Views and Opinions of Healthcare Workers in the South of England on Community Mental Healthcare

Eleanor M Jack
BA, RGN, RMN

September 2003
ISBN: 1-85899-163-3

Institute of Health and Community Studies
Bournemouth University

Acknowledgements

My thanks to Tom Anderson for his general assistance on the project, Dr Jerry Warr for his direction and support, Professor Peter Thomas for statistical help, Dr Les Todres for supervision and Clive Andrewes for ongoing support and encouragement. Thanks also to Kate Galvin, Dawn Freshwater, Anita Somner and all my colleagues within IHCS for their help and inspiration.

Most importantly, my thanks go to all those who took the time to complete the questionnaire and be part of this study.

Contents

List of Tables and Figures

Executive Summary

Summary of Results

Respondents

There was a 34.6% response rate with the majority of responses from either Community Psychiatric Nurses or GPs (as reflected in the sample groups) aged 31-50 years, with a professional qualification linked to either medicine or nursing.

Mental health qualifications

Respondents were asked firstly if they had a recognised qualification in mental health, and secondly if they had experience of working in mental health. Just over half the respondents had a mental health qualification (52%, n=178). Notably, GPs were the most likely group to report that they had no mental health qualification.

Of the GPs who answered the question about having *experience* of working in mental health, 85% (n=66) stated that they dealt with mental health problems as an integral part of their GP role. However, when subsequently asked if they had a mental health qualification, 73% (n=63) stated that they had *no* formal mental health qualification.

The Questionnaire

Awareness of the term 'Community Mental Health Worker'

Over half (52%, n=182) of all the respondents had heard of the term Community Mental Health Worker in the context of recent Government documents and press coverage. However, this was not uniform throughout the groups. Indeed, 63% (n=71) of GPs 'had not' heard the term, whereas only 35% (n=34) of Community Psychiatric Nurses had not heard the term.

How had they heard Community Mental Health Workers described?

The most common description chosen was that of a generic mental health/social care worker, with 42% (n=131) of respondents stating this.

The role of the new Community Mental Health Worker

A total of 68% (n=115) stated that the workers should look after those with a more serious mental health problem on a 'long-term' basis with 56% stating that the same group should be cared for on a 'short-term' basis. Only a few respondents (n=5) stated that the worker should care for those deemed to have a milder mental illness only.

Thus, overall, respondents felt that care would be best targeted at those clients described as having a long-term mental illness, although a significant number also felt that care should be directed towards those with a milder mental illness. It could therefore be said that respondents made it clear that there are gaps in the service for both those with a milder mental health problem and those with a severe mental illness.

Did respondents feel that this type of worker already existed?

Over half (56%, n=116) of the respondents felt that this type of worker already existed. When asked to describe who might already be doing this type of work, the most common response was either a Community Psychiatric Nurse (n=21) or a Community Mental Health Worker/unqualified support services worker (n=17). Other suggestions included qualified Social Workers, Assertive Outreach Workers, and Practice Counsellors (all n=5), practice-based nurses and voluntary sector workers (n=3), specific social service workers (n=2), and Occupational Therapists and GPs (n=1).

Current perceptions of community mental healthcare

Physical aspects of mental healthcare

45% (n=176) of respondents felt that this aspect of care was 'Poor', with a further 38% rating it as 'Satisfactory' and only 12% rating it as 'Good'. Comments made reflected the view that those with long-term mental health problems require greater attention to their physical healthcare needs as well as the input of a regular worker to maintain a long-term relationship with the client.

Mental healthcare

This aspect seemed to be rated slightly better than the previous question, with only 31% (n=181) rating it as 'Poor', 45% (n=181) rating it as 'Satisfactory', and 19% stating that it was 'Good'. Notably, over half the GP respondents (n=72) said that this aspect of care was 'Satisfactory' – the literature comments that GPs are the most likely professionals to be dealing with this group.

Despite its higher rating, comments also identified gaps in service provision for this client group. The physical health of the long-term mentally ill was of concern to respondents, as reported in the literature. There were also comments about lengthy waiting lists for 'talking therapies' and access to psychological therapies for all clients.

Focus on community mental healthcare

Clients' ability to make contact with services

Overall, 41.4% (n=186) stated that clients could make contact with services if they needed to 'Most' of the time, with 35.4% stating that this was the case 'Sometimes'. This spread was similar for all groups of

respondents, although Community Psychiatric Nurses were more likely to rate this aspect of care more highly: 73% (n=33) gave it a rating of 'Most' or 'All' of the time, with 82% (n=71) of GPs giving it a rating of 'Sometimes' or 'Most' of the time.

This may be because Community Mental Health Teams, along with some other service providers (Approved Social Workers), are currently most likely to provide 'out of hours' emergency mental health cover as described in the Workforce Action Team Special Report (2001).

Client access to a range of talking therapies

Overall this was not rated so highly, with only 28% (n=186) stating that clients had access 'Most' of the time and 45% 'Some' of the time. Again, this response was similar throughout the groups of respondents. The only figures to note were that voluntary/development workers were more likely to state that access was 'Rarely' available (62.5%). However, the number in this group was small (n=8), as was the case with Psychiatrists, Assertive Outreach Workers and Clinical Psychologists.

Communication between agencies

36% (n=186) stated that communication between agencies was effective 'Most' of the time and 43.5% felt that it was 'Sometimes' effective. This spread was similar throughout the groups with the only discrepancy being that 62% (n=34) of Community Psychiatric Nurses felt that it was effective 'Most' of the time. Those professional groups that believed communication between agencies was rarely effective included Clinical Psychologists and Health Visitors. Respondents made specific comments about communication between the agencies, generally citing negative experiences.

Staff skill base

This question asked whether staff had the correct skills for those they cared for. This was rated favourably by respondents, with 51% (n=185) stating that community staff seemed to have the correct skills for the needs of those they cared for 'Most' of the time and 4% stating this was the case 'All' of the time.

Looking at all the groups, 67% (n=15) of Managers said they felt that staff had the correct skills 'Most' of the time, as did 62% (n=34) of Community Psychiatric Nurses and 75% (n=8) of Primary Care Counsellors.

Clarity of role

This was rated most favourably by respondents: 50% (n=183) stated that staff were clear about their roles and who they should be caring for 'Most'

of the time, with 9% 'All' of the time and 35% 'Sometimes'. This pattern was reflected throughout the professional groups.

Appropriate client care

This question asked respondents if they felt that clients were receiving the most appropriate care for their needs. It was not rated favourably by respondents, although it was better than those responses for talking therapies, with 54% (n=184) feeling that clients received the most appropriate care 'Sometimes' and 34% 'Most' of the time.

As a whole, the aspect of care most likely to receive a favourable response was that of community staff seeming clear about their role, followed by staff having the correct skills for those they care for. The ability of clients to make contact with services when they need to was next, followed by communication between agencies and subsequently clients receiving the most appropriate care for their needs. Finally, access to a range of talking therapies was rated least favourably.

Comments offered about the aspects above, by and large, tended to reflect the respondents' answers to the questions. The two most frequent comments appertained to the restriction of 'talking therapies' with long waiting lists, and limited services and resources for community mental healthcare generally (n=18).

Who could be a Community Mental Health Worker?

Respondents were more likely to select Community Psychiatric Nurses (86%, n=180) and Social Workers (76%, n=180) as the most likely professionals to be Community Mental Health Workers. When examined individually, each sample group also showed this response. Health Visitors also scored relatively highly, which corresponds with the literature, whereas GPs were among the least likely professionals to be selected as possible Community Mental Health Workers (13%).

'Expert patients' in this survey were suggested as possible workers more often than Practice Nurses. This is an interesting finding given that a great deal of the literature suggests that Practice Nurses would be well placed to extend their role further and develop their mental health skills.

Where respondents indicated 'Other', the most likely suggestion as to who could be a Community Mental Health Worker was an Occupational Therapist (29%, n=45). There was no preference shown by any particular professional group of respondents.

When asked to make comments, one of the most common remarks (50%, n=28) was that the most limiting factor for the selected

professionals (see question above) would be time. Community health professionals are, at present, are under severe pressure with the workload they already have without additional responsibilities for mental healthcare. Respondents also commented that the (new) workers in community mental healthcare should work with clients on a long-term basis (37%, n=19).

Skills for the Community Mental Health Worker to possess

The five skills most likely to be described as either 'Very important' or 'Important' were:

- Communication and listening skills;
- Knowledge of local health services;
- Ability to assess and identify needs;
- Ability to work with others who may be involved in the client's care;
- Ability to build therapeutic relationships.

The three skills described as least important were:

- Experience in computerised cognitive behavioural therapy;
- Possession of research skills;
- Complementary therapy skills.

All professional groups were likely to rate communication and listening skills highly in conjunction with knowledge of local health services and ability to assess and identify needs.

The ability to promote self-help skills in clients was rated highly by all groups, but especially Community Psychiatric Nurses, with 67% (n=40) rating this as 'Very important'. This was similar to ratings for the ability to work in a holistic manner; 72% (n=40) of Community Psychiatric Nurses rated this as 'Very important', along with experience of risk management (65%, n=40). However, the comparatively larger number of Community Psychiatric Nurses among the respondents may have contributed to these findings.

The most common comment was to emphasise the importance of communication skills (25%, n=130), followed by the need for knowledge of local resources (15%, n=130) and an ability to assess and identify the needs of the clients (14%, n=130).

Salary

The most popular answer suggested that the workers should receive a salary of £22,001-£27,000. 78.5% of respondents (n=28) who selected 'Other' and made a comment, stated that the salary should reflect the individual's experience, knowledge and managerial responsibilities.

When asked who or what organisation should pay this salary, respondents (n=158) were most likely to propose that a 'Mental Health Trust only' or, secondly, that a 'Primary Care Group/Trust only' pays the salary. This was uniform across all the groups. Where a combination of providers was suggested, 48% suggested that Social Services and Health should pay the salary.

Training

The following two aspects of training were rated extremely highly:

- Experience of working autonomously;
- Experience of working in the community.

The most common comment made (n=7) suggested that the topic of medication should be included in the training – prescribing practice, side-effects etc. Community Psychiatric Nurses were the most likely group to suggest this. The second most common comment (n=6) suggested that training should include assessment issues incorporating aspects of risk and risk management.

Expert patients/service users as Community Mental Health Workers

Over half the respondents felt that 'expert patients'/service users *could* indeed be Community Mental Health Workers. However, GPs were more likely to state that they felt expert patients 'could not' be Community Mental Health Workers. Respondents were asked to comment on their answer. The most significant comment (35%, n=94) was that experience and training would be essential for service users to fulfil this role.

Other comments

- Supervision and support would be necessary for service users to fulfil the role (n=10).
- Service users would be in a position to share experience and skills which would benefit clients (n=8).
- Service users could be befrienders/promote self-help/provide general support only (n=3).
- Concerns appertaining to the ability of service users to be 'objective' (n=6), possible illness relapse (n=5), and lack of training (n=4) were expressed, along with concerns about confidentiality issues (n=4).

The general comments made about expert patients expressed the depth of feeling that respondents held about this issue.

Will the new Community Mental Health Workers make a difference to those with a mild/moderate mental health problem?

Over half of all respondents felt that the new Community Mental Health

Worker *would* make a difference to those with mild/moderate mental health problems. This was similar throughout the groups. When asked to comment, one of the most common responses (21%, n=33) was that the money should be available for the severely mentally ill only.

Will the new Community Mental Health Workers make a difference to those with a more severe mental illness?

Again, over half of all respondents felt that the new Community Mental Health Worker would make a difference to those with a more severe mental health problem – a marginally more positive result compared with the previous statement. This was similar throughout the groups.

The responses to the above two statements can be seen to underline earlier findings in the report by identifying gaps in service provision for those with both severe and less severe mental health problems. As before, however, respondents felt that those with a more severe mental illness were marginally more in need of increased input.

The most common comment (n=7) was that long-term support was necessary for those with a more severe mental health problem. The next most frequent comment (n=4) was that if the new workers worked with this client group, they should be based within a specialist team, such as a Community Mental Health Team.

Management

Respondents were asked who they thought should manage the new Community Mental Health Workers, i.e. who they should be accountable and responsible to. The most common response was that the new workers should be managed by an appropriate line manager. This response was similar throughout the groups except for GPs – only 6% (n=47) of them selected this answer compared with 36% across the other groups. GPs' most likely response was that the Community Mental Health Team should be the workers' line manager. There were few additional comments made on this subject.

Caseload issues

An overwhelming 83% (n=174) stated that they 'Agreed' or 'Strongly agreed' with the new workers carrying a caseload. This was the same throughout all the groups apart from Community Psychiatric Nurses. Over half of all the Community Psychiatric Nurse respondents (n=31) 'Strongly agreed' that the new workers should have a caseload. The most common comment (n=8) suggested that carrying a caseload was an important aspect of the role as it ensured 'continuity of care' for clients.

Where should the Community Mental Health Worker be based?

The final question asked respondents where the new worker should be based from a choice of three: within primary care, within a Community Mental Health Team, or 'other'. The most common response was that the new worker should be based within a Community Mental Health Team. This response was similar throughout the groups, and would appear to correspond with the management question whereby respondents frequently suggested that the Community Mental Health Team should manage the new worker.

Where 'Other' was selected, the most common description was that the worker should be based in both primary care *and* a Community Mental Health Team (62%, n=39). Similarly, it was stated that the worker should be based within the Community Mental Health Team so that they received adequate support and supervision.

Introduction and Rationale

The Dorset and South Wiltshire Education Consortium funded this project with four key aims:

- To undertake a feasibility study into the need for a new healthcare worker role to support people with mental health problems that are being managed by the Primary Healthcare Team, and to promote the physical health of people with mental health problems.

- To identify whether the activities underpinning this role (and the above tasks) can be combined in one role or whether two separate roles need to be created.

- To clarify the role of a Community Mental Health Worker and the relationship within a Primary Care Team and/or Mental Health Team.

- To design the education that would be needed for such a role.

The expected outcomes were as follows:

- analysis of the feasibility of the role of a Community Mental Health Worker;
- clarification of the nature of the work undertaken by the person in this role;
- clarification of the role and accountability within the Primary Care Team and/or Mental Health Team;
- clarification of the alliances that the Community Mental Health Worker would build;
- analysis of the education and qualifications needed for this role.

A self-report questionnaire was sent out in May 2002 to over 500 Community Mental Health Workers employed predominantly in the Dorset area. Those surveyed included GPs, Community Psychiatric Nurses, Managers, Lecturers, and Psychologists among many other groups of workers.

Background and Literature Review

The National Health Service

General structure of the NHS and policy developments

As a public service funded by the tax payer, the NHS is accountable to Government Ministers who are in turn accountable to Parliament. Different arrangements exist in different parts of the country, both in Government responsibilities for the NHS and how that responsibility is carried out (Department of Health, 1998a).

At the time of the survey, the structure of the NHS was as outlined in the Royal College of General Practitioners Information Sheet (1999) i.e. the NHS could be divided into sections that dealt with strategy, policy and managerial issues (Government departments and health authorities/boards) and those that dealt with the clinical aspects of care (GPs and hospitals) (Royal College of General Practitioners Summary Paper, 1997).

The parts of the NHS that dealt directly with patients were divided into three: 'primary care' (GPs and the Primary Healthcare Team, Opticians, Dentists and Pharmacists), 'secondary care' (e.g. hospitals) and 'tertiary care' (specialised doctors and health professionals).

Two major changes to the structure of the NHS had already happened by the time the survey took place. The first occurred under the Conservative Government in the 1990s.

The 1989 White Paper *Working for Patients* outlined plans to introduce competition into the health service via an 'internal market' system, with purchasers and providers of healthcare. These changes came into effect in April 1991 following the *NHS and Community Care Act 1990*.

NHS hospitals developed into NHS Trusts, independent of the local health authority (health board in Scotland, health and social services board in Northern Ireland), and provided health services to patients, purchased either by the local authority/board or by fundholding GPs. Fundholding was the scheme that allowed general practices to hold their own budget to purchase certain services for their patients. Community fundholding extended the types of services GPs were able to purchase, and by 1995 the Government permitted some fundholders to combine with health authorities/boards to purchase the full range of NHS services for their patients (Royal College of General Practitioners Information Sheet, 1999).

The second major change to the NHS was announced in the November 1998 Queen's Speech, when the Labour Government outlined its plans to replace fundholding with commissioning, and to revise the role of health authorities/boards. Fundholding was stopped in March 1999 (Royal College of General Practitioners Information Sheet, 1999).

