changes on the lives of those who provide and experience services. This evaluation examined the impact of the new commissioning and provider organisational arrangements on primary care health services, mental health services, other agencies, service users and carers in Plymouth.

How the study was conducted

The study entailed a baseline and a 12-month follow-up evaluation. The baseline evaluation was completed in 2001; the follow-up evaluation was undertaken towards the end of 2002/early 2003.

Multiple research methods were used among the following stakeholder groups:

Primary health care services:

- ◆ an audit conducted one week per month over a three-month period in three general practices, one from each of the city localities, of patients consulting their general practitioner (GP) with mental health problems.
- ◆ semi-structured interviews with four primary health care staff from each of the three selected general practices.

Mental health services

- ◆ analysis of mental health service provision and activity based upon existing data.
- ◆ semi-structured interviews with members of each Primary Care Liaison Team (PCLT) linked to the three general practices, and staff from the Home Treatment Team (HTT), the Assertive Outreach Service (AOS), the acute wards, psychology, consultant psychiatrists and social workers.

Other agencies

- ◆ semi-structured interviews with a number of additional key informants from: MIND, Rethink, the Court Diversion Service, Housing services, Accident and Emergency, the Psychiatric Liaison Team and mainstream Social Services.

Service users and carers

- ◆ semi-structured interviews and focus groups with users of mental health services and carers.

Central to these interviews and group discussions were five themes identified by the evaluation's Steering Group: Communication; Integration; Accessibility; Information; and Satisfaction with Care.

Slight amendments were made to the follow-up interview schedules that (i) addressed the government's social inclusion and citizenship agenda and (ii) investigated areas of local interest (e.g. Local Care Centres).

Key Study Findings

A. Characteristics of primary care patients with mental health problems consulting their GP

Of the total 357 patients about whom GPs recorded information over the two years of the evaluation, 138 (38.7%) were seen at baseline, 219 (61.3%) seen at the follow-up stage.

The key findings found included:

Socio-demographic characteristics of primary care patients consulting their GP with a mental health problem

- No statistically significant change in the socio-demographic characteristics of patients attending their GP practice with mental health problems at follow-up when compared with the baseline findings.
- Attendees were predominantly female across all general practices, more likely to be married / co-habiting in two surgeries and single / divorced-separated / widowed in practice 2, and were predominantly 'White' across baseline and follow-up.
- Whilst there has been a slight change from the baseline finding, the majority of patients report to their GP with depression. Whereas at baseline mixed anxiety and depressive disorder was the second highest proportion of diagnosis for two general practices and generalised anxiety

disorder was for the third, at follow-up they were personality disorder, generalised anxiety disorder, and drug dependence.

- Whereas at baseline the three practices rated over half of all patients who consulted with a mental health problem as having a 'moderate/severe' level of symptom severity, at follow-up only two practices did so, with practice 2 rating the majority as having a 'mild' level of severity.

Service history of patients with mental health problems who consulted their GP

- A significant minority of patients who consulted their GP during the evaluation period did so due to the deterioration of an existing mental health problem.
- At baseline new mental health problems accounted for between 15.4-23.8% of consultations.
- At follow-up, the primary reason for consultations was to review existing mental health problems.
- At both baseline and follow-up, few patients had been compulsorily admitted into hospital.
- The percentage of admissions to a psychiatric hospital (either current or not current) in the last year varied between practices at baseline but were more similar at follow-up.

Outcomes for patients consulting their GP with mental health problems

- While approximately three-quarters of patients had their medication reviewed within each of the three practices at baseline, a greater percentage did so at follow-up.
- While approximately 5%-12% of patients were referred on to the PCLTs at baseline, at follow-up this decreased to between 1-3%.