Authorities and boards now had a duty to improve the health of their population, to encourage co-operation between the various sections of the health service, and to oversee the development and implementation of local health targets. Details of the changes for England, Scotland and for Wales were given in three White Papers (e.g. in England, *The New NHS. Modern. Dependable*).

Two further key features were the introduction of health improvement targets for local populations, and increased quality control for health professionals through the use of clinical governance procedures (Royal College of General Practitioners Information Sheet, 1999).

Structure of the NHS in England to early 2002

At the time of the survey, the structure was as follows:

- The head of the NHS in England is the Secretary of State for Health (at the time of writing, this was Alan Milburn) who chairs the NHS Policy Board responsible for strategy and finance issues, licensing new drugs, monitoring waiting times, and setting official health targets. The Board and the Secretary are accountable to Parliament.

- The NHS Executive is the administrative head office of the NHS in England. It develops and implements policy for the NHS, and monitors the provision of healthcare through eight regional offices.

- Each region consists of a number of 'health authorities'; there are about 100 health authorities in England. They have responsibility for improving the overall health of their populations and for reducing health inequalities through the implementation of Health Improvement Programmes. They also help develop 'Primary Care Groups' (see below), allocate resources to the Groups and hold them accountable.

- Each health authority has a number of NHS Trusts and Primary Care Groups (PCGs) within its area. The role of the NHS Trusts is to provide hospital and community health services; they account for about 72% of the total NHS budget. They are accountable both to their local health authority and the PCGs with which they have service agreements.

- In England, commissioning is undertaken by the PCGs. Membership of these groups is compulsory for GPs. By working closely with social services, the PCGs commission health services for their local community, with each group typically covering about 100,000 patients (Royal College of General Practitioners Information Sheet, 1999).

Contemporary Issues in the NHS

At the time of writing, many changes were happening within the NHS and to the service provided. In order to understand the direction of these changes, it is relevant to consider in more detail some of the aforementioned policy changes.

The New NHS. Modern. Dependable

Following being elected to power in May 1997, the new Labour Government issued a policy statement later that year setting out a series of proposed changes to the NHS in a paper called *The New NHS. Modern. Dependable* (Department of Health, 1997).

The 'White Paper' (i.e. a document produced by the Government setting out details of future policy, giving them an opportunity to gather feedback before it formally presents the policies as a Bill) set out proposals for modernising the NHS to meet the wishes of patients for an up-to-date, quicker and more responsive service.

The White Paper set out an ambitious and far-reaching programme, with the target of a ten-year programme to modernise the NHS. It was described as providing a 'third way' to progress the NHS; the other two being the centralised control systems of the 1970s and the internal market system of the 1990s.

The Government believed that the NHS needed to modernise if it was to meet patients' aspirations for quicker, more responsive services. The White Paper set out the Government's plan to do this, e.g. replacing the internal market while keeping some aspects of the previous Government's changes that worked; the separation between planning of hospital care and provision; the important role of primary care in the NHS; and decentralised responsibility for operational management. The paper focused particularly on structures, quality and efficiency (Department of Health, 1997).

Principles

There were six key principles underlying the changes set out in the White Paper:

- renew the NHS as a genuinely national health service (set national standards);
- devolve the responsibility for meeting these new national standards to a local level;
- get the NHS to work in partnership (for example, forging stronger links with local authorities);
- improve efficiency so that all money is spent to maximise patient care;
- shift the focus on to quality of care so that excellence is guaranteed to all patients;
- make the NHS more open and accountable to the public.

Developments

The three main developments highlighted in the White Paper were:

- new 24-hour telephone advice lines staffed by nurses to give immediate advice and help;
- the development of NHSnet – the NHS's own website to expedite the making of hospital appointments, obtaining test results, and providing specialist on-line advice at the GP surgery;
- everyone with suspected cancer to see a specialist within two weeks of their GP deciding they need to be seen urgently, and requesting an appointment.

Actions

Three areas for action were set out as follows:

- National standards and guidelines through:
    - *National Service Frameworks* to ensure consistent access to services and quality of care. They were to set national standards and define service models for a particular service or care group, put in place procedures, and establish performance measures. They were not only to establish clear national standards to improve quality but also to reduce unacceptable variations in treatment.

    - *National Institute for Clinical Excellence* was to be established to promote high quality treatment and technology in the NHS. Its aims were to give advice on best clinical practice to the NHS, patients, carers, health authorities and Primary Care Groups. The advice was to cover health technologies including medicines, medical devices, and diagnostic procedures, as well as the management of specific conditions. The White Paper described it as a partnership between the Department of Health, the NHS, health professionals and patients.

- A local drive for quality through:
  - Primary Care Groups (PCGs) replacing the old GP fundholding, whereby groups of Community Nurses and GPs work together to build services for patients locally by planning and commissioning services, including secondary services. They also had to address improving the health of their community, (e.g. promoting health needs), delivering effective and appropriate care, developing primary and community health services by addressing professional development/training and investing in improving services.

  - Replacing annual contracts between health authorities and PCGs/Trusts with long-term service agreements which have integral quality standards which must be met (in England and Wales, health authorities identify the health needs of local people and make arrangements for services to be provided by NHS Trusts, primary care and other agencies, using funding provided by the Government. They are monitored by the regional offices of the NHS Executive which manages the NHS for the Government).

  - Introducing 'clinical governance' to ensure that clinical standards are met and strategies are in place for continuous improvement, plus a statutory duty for quality in NHS Trusts.

- A new organisation was formed, the *Commission for Health Improvement* (CHI), to ensure standards were being met. Local healthcare organisations in the NHS were to be reviewed every three or four years by this independent statutory body. Its focal point was to be the implementation of clinical governance, National Service Frameworks and NICE guidelines. The CHI has power to intervene and help sort out any serious clinical problems (Department of Health, 1997).

Efficiency and Quality

The paper also addressed efficiency and quality. It outlined a National Performance Framework to hold the NHS to account on six main areas, namely patient experience, fair access to services, better quality, care outcome, improvements in health, and efficiency gains.

The role of the health authority was to adopt stronger powers to influence the healthcare of those patients in their area and address health promotion problems. With other bodies such as PCGs, Trusts, and local authorities, they were to design three-year *Health Improvement*

Programmes which would provide the framework within which all NHS bodies would operate. It also stipulated that links with social services were to be strengthened.

PCGs were to be established whereby all the GPs in an area, along with Community Nurses, take responsibility for commissioning services working closely with social services, ultimately being able to become a Primary Care Trust responsible for running community hospitals and community health services.

NHS Trusts were to agree long service contracts with PCGs/Trusts and have new statutory duties of quality, being more accountable to the public, and publishing performance details. With regards to staff, they were to demonstrate their development and involvement (Royal College of General Practitioners Summary Paper, 1997).

The Department of Health, and the NHS Executive within it, were to tackle health at a national level and work with the health professions to develop the National Service Frameworks. Annual surveys were to be used to establish what patients and carers think of the NHS services, along with a new NHS Patient's Charter identifying rights and responsibilities for patients.

In summary, the White Paper, published in December 1997, reflected the Government's commitment to abolishing the internal market and replacing it with a system of integrated care between NHS bodies and other local agencies. The changes it set out were designed to deliver a better service to patients, through improved quality and efficiency, offering prompt, high quality treatment and care, built around the needs of individuals. The plan formed the basis of a ten-year programme to renew and improve the NHS through evolutionary change rather than organisational upheaval (Department of Health, 2000a).

Our Healthier Nation

The *Saving Lives: Our Healthier Nation* White Paper was published in July 1999. It is described as a Government-wide public health strategy with the twin goals of improving health and reducing inequalities in health. The strategy aims to prevent up to 300,000 untimely and unnecessary deaths by the year 2010.

It can be seen to follow on from the Conservative Government's *The Health of the Nation: a Strategy for Health in England*. Launched in July 1992, the paper identified the cost to employers of 'avoidable' ill health and sickness rates as well as the cost to the NHS. Its aim was to secure continuing improvement in the general health of the population of England (Department of Health, 1999a).

> Good health is no longer about blame, but about opportunity and responsibility. While people on their own can find it hard to make a difference, when individuals, families, local agencies and communities and the Government work together, deep-seated problems can be tackled. Our third way is a national contract for better health. Under this contract, the Government, local communities and individuals will join in partnership to improve all our health (Department of Health, 1998b).

The paper addresses the factors affecting health. Lifestyle choice factors include diet, exercise and sexual behaviour but other factors such as poverty, social exclusion, employment, housing, education and the environment are equally influential, but people are not always afforded the luxury of choice or preference. These issues, and the fact that generally the population is living longer with increasingly poorer health as age progresses, plus the ever widening gap between the worst and best health status, leads the paper to identify that Government needs to address not only these issues but also communities and individuals themselves (Department of Health, 1998b).

Each local area in the country has to examine coronary heart disease and stroke, cancer, accidents and mental health and set local targets for tackling them. Local needs were to be identified by health authorities developing Health Improvement Programmes (Department of Health, 1998b) i.e. health improvement to be integrated into the local delivery of healthcare.

The Government stated it would give the NHS £21 billion to 'help secure' a healthier nation. It would tackle smoking, integrate Government and local government work to improve health, plus stress health improvement as a key role for the NHS, with high standards for all not just a few (Department of Health, 1999a).

Health authorities were to have a new role in improving the health of local people, and PCGs/Trusts would have new responsibilities for public health. Local authorities were to work in partnership with the NHS to plan for health improvement.

A Health Development Agency was to be set up to raise the standards and quality of public health provision. The paper also identified three settings for action: schools, workplaces and neighbourhoods. Furthermore, the paper outlined the introduction of the Healthy Citizens Programme, a new approach to help individuals to improve their own and their families' health, incorporating:

- NHS Direct and NHS Direct On-line – a nurse-led telephone helpline and internet service providing information and advice on health.
- Health Skills – programmes for people to help themselves and others, e.g. Sure Start parenting skills for those with young children and first aid for school children.
- Expert Patients – programmes to help people with long-term chronic conditions manage their own illnesses.

> We want to see healthier people in a healthier country. People improving their own health supported by communities working through local organisations against a backdrop of action by the Government (Department of Health, 1999b).

In summary, the paper had two key aims:

- to improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness;
- to improve the health of the worst-off in society and to narrow the health gap (Department of Health 2000a).

The NHS Plan: A Plan for Investment, A Plan for Reform

Following the winter health pressures of 1999-2000 and a flu epidemic pushing the NHS to crisis point (with resulting newspaper reports of 'third world wards'), the Government responded with *The NHS Plan*, published in July 2000. It was a radical action plan for the next ten years, setting out measures to put patients and people at the heart of the health service and promising a 6.3% increase in funding over five years to 2004. It has been described as the 'biggest thing since the health service was first created' (Department of Health News Desk: Inside Story, 2000c) and was described as a blueprint for how the Labour Government planned to meet health and social care needs for Britain over the next ten years. It re-affirmed the NHS tradition of free access to services on the basis of clinical need funded by the state and endorsed commitments to improved standards of care, an end to 'the postcode lottery of care', more investment in staff development, increased partnership between health and social care, and also a renewed commitment to improving the health of the nation (Butler, 2001).

The aim of *The NHS Plan* was to give the people of Britain a modernised health service 'fit for the 21st century: a health service designed around the patient' (Department of Health, 2000b). Public consultation for the Plan showed that the public wanted to see more and better paid staff using new ways of working, reduced waiting times and high quality care centred on patients, and improvements in local hospitals and surgeries (Department of Health, 2000b).

NHS Plan assurances

NHS resources will grow by a third over five years, with:

- more power and information for patients;
- 100 new hospitals and 7,000 new beds and 3,000 new health centres;
- 1,000 more medical school places, 7,500 more consultants, 2,000 more GPs, and 20,000 extra nurses, plus 6,500 therapists;
- much shorter waiting times for hospital and doctor appointments;
- cleaner wards, better food and facilities in hospitals, with child-care support for NHS staff;
- improved care for older people;
- tougher standards for NHS organisations and better rewards for the best (Department of Health, 2000b; Butler, 2001).

NHS Plan priorities

The Government prioritised and focused on:

- targeting the diseases that are the biggest killers, such as cancer and heart disease;
- pinpointing the changes that are most urgently needed to improve people's health and well-being and delivering the modern, fair and convenient services people want.

Three bodies were identified as working together to guide through the changes:

Modernisation Board

The Modernisation Board, which meets four times a year and is headed by the Health Secretary, is to lead proposed changes – its role is described as ‘high level steering to make sure actions match the aims of the plan’ (Department of Health, 2000c, p1).

Taskforces

The Department of Health put in place ten taskforces to drive forward the ideas and improvements outlined in *The NHS Plan*. Six of these focused on 'what' services are to be improved:

- coronary heart disease;
- cancer;
- mental health;
- older people;
- children;
- waiting times and access to services.

The remaining four concentrated on 'how' these improvements will be made, focusing on:

- the NHS workforce;
- quality;
- reducing inequalities and promoting public health;
- investment in facilities and information technology.

Modernisation Agency

The Modernisation Agency ensures the commitments in the plan are translated into reality. The agency works with NHS Executive regional offices and with all NHS Trusts to help them redesign their services around the needs and convenience of patients. It consists mainly of NHS staff on secondment and works locally with Trusts and other health organisations to disseminate examples of best practice (Department of Health, 2000b; source: www.nhs.uk).

In summary, *The NHS Plan* focused on the Government's plans for investment in, and reform of, the NHS. In return for the increased funding, the NHS was expected to improve its quality of service and focus on patient needs as well as promoting greater integration of health and social services (Belman, 2000).

The Health and Social Care Bill

This is the legislative machinery that was presented to Parliament in December 2000, allowing the Government to take forward some of the reforms it outlined in *The NHS Plan* (Unknown, The Guardian Unlimited, 2001).

Mental Health and Community Care

A brief history: the early years

> Most people who need long-term care can and should be looked after in the community. That is what they want for themselves and what those responsible for their care believe (*Community Care Act 1981*, as quoted by Roberts, 1981).

Under the 1834 Poor Law, workhouses for paupers were established in every part of England and Wales. The development of asylums and other institutions was a consequence of this act, as many of those who were residents of the workhouses were children. Thus, schools were required, those who were physically unwell needed hospitals, those with a mental illness/learning disability needed asylums, and the elderly needed old people's homes. Indeed, it was believed at the time that to remove those with a mental illness from the stresses of life, such as poverty and social unrest, to a peaceful place of rest could help, especially in the early stages of mental disease (Roberts, 1981).

The 20th Century

In the intervening years between World War I and World War II, another approach to mental ill health gained much interest. Sigmund Freud stimulated a new interest in psychiatry as he explored the unconscious mind. This awareness and the integration of the existing asylums into the new National Health Service (which came into operation in 1948) brought about a change in care perspective away from institutional policy.

In 1957, the Percy Report recommended that mental illness should be seen in much the same way as physical illness and disability, with mental illness hospitals run the same way as general hospitals. By the 1960s and the growth of television as an entertainment medium (which broadcast groundbreaking programmes highlighting the myths and realities of mental illness), there was to be a transfer of hospital treatment for the mentally ill from the isolated institutions to general local hospitals (Roberts, 1981). Enoch Powell, as Health Minister, made his famous 'Water Tower' speech to the Annual Conference of Mind (then called the National Association for Mental Health). He visualised the reduction of psychiatric hospitals and care provided in the community. Powell's plan was for 'nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand'. In 1962, *The Hospital Plan for England and Wales* stated that large psychiatric hospitals should close and that local authorities should develop community services. In-patient numbers continued to fall but many local services were not yet in place. A new group of 'long-stay' patients began to accumulate in the hospitals. The era of community care had begun and it has remained official policy since 1962 (Mind Publications, 1999).

This change in thinking not only reflected the adjustment in social attitudes but also the development of psychotropic drugs which meant that patients could be cared for outside of hospital as their behaviour became modified and less disturbed. However, it remains a moot point whether psychotropic drugs were used as a chemical straight jacket instead of the traditional hospital restraints.

During the 1970s, large-scale psychiatric hospitals steadily disappeared. The new district general hospitals which provided some psychiatric services contributed to the reduction in the number of beds in mental hospitals from 150,000 in the mid-1950s to 80,000 by 1975 (BBC News Online, 1998).

In 1975, the White Paper *Better Services for the Mentally Ill* set out a blueprint for an integrated local approach to mental healthcare involving the health service, local authorities and the voluntary sector, setting out what facilities were required, such as day centres and hostels. The paper

came at a time of recession and pessimism about public services; it had little impact on the haphazard dissolution of the hospitals and the almost total failure of statutory authorities to provide adequate community-based care (Mind Publications, 1999).