B. In-depth interviews and focus groups

Theme 1: Communication

The key findings found at the baseline evaluation included:

- Overall communication between the Primary Health Care Teams (PHCTs) and the PCLTs tended to be very good. Communication links appeared to be less satisfactory between the PCLTs and the specialist services. The main problem in communication arose over changes in a service user's medication.
- As expected, the exact nature and extent of communication varied from GP to GP, from practice to practice, and from PCLT to PCLT.
- Service users assumed that their key workers communicated with other service professionals but this was not always clear.

The key findings found at the follow-up evaluation included:

- ❑ Overall communication between services has not changed significantly since baseline. It remains broadly satisfactory even though specific problems (e.g. only one telephone line into Nuffield Clinic) remain.
- ❑ Importantly, staff shortages in the PCLTs have compounded the baseline communication problems evident between the PCLTs and the specialist mental health services, and also impacted upon housing services and the voluntary sector agencies. Despite being seen as a temporary problem, these staff shortages have hampered the anticipated advantages of integration between health and social care.
- ❑ The role of the designated care co-ordinator, and also continuity of care for the service user, is being undermined by inadequate inter-service communication. Particular problems emerge around discharge from the acute wards. However, ward staff also report insufficient engagement with the ward by service partners.
- ❑ The PCLTs appear generally satisfied with their communication with GPs (even though prescription changes made by GPs and not conveyed to the PCLTs remains a problem), who have in turn appreciated the challenges to the PCLTs caused by staffing shortages.
- ❑ Service users remain largely unaware of communication between primary and secondary care professionals. Some service users also cite the lack of empathetic communication that is responsive to individual needs as they arise.
- ❑ There has been a reported improvement in communication with the voluntary sector, too, which for one organisation has resulted in their increased respect as an effective partner organisation. This perceived improvement in communication between the voluntary and statutory sectors is echoed by the latter, in part arising from closer working practices.
- ❑ An ongoing concern for carers is the extent to which they feel relatively uninformed of the care their relatives receive, with services also seen as unresponsive to *their* input. Carers still feel they are largely excluded from communication regarding their relatives. However, not all carers reported negatively on their communication with services, with some believing it had improved.

Theme 2: Integration

The key findings found at the baseline evaluation included:

- ❑ Integration between the PHCTs and the PCLTs was generally perceived to be satisfactory by staff, in part facilitated by effective communication channels that existed between the services. However, some PCLT staff members felt that they could be more fully integrated into the primary care work environment, with some advocating they be physically based in the surgeries.
- ❑ Specialist mental health professionals generally viewed their links with the PCLTs more negatively. Some perceived a number of users falling between services through a combination of delays in communication, paperwork, and referral difficulties. Mainstream social services also perceived themselves less integrated with mental health services, reporting a need for a single point of access for those people who continue to present in the locality social services offices.
- ❑ Rethink reported that they are not as fully integrated into statutory mental health services as they would like, primarily due to structural linkages and barriers. Accident and Emergency also felt relatively isolated, having links with primary care but not being fully integrated with them,

with no follow-up of service users after they have been discharged from Accident and Emergency.

- ❑ Shared information technology (IT) systems were more problematic to achieve. For example, access to the EPEX data system was difficult, despite the fact that it contains vital information regarding 'at risk' clients. Ethical and confidentiality issues provided additional concern regarding the use of shared information systems. Non-mental health agencies expressed a desire for shared ways of working (including IT systems), but with the caveat that such shared working should be framed within a respect for clients' confidentiality.
- ❑ There appeared to be minimal co-working among the specialist services, but rather evidence of a silo mentality: when one client leaves a service s/he is no longer seen as the responsibility of that service.
- ❑ Some staff viewed the Care Programme Approach (CPA) paperwork as having minimal connection with the provision of effective clinical and social care and more as a burdensome, bureaucratic exercise.

The key findings found at the follow-up evaluation included:

- ❑ The PHCTs and PCLTs appear slightly more integrated than 12 months ago, although some staff reported no discernible differences. Proposed changes to the physical location of CPNs in GP surgeries, as opposed to the present 'floating' arrangement, was generally welcomed by PCLT staff, seen as potentially accelerating referrals to services and enhancing the understanding and appreciation of colleagues among service providers.
- ❑ However, the CPN-attached model is not seen as a panacea to present deficiencies, with some CPNs preferring the 'breathing space' from primary care afforded by the existing service model.
- ❑ Whilst PCLT members in the outer locality believe their involvement in the establishment of the HTT has aided integration, the staffing problems faced by the inner PCLT have hindered integration with the HTT, leading to a deterioration in service effectiveness.
- ❑ Notwithstanding these problems, however, some respondents identified an improvement in information and shared protocols across service boundaries.
- ❑ Integration with the acute wards varies: the HTT felt that ward staff are intolerant of them, whereas AOS and MIND felt that joint working with the ward has improved.
- ❑ Social workers were in a period of transition at the time of the follow-up evaluation as their contracts were changing from social services to the health service and they awaited the physical relocation of their work base. Consequently, social workers felt both detached from social services and equally unattached to health. The lack of a shared accommodation base between CPNs and social workers appears to have had a deleterious impact upon the latter. Individual social workers feel isolated and not integrated with other mental health services.
- ❑ Accident and Emergency, who are most closely associated with the Psychiatric Liaison Team, are more integrated working at the clinical, operational level, in part facilitated by the development of a new observation ward.

Theme 3: Accessibility

The key findings found at the baseline evaluation included:

- ❑ Referral procedures between the PHCTs and the PCLTs were well established: either written or telephoned depending on the urgency of the service user's presenting problem. Problems did exist, however, including delays and inappropriate referrals.
- ❑ There were difficulties reported in finding appropriate services for people with severe personality disorder.
- ❑ Housing services reported few problems with referral routes.
- ❑ Generally, service users reported being fairly satisfied with their ability to access their key worker, GPs and emergency services and knowing who to contact in times of crises.
- ❑ Carers' experiences of caring for, and knowledge of, service users were not always perceived as being acknowledged by health professionals. One carer described the service they provide its users as being a 'mini hospital'. This 'mini hospital' offers a 24-hour service with minimal respite for its 'staff'. Carers reported that they often felt unsupported.
- ❑ Substantial variation in waiting times was evident for patients to the PCLTs (depending on the severity of their presenting problems). Overall waiting times were not deemed excessively long; moreover, where there were delays, both staff and service users appreciated the reasons.

The key findings found at the follow-up evaluation included:

- ❑ From a PHCT perspective, accessibility to secondary mental health services over the last 12 months has been hampered by the PCLTs' staffing levels. Similarly, in terms of their ability to transfer service users back to the PCLT, the HTT find problems identified at baseline have deteriorated further.
- ❑ Whilst referral procedures to access more specialist mental health services (especially AOS) are in place, problems exist with the capacity of teams to accept referrals. Part of the problem, notwithstanding staff ill-health, arises from the duration of time the AOS retain service users as active cases.
- ❑ Local authority housing services appear more accessible, even though some of that attempted access may be inappropriate. The pressures to find housing are considerable, but available housing stock is insufficient to address that need.
- ❑ The repercussions of relatively inaccessible community-based mental health services are readily seen in increased admission rates to the acute wards, and the referral of inappropriate service users. The acute wards can also experience problematic bed blocking when their attempts to access community mental health facilities for service users requiring discharge are frustrated by both the incongruent working hours of the community-based teams and inadequate rehabilitation services.
- ❑ Whilst some social workers reported referrals from GPs are more appropriate than they were 12 months ago, there remains a sense of detachment from the PCLT.
- ❑ The work of the mainstream Social Services appears to have improved with the introduction of the front-desk system to address referrals. However, problems remain where a person does either not have a GP or where the individual does not meet the referral criteria. The net result

is seen as a service that is skewed to meeting the needs of a small percentage of those with mental health problems.