In 1979, the Conservative Government came to power under Margaret Thatcher. The Parkinson Report, not published until 1981, strongly endorsed community care and the closure of hospitals, linked to a statutory duty and financial incentives for councils to make community provision (Roberts, 1981). However, Cecil Parkinson also stated that, although patients left hospital, the skills and money did not transfer with them into the community.

Final Decade

In 1981, the Department of Health published a consultative document entitled *Care in the Community.* It suggested ways of moving money and care away from the NHS to local councils and voluntary organisations as a way of implementing the Parkinson Report. It applied especially to the mentally handicapped, mentally ill and elderly patients (Roberts, 1981).

In 1982, the Barclay Report was published. This was a Government prospectus for the future planning of social work, recommending that people in need should no longer be seen as isolated individuals, but in terms of their relationships with family, friends, local community, etc. The Report stated that social services should be organised on a local patch basis (Mind Publications, 1999).

The Social Services Select Committee Report of 1985, *Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People,* stated that hospital closures had outrun community care provisions, especially in relation to people with mental health problems. There were then calls for Government action and increased spending (Mind Publications, 1999).

In 1986, the Report of the Audit Commission for Local Authorities in England and Wales*, Making a Reality of Community Care*, highlighted that despite the reduction in hospital beds, local authorities had not been allocated the resources necessary to provide alternative forms of care (Mind Publications, 1999).

A Government inquiry into community care led by Sir Roy Griffiths resulted in the paper *Community Care: Agenda for Action* (Griffiths 1988), which was published in response to the 1986 Select Committee report. Its recommendations included the appointment of a Minister of State for Community Care and the transfer of all community care to local

authorities. It recommended giving allotted grants, partly funded by Central Government, to local authorities, and that those local authorities be allowed to purchase services from other agencies (Mind Publications, 1999).

In 1989, the White Paper *Caring for People* was published in response to the Griffiths Report. It set out the structure for the community care changes, including a new funding structure for social care. This was the beginning of the purchaser/provider split whereby departments were encouraged to purchase services provided by the independent sector. The next decade marked a dramatic increase in the number of voluntary and private sector service providers (Mind Publications, 1999).

The *NHS and Community Care Act 1990* made all the legal changes necessary for the implementation of *Caring for People*. Local authorities, in collaboration with health service and independent sector agencies, now became responsible for assessing need, designing care packages, and ensuring their delivery (Mind Publications, 1999).

By 1998, community care was declared to have been a failure. Health Secretary, Frank Dobson, stated that:

> Care in the community has failed. Discharging people from institutions has brought benefits to some. But it has left many vulnerable patients to try and cope on their own. Others have been left to become a danger to themselves and a nuisance to others. A small but significant minority have become a danger to the public as well as themselves (Mind Publications, 1999, p8).

He then announced a national strategy and an extra £700 million to deliver ‘safe, sound and supportive services, underpinned by extra resources, better treatment and modern legislation’ (Mind Publications, 1999).

Mental Health Services: Contemporary Issues

> Mental health problems are common. At any one time around one in six adults have a mental health problem such as anxiety or depression, although less than 1% of the population suffers from severe mental illness. The stigma which attaches to mental ill health leads to discrimination and to social exclusion. Suicide is now the second most common cause of death in those under the age of 35 years. Although the rate has begun to decline, there are still over 4000 deaths from suicide in England each

> year. People with severe mental illness are at higher risk. There is a relationship between active mental illness and violence. The risk is significantly greater if the individual loses contact with services, or receives inadequate care. The public is understandably concerned about the risks of violence (Department of Health, 1998c).

Anxiety and depression, often occurring together, are the most prevalent mental disorders in the general population (Craig, 1997).

> In Britain, most psychotropic drugs are prescribed by General Practitioners, and most moderate anxiety and depressive disorders are entirely and successfully managed in primary care (Craig, 1997).

Specialist mental health services are provided by the NHS in a range of settings. The backbone of the service is provided by the 'general' mental health services: a combination of in-patient (acute) beds and community-based services, usually delivered through geographically-based Community Mental Health Teams.

In addition to Community Mental Health Teams, local Mental Health Trusts may also provide 'assertive outreach' teams which have much smaller case-loads than their colleagues in Community Mental Health Teams, and which aim to keep in touch with patients who would otherwise be hard to engage with services. Increasingly, Trusts may also provide 'home treatment' or 'crisis services', which aim to care for individuals experiencing acute mental distress to enable them to stay at home. These services may be provided by dedicated home treatment teams, general Community Mental Health Teams, or by specialist crisis teams. A substantial proportion of mental health services are also provided in primary care settings.

It is suggested that one in four GP consultations have a mental health element, whether a mental health problem alone or a mental health element within a broader range of difficulties, and that over 90% of patients with mental health problems are cared for within primary care. Patients attending may have a classifiable mental disorder or personal/social difficulties causing distress.

Primary care provides treatment, care and support as well as referral to specialist mental health services, and now directly cares for patients with psychotic disorders, depressive illnesses and anxiety disorders.

The current emphasis on the role of primary care, and the development of Primary Care Groups and Primary Care Trusts, is likely to encourage this trend further. Primary care is increasingly providing a range of services beyond the traditional GP consultation and involving a broader range of primary care professionals and sometimes staff from specialist services working within and alongside the Primary Care Team (Select Committee on Health, 2000a).

This project seemed timely given the Government's specific proposals for developing mental health services.

Modernising Mental Health Services, safe, sound and supportive

In July 1998, the then Secretary of State for Health declared that 'Care in the Community' had failed and that another option, described as a third way, was possible with more acute beds and more secure facilities, with an increase in the numbers of 24-hour crisis teams, more hostels and supported accommodation, home treatment teams and assertive outreach teams. It was then that the National Service Framework for Mental Health was first mentioned along with a review of the *Mental Health Act* (Select Committee on Health, 2000a). This was followed in December 1998 by the Government presenting its initial plans for improving mental health services for working age adults in England in the White Paper *Modernising Mental Health Services, safe, sound and supportive.*

It referred to *The New NHS, Modern and Dependable* whereby health services were to address causes of ill health, and the speed and standard of treatments. The services were to be safe for the public, users and carers. They had to be sound, i.e. based on the evidence of what works best, and supportive in helping to build healthier communities (NHS Executive Briefing Notes, 1998).

Key features included more and better trained staff, extra hospital beds, early interventions, better outreach facilities, 24-hour access to care and services, good primary care, effective treatment and care processes, and a review of the *Mental Health Act* and those with a personality disorder. Around £700 million was to be made available over three years to work towards those goals. Those using the services were to play an active role in the care process and to receive assistance with employment, education and housing (Our Healthier Nation Website b). Closer working partnerships between the NHS and social services were to be developed along with a drive over the following three years to improve quality and consistency of care (Our Healthier Nation Website a).

The National Service Framework for Mental Health

Seven Standards of Care for Mental Health Services

The National Service Framework for Mental Health, launched by the Government in September 1999, was the first comprehensive statement describing what is expected of health and social services in England. The document set out how mental health services were to be planned, delivered and monitored until 2009 (Steele & Petit-Zeman, 2001).

The Department of Health describes National Service Frameworks as a systematic approach to setting national standards and defining service models for a specific service or care group, and a means by which programmes can support implementation and measure progress within an agreed timescale. The Frameworks should ensure greater consistency in the availability and quality of services throughout the NHS. Health professionals, service users and carers, as well as health service managers and other agencies, are involved in the formulation of Frameworks, thus addressing a whole system of care which acknowledges the input required from other agencies, such as social services and the voluntary sector (Department of Health Website a).

There are four National Service Frameworks, which address mental health, coronary heart disease, older people, and diabetes. The mental health National Service Framework sets new standards for the delivery and monitoring of mental health services (Tyrer, 1999). It can be seen as building on *Modernising Mental Health Services, safe, sound and supportive,* and described what was expected of health and social services in England. An expert reference group was set up to advise MPs, which included users, carers, health professionals and academics. The resulting Framework covers the mental health needs of working age adults up to 65 and specifically addresses service variations in England (Our Healthier Nation Website b).

The Framework set standards for health and social care that mental health services across the country should aim to achieve, and set targets to measure performance and basic criteria. It addressed primary and secondary care and aimed to ensure that those who need help receive it. These seven standards set targets for mental healthcare and cover five areas applying to health, social and independent agencies:

Standard one

Health and social services should:

- promote mental health for all, working with individuals and communities;
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Standard two

Any service user who contacts their Primary Healthcare 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.

Standard three

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care;
- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist help-lines or to local services.

Standard four

All mental health service users on the Care Programme Approach (CPA) should:

- receive care which optimises engagement, prevents or anticipates crisis, and reduces risk;
- have a copy of a written care plan which includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators, advises the GP how they should respond if the service user needs additional help, and is regularly reviewed by the care co-ordinator;
- be able to access services 24 hours a day, 365 days a year.

Standard five

Each service user who requires a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment, consistent with the need to protect them and the public, as close to home as possible;
- a copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

Standard six

All individuals who provide regular and substantial care for a person on the CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan, which is given to them and implemented in discussion with them.

Standard seven

Local health and social care communities should prevent suicides by:

- promoting mental health for all, working with individuals and communities (standard one);
- delivering high quality primary mental health care (standard two);
- ensuring that anyone with a mental health problem can contact local services via the Primary Care Team, a help-line or an A&E department (standard three);
- ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (standard four);
- providing safe hospital accommodation for individuals who need it (standard five);
- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (standard six);

and in addition:

- support local prison staff in preventing suicides among prisoners;
- ensure that staff are competent to assess the risk of suicide among individuals at greatest risk;
- develop local systems for suicide audit to learn lessons and take any necessary action.

It also addresses values such as social inclusion, care in the least restrictive setting, carer support and consideration of the needs of those from ethnic minorities.

With regard to primary care and access to services, the framework suggests extending specialist services, such as psychological therapies, to those with more common mental health problems as well as helping those with more severe mental illness.

To date, local health and social agencies across England are responsible for implementing the National Service Framework. The *Health Act 1999* emphasised that health and social services were to work together using pooled budgets and integrated provision and commissioning. Practical support comes from the National Mental Health Implementation Group (led by the Department of Health). Sophie Petit-Zeman (2000a) highlights that there are five national underpinning programmes which support implementation:

- finance;
- workforce planning and education and training;
- research and development;

- clinical decision support systems;
- information strategy.

Local Implementation Teams (from each health community) are to produce a ten-year strategic plan, with a more detailed three-year plan which feeds into the Health Improvement Plan for overall health improvement.

In summary, the National Service Framework was developed with the advice of an external reference group, which included health and social care professionals, managers, service users and carers. A wide range of evidence was drawn together and graded, using systems such as Bandolier (a health evidence-grading system). The National Service Framework fleshes out the policies first announced in *Modernising Mental Health Services* (Steele & Petit-Zeman, 2001).

The Green Paper *Our Healthier Nation* (Department of Health, 1998) also addressed mental health by making it a priority area, with its target to reduce the death rate from suicide and undetermined injury by at least a further sixth. This was again mentioned in the July 1999 White Paper *Saving Lives: Our Healthier Nation,* this time stating that the target was a reduction of one fifth.

Both the Green and White Papers acknowledged that mental health problems are common, with as many as one in six at any time experiencing anxiety or depression at some point in their lives. Less than 1% suffer from more severe mental illnesses such as schizophrenia but the risk is greater for social exclusion and discrimination. The cost of working days lost due to mental ill health is said to be £3.7 billion (Our Healthier Nation Website a).

As stated earlier, *The NHS Plan* also addressed mental health, enhancing the issues addressed by the National Service Framework for Mental Health by announcing new resources and further areas of mental health service development (Northern and Yorkshire Regional NHS Modernisation Programme Website). Indeed, it gave the same priority to mental health as it did to cancer and coronary heart disease.

While the National Service Framework for Mental Health identified national standards and how they should be developed and delivered, *The NHS Plan* provided the extra funding ending supposedly years of underfunding. In effect, *The NHS Plan* allocated £300 million extra to expedite the National Service Framework (Petit-Zeman, 2000b).

The Plan targeted eight areas of mental healthcare:

- 1,000 graduate primary care workers and 500 community staff to be on hand to help GPs, A&E departments and NHS Direct;
- Over the next three years, 50 'early intervention in psychosis' teams to be established to support young people, mainly those with schizophrenia, and their families;
- 335 crisis resolution teams to be set up. By 2004, the aim is for mental health service users to have access to crisis help at any time;
- For people with severe mental health and other problems, such as addiction and chaotic lifestyles, not in touch with mainstream services, 170 new assertive outreach services should be in place by April 2001 and 50 more are promised over the next three years;
- By 2004 there will be women-only day centres in every health authority;
- By 2004 support for carers is to be increased, with 700 staff boosting respite care and strengthening support networks;
- By 2004 up to 400 people in secure hospitals who do not need to be there should be re-housed. The Government has earmarked £25m to provide 200 long-term secure beds and employ 400 community staff to support them;
- Prison services are to be strengthened with 300 extra staff to support new NHS and prison partnerships, with the aim that no one with a serious mental illness should leave prison without a care plan and care co-ordinator (Petit-Zeman, 2000b).

The overall aims of *The NHS Plan* for mental health were to improve care for patients ensuring services are responsive to their needs, to reduce the number of people who suffer from mental illness, and to reduce the number of people who die as a result of mental illness.

Current Provision of Mental Health Services

Command paper 4888 (Select Committee on Health Fourth Report – Provision of NHS Mental Health Services) highlights the fact that:

> The recruitment, retention and morale of the mental health workforce is clearly going to be central to the success of the National Service Framework (Select Committee on Health, 2000a, p3, par. 72).

The Department of Health set up a Workforce Action Team to look at workforce planning, recruitment and retention, education and training, and developing and supporting leadership.

The current workforce

As there are significant shortages of key professions, e.g. Psychiatrists, it has been suggested that experienced GPs could be trained to be Psychiatrists within two years, or David Joannides of the Association of Directors of Social Services has suggested using competent staff trained to NVQ Levels 2 and 3 'who can alert more senior staff when a deterioration in condition is noted so action can be taken' (Select Committee on Health, 2000a, p3, par. 74).

The Royal College of Psychiatrists highlighted work currently being carried out by the Department of Health, including some 'core skills' courses across all professional training and also of the possible development of a Diploma in Psychiatry which might interest committed GPs (Select Committee on Health, 2000a).

The Royal College of Nursing pointed out that one third of all nurses in the country would reach retirement age within the next five years and that, because mental health traditionally attracts 'a more mature student', the situation within the mental health workforce was likely to be particularly acute.

The situation for Clinical Psychologists and Occupational Therapists is different: there are no recruiting difficulties but there is a very limited number of training places. The British Psychological Society reports that 'we have only just got over the stage where we take more than 300 people a year into training' (Select Committee on Health, 2000a).

Identified gaps in the service

The Select Committee on Health Fourth Report highlighted generally that localities had identified the lack of 'talking treatments', such as psychotherapy and cognitive therapy, despite the consensus that such services are beneficial, both to those with mild mental health problems and those with more severe illnesses such as manic depression (along with medication) and schizophrenia, where both cognitive and psychotherapy are successful.

The information from the report did not extend to reasons why there was poor provision of 'talking therapies', such as the shortage of appropriately qualified professionals able to deliver them, or perhaps a lack of awareness among those responsible for purchasing mental health services as to their benefits or cost.

The report also highlighted that there were frequently accommodation gaps between hospital beds and supported accommodation, e.g. ordinary housing with intensive support, sheltered accommodation, group homes, low support hostels, care homes and high support accommodation, to 24-

hour nursed accommodation. The importance of daytime activity can be seen to be related to accommodation and support issues. Indeed, many reports have highlighted the importance of meaningful daytime activity as important to improving mental health.

The report confirmed that standards and provision of services across the country vary and that different areas require different services.

Primary care or mental health care

Issues regarding the workforce can be examined in relation to where the care is carried out as well as by whom. Mental health and ill health can be seen as a continuum flowing from one to the other, so even as the same client experiences a relapse of depression, for example, it may not be severe enough to require hospital admission as had been the case on a previous occasion. Mental and physical health cannot often be separated and compartmentalised. Indeed, those with mental ill health also need to visit their GP for physical health issues.

It was mooted in the Select Committee Report that it could be an advantage to have Psychiatrists working in GP surgeries for ease of access close to the patient's home, which would be less stigmatising and less threatening. However, it was also recognised that care in the primary care setting would also be dependent on the mental health knowledge of the staff there.