- ❑ Carers feel there is insufficient contact between themselves and the CPNs, who in turn should be more flexible in where they meet clients, and more sensitive to the disabling impact of the stigma associated with mental ill-health. Similarly, for some service users there can be frustration securing a consultation with psychiatrists, whilst the personal manners of some staff can also deter access.

Theme 4: Information

The key findings found at the baseline evaluation included:

- ❑ There was a broad agreement that information received by both the PHCTs and the PCLTs was satisfactory. Where there were problems, they arose in respect of the insufficient amount of information PCLTs received from some GPs regarding the nature of the presenting mental health problem, what interventions had been tried to date, and what additional interventions might best have served that individual.
- ❑ For some specialist mental health services, there was a problem receiving referral documentation from the PCLTs.
- ❑ The Criminal Justice services reported on the poor quality of information received by the Mental Health Assessment and Diversion Service. The telephone call they usually received from the inpatient units or the PCLTs was seen as insufficient.
- ❑ Local Authority housing reported that their level of satisfaction with the information they received depended upon the individual client and the complexity of the presenting case.
- ❑ One of the difficulties identified in providing service users with information was the balance between offering enough information to ensure people can identify their health problems without generating the very symptoms the information seeks to enlighten (e.g. panic attacks). Often service users complained that they were given excessive amounts of information, or given information at a time when they could not process it effectively.

The key findings found at the follow-up evaluation included:

- ❑ The quality of the information received by the PCLTs from the PHCTs still varies, as does their satisfaction with that fact. However, whilst the flow of information from the PCLTs to the PHCTs has apparently improved, minimal information is provided on discharge from mental health services back to the PHCTs, especially by more specialist services.
- ❑ For some in the PCLTs, the amount of paperwork needed to be completed, combined with the existence of separate systems for the PCLTs and Social Services, causes unnecessary duplication.
- ❑ Communication between the PCLTs and other mental health teams and the ward staff remains inconsistent. There is a perceived gap between community-based services and the acute ward, a fact explained by different working practices, questions over people receiving discharge and pressures on ward staff.
- ❑ The HTT are relatively content with the amount of information provided by referring GPs, reflecting a general improvement in the flow and quality of information across mental health services, in part aided by computerisation.

- ❑ For the voluntary agencies, information is either satisfactory or has improved as a result of new staff and local resources.
- ❑ Staff at the Criminal Justice service report an improvement in information from mental health services generally. However, problems remain with discharge from the acute wards as they continue not to be informed. Information between the Criminal Justice service and the non-statutory drug and alcohol services are also seen as problematic.
- ❑ Some service users reported having insufficient information about their illness and the medication they receive.
- ❑ Housing services feel they should be told information about people (especially higher risk residents) they house rather than relying on the tenants themselves. They raised concerns that often information does not involve a full assessment of risk or is more a historical record than a useful up-to-date contribution to care provision. Similar concerns regarding risk information were echoed by the Psychiatric Liaison Team and the HTT.

Theme 5: Satisfaction with Care

The key findings found at the baseline evaluation included:

- ❑ PHCT staff were satisfied with the ease with which they could contact the PCLTs, a sentiment echoed by the PCLTs.
- ❑ Specialist services sometimes found the working hours of PCLTs problematic when they required information on a client outside office hours.
- ❑ MIND were generally satisfied with the care their clients received but raised the problem of adequate care provision when staff are either sick or on annual leave.
- ❑ Accident and Emergency reported they were also satisfied with the care provided to their clients by themselves and other services.
- ❑ Perceptions of satisfaction with care varied from service user to service user, and from carer to carer. A couple of service users described the attitudes of some mental health workers to their clients as 'patronising'. Some service users also felt there was a lack of staff skills in listening, understanding, and the ability to empathise.
- ❑ Hospital care was considered mainly satisfactory by service users in terms of the treatment provided but changes were requested in terms of the acute environment and its gender mix.
- ❑ Carers talked extensively about the stigma associated with mental ill-health and the need to address stigma on a much wider scale.

The key findings found at the follow-up evaluation included:

- ❑ Whilst the Gateway service is described as effective, the relative absence of meaningful daytime activities was noted by both the PHCTs and the specialist mental health services.
- ❑ From a HTT perspective, it is felt that care for those with borderline personality disorder has improved with the introduction of Dialectical Behavioural Therapy specifically, and psychological therapies generally.

- ❑ Accident and Emergency staff feel delays in patients receiving treatment and care can lead to distress among grieving individuals. Moreover, of particular concern are those patients who present with a dual diagnosis (especially alcohol-related).
- ❑ The lack of care continuity with psychiatrists can be problematic for some service users, as can the use of inadequately trained staff. Some service users also reported receiving unhelpful advice from their key workers, or inadequate support at times of distress. Not all service users recounted negative experiences, however, and indeed praised their care over the last 12 months.
- ❑ Carers are less satisfied with the care and support they receive, in part arising from a failure to appreciate the role of the carer and the challenges they face performing that role. Carers comment that staff can be one of the main causes of dissatisfaction with care. Additional concerns exist over the almost exclusive adherence to medication as a treatment option to the neglect of others and the lack of information regarding prescribed medication.
- ❑ However, there is a perception that people are committed to changing their practices but that it takes time to achieve organisationally.

Additional Themes

The additional themes investigated only at the follow-up stage of the evaluation, included: user voices; social inclusion; the interface with Child and Adolescent Mental Health Services (CAMHS); Local Care Centres; and Primary Care Mental Health Workers.

User Voices

- ❑ Most interviewees thought that opportunities existed for service users to voice their preferences etc., but were uncertain as to its effectiveness. Moreover, an over-reliance on key individuals within the service user community was seen as giving rise to workload problems for the active few.
- ❑ Consultation with service users appears to vary across services. While the HTT are directly involved in service user advocacy and the evaluation of service users' views, the AOS see service user involvement undertaken on a Trust-wide basis rather than specifically within the AOS.
- ❑ Among the statutory sector agencies, MIND recognise the importance of the Mental Health Forum, but also advance the service user agenda themselves, holding consultation days when its members can have a say in how its service is run. Rethink has an organisational ethos which is service user-led but has only recently reinstated its service user forum.
- ❑ Local authority housing services have service user representation and encourage tenants to become involved in service development. Similarly, the acute sector acted on the results of a survey and introduced suggestion boxes, community meetings and a complaints procedure, which they actively listen to.
- ❑ For some interviewees, a question mark remains over the representativeness of local service user groups. However, engaging involvement from the wider service user constituency is recognised as a challenge.

Social Inclusion

- ❑ GPs appear to believe that, although they primarily address patients' medical rather than social needs, the PHCT are involved with the social inclusion agenda.
- ❑ Housing is a recurrent problem from the PCLT perspective, with limited stock preventing the movement of service users to more appropriate / desirable accommodation.
- ❑ The CPN role is seen as both a social inclusion resource in itself, but also as a broker service to access other organisations that advance social inclusion. However, the extent to which the pursuit of the social inclusion agenda is seen as integral to the role of the CPN varies between individual practitioners.
- ❑ One psychiatrist commented on the relative lack of vocational training and more traditional day care provision.
- ❑ Whilst social workers have had to be more cautious in assisting service users with their Disability Living Allowance claims, there are new initiatives for helping people with mental health problems get into work.
- ❑ MIND highlighted a number of new projects that not only encourage people to volunteer as a potential way into work or training, but which also offer work opportunities via the statutory sector services. A major issue raised by Rethink is the need to address routes into employment for people with mental health problems:
- ❑ Acute wards use occupational therapists (OTs) to support service users to access training and educational opportunities, with one ward reporting the recruitment of a new Housing Officer to address accommodation issues.