The relationship between the specialist services and individual GPs will continue to be of importance whether the specialist services are provided in the surgery itself or are simply to ensure continuity of care.

Considering some of the care options (intensive support at home, crisis intervention or assertive outreach), the topic of medication is an important one, especially if legislation permits providing medication in the above settings, perhaps even compulsorily. Thus, the issue of by whom the care is delivered needs to address the responsibility, accountability and educational needs of the staff involved.

Mental (Ill) Health and Physical (Ill) Health

> We will only make real progress in improving the health of the individual and the nation when the dominant hand of medicine is balanced by others involved with housing, education, work, recreation, environment, and all the other myriad aspects of our lives which affect our growth and well-being. (www.wealdenclinic.co.uk/Jumphealth/holist.html)

Background

It was in the 1930s that an association between mental illness and poor physical health was first acknowledged. Phelan et al. (2001) draw our attention to this and the fact that psychiatric patients have high rates of physical illness, much of which go undetected. Indeed, those being cared for as psychiatric out-patients are nearly twice as likely to die as the general population.

Osby et al. (2000) state that, in Sweden, mortality in patients with schizophrenia is two to three times higher than that in the general population. Davidson quotes Ruschena et al. (1998) as stating that unexpected deaths from natural causes, notably cardiovascular disease, were almost three times greater among those with schizophrenia than the general population. Kendrick (1996) also found that those with mental health problems had high levels of cardiovascular and respiratory risk factors and symptoms, particularly smoking, obesity and hypertension. Brown et al. (2000a) state that, compared with the general population, people suffering from schizophrenia were more likely to eat a more fatty diet that was lower in fibre, were more likely to be overweight and smoke heavily, but were less likely to drink alcohol. Davidson et al. (2001a) point out that, because of the weight and obesity issue, the mentally ill are perhaps at risk of raised blood cholesterol levels.

An Australian study by Davidson et al. (2001a) found results whereby out-patients attending a community mental health centre had a higher prevalence of smoking, were more likely to be obese and overweight (perhaps influenced by medication such as *clozapine*), were less likely to take moderate exercise and more likely to take harmful levels of salt and alcohol than a community sample. Their conclusion therefore was that:

> Psychiatric out-patients have a high prevalence of cardiovascular risk factors which may account for the higher rate of cardiovascular mortality amongst the mentally ill (Davidson et al., 2001a, p196).

In addition to a possible lack of weight loss counselling for the mentally ill, there is growing concern that the newer atypical antipsychotic medications cause additional weight gain. Given the associations between obesity and chronic disease, the current results may forecast further increases in cardiovascular related deaths.

Depression

Dinan (1999) states that there are physical consequences of depression, in particular the increased risk of coronary artery disease, and that there is an impact on bone mineral content. He comments on a study which reported that after an episode of depression the risk of myocardial

infarction increased fourfold to fivefold, and that women with a current or past history of depression had decreased bone mineral density at each trabecular bone site studied, given that once bone density is decreased it is difficult to re-establish (given the recurrent nature of depression, these effects on the bone are probably cumulative). He also states that:

> The most consistently shown biological abnormality in major depression is increased activation of the hypothalamic-pituitary-adrenal axis…hypercortisolism is known to decrease bone density and to redistribute body fat, increasing the risk of coronary heart disease (Dinan, 1999, p826).

Dinan then highlights the fact that the resultant increase in intra-abdominal fat is a known risk factor for coronary artery disease.

Lori Brown (1996) examined another link between physical and mental ill health, that of lowered serum cholesterol and low mood. He suggested that although coronary heart disease mortality tended to be lower in men treated with cholesterol-lowering regimes, the overall mortality did not decrease because of an increase in deaths from accidents, suicide or homicide. It was the behavioural aspects of these deaths that gave rise to the idea of low cholesterol influencing mood and/or behaviour by affecting neuronal membrane fluidity and subsequently altering serotonin binding, re-uptake, or metabolism. To date, however, it is quite clear from current research that the link has *not* been proven beyond reasonable doubt but still gives food for thought.

After their literature review, Harris and Barraclough (1998) came to the conclusion that 'All mental disorders have an increased risk of premature death' (Harris & Barraclough, 1998, p11). They concluded that the highest risks of premature death, from natural and unnatural causes, are for substance abuse and eating disorders, and that the risk from unnatural causes was especially high for schizophrenia and major depression. They noted that deaths from natural causes are increased for organic mental disorders, mental retardation and epilepsy. Hoyer et al. (2000) propose that:

> …too little attention is given to the physical health of patients with psychiatric diseases, and that physical symptoms are ascribed to the psychiatric illness or to psychological distress by the patients as well as the doctors (Hoyer et al., 2000, p79).

They also report that several studies demonstrate that there is more alcohol abuse in those with depression than in the general population

and that the poor self-care during depressive episodes contributes to poor physical health. They quote Murphy et al. (1998) who put forward the idea that depression itself could predispose to subsequent mortality from natural causes, or that there is a hidden disease present that is associated with depression. Hoyer et al. concludes by stating that:

> …affective disorders are potentially fatal diseases…there may be a need for general improvement in the diagnosis and treatment of physical illness in all patients admitted to hospital for affective disorders, and for continuing research into the risk factors for suicide (Hoyer et al., 2000, p76).

Schizophrenia

Brown et al. (2000a) highlight the fact that the excess mortality of schizophrenia is well recognised if not clearly understood. In their study of schizophrenics, the standardised mortality ratios (SMR) for all causes, natural and unnatural, were higher than those to be expected in the general population, as was the SMR for circulatory, digestive, endocrine, nervous and respiratory diseases, plus suicide and undetermined death. They go on to suggest that other reasons for raised *natural* mortality may include unrecognised medical disease, poor compliance or refusal of treatment for medical disease, unhealthy lifestyle, and substance misuse. They also suggest that, as far as natural causes were concerned, there was a higher rate of death from cerebrovascular disease, diabetes and epilepsy than the general population. Most *unnatural* deaths were stated to be as a result of suicide.

Other issues they raised include failed recognition of medical disease by patient or carer, missed medical diagnosis, poor treatment compliance and treatment refusal. It was also recognised that social disadvantage explains only a small part of the excess mortality, although further work needs to be done on this issue.

In 1997, Brown reported that 28% of the excess mortality in schizophrenia is attributable to suicide and 12% to accident. Indeed, in a later paper (1998) he goes on to say that suicide is the largest single cause of excess mortality for patients with schizophrenia.

Cannabis use

Hambrecht and Hafner (2000) report that, generally speaking, cannabis is seen to worsen the course of schizophrenia and apparently encourages relapses of the disease, resulting in poor social outcome. Yet they also comment that other research has shown that patients with schizophrenia seek the mood elevating and relaxing experience that cannabis gives non-schizophrenic users. They record that cannabis abuse has been reported in 5%-40% of all schizophrenic patients and

that it is the most frequently misused substance second to alcohol. They acknowledge that the debate still continues as to whether cannabis will improve or exacerbate symptoms of schizophrenia.

Their own clinical experience, however, leads them to believe that schizophrenic patients who abuse drugs are more antisocial and more likely to be involved in social conflict, and are also more likely to associate with occult type groups as well as less likely to comply with prescribed medication. Given that Hambrecht also reports that there is often multi-drug abuse, this should be another area of concern for health professionals to address when considering improving the physical health of the mentally ill.

Medication/ prescribed drugs

As far as medication is concerned, Brown et al. (2000a) noted a small but significant mortality associated with antipsychotic drug treatment. Appleby et al. (2000) confirm that psychiatric patients are at increased risk of death from a number of natural causes, including cardiovascular disease, but that cases of sudden death in young patients, and the recent evidence of a high rate of sudden death in schizophrenics without 'explanatory post-mortem findings', suggested to them that factors other than coronary artery disease may be involved.

Gray et al. (2000) state that antipsychotic agents have been a mainstay in the management of schizophrenia since they were introduced in the 1950s. However, there are side-effects, including extra-pyramidal symptoms (EPS). Up to three-quarters of patients treated with conventional antipsychotic medication experience EPS. A number of studies found that many side-effects go undetected by clinicians. Gray et al. go on to suggest these findings may be explained by clinicians underestimating the importance of antipsychotic side-effects. Evaluating the efficacy and tolerability of treatments is clearly a critical component of good mental healthcare. The use of valid and reliable measures, such as the Liverpool University Neuroleptic Side-Effect Rating Scale (LUNSERS; Day et al., 1995) has been recognised as the most robust way of reviewing the impact of pharmacological interventions. Indeed, such practice is embedded within the new National Service Framework for mental health (Department of Health Website a).

A report by an expert committee convened by the Royal College of Psychiatrists recommended that a study be undertaken to examine the relationship between psychotropic drugs and sudden death. This is the result of findings indicating that the mechanism by which antipsychotic drugs bring about sudden death is by inducing cardiac arrythmias (via sodium channel blockade and delay to ventricular re-polarisation). In their

report, the drug *thioridizine* (regularly used in psychiatry) is said to be frequently implicated in sudden cardiac death or arrythmias by causing 'concentration-related QT interval prolongation' as do other psychotropic drugs such as lithium and tricyclic anti-depressants, which can be used alone or in combination with other drugs. Buckley and Sanders (2000) report that minor adverse cardiovascular side-effects are common with psychotropic medication and cite postural hypotension and tachycardia.

It is suggested that combinations of drugs can be harmful. Chong (2001) claims that tricyclic medication and lithium 'with their propensity to prolong the QT interval, may have a synergistic additive effect when combined with anti-psychotic medication'. Chong quotes another study naming *haloperidol, sertindole, respiredone*, and *olanzipine* as other psychotropic drugs which can prolong the QT interval. He goes on to discuss that inhibition of P450 enzymes involved in the metabolism of psychotropic drugs can lead to increased blood levels of the drug. Some selective serotonin re-uptake inhibitors, i.e. *fluvoxamine* and *paroxetine,* are potent inhibitors of the enzyme as are some diuretics (Buckley, 2000) and grapefruit juice! Concerns about grapefruit juice and the metabolism of *clozapine* (which is also known to carry the risk of agranulocytosis (Alyas, 2001) and perhaps myocarditis and cardiomyopathy (Buckley, 2000)), *amitryptilline, imiprine*, and *clomiprimine* are also raised by Chong.

Recent letters in the medical press show that this issue is still being investigated. Alyas (2001) pointed out that the use of *thioridizine* is now recommended to be used for schizophrenics deemed not at risk of cardiovascular disease, and the drug *droperidol* on a named patient only basis. These recommendations have given rise to:

> …more thoughtful prescribing with greater consideration given to the indication for prescription and less corruption of drug use as blanket cover (Alyas, 2001, p1207).

Sudden death

Appleby et al. (2000) confirm that many questions about sudden death in psychiatric patients remain unanswered and further work needs to be done, perhaps looking at issues such as illicit drug use, smoking, underlying physical illnesses, alcohol consumption, use of physical restraint with its arousal processes, and the mix and dosage of drugs used.

Ruschena et al. (1998) concluded from their study that the rates of sudden death in psychiatric patients were raised sufficiently to encourage investigation into, and attention given to, suicide risk particularly among

young people, and to seek early detection of cardiovascular disorders as well as examining substance misuse.

HIV and Hepatitis C

It has been suggested that individuals with chronic mental illness are asexual. Davidson et al. (2000) report that their study and several other studies have clearly demonstrated this is not so. They state that high rates of unprotected sex, multiple partners and injecting drug use suggest that the mentally ill may be the new high risk group for HIV in Australia. Drug use among people with mental illness was high. Indeed, respondents in their study were twice as likely as people in the National Drug Strategy Household Survey to have used illicit drugs in the last 12 months, and 13 times more likely to have used heroin; 14% of participants had injected drugs and 8% reported sharing injecting equipment at some stage in their lives. Less than half (46%) the participants had been sexually active in the past 12 months. Of those who had been sexually active, 32% of men and 10% of women had three or more partners in the past year. They reported that injecting drug use among patients attending community mental health clinics is considerably higher than among the general Australian population.

Davison et al. (2001b) conclude that, in Australia, those patients with chronic mental illness should be regarded as a high risk group for HIV/AIDS and Hepatitis C. Is this the case in Britain?

Healthcare in the community

The reforms in mental healthcare with the resulting closure of hospitals led to the development of Community Health Teams attending to all aspects of their patients' care including health and social needs. It is perhaps ironic that Community Mental Health Practitioners not only have 'little training in physical care' but also their 'monitoring of physical health and health education is generally unsatisfactory' (Phelan et al., 2001, p444), yet admission to hospital provides little more physical healthcare. Indeed, admissions to psychiatric hospitals are short, with 'physical assessments of psychiatric in-patients by junior psychiatrists [are] poor' (*ib id*). The National Service Framework addresses this by stating that people with a severe mental illness should have their physical needs assessed, and the NHS Executive has suggested that GPs should be paid for showing that they have assessed the general physical health of patients with severe mental illness and prescribed care/treatment if required. One aim of this is to identify physical symptoms, unmet physical needs and screening issues, e.g. breast screening, cervical screening and dental care.

Brugha et al. (1989) concluded from their small study that long-term mentally ill patients need to be regularly medically assessed and

supervised to ensure that there are as few unmet medical needs as possible, also addressing the issue of poor compliance and attendance for treatment. Honig et al. (1992) report that, in their study, the majority of physical complaints and diseases, as well as the functional illnesses, were just as persistent as the psychiatric diagnoses, and they go on to suggest that GPs are best placed to care for this groups' physical health. Davidson et al. (2001a) state that people with long-term mental health problems have more contact with health professionals than other people, but despite this have a significantly higher prevalence of key risk factors for cardiovascular disease. They go on to suggest that perhaps health professionals have neglected the health needs of the mentally ill and question whether people with mental illness receive the same services as other people when they visit a health professional.

Phelan et al. (2001) suggest that there are several reasons why people with mental illness are prevented from receiving good physical healthcare, despite the fact that they are often in frequent contact with the primary care services. He suggests that those with schizophrenia are less likely to report physical symptoms without prompting, and that the very nature of the disease, with its cognitive impairment often giving rise to suspicion and then isolation, adversely affects the seeking of treatment and following a treatment regime. These characteristics combined with short consultation times make it difficult for a doctor (who may be unfamiliar with mental healthcare) to adequately assess a patient physically or mentally. Phelan suggests that the orientation of primary care is reactive and does not encourage patients who, for various reasons, find it difficult to seek help.

Galuska et al. (1999), as quoted by Davison (2000), suggest that physicians in America at least may tend to counsel those people who, they believe, are most likely to make positive lifestyle changes, inadvertently precluding those patients most at risk, including of course the mentally ill. Could it be that perhaps British doctors also neglect those whom they feel would not change their health lifestyle?

Koryani (1979) claimed that:

> Major medical illnesses remain undiagnosed and patients' ailments are being labelled 'psychosomatic' at an alarming rate...Morbidity in the psychiatric clinic patients far surpassed the expected rate found in the general population. Among others, diabetes mellitus was a frequently overlooked diagnosis… (Koryani, 1979, p414).

He concluded that a medical orientation on the part of the Psychiatrist was necessary when evaluating patients.

Health promotion issues

From the above information, health promotion would do well to target diet, exercise, drug and alcohol issues, and provide information about prescribed medication, namely lifestyle concerns that have been identified by Brown et al. (2000a) as contributing to raised natural mortality. Indeed, many patients with schizophrenia eat poor diets and are obese. Brown et al. (2000a) identified that smoking-related fatal disease was more prominent than in the general population.

Goff et al. (1992) studied patients with schizophrenia who smoked and found that cigarette smokers received significantly higher neuroleptic doses, in part because of a smoking-induced increase in neuroleptic metabolism which has implications for health regarding side-effects from medication. Smoking is also associated with a significant reduction in levels of Parkinsonism. They conclude that smoking status is a significant factor that should be considered in assessment of neuroleptic dose requirements and neuroleptic side effects. Groupwork, according to Phelan et al. (2001), is effective in helping patients with schizophrenia to stop smoking.

Davidson et al. (2001a) suggest the inclusion of physical health factors on patient assessments, e.g. smoking, obesity, drug abuse, and also suggest providing additional training for keyworkers/case managers on physical health. For cardiovascular and respiratory disease, they also advocate the use of referring to specialists, such as Dieticians, exercise programmes, and other health promotion interventions.

Psychosocial issues

Davidson et al. (2001a) state that:

> Economic and social disadvantage are additional impediments to those with mental illness achieving control of their lives. Psychosocial factors may be linked to coronary heart disease in three ways: health related behaviours, pathophysiological changes and access and content of medical care (Davidson et al., 2001a, p199).

Furthermore, low economic status is a ‘relatively stable characteristic’ of the chronically mentally ill and is ‘an essential consideration when determining intervention programmes’ (Davidson et al., 2001a, p201).

Other issues

Looking at another side of this issue, Hall et al. (1978), in a study of 658 psychiatric out-patients, found an incidence of 9.1% of medical disorders which were ‘producing’ some psychiatric symptoms, namely depression,

confusion, anxiety and speech or memory disorders. The major medical disorders with psychiatric disorders were infectious, pulmonary, thyroid, diabetic, hematopoietic, hepatic and CNS diseases; 46% of these patients suffered from medical illnesses previously unknown to either them or their physician.

Conclusion

Phelan et al. (2001) concludes that it is possible to improve the physical health of the severely mentally ill if those involved in mental healthcare and primary healthcare become more aware of the problem and find solutions 'acceptable and useful' to patients.

Brown and Barraclough (2000, p214) make the recommendation that:

> Psychiatry as a branch of medicine should aim to treat disease. Mortality, the most objective measure of disease outcome and effectiveness of medical treatment, should continue to be monitored, to assess the impact of national policy change.

In their opinion, most of the excess mortality of schizophrenia can be explained by known mechanisms, which could be successfully addressed. In particular:

> Psychiatrists should ensure that they maintain their diagnostic skills, and mental health services should be assertive in addressing patients' smoking, alcohol use, diet and other lifestyle factors (Brown and Barraclough, 2000, p214).

They go on to question whether Psychiatrists or GPs are best placed to treat medical disease in the seriously mentally ill but emphasise that the responsibility should be explicitly allocated. Doctors should consider regular physical examinations of people who might fail to recognise that they are ill and to seek treatment, while still acknowledging that some of the factors contributing to the excess mortality of schizophrenia are not susceptible to medical intervention. Poynton and Higgins (1991) found that, in their London study, most GPs would be happy to share the care of the long-term mentally ill by monitoring their physical health, while the Psychiatrist continues to monitor their mental health, and a Community Nurse acts as the key-worker.

> Psychiatrists, General Practitioners, and public health experts need to work together towards reducing cardiovascular risk and to prevent the gap in health status between those with mental illness and those without from widening even further (Davidson et al., 2001a, p199).

> The closure of mental hospitals and the down-sizing of district general hospitals have thrown a far greater burden onto primary care…The pressure to manage mental healthcare on ever-reducing budgets has caused mental health services to confine their attention to those with severe psychotic illness, leaving the task of common mental disorders to the Primary Care Team (Goldberg & Gourney, 2000, p2).

Project Perspective and Literature Summary

Taking on board all the policy and legislative changes currently taking place, it seemed particularly relevant to consider in depth how best to move forward with some aspects of mental health service provision.

In particular, this project was concerned with the physical care of the long-term mentally ill and the service provision for those identified as having a 'mild mental illness' from a human resource perspective – *who* is best placed to deliver the care to those two groups of clients? As previously described, the policy changes over the last decade have had an effect on mental health service provision.

The New NHS. Modern. Dependable raised consciousness about improving health generally with local health strategies, and emphasised the importance of primary care. *Our Healthier Nation* actually targeted mental health for improvement and mentioned 'expert patients' who could provide knowledge about the best care for a specific medical condition, including mental health. *Modernising Mental Health Services* addressed the need for more and better trained staff with mental healthcare having a firm base in good primary care.

The National Service Framework for mental health identified that, for example, clients should have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it, be able to make contact at any time with the local services necessary to meet their needs, and receive adequate care. Indeed, it states that those with long-standing mental illness should have their own written care plan, given to them and implemented in discussion with them, including assessment of their caring, physical and mental health needs, and repeated on at least an annual basis. The Workforce Action Team began work in December 1999 looking at developing the workforce in order to implement the National Service Framework. The Team's interim report highlights the need for innovation and flexibility in workforce planning, training and education (Petit-Zeman, 2000a).

Our Healthier Nation as a health strategy re-emphasises the public health approach and recognises the multifactorial nature of health, which can be seen as respecting the influences of the physical environment, the social environment and individual behaviour on health (Elliott et al., 2001).

The NHS Plan introduced the Mental Health Taskforce with a promise of more staff and the examination of the existing NHS workforce. The paper *Modernising Social Services* highlighted the three priorities for personal social services; that of promoting independence, improving protection, and raising standards, and re-emphasised the need for joint working in the quest for improved (mental) health and social care provision. Indeed, the NHS and social services are vital to the success of the National Service Framework (Petit-Zeman, 2000a).

It has already been stated that a substantial proportion of mental health services are provided in primary care settings. One in four GP consultations have a mental health element and over 90% of patients with mental health problems are cared for within primary care. Primary care is increasingly providing a range of services beyond the traditional GP consultation and involving both a broader range of primary care professionals and staff from specialist services working within and alongside the Primary Care Team (Select Committee on Health, 2000a).

If the care required is to have a firm base in primary care, the question arises as to which professionals would be best placed to provide that care. Can/will they be responsible for promoting mental health, combating discrimination, assessing and identifying mental health needs, offering treatments or referring on, giving the care (on a written care plan) to reduce the risk of deterioration/suicide and prevent crisis?

Several questions were raised when considering this project:

- Which primary care individual is best placed to address the issues described above?
- Is there already a role in existence that could fulfil the requirements? Hayward, for example, suggests that ‘health visitors can successfully target and affect the mental health of low income families’ (Elliott et al., 2001, p57).
- Is there already a role in existence that could fulfil the requirements with appropriate training? Using the £280 million set aside to develop the skills of staff (Department of Health, 2000d), perhaps look at background and previous work experience, including mental health work, current formal and informal training opportunities, mental health issues encountered on a regular basis and preferred learning formats.

- Is more than one individual required?
- Have there been any proposals so far for new workers?

Primary care staff and mental health – training issues

Secker et al. (1999) underline the work of Wright (1996) whose research identified GPs as performing poorly when diagnosing and treating clients with anxiety and depression in their practices. They then go on to suggest that primary care nurses in general are undertaking a 'wide range and increasing volume of mental health work with little preparation and training' (Secker et al., 1999, p643).

This is due, in part, to the varied Government policies which have addressed both the severely mentally ill with specific mental health policies, and those with less severe mental illness through general health and social policies. One outcome of this for nursing is the reduction of clients with less severe mental illness in Community Psychiatric Nurse caseloads. Perhaps as a consequence of this, other members of the Primary Care Team are becoming more involved in mental healthcare e.g. Practice Nurses, Health Visitors, School Nurses, District Nurses and even Midwives. The nurses in the Secker et al. (1999) study also felt that the rise in the number of elderly clients in their population meant that they were increasingly having to deal with mental health issues such as dementia/Alzheimer's disease, and the depression and bereavement that can be suffered by the patients themselves and their families.

The study identified training needs such as counselling skills, recognition and management of anxiety, and depression, including post-natal depression, coping with professional stress, teamwork, the roles of other professionals (especially mental health professionals), the role of the voluntary sector, trends in mental healthcare and treatments, assessment of those with psychotic illnesses and bipolar disorders. Also, eating disorders and obsessions/phobias, defusing potentially violent situations, cultural issues of relevance to mental health, and the physical and emotional effects of childhood abuse.

As well as identifying some possible themes for training sessions, the study also found that joint training was a welcome idea to all the nurses involved; shared learning opportunities with other nurses from other backgrounds or a 'cascade' system of learning, whereby one nurse is identified as a source of information on a particular topic and expected to disseminate that knowledge (Secker et al., 1999).

Anthony Mann et al. (1998) attempted to evaluate the benefit of practice nurse involvement in the care of depression. The participating nurses, who had no training in mental health, quickly became familiar with the

assessment of depression, accompanying factors and monitoring progress. Depression greatly improved for both intervention and control groups: three months after inclusion in the study, three out of four no longer met the criteria for major depression. This study apparently showed that practice nurses can work with depressed patients and there is indirect evidence that the presence of a trained and interested nurse has a beneficial effect on the management of depression in the practice (Goldberg & Gourney, 2000). The practice nurses in the Secker et al. study felt that they were undertaking a 'significant amount of mental health work with very little formal preparation' (Secker et al., 1999, p647). Bower et al. (1997) confirm this, suggesting that as mental health work does not generate income for their GP employer, they are reluctant to spend on staff training needs.

The *Maudsley Discussion Paper No.1* (Goldberg & Gourney, 2000) argues for a great increase in the numbers of practice nurses, and for them to be trained in mental health skills, e.g. giving depot medication, detection of mental health problems, management of depression, working briefly with phobic and obsessional disorders and, of importance to the project, screening the physical health of those with chronic mental disorders.

Secker et al. (1999) believe that if Community Psychiatric Nurses continue to focus their service on the more severely mentally ill, the other members of the Primary Healthcare Team will find it hard to cope with the increasing number of clients experiencing milder mental health problems, unless the Community Psychiatric Nurses communicate their knowledge and expertise through training. In return for this input however, they suggest (perhaps rather vaguely) that the 'Community Psychiatric Nurse service may be enhanced through the increased capacity of the PHCT to provide services to people experiencing severe and enduring illness' (Secker et al., 1999, p649). Without further elaboration on this point, the assumption is that the 'enhancement' would be a reduction in caseload.

Crucially, Secker et al. conclude by raising awareness of several issues for NHS Trusts, Primary Care Groups, and health authorities, i.e. which professionals are dealing with those suffering from the less severe mental health problems and is it appropriate for the remit of their role? They summarise by stating that policies, procedures, preparation and training should all support and facilitate recognised roles.

The Workforce Action Team (Workforce Action Team, 2001) highlighted gaps in capabilities/education for nurses, such as the Mental Health Act legislation and the Criminal Justice System, how to work effectively with

users, joint working with health and social care providers, nursing diagnosis, ECT, complementary therapies, group skills, rehabilitation skills and equal opportunities training. They also suggest input into the mechanisms of assertive outreach, addressing carers' needs, and caring for those with a learning disability and mental health problems.

Primary care staff and/or Community Psychiatric Nurses?

The project sought to examine the potential role of the Community Mental Health Worker especially appertaining to the health needs identified above. Having reviewed the roles of other nursing professionals in the Primary Healthcare Team, it seemed pertinent to look at the role of the Community Psychiatric Nurse (CPN).

Gournay and Brooking (1995) reported that it was uneconomic for Community Psychiatric Nurses to have those with less serious mental health problems on their caseload when compared with GP care for the same client group, concluding that Community Psychiatric Nurses should target those with more severe mental illness.

Another study, also by Gournay and Brooking (1994), concluded that there was no difference in improvement between those patients seen by a GP and those seen by the Community Psychiatric Nurse (for those with milder mental health problems) and that there was no evidence that referral to a Community Psychiatric Nurse saved GP time. Therefore they suggest that Community Psychiatric Nurse education should refocus its activity on those with a more serious mental illness and that their education should focus on 'skill acquisition and interventions of proven effectiveness' (Gournay & Brooking, 1994, p238).

Both these studies were several years before the more recent Government initiatives but came after the introduction of 'Community Care'. In some ways, they could be seen to have introduced the concept of possible changes in mental health clientele for community professionals. As Bowers (1997) stated:

> Community Psychiatric Nurses in the United Kingdom are being repeatedly urged to focus their attention on those with serious and enduring psychotic illnesses, and to withdraw from the 'worried well' in the primary care setting (Bowers, 1997, p930).

The *Review of Mental Health Nursing* in 1994 recommended that Community Psychiatric Nurses focus on those with serious and enduring mental illness. This report suggested that Community Psychiatric Nurses had a valid role to play in the care of those with non-psychotic illnesses. However, by implication, it seemed to suggest that unless a psychosis

was diagnosed, the client was 'worried well', i.e. not as ill as someone with a psychotic illness. This would seem extreme given that the spectrum of mental health/ill health is very wide. As Karen Shore (2000) succinctly says, 'It seems demeaning, insulting, and dismissive of people who are truly in pain' (Shore, 2000, p3). She goes on to state:

> The costs to our nation because of the emotional problems in the general population are enormous. People with emotional problems have an impact on their families, schools, workplaces, communities, and on the nation as a whole. Problems such as alcohol and drug abuse, absenteeism, workplace accidents, under-productivity, white-collar crime, bad divorces that hurt children, domestic violence and other forms of violence, vandalism, theft, runaway teens, child abuse, teen pregnancies, smoking and overeating, and families in pain that raise children who hurt and go on to raise another generation of hurt children, are more often than not the result of emotional problems of people who are not seriously mentally ill (Shore, 2000, p3).

Shore identifies the need for high-quality care e.g. long-term psychotherapy and/or medication. This premise adds weight to the identification of a 'skilled' worker to work with this client group.

It has been reported that cognitive behavioural interventions, including social skills training to solve interpersonal problems and regulate emotions, may have the desirable effect of reducing repeated suicide attempts in high risk subjects (Elliott et al., 2001) and that as well as the provision of respite care, individualised psycho-social interventions are beneficial in improving the psychological health of carers.

The same report highlights that nurses are well placed to identify subjects at risk of mental illness e.g. the elderly, carers of the chronic sick, children with behavioural problems or family members who are experiencing major life events. It is highlighted that counselling alone is ineffective in the prevention of mental disorders but that cognitive behavioural therapy can be useful.

Research has also shown that increasing the time that severely mentally ill patients spend with health professionals does not benefit their health, but that it is the quality and co-ordinated nature of the care that is more vital (BBC News Online, 1999). Similarly, intensive care management does not always improve clinical or social functioning.

In summary, research reports confirm that simply increasing the number of healthcare professionals will not benefit those with mental health problems and that for intensive care management to be effective, it depends on the skill and co-ordination of the professionals involved (BBC News Online, 1999).

A Mental Health Foundation survey found that the users' overwhelming concern was to have relationships with other people, and suggested the use of creative and flexible services with an emphasis on relationships (not just medication) while considering the potential of complementary/alternative therapies and making use of a self-management approach (perhaps akin to expert patients). The importance of physical exercise and the expression of spiritual and religious beliefs were recognised also (BBC News Online, 2000).

According to Webb et al. (2000), a lack of information, communication and consultation are ubiquitous complaints made by mental health users. Hence, for a quality service to be delivered, skilled staff need to be aware of the importance of these requirements. Bower et al. (1997) suggest that training in interviewing skills would assist primary care nurses in asking pertinent questions to gain an accurate and consistent assessment of any problems not immediately obvious on initial presentation, such as the use of the Edinburgh Post-Natal Depression Scale by Health Visitors to establish depression. The assessment process would then assist the nurse in deciding what course of action to take, and whether that service can be provided or if referral is needed (Bower et al., 1997). They seem to infer that, as nurses often use the skills for 'therapeutic listening' as part of their daily work, the development of further counselling skills would seem appropriate for use in the primary care setting.

Skills in using cognitive approaches to manage anxiety and depression have been successfully employed by nurses in the primary care setting, as have the setting up of self-help groups and using information and support from national groups and organisations (Bower et al., 1997). Bower et al. (1997) also point out that collusion can occur between primary care staff and patients whereby there is distinct avoidance of emotional issues for a variety of reasons. For staff and patients to have confidence in dealing with mental health issues, the authors suggest competent training and support, pointing out that the research indicates that practice through role-play and feedback from audio/video tapes is the favoured method of developing skills, and the use of nursing support groups facilitates the sharing of skills and discussion of difficult issues.

In its policy briefing, *Mental Health Policy: the Challenges facing the new Government,* the Sainsbury Centre for Mental Health stated that there

was a need to look at more radical options such as changing the skill mix, no longer investing in ineffective services and smarter working to solve the shortfall in workforce numbers and skills.

> Nurses clearly have the potential to assist in the management of emotional problems in primary care. The views of nurses, GPs and patients must be canvassed to indicate how this potential might best be developed alongside other clinical demands (Bower et al., 1997, p59).

> NHS Trusts, Primary Care Groups and health authorities need to clarify which aspects of nurses' mental health workloads are appropriate to their role and develop policies, procedures and training to support them undertaking that role (Secker et al., 1999, p643).

At present, primary care nurses are increasingly involved in the care of those with significant mental health problems as part of their routine caseload. They already have a wide skill base from which to draw interventions that could be expanded with appropriate input, guidance and training. This can be seen as a 'result of' or 'resulting in' Community Psychiatric Nurses working with the more severely mentally ill.