Interface with Child and Adolescent Mental Health Services (CAMHS)

- ❑ The PHCTs' links with CAMHS appear more problematic than those with other mental health services. Central to these difficulties is the ease of referrals, resource pressures having resulted in the service only accepting severe cases, and an accusation of crisis management.
- ❑ Given these pressures, alternatives (e.g. the GP-led service, Family Matters) are normally sought.
- ❑ The main contact between the CAMHS and the PCLTs arises when CAMHS' users are transferred to the adult mental health services. One CPN indicates areas where there have been improvements in communication due to both services using the CPA paperwork.

Interface with Elderly Services

- ❑ The interface between the PHCTs and the elderly services is reportedly satisfactory. However, problems are evident, especially around the lack of adequate consultant-level staffing.
- ❑ PCLT staff cannot transfer patients automatically to elderly mental health services unless they have been discharged and re-referred.
- ❑ The referral criteria to the elderly mental health team changed over the last few years and has given rise to problems. Underpinning this change is the issue of resources and inadequate service capacity.

Local Care Centres (LCCs)

- ❑ Awareness of the planned development of the LCCs varied between PHCT staff, with some being entirely unaware of the initiative.
- ❑ Those who were aware of the plans expressed concern that either their role was unclear or that their remit was too narrow and needed to be expanded.
- ❑ There were some concern that staffing levels could be an issue, and that the level of resources more generally would not match the need the LCCs seek to address.
- ❑ On a positive note, there was a hope that the LCCs would encourage joint working.

Primary Care Mental Health Workers (PCMHWs)

- ❑ Awareness of the PCMHWs also varied between staff. One GP, who was unaware of the initiative, was uncertain of the difference between PCMHWs and practice-based CPNs.
- ❑ For those GPs aware of the plans, the introduction of PCMHWs was viewed as problematic, with the suspicion that the numbers of workers estimated for Plymouth will be insufficient to exert any significant impact.
- ❑ Other PHCT staff who were aware of the planned PCMHWs were generally positive.
- ❑ Feelings among the PCLT staff on the potential role and value of the PCMHWs varied, from warm acceptance and eager expectation, to scepticism and confusion.

Recommendations

A. Characteristics of primary care patients with mental health problems consulting their GP

- ◆ Investigation of the possibility of unmet mental health needs among men could be undertaken.
- ◆ If differences in patients' diagnoses across the GP practices are attributable to GP skills rather than the socio-demographic profile of the local populations, educational events to improve GP detection of other mental health illness could be initiated.
- ◆ Further evaluation of the impact on primary care services of integrating health and social care in Plymouth is needed before informed commentaries can be made.

B. In-depth interviews and focus groups

Theme I: Communication

- ◆ Access to those PCLT staff based at the Nuffield Clinic needs to be improved. Suggestions from interviewees include the increased use of mobiles phones and more effective use of IT (including email, which is additionally seen as a means of reducing the need for paperwork). Additionally, improved communication could be achieved by increased attendance of PCLT staff at PHCT meetings, or the co-location of secondary services in the same building as primary care staff.

- ◆ A consistent finding throughout this report is the deleterious impact the staff shortages in the PCLTs had upon effective operation between services. If the anticipated advantages of integration between health and social care are to be realised, this is an area that needs to be addressed.
- ◆ Another factor that impacts adversely upon service users' perceptions of local services is the disjunctures in care provision that can arise as users move from one service to another, or from one service to back into the community. A particular priority should be the re-evaluation of discharge procedures from the acute wards to those community-based services (e.g. HTT, PCLTs and PHCTs) responsible for after care. Similarly, the pivotal role of the care co-ordinator as the constant in a service user's experience of services should be reaffirmed so that potentially adverse events (e.g. arising from a CPNs lack of awareness of changes to their client's medication) can be avoided.
- ◆ The inclusion of carers in a therapeutic partnership to address common service users needs may start to address carers' demands for greater communication.