Wally Barr (Barr, 2000) states that Community Psychiatric Nurses have been criticised for not working with the severely mentally ill, leaving their care to the Primary Healthcare Team. He says that the role of Community Mental Health Nurses was originally to work with those patients discharged from hospital diagnosed as suffering from a psychotic illness, but evidence in the early 1990s seemed to suggest a move to caring for those with milder mental illness. Barr does acknowledge, however, that this trend is beginning to change back again. The effect of demographic changes in the population, as well as general policy changes could also be seen to influence fluidity of the caseload dynamic between Community Psychiatric Nurses and primary care. Specific courses now exist to support Community Psychiatric Nurses in the development of expert skills for working with psychosis, such as Thorn. This course:

> …aims to aid the recovery of people with psychosis, prevent their relapse, promote their autonomy, reduce their distress and develop their ability to manage their own symptoms by improving understanding of the nature of psychosis, by developing in all students advanced clinical skills and knowledge of the needs of people with a psychotic disorder… (Bournemouth University/Dorset Healthcare Trust, 2001).

One issue that could contribute to the blurring of roles and caseloads between primary care and the Community Mental Health Team is the issue of where Community Psychiatric Nurses are based. It has been suggested that one reason for Community Psychiatric Nurse input to mainly non-psychotic patients occurs when the Community Psychiatric Nurse is used by a GP fundholder (Goldberg & Gourney, 2000). Thus there would seem to be wide discrepancies across the country as to the role, function and training expected of Community Psychiatric Nurses, from care of all those deemed non-psychotic to specialised care of psychotic clients.

In his research, Barr (2000) points out that Community Psychiatric Nurses can feel that, by targeting the less severely mentally ill, they are providing early intervention and health promotion via their clinical skills, rather than addressing the more social and practical needs of the severely mentally ill. However, it could be argued that it is the care of the severely mentally ill that requires more skill and expertise. Perhaps some of the above issues contribute to the uncertainty over the role of the Community Mental Health Worker.

The role of the GP Practice Counsellor has become more prominent in recent years as the Community Care Act and Care Programme Approach have begun to require more time from members of the Community Mental Health Team, and Counsellors are now seeing those patients the Community Mental Health Teams had to discharge from their caseload (Davison et al., 1998). If this role was developed further, could it fulfil the role of the mental health worker?

The *Maudsley Discussion Paper No.1* (Goldberg & Gourney, 2000) draws together both these approaches to mental healthcare. It suggests a reappraisal of the mental health work undertaken by the Primary Care Team and the Community Mental Health Team. It argues that patients need to be treated by the Community Mental Health Team if they require a skill not available in the Primary Care Team, and that Community Psychiatric Nurses should carry out less supportive work and more cognitive behavioural and other active treatment programmes. To facilitate this, the paper suggests the creation of 'Generic Mental Health Workers' to carry out supportive work and help with needs such as the activities of daily living. It also suggests a 'Link Worker' (trained in cognitive behavioural skills) from the Community Mental Health Team to work with those patients who are cared for jointly by the Community Mental Health Team and the Primary Care Team, and for this worker to enhance the mental health skills of other members of the Primary Care Team. Those who require only supportive care could be shared with the

voluntary sector. The report also points out that the public are now demanding non-drug treatments and alternative medicine, which have not (as yet!) met the current standards of evidence-based medicine, adding a further 'burden' on an already hard-pressed service.

One approach to dividing the caseloads between the numerous personnel mentioned above would be to review the disorders seen in primary care and group them accordingly, as in the discussion paper:

- severe mental disorders e.g. schizophrenia, organic disorders, bipolar disorders – Community Mental Health Team input mainly required;
- disorders which can be managed with effective drug and psychology input e.g. depression and anxiety – primary care input with involvement from Community Mental Health Team and/or specialist psychology input;
- somatised presentations of distress where psychology is most useful e.g. agoraphobia, panic disorders – primary care input with little medical intervention, if any, provided primary care staff have appropriate skills, supervision from Community Mental Health Team;
- disorders which resolve spontaneously, requiring supportive rather than specific skills – GP care shown to be no more effective than Community Mental Health Team input. Supportive care from a variety of sources e.g. counsellors, self-help, voluntary agencies.

The discussion paper also suggested that an increase in Nurse Behaviour Therapists (in existence since the early 1970s) might help ease the burden by providing training and supervision for members of the Primary Healthcare Team. With regard to Clinical Psychologists, the paper reports that the Clinical Standards Advisory Group noted the shortage of these clinicians while acknowledging the role they have in helping those with psychotic conditions. The paper suggests that Psychologists are not 'exploited enough' (Goldberg & Gourney, 2000) as a training resource. Occupational Therapists are also mentioned as having potential to deliver effective interventions; indeed their work can overlap that of the Community Psychiatric Nurse.

Significantly, the report states that there is a shortage of Community Psychiatric Nurses regardless of their client caseload. In some inner city areas, there are not enough Community Psychiatric Nurses to operate the Care Programme Approach and Supervision Register.

Current Proposals

According to Sophie Petit-Zeman (2000b), the Workforce Action Team welcomes £1 million to support Community Psychiatric Nurse training and Community Nurses in mental health, £2 million to support clinical

psychology training, £2.5 million for psychiatry training, £3.9 million for social work training and £4 million for Mental Health Nurses.

The NHS Direct website (www.nhsatoz.org) states that:

> The NHS Plan means an additional investment of £300 million on mental health services by 2003-2004. An emphasis is being placed on community-based services with an extra 1000 new graduate primary care mental health workers, preferably with psychology degrees as well as 500 more community mental health staff in GP surgeries, A&E departments and NHS Direct.

Also, the number of Nurse Consultants is to reach 1,000 and there is to be a new role of Consultant Therapist (Department of Health, 2000d). However, there appears to be some confusion over the role of Community Mental Health Workers. The Department of Health website, for example, claims that under the auspices of *The NHS Plan* the 1000 new primary care workers are to help GPs manage and treat common mental health problems (Department of Health Website b). It also suggests that the 500 community health staff are to work with GPs, Primary Care Teams, NHS Direct and A&E departments (Department of Health Website b).

With regards to staff shortages and the shortage of psychologically-based treatments, the Select Committee on Health First Special Report (2000b) states:

> We would particularly draw attention to the evidence we received on the limited numbers of training places for Occupational Therapists and Clinical Psychologists, the importance of providing early placement in mental health services for nurses in training, and the desirability of developing 'core-skills' training across professions. We would also urge active consideration of the development of appropriate training and recognition for workers to be the 'eyes and ears' of professionals, as described by David Joannides and others (Select Committee on Health, 2000b).

In other words, the Committee was well aware of the shortage of mental health workers and also recognised the need for core skills to be developed in all mental health workers, with or without formal qualification, especially focusing on communication skills with patients. The idea of an 'eyes and ears' worker is presumably a mental health worker who works alongside a qualified member of staff and feeds back

regularly on the health and well-being of clients. They should have enough knowledge and expertise to know when further intervention is required from qualified staff in whichever background (social work, medicine, nursing etc.). A skill-base for this worker could be the new Mental Health Foundation Certificate in Community Mental Health, which is equivalent to NVQ Level 3.

Writing about the *NHS Plan*, Pollock (2000) states that Ministers want more early intervention with regard to mental health problems so that the necessary skills can be delivered by people other than specialist Community Mental Health Nurses and Psychiatrists. As the plan states:

> One thousand new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness, will be employed to help GPs manage and treat common mental health problems in all age groups, including children (Department of Health Website b).

The Government's mental health 'tsar', Louis Appleby, suggests psychology graduates would be good candidates, or Gournay has suggested that service users could be recruited. The new Primary Care Mental Health Workers would work with those suffering from panic attacks, agoraphobia and depression, using basic cognitive therapy rather than medication-based solutions. One reason for considering psychology graduates is the fact that so many are unable to continue their education and career into clinical psychology given the limited number of training places (Pollock, 2000).

A Government memorandum in May 2000 (Department of Health, 2000e) detailed reference to a 'generic mental health worker'. It reiterated that the Workforce Action Team was working on NHS skill mix issues and the current roles of NHS staff. They described the generic mental health worker as someone 'who would prioritise aspects like benefits and housing as well as social and healthcare' (Department of Health, 2000e). This worker could traverse the boundaries between health and social care but not 'replace' a professional with specialist skills, e.g. an Art Therapist. Indeed, the Secretary of State for Health stated that the Government still wanted to increase numbers of GPs and Community Psychiatric Nurses independently of the creation of a new worker.

Two types of 'new' mental health worker appear to dominate the literature. One is the Graduate Primary Care Worker to help GPs using effective 'brief therapy' and the other the generic mental health/social care worker meeting health and social care needs. Allen (2000),

however, identified the new community mental health staff as fulfilling 'gateway' posts, thus perhaps describing a third type of worker: a Mental Health Nurse. They would be responsible for people needing immediate help and access to mental health services, based with GPs, primary health care staff, NHS Direct and A&E departments.

Throughout the literature, writers have highlighted role conflict issues regarding the new workers, in particular the overlap of their role with Community Psychiatric Nurses, Counsellors and Social Workers. Brown et al. (2000b) stated that when staff operate out of their usual area of expertise, then inefficiency can result, compounded perhaps by the sense of isolation that staff can experience when part of a multidisciplinary team away from the main body of peers. Brown et al. (2000b) also reported staff feeling unclear about the limits of their responsibilities and whom to approach when they felt overwhelmed. They reported that boundaries are important as they can make individuals feel secure and pleased with achievements, and institutional roles contribute to the individual's sense of selfhood. Lang (1982) stated:

> The concept of community mental health calls for an unlearning of traditional patterns of professional interaction and of traditional conceptions of the nature of psychiatric disorders. Mental health workers are asked to break free of the historically grounded frameworks which have shaped their ideas, their respective professional identities and the habits of their collective and individual work (in Brown et al., 2000b p425).

Brown et al. (2000b) highlighted the need for flexibility with regard to professional boundaries. This highlights the need for the Community Mental Health Worker role to be clearly defined – but not necessarily within the confines of existing roles.

The Sainsbury Centre for Mental Health, however, showed concern about the use of graduate assistants for primary care, suggesting that they may be an unstable workforce and keen to move on (Petit-Zeman, 2000a). They suggested that these graduates would ultimately prefer to work in the field of clinical psychology but, due to restricted intakes on the appropriate courses, they are unable to pursue their career choice. To balance this situation, they suggest a foundation course in mental health to prepare these graduates for mental health work and as a pathway towards their goal of clinical psychology (The Sainsbury Centre for Mental Health).

The report also emphasised the need for supervision of these graduates in the workplace by Counsellors/GPs/Community Psychiatric Nurses etc. and that this supervision would consume time spent with patients for both parties. Each graduate (of the 1000 in total) is expected to see 300 people a year, therefore if there are 30,000 GPs in England, each worker will have to cover 30 GPs and see 10 patients a year. Although this will not make a huge impact on mental health and the need for more psychological therapies, it perhaps will begin a developmental process. The Sainsbury Centre stated that the 500 community staff are to fill liaison roles between primary and secondary care with a remit of basic co-ordination working with around 1000 patients annually.

The graduate workers are seen to be addressing the patient needs of the less severely mentally ill, whereas the community workers are to co-ordinate the care of the more severely mentally ill (The Sainsbury Centre for Mental Health).

THE PROJECT REPORT

Note: Where the term 'mental healthcare worker' is used, this describes a person who is involved in the care/support, at any level, of those adults perceived to have a mental health problem, irrespective of employer, background, qualifications or experience.

Location

The majority of mental healthcare workers that participated in this survey were from Dorset on the south coast of England.

Demographic and social profile of Dorset

Dorset is surrounded by the counties of Devon to the west, Somerset to the north west, Wiltshire to the north east and Hampshire to the east. The population of Dorset (living in a mix of town and rural settings) has experienced rapid growth in the last ten years. According to Government figures, growth is expected to continue but at a slower rate.

Dorset is classified as a 'resort and retirement' area and, as such, has a higher proportion of residents aged 65 years and older than other areas of England and Wales. The percentage of children aged under 15 years in Dorset is over 2% lower than the national average.

The unemployment rate in Dorset continues to decline since its peak in January 1993, but pockets of relatively high unemployment remain in the urban areas, particularly in Bournemouth and Bridport. Distribution of unemployment is uneven across Dorset, with some wards having more than twice the county rate, mainly in Bournemouth and Weymouth and Portland.

There are areas of deprivation in Weymouth and Portland, Purbeck and Christchurch, with significant numbers of gypsies and travellers passing through the county (up to 1,000 vehicles at peak periods).

Over recent years, Dorset has been noted for its relatively good educational attainment and relatively low level of recorded crimes.

(Information from www.dorset.swest.nhs.uk/public_health_report_99_02.htmha.swest.nhs.uk)

NHS in Dorset

As a result of the Government document *Shifting the Balance of Power in the NHS,* Dorset Health Authority and Somerset Health Authority ceased

to exist on 1st April 2002. They were replaced by Somerset and Dorset Strategic Health Authority. Strategic Health Authorities lead the strategic development of the local health service and manage the performance of the Primary Care Trusts (PCTs) and NHS Trusts in the area.

The aforementioned Government document outlined arrangements for the basic shift of power, resources and responsibilities to the front line of the NHS. Financial allocations are moving directly to PCTs (which already provide primary and community services directly for their local populations) to buy secondary care services for their patients – such as those provided in large district hospitals. The PCTs work in partnership with outside organisations such as councils to ensure local health needs are met.

Dorset Health Authority serves an estimated population of 708,244. Somerset and Dorset Strategic Health Authority, however, serves a population of 1.2 million and has nine PCTs planning and delivering care. The project was carried out before these changes were implemented.

At the time of the project, there were 445 GPs working in 109 General Practices within Dorset. The PCTs were as they are currently: North Dorset Primary Care Trust, Poole Primary Care Trust, South and East Dorset Primary Care Trust, South West Dorset Primary Care Trust and Bournemouth Primary Care Trust. Mental health (secondary) services are provided in the main by Dorset Social Services and North Dorset Primary Care Trust (providing services in North Dorset, West Dorset and Weymouth and Portland) and Dorset Healthcare NHS Trust.

Mental health services for the county included Community Mental Health Teams, Assertive Outreach Services, In-Patient Services, Clinical Psychology Services, Practice Counselling Services, and specialist services including forensic.

Methodology

When consideration was given to the large numbers of mental healthcare workers to be included in the project, self report questionnaires were selected as the method of choice.

> Self report questionnaires differ from the interview method primarily in that they are self administered i.e. the respondent reads the questions on a written form and gives an answer in writing. It is also recognised as the least expensive form of survey (Polit & Hungler, 1987, p150).
>
> Limitations of this method include the fact that the generated information will be relatively superficial and there can be little inference for cause and effect (Polit & Hungler, 1987, p152).

Benefits of this include respondents' ability to reply at their own convenience, avoidance of interviewer bias, easier and faster analysis of data, given the type and form of data collected.

> The questionnaire is also believed to provide a reliable method of data collection as all respondents are asked the same standardised questions (Parahoo, 1993, p12).

Format of the questionnaire

The questions were drawn up to meet the requirements of the initial project proposal with the help of an assistant researcher who also worked as a Community Psychiatric Nurse in Dorset. (There was no existing tool available that would have met the project requirements.) The literature search facilitated question development, as did an initial interview survey with relevant participants (not included in this survey) carried out by the assistant researcher. Microsoft Excel 5.0 software was used to design the questionnaire.

A large number of open questions were included to enhance the quantitative data – views and opinions were sought, not just facts and figures, along with the use of Likert scales and attitudinal statements. The questionnaires were sent out to a variety of mental healthcare workers, from GPs to unqualified voluntary sector workers/users. Therefore, questions were designed to be easily understood, without using jargon and without seeming patronising to the reader. As much relevant material as possible was covered without repeating or eliciting irrelevant data. The result was a lengthy questionnaire but filled with relevant questions. It was peer reviewed several times and amendments were made to improve validity and reliability.

Sampling

As suggested in the project proposal, a variety of mental healthcare workers were to be included in the survey; GPs, Counsellors, Health Visitors, Lecturers, Managers, General Nurses, Occupational Therapists, Psychiatrists, Clinical Psychologists, Social Workers, and voluntary sector workers/organisations. The workers selected were involved in 'adult' mental health. The numbers in each group varied dramatically, so different sampling methods had to be employed.

GPs made up the largest group and Microsoft Excel was used for random selection. The voluntary organisations were selected from the *Bournemouth Council for Voluntary Service Book*, and all those with links to mental health were selected. Where possible, all the mental healthcare staff from the Trusts involved were selected using Trust directories and websites, plus colleague information. Non-mental healthcare Trust staff were randomly selected from the sources described above.

Having completed the above tasks, the number of workers selected for inclusion in the survey was 549. Given an expected response rate of 30% for a self report questionnaire (as suggested by the literature), this was considered an adequate sample number in terms of data generation, although it was recognised that generalisations could not be made from this style of mixed sampling. Assistance with regard to the sampling was obtained from the Dorset Research and Development Support Unit based at Poole Hospital and from within the Institute of Health and Community Studies at Bournemouth University.

Each questionnaire was given an identification number to correspond with each individual mental healthcare worker and was sent out with an explanatory letter, including contact telephone/address details, and a freepost return envelope. A spreadsheet was set up to record returned questionnaires and identify those workers who would require a prompt questionnaire.

To enhance the response rate, simple measures were employed. Firstly, the assistant researcher contacted the practice managers of the primary care staff in the survey to make them aware of the study and gain their support in encouraging respondents to reply. Secondly, the name, address and postcode were double checked to ensure that the questionnaires were delivered to the correct person.

Ethical approval was granted in May 2002, and the questionnaires were sent out in the same month in one batch by second class post. The prompt questionnaires were sent out in July 2002.

Data Analysis

As the questionnaires were confidential and not anonymous, all the information gleaned from the questionnaires was kept on one computer based within IHCS, using password-coded files and accessed by one researcher only.

The responses were coded and themed by one researcher. The qualitative data corresponded with the quantitative data.

Microsoft Excel 5.0 software was used to clean the data, with cross tables and pivot tables used to examine it. Charts, graphs and tables visually summarised the results.

Results

Microsoft Excel 5.0 software was used to analyse the data throughout. On occasion, respondents chose not to answer specific questions, therefore 'n =…' shows the total number of replies given to that particular question.

Due to the different methods of sampling used, and the qualitative nature of the study, the report takes the form of description without the use of statistical tests, which would not be appropriate or enhance the findings.

Where general trends in responses are described for each question, all the different groups of respondents will have been examined separately but found to exhibit similar responses, and therefore are described universally to avoid unnecessary repetition.

Response Rate

Of the 549 questionnaires distributed, 214 were returned (39%). However, this number included 23 active refusals (questionnaires sent back incomplete with an apology from the respondent) plus one returned incorrectly addressed. Hence, the actual number of returned completed questionnaires for analysis was 190, signifying an actual response rate of 34.6%. The prompt questionnaire had been sent out five weeks after the initial one.

The majority of completed questionnaires returned (see Table 1) were from GPs and Community Psychiatric Nurses, which reflects the numbers originally sent out to each sample group although, as a percentage, Community Psychiatric Nurses had a higher response rate. Of the 23 refusals, the majority were GPs (n=17), most commonly citing pressure of work as the reason for non-participation.

Respondent Details

Gender

Of those who replied to the question about gender (n=185), the split was almost even, with 51% being male respondents.

Age

With regard to the age of the respondents, 74% (n=184) were in the 31-50 years age group and 21% were 51-65 years. The gender split was even in both these groups.

Registered professionals

A total of 94% (n=181) were registered professionals. As expected, given the sample groups (see Table 1), the most common professional registration was described as that of a 'Medical degree/doctor' (46%, n=168) with the second most common registration (32%) being linked to nursing e.g. 'Registered Mental Nurse', 'Health Visitor'.

Table 1. Response rate by different professions to the questionnaire

Group	No. of questionnaires sent	No. returned completed	Response rate %
Practice Counsellors	41	9	22
Community Psychiatric Nurses	95	41	43
Director/Deputy of Nursing	2	2	100
General Practitioners	253	73	29
Health Visitors	7	4	57
Lecturers/Lecturer Practitioners/Training and Development Personnel	22	11	50
Managers	42	19	45
Nurses	1	0	0
Other Organisations (e.g. voluntary groups)	20	7	35
Consultant Psychiatrists	21	8	38
Clinical Psychologists	35	10	29
Social Workers (mental health)	4	2	50
Social Workers (primary care mental health)	6	4	67
Total	**549**	**190**	**34.6**

Table 2 highlights respondents' description of their professional registration. Of those who had no professional registration (n=11), their job titles included workers in the voluntary sector (e.g. Development Workers), Managers and Social Work Assistants. 74% (n=19) of Managers had a professional qualification, generally in nursing. Those Managers with no professional registration/qualification tended to work in non-NHS environments e.g. voluntary sector rehabilitation units, but they did have mental health experience.

Table 2. Respondents' description of their professional registration

Group	No. returned completed	% of total
Medical	78	47
Nursing	55	33
Social Work	12	7
Psychology (including counselling)	8	5
Occupational Therapy	4	2
Counselling	9	5
Physiotherapy	1	1
Total	**167**	**100**

Mental health qualifications and experience

Respondents were asked firstly if they had a recognised qualification in mental health, and secondly if they had experience of working in mental health. Just over half of the respondents had a mental health qualification (52%, n=178), mainly a psychiatric nursing qualification. Other qualifications included psychology, counselling, psychotherapy, social work, and the Certificate in Mental Health. Notably, GPs were the most likely group to report that they had *no* mental health qualification.

It is striking that, of the GPs who answered the question about having 'experience' of working in mental health (n=66), 85% stated that they dealt with mental health problems as an integral part of their GP role, yet when subsequently asked whether they had a mental health qualification, 73% (n=63) stated they had *no* formal mental health qualification.

Other respondents who did not have a mental health qualification, but were involved in mental healthcare at some level, included Support Workers, Health Visitors, Counsellors, Lecturers and Managers. However, all had previous experience of working in mental health.

The Questionnaire

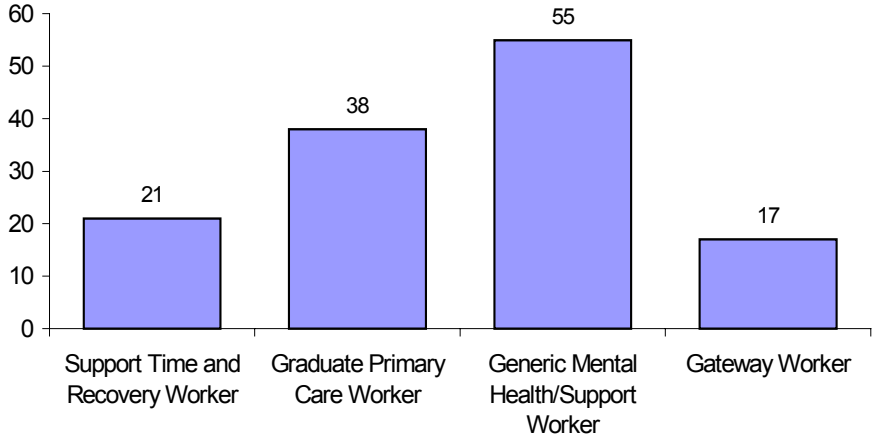
Awareness of the term Community Mental Health Worker

Over half (52%, n=182) of all the respondents had heard of the term Community Mental Health Worker in the context of recent Government documents and press coverage. However, this was not uniform throughout the groups: 63% (n=71) of GPs had not heard the term, whereas only 35% (n=34) of Community Psychiatric Nurses had not heard the term.

How respondents had heard them described

Where respondents had heard of the Community Mental Health Worker, they were asked to choose how they had heard them described. The most common description (n=131) was that of a 'Generic Mental Health/Social Care Worker', with 42% of respondents stating this (see Figure 1, below).

Figure 1. Respondents' descriptions of the Community Mental Health Worker



Perhaps unsurprisingly, the two groups that influenced the spread of responses were GPs and Community Psychiatric Nurses who, as stated earlier, made up the biggest group of respondents generally.

The Role of the Worker

The respondents were given choices as to which group of clients the new workers should be caring for, namely:

- long-term/short-term for those described as having 'milder mental illnesses';
- long-term/short-term for those described as having 'more serious mental health problems';
- all/some/none of these choices:
  - 34% (n=116) stated that they should care for 'All of the above';
  - 40% (n=113) stated that it should be 'Some of the above';
  - only 3% stated it should be 'None of the above'.

Where 'Some of the above' was selected, 58% (n=45) of respondents stated that the workers should look after those with 'more serious mental health problems' on a 'long-term basis' with a fairly even spread among the other remaining choices.

Regarding the specific choices indicated (respondents could choose more than one option):

- 68% (n=115) stated that the workers should look after those with a more serious mental health problem on a long-term basis;
- 56% felt they should care for the same group on a short-term basis;
- 51% and 45% of respondents (n=115 for each) stated that the care should also be given to those with milder mental illness on a short-term and long-term basis respectively.

Only a few respondents (n=5) stated that the worker should care for those deemed to have a milder mental illness only.

Overall, respondents felt that care would be best targeted at those clients described as having a long-term mental illness, although a significant number also felt that care should be directed towards those with a milder mental illness. It could therefore be said that respondents made it clear that there are gaps in the service for those with a milder mental health problem *and* those with a severe mental illness. There were no differences in responses between the groups of respondents.

When it came to making additional comments, the most common response was that the workers should target the seriously mentally ill (32%, n=47), with 28% suggesting that care should be based on a long-term or short-term basis 'as needed', regardless of the criteria of mental health problem. Where comments were made, it was apparent that respondents felt strongly about the target client group for the workers, and demonstrated the strength of feeling towards perceived gaps in mental health service provision, which as the above indicates, include healthcare for those with *both* severe and less severe mental illness.

Comments:

Resources are limited and should be focused on 'severe and enduring' SMI (severe mental illness). (Male, Assertive Outreach Worker, aged 31-50)

The role should include care both long and short-term for those with long-term mental illness. (Male, GP, aged 51-65)

The mild to intermediate group are much less well provided for and it is here that any Community Mental Health Worker should be placed. (Male, GP, aged 31-50)

Recent service user surveys here indicate the help they [those with long-term mental health problems] *particularly value, that is not readily available, is practical ongoing support with activities of daily living e.g. shopping, budgeting, maintaining a property – and help accessing leisure and social activities.* (Male, Community Mental Health Nurse, aged 31-50)

I think it is important that this new role should address the group of patients who currently lack any community support other than their GP…re. mild to moderate cases. (Male, GP, aged 31-50)

A mixture of short and long-term work. Allocation would be based on client needs and workers' skills rather than whether the illness is mild or not. (Female, Project Manager, aged 31-50)

Long or short-term these people still need help and possibly the best care to give them a better quality of life and some sunshine. (Female, Voluntary Sector, aged 31-50)

My understanding was that these new workers would bridge the gap between secondary services who should focus on long-term serious mental illness and Primary Care services who care for people with serious mental illness but also a great deal of people with short and long-term mild mental illness. Therefore they would have an assessment and treatment role as well as liaison and 'new' referrer to secondary services. (Female, Lecturer/Clinical Nurse Specialist, aged 31-50)

This is probably the most neglected client group [long-term mentally ill with long-term needs] *with most resources tending to be absorbed by the more acutely ill client group*. (Male, Community Psychiatric Nurse, aged 31-50)

I reckon a CMHW should be flexible and able to work with [long or short-term] *people who have* long-term *mental ill health. I firmly believe that they should be able to support and advise GP practices in how to support people with milder mental ill health.* (Female, Project Co-ordinator, aged 20-30)

At present, services require people to 'have a crisis' before help can often be gained. The biggest gap in service provision may lie here, but it is very difficult to quantify. There is a massive role for secondary prevention services that would in turn relieve pressure on acute services. (Male, Mental Health Educator, aged 31-50)

Did respondents feel that this type of worker already existed?

Overall, 56% (n=116) of respondents felt that this type of worker did exist; 74% (n=23) of Community Psychiatric Nurses stated that they thought this type of worker already existed with only 50% (n=35) of GPs stating the same.

When asked to describe who might already be doing this type of work, the most common response was either a Community Psychiatric Nurse (n=21) or a Community Mental Health Worker/unqualified support services worker (n=17). Other suggestions included qualified Social Workers, Assertive Outreach Workers, and Practice Counsellors (all n=5), practice-based nurses and voluntary sector workers (n=3), specific social service workers (n=2), Occupational Therapists and GPs (n=1).

Comments:

The term 'Community Mental Health Worker' is confusing as [they] *already exist within Community Mental Health Teams. The term 'new' mental health worker should be used till the role is clearly defined then a more descriptive title could be chosen*. (Female, Lecturer/Clinical Nurse Specialist, aged 31-50)

They have a variety of titles Social Workers, Counsellors, CPNs, NSF workers, community support workers etc. all linked by the GP and CMHT. (Female, Bank Community Psychiatric Nurse, aged 31-50)

Physical Healthcare

Respondents were asked to describe their view of the 'physical healthcare of those with long-term mental health problems' by rating their overall opinion of care on a scale of 1 (very poor) to 5 (very good). 45% (n=176) of respondents felt that this aspect of care was 'Poor' with a further 38% rating it as 'Satisfactory' and only 12% rating it as 'Good'. These findings were similar throughout the groups of respondents.

Comments:

In my experience people with long-term mental illness tend to be less likely to visit [their] *GP for routine checks which would better mange their general well-being.* (Female, Nurse Manager, aged 51-65)

I would expect other members of the Primary Healthcare Team to focus on physical healthcare. (Male, GP, aged 31-50)

GPs are very good at dealing with physical health issues. (Female, Community Mental Health Nurse, aged 31-50)

In my experience, people with long-term mental illness are very often so absorbed in their mental health they fail to attend to physical problems. They need prompting to attend 'Well Man Clinics' etc. (Male, Community Psychiatric Nurse, aged 31-50)

Physical care of long-term MH patients can be very patchy depending on GP and Social Services. (Male, Community Psychiatric Nurse, aged 31-50)

You cannot be a mental health worker without mental health training any more than a mental health worker could make decisions on physical health issues. (Female, Clinical Psychologist, aged 51-65)

95% of schizophrenics smoke as a distraction. I would if I was one! (Male, GP aged 31-50)

General comments about those with a long-term/serious mental health problem:

People with [long-term] *mental health problems and their carers value consistency i.e. the same face. CMHT workers* [are] *more effective the better they know someone*. (Male, Assertive Outreach Worker, aged 31-50)

These are the areas nurse training was traditionally aimed at [to deliver short-term and long-term care to those with long-term mental illness]. (Female, Community Psychiatric Nurse, aged 31-50)

It is important that clients with severe mental health problems are seen on a regular basis and can build up a relationship with their workers. Lots of people working with mental health clients see themselves as therapists and do not see the whole patient. (Male, Day Services Manager, 51-65)

Mental healthcare

Respondents were asked to describe their view of the 'mental healthcare of those described as having a less severe mental illness' by rating their overall opinion of care on a scale of 1 (very poor) to 5 (very good).

This aspect seemed to be rated slightly better than the previous question with only 31% (n=181) rating it as 'Poor', 45% (n=181) rating it as 'Satisfactory', and 19% stating that it was 'Good'. This would support the previous findings which asked respondents to indicate which group of clients the workers should care for. Here, also, respondents were more likely to suggest input to those with 'long-term' mental health problems.

Notably, over half of GP respondents (n=72) said that this aspect of care was satisfactory – the literature comments that GPs are the most likely professionals to be dealing with this group.

There were over 80 free comments made about community mental healthcare. The most frequently occurring singular comment (n=16) referred to community mental healthcare as being 'for the severely mentally ill only', in the sense that secondary mental health services cater *only* for the severely mentally ill so that those with a less severe mental illness have to be cared for within primary care. Only one of those respondents previously inferred that this was unacceptable.

This would correspond with the literature which suggests that Community Mental Health Teams (and other mental health specific professionals) generally do, and should, cater for those clients with a more severe mental health problem.

Secondly, 17 respondents commented that clients with a more severe mental health problem were more likely to be 'at risk' generally, and also less likely to visit their GP compared to the general population. Three of those suggested that physical symptoms can be dismissed as psychotic/psychosomatic symptoms instead.

Twelve respondents commented on physical healthcare generally; six commented that physical health was the responsibility of the GP and five that it was the responsibility of either existing Community Mental Healthcare Workers or the new Mental Health Worker. One commented that there was little care for those with chronic mental health problems and those who were physically frail.

The next most frequent comment (n=13) was that mental healthcare services (for both severe/long-term mental health problems and milder mental illnesses) were variable, as well as being over-stretched and under-funded.

Six respondents commented that primary care counselling is beneficial to those with milder mental health problems and that more psychologists and counsellors are needed. One did comment that primary care counselling was not beneficial to those with a mild mental health problem, and another stated that he felt primary care was the correct place for caring for those with less severe mental health problems.