Theme 2: Integration

- ◆ Proposed changes to the physical location of CPNs in GP surgeries has arguments in favour and against. The debate regarding the alternative merits should be inclusive.
- ◆ The inclusive involvement of the outer locality PCLT members in the establishment of the HTT should be seen as a template for future service developments.
- ◆ Integration between community-based services (especially the HTT) could be re-examined to identify reasons for the differential satisfaction with joint working.
- ◆ The understandable concerns of social workers during a time of transition should be addressed. These worries have been repeated elsewhere (e.g. fears that the social model of care will be subsumed under the medical model as social workers become absorbed by their new employers). Initiatives to value their involvement and encourage a team identify across health and social care professionals is imperative.

Theme 3: Accessibility

- ◆ A fundamental impediment to service accessibility has been the staffing problems encountered in the PCLTs. As mentioned, if the anticipated advantages of integration between health and social care are to be realised, this is an area that needs to be addressed.
- ◆ Demand for the AOS service, and referral problems, indicates a need to increase service capacity. This could additionally reduce the need for acute inpatient stays, which arise as a knock-on effect from problematic community-based service provision.
- ◆ Housing stock (both in terms of its quantity and quality) need to be improved to address what is a clear need.
- ◆ Rehabilitation services need to be reassessed to ease the bed blocking problems experienced by the acute sector searching for appropriate move-on alternatives.

- ◆ Further work needs to be undertaken with mainstream Social Services to clarify referral routes for those people with a mental health problem who either do not have a GP or do not meet the service referral criteria.

Theme 4: Information

- ◆ As mentioned, discharge procedures from the acute sector (and some other specialist mental health services) need to be re-examined, and reasons for existing problems identified, to ensure that community-based services (including the Criminal Justice service) are aware of an imminent discharge.
- ◆ For social workers in the PCLTs, the duplication of paperwork (i.e. CPA and Care Management) needs to be addressed if the impression and reality of a unitary, integrated team is to be realised.
- ◆ The imperative to conduct a full assessment of a client's risk status, and to ensure that that information is up-to-date to ensure it has clinical value needs to be reasserted. This will also help to ensure optimal patient care.
- ◆ The greater use of IT and the use of shared patient records is still seen as a key means of improving information flow between services.

Theme 5: Satisfaction with care

- ◆ Existing provision of opportunities for meaningful daytime activities needs to be reassessed. Not only do such opportunities offer clinical value, but also advance the social inclusion agenda.
- ◆ An appropriate response needs to be developed to address those patients with alcohol-related problems who present in Accident and Emergency and draw heavily and disproportionately upon finite resources.
- ◆ The role of the carer needs to be appreciated more, possibly including realistic respite opportunities.

Additional Themes

User Voices

- ◆ Consider alternative vehicles beyond the Mental Health Forum by which the service user voice can be aired and user participation broadened.
- ◆ Given the challenge to involving the wider service user constituency, imaginative methods may have to be considered.
- ◆ Funding levels must be adequate if the work expectations placed on service user representatives are to be met effectively.
- ◆ Consultation with service users should be undertaken more consistently across local mental health services as evidence of a generalised 'culture of listening.'

Social inclusion

- ◆ Local housing stock remains an issue that needs to be addressed.
- ◆ The extent to which existing vocational training schemes and traditional day care provision are adequate to advance service users' social inclusion could be reviewed.
- ◆ CPNs are pivotal to the social inclusion agenda. Training sessions could be initiated that reinforce the potential significance of this role so there is a common understanding of the centrality of this agenda to the CPNs' work remit.
- ◆ Ensuring effective employment routes for people with mental health problems is fundamental to advancing social inclusion. This is an area which could be explored locally.

Interface with Child and Adolescent Mental Health Services

- ◆ Resource pressures have limited the role of the CAMHS to one of crisis management and precluded any preventative work with children.
- ◆ Staffing levels will have to be evaluated if the service is to exert any benefit from intervening early in the onset of mental health problems among the young.

Interface with Elderly Services

- ◆ Similar to the CAMHS, there is a general perception that existing service capacity is insufficient to meet the demands placed upon the elderly mental health service.
- ◆ Existing consultant staffing levels should be reviewed with the referral criteria subsequently re-examined.

Local Care Centres

- ◆ Awareness exercises (e.g. training days) need to be organised to ensure all staff are aware of the LCCs and how they and their service fits into the picture.
- ◆ These awareness exercises should clarify and explain the role and remit of the LCCs, and reassure local staff that the resources available to the LCCs are sufficient to meet demand.
- ◆ The LCCs should emphasise and clarify the opportunity for joint working between health and social care professionals.

Primary Care Mental Health Workers

- ◆ Lack of awareness is potentially indicative of the number of new initiatives that are currently being generated in mental health specifically and the National Health Service generally. Similar to the LCCs, awareness exercises need to be organised to ensure all staff are aware of the PCMHWs.
- ◆ Reassurance should be given that the role of the PCMHWs will have a beneficial impact and will not simply duplicate existing professional roles.

- ◆ The awareness exercise needs to address any scepticism and confusion that may exist among local staff.

Conclusions

In its briefing paper *Positive Approaches to the Integration of Health and Social Care in Mental Health Services*, the National Institute for Mental Health in England concluded: 'Integration of health and social care in the field of mental health promises major gains for users, staff and communities. But this will only be achieved if whole persons and whole systems approaches, with an accent on citizenship and recovery, are the driving values and precepts.'

An effective whole systems approach is dependent upon the development of successful working partnerships between myriad agencies. These partnerships extend service provision beyond the integration of health and social care to embrace the wider citizenship agenda service users have demanded.

Whether or not specialist mental health trusts rather than PCTs are the optimal means by which this agenda can be implemented is open to debate. Certainly, there is a justifiable debate to be had over whether or not, in an attempt to minimise the stigma associated with mental illness, services that fall under the remit of an organisation dedicated to addressing the general population's health needs are more appropriate, desirable or effective than those dedicated to a particular sub-group of illnesses.

Of course, health and social care partnerships under a PCT umbrella are not necessarily the organisational panacea, either. Evidence from this evaluation, undertaken over a 12-month follow-up period, indicates that discernible changes in the provision and experience – as evidenced by inter-service communication, service accessibility, service integration, information exchange and general satisfaction with care – of mental health services in Plymouth have not been major. Some problems evident in the baseline evaluation persist. Moreover, the impact upon primary care appears to have been minimal.

It should be noted, however, that, firstly, the degree of positive integration between certain services reported at baseline suggested it was unlikely that the follow-up evaluation would detect a marked improvement. Secondly, intuitively it would seem more likely that the benefits accrued from health and social care integration would first be experienced in secondary care services, with benefits experienced in primary care dependent upon those achieved in the former. Thirdly, there does appear to be an acceptance in Plymouth of the importance of partnerships and a willingness to make them work effectively. Fourthly, and importantly, organisational changes of this nature can take many years to evolve, function optimally and deliver their maximum impact. Plymouth's experiences of service integration are not unique. Despite the fact that integration between health and social care has been a pivotal part of government policy for a number of years, progress has been slow, primarily because of the practical difficulties encountered – the devil is in the detail.

It is this detail, and the potential myriad additional logistical problems – e.g. the physical co-location of staff, improved access to information systems, traditional workplace practices, embedded cultures, and depleted levels of staff from sickness – that will determine whether the integration agenda can be achieved or not; and this will take time.

This study ideally needs to be repeated in several years time in order to detect the fundamental changes in mental health services that integration between health and social care, under the umbrella of the Plymouth PCT, seeks to achieve. However, sufficient evidence exists to indicate that service integration is gradually exerting its desired impact upon staff, service users and carers, and that, while not reduced to rubble, the 'Berlin Wall' that has traditionally separated health and social care is slowly being dismantled in Plymouth.