All the different groups of respondents took the opportunity to make a comment, with the spread of comments similar throughout the groups.

Other comments included:

Difficulties with accessing appropriate mental health treatments and long waiting lists for the above, little continuity of care, GPs providing both physical and mental healthcare for both groups, and poorly supported despite an increase in the numbers of both groups.

General comments about the care for those with a less severe mental health problem:

> *Practice Counsellors could provide longer term work for those with mild mental health problems.* (Female, Development Worker for Mental Health, aged 31-50)

Less severe mental illness is often not recognised particularly by GPs and only becomes apparent in crisis. (Female, Social Worker, aged 31-50)

The new Community Mental Health Worker will reduce stigma [for those with less severe mental illness] *by being seen in primary care.* (Male, Community Psychiatric Nurse, aged 31-50)

Stress/depression/anxiety – less community help available for these problems than severe mental health issues – needs addressing urgently. (Female, Primary Care Counsellor, aged 31-50)

CMHTs do not have the resources at present to deal with this client group. Caseloads are taken up with SMI and increasingly personality disorders. (Female, Community Mental Health Nurse, aged 31-50)

Clients on ICPA can make contact with services 24hrs, 365 days a year. Those with milder MI have no service. (Female, Community Mental Health Nurse, aged 31-50)

Specific comments made about counselling and waiting lists:

Talking therapies – again notoriously underfunded. (Female, Project Co-ordinator, aged 20-30)

Although patients have access by way of referral to counselling, often the waiting time is prolonged – most counselling is done by the GP/Practice Nurse despite having an in-house Counsellor. (Male, GP, aged 51-65)

Therapy availability particularly psychology is limited by very long waiting lists. (Female, Project Manager, aged 31-50)

Focus on community mental healthcare

The next question asked respondents to focus on mental healthcare and to describe their opinion of six aspects using the rating scale of 5 for 'always' to 1 for 'never'.

The first aspect appertained to perceptions about clients' ability to make contact with services at any time if they felt they needed to. Overall, 41.4% (n=186) stated that clients could make contact with services at any time if they needed to 'Most' of the time, with 35.4% stating that this was the case 'Sometimes'. Of the remaining options, 10.2% felt this situation was 'Rarely' the case and 13% felt it was 'Always' the case.

This spread was similar for all groups of respondents, although Community Psychiatric Nurses were more likely to rate this aspect of care more highly: 73% (n=33) gave it a rating of 'Most' or 'All' of the time, with 82% (n=71) of GPs rating it as 'Sometimes' or 'Most' of the time.

The next aspect asked about clients' access to a range of talking therapies. Overall, this was not rated so highly, with only 28% (n=186) stating that clients had access 'Most' of the time and 45% 'Some' of the time. Again, this response was similar throughout the groups of respondents. The only figures to note were that voluntary/development workers were more likely to state that access was 'Rarely' available (62.5%), although the number of this group was small (n=8), as was the case with Psychiatrists, Assertive Outreach Workers and Clinical Psychologists.

Communication between agencies was the next aspect to be examined, with 36% (n=186) stating they felt it was effective 'Most' of the time and 43.5% feeling that communication was 'Sometimes' effective between agencies. Again, this spread was similar throughout the groups with the only discrepancy being that 62% (n=34) of Community Psychiatric Nurses felt that it was effective 'Most' of the time. Those professional groups that commented that communication between agencies was rarely effective included Clinical Psychologists and Health Visitors.

Comments made about communication issues between the agencies:

> *Communications between GPs and CMHTs is very hit-and-miss. GPs almost never attend CPA meetings.* (Female, Community Psychiatric Nurse, aged 51-65)

> *Different agencies are too precious with confidentiality or lack understanding around the different accountabilities.* (Female, Community Psychiatric Nurse, aged 31-50)

> *We do need an improvement on current system. A lot of CPNs are prima donnas.* (Male, GP, aged 31-50)

The next question asked about staff having the correct skills for those they care for. This was rated favourably by respondents with 51% (n=185) stating that community staff seemed to have the correct skills 'Most' of the time and 4% stating that this was the case 'All' the time. Looking at all the groups, 67% (n=15) of Managers said they felt that staff had the correct skills 'Most' of the time, as did 62% (n=34) of Community Psychiatric Nurses and 75% (n=8) of Primary Care Counsellors.

Respondents were then asked about clarity of role for community staff and whom they should be caring for. This was rated most favourably by respondents: 50% (n=183) stated that staff were clear about their roles 'Most' of the time with 9% 'All' of the time and 35% 'Sometimes'. This pattern was reflected throughout the professional groups.

The final aspect appertained to clients receiving the most appropriate care for their needs. This was not rated favourably by respondents, though it was better than those responses for talking therapies. 54% (n=184) felt that clients received the most appropriate care 'Sometimes' and 34% 'Most' of the time. Unlike GPs and Community Psychiatric Nurses, groups such as Managers, Clinical Psychologists, Psychiatrists, Occupational Therapists and Social Workers were more likely to feel that appropriate care was delivered only 'Sometimes' and rarely commented that it was 'Most' of the time.

As a whole, the aspect of care most likely to receive a favourable response was that of community staff seeming clear about their role, followed by staff having the correct skills for those they care for. The ability of clients to make contact with services when they need to was next, followed by communication between agencies and subsequently clients receiving the most appropriate care for their needs. Finally, access to a range of talking therapies was rated least favourably.

This would correspond with the identified deficits in healthcare provision for physical aspects of those clients with a long-term mental health problem and the care available for those with milder mental health problems.

The comments offered about the aspects above, by and large, tended to reflect the respondents' answers. There were two frequently made comments. The first (n=21) was that 'talking therapies' were restricted and had long waiting lists, and secondly (n=18) that there were limited services and resources for community mental healthcare.

General comments about community mental healthcare:

> *General feeling of too few, doing too little, for to many*. (Female, GP, aged 31-50)
>
> *Quite often patients are 'bounced' between social services and the mental health team.* (Male, GP, aged 31-50)
>
> *The large group of patients with less severe mental problems tend to be assessed by the LMHT* [local mental health team] *as*

not needing mental health care. They remain untreated and at greater risk. (Male, GP Principal, aged 51-65)

Community mental health care for those with long-term MH problems is better than for those with less severe problems. (Male, Community Psychiatric Nurse, aged 31-50)

CPNs see their role as providing care for serious long-term mental health patients only. (Male, GP, aged 31-50)

The initial contact is via GP/Practice Nurse/Health Visitor. Other professionals seem very removed from the day-to-day care needed by these clients. (Male, GP, aged 51-65)

Long waiting lists mean a lot of people are managed with sub-standard care for too long whilst they wait for proper care. (Female, GP Job Sharing Principal, aged 20-30)

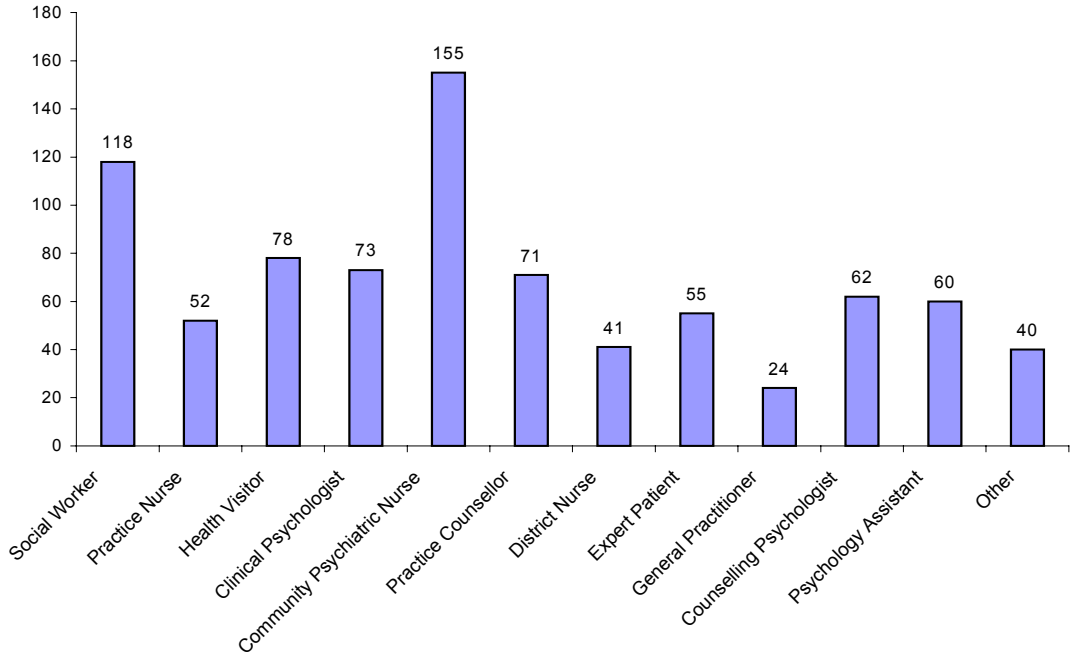
Carers do not often have access in times of distress. (Male, Community Psychiatric Nurse, aged 31-50)

We need to move more towards mental health promotion and maintenance with less emphasis on reactive crisis/acute/ assertive outreach that are all currently so in vogue! (Male, Mental Health Educator, aged 31-50)

Who could be a Community Mental Health Worker?

The next question asked respondents to choose who they felt could be a Community Mental Health Worker from a chosen list. Figure 2 demonstrates that out of the 12 choices, respondents were more likely to select Community Psychiatric Nurses (86%, n=180) and Social Workers (76%, n=180) as the most likely professionals to be Community Mental Health Workers. When examined individually, each sample group also showed this response.

Figure 2. Who could be a Community Mental Health Worker?



Health Visitors also scored relatively highly (this corresponds with literature covering the subject of Health Visitors and their input to community mental healthcare, particularly with regard to postnatal depression). The next most common group were those allied to the psychology profession, e.g. Clinical Psychologists, Practice Counsellors, Counselling Psychologists and Psychology Assistants. GPs were among the least likely professionals to be selected as a possible Community Mental Health Worker (13%).

The author noted that 'expert patients' in this survey were suggested as possible workers more often than Practice Nurses. This is an interesting finding given that a great deal of the literature on the subject suggests that Practice Nurses would be well placed to extend their role further and develop their mental health skills. Respondents were asked in more detail about 'expert patients' later in the questionnaire.

Where respondents indicated 'Other', the most likely suggestion as to who could be a Community Mental Health Worker was an Occupational Therapist (29%, n=45). Other suggestions included:

- Support workers 18%
- New Community Mental Health Worker 16%
- Any paramedic with additional training 11%
- Voluntary sector workers 7%
- Any with an interest but no formal qualification 7%

- Outreach workers 4%
- Student nurses 4%
- Drug and alcohol workers 2%
- Psychiatrists 2%

There was no preference shown by any particular professional group of respondents.

When asked to make comments, one of the common remarks made by respondents (50%, n=28) was that the most limiting factor for the selected professionals (see question above) would be time. Community health professionals are, at present, under severe pressure with the workload they already have without the possible additional responsibilities for mental healthcare. Respondents also commented that the 'new' workers within the field of community mental healthcare should work with clients on a long-term basis (37%, n=19).

Another frequent remark (31%, n=32) was that the selected worker *must* have mental health knowledge, with 19% (n=32) suggesting that an understanding of psychological therapies was important and that the skills required for a Community Mental Health Worker could be consolidated within one role (32%, n=19).

Comments made generally about who could be a Community Mental Health Worker:

> *Role needs to be both administrative – care co-ordinator/scheduler – managing the interface between primary and secondary care, social services and the family etc. Professional caring skills would be advantageous. A GP 'specialist' – with reduced clinical commitments could do this, a psychiatric social worker/CPN could.* (Male, GP, aged 31-50)

> *District/Practice Nurses or Health Visitors could build on skills and focus less on physical health e.g. Health Visitors being able to recognise post-natal depression.* (Female, Social Worker, aged 31-50)

> *Clients are offered counselling or CPN follow up but there are many who see other Primary Care professionals, GP, district nurses, practice nurses and I don't feel (and know) that they have the knowledge or skills to deal with those with mental health problems, and sometimes/often they are hampered by their own prejudices.* (Female, Community Mental Health Nurse, aged 31-50)

User surveys suggest that none of the above [as suggested in the questionnaire pp4 & 5] *are valued as highly as someone who can provide practical help and support. Hence highly qualified professionals are not necessarily needed for the kind of role described here.* (Male, Mental Health Educator, aged 31-50)

Counselling psychologists may have a role as increasingly as research shows many clients are being referred with psycho/social problems due to dysfunctional childhood, sexual abuse, lone parenting and other childhood maladaptive behaviours which result in a dysfunctional/acopic adult. (Female, Community Mental Health Nurse, aged 31-50)

Mature life experienced workers are well equipped to fulfil the role. The typical 'professional' approach and appearance can be negative though obviously some clients benefit from this too. The main criteria necessary must be safe, approachable, people orientated individuals… (Female, Community Psychiatric Nurse, aged 31-50)

Skills

The next question asked respondents to rate the importance of a selection of identified skills that the Community Mental Health Worker should possess, using a scale of 1 (unimportant) to 5 (very important).

To simplify the report, the author chose to combine both ratings of 'Important' and 'Very important' as they both indicate positive feelings towards the skill in question.

Table 3. Skills that respondents felt the Community Mental Health Worker should possess.

Skills	No. rated 4 and 5	Total (%)
Communication and listening skills	187	100.0%
Ability to assess clients and identify needs	178	95.7%
Knowledge of local health services	179	96.8%
Cognitive behavioural therapy skills	98	52.4%
Psychosocial skills	138	75.8%
Brief effective therapy skills	59	47.2%
Health promotion experience	85	46.2%
Problem solving skills	157	84.4%
Knowledge of benefits, housing issues, supported employment	130	69.9%
Knowledge of, and links to, voluntary associations & work placements	146	78.1%
Skills in complementary therapies	20	16.0%
Experience of risk management	152	81.7%
Experience of family work/couples	77	41.4%
Drug knowledge (prescription/non-pescription, legal, illegal etc.)	131	70.1%
Teaching skills for staff and clients (health education etc.)	108	58.1%
Ability to build therapeutic relationships	170	90.9%
Ability to work in a holistic manner	163	87.6%
Ability to motivate	156	83.9%
Ability to supervise and be supervised	139	75.5%
Group skills	76	40.9%
Health promotion skills	88	47.3%
Awareness of, and ability to work with, various cultural and religious aspects (clients with English as second language etc.)	138	74.2%
Information management skills (developing registers, managing self-help material etc.)	83	45.4%
Experience in computerised cognitive behavioural therapy	15	8.7%
Ability to promote self-help skills in clients	167	90.3%
Possession of research skills	26	14.0%
Ability to work with others involved in client's care	176	94.6%

The five skills *most* likely to be described as either 'Very important' or 'Important' were:

- communication and listening skills;
- knowledge of local health services;
- ability to assess and identify needs;
- ability to work with others who may be involved in the client's care;
- ability to build therapeutic relationships.

The three skills *least* likely to be described as either 'Very important' or 'Important' were:

- experience in computerised cognitive behavioural therapy;
- possession of research skills;
- complementary therapy skills.

All professional groups were likely to rate communication and listening skills highly in conjunction with knowledge of local health services and ability to assess and identify needs. The other highly rated skills also appeared uniformly across the groups, including the ability to assess clients and identify needs, the ability to build therapeutic relationships, and work effectively with others who may be involved in a client's care.

The ability to promote self-help skills in clients was rated highly by all groups but especially Community Psychiatric Nurses with 67% (n=40) rating this skill as 'Very important'. Similarly, 72% (n=40) of Community Psychiatric Nurses rated the ability to work in a holistic manner as 'Very important' along with experience of risk management (65%, n=40). The comparatively larger number of Community Psychiatric Nurses among the respondents may have contributed to these findings.

Problem solving skills, ability to motivate, knowledge of and links to voluntary associations and work placements, psychosocial skills, and ability to supervise and be supervised, were also rated fairly highly across all the groups, along with cultural issues, knowledge of housing/benefits and drug knowledge. (Psychiatrists and those working for voluntary organisations seemed most likely to rate this as 'Very important' although the numbers were small.)

Those skills rated only moderately highly across all groups include teaching and cognitive behavioural therapy skills. Psychologists, although a small group, were more likely to rate this skill highly than the others, with 80% (n=10) rating this skill as either 'Very important' or 'Important'.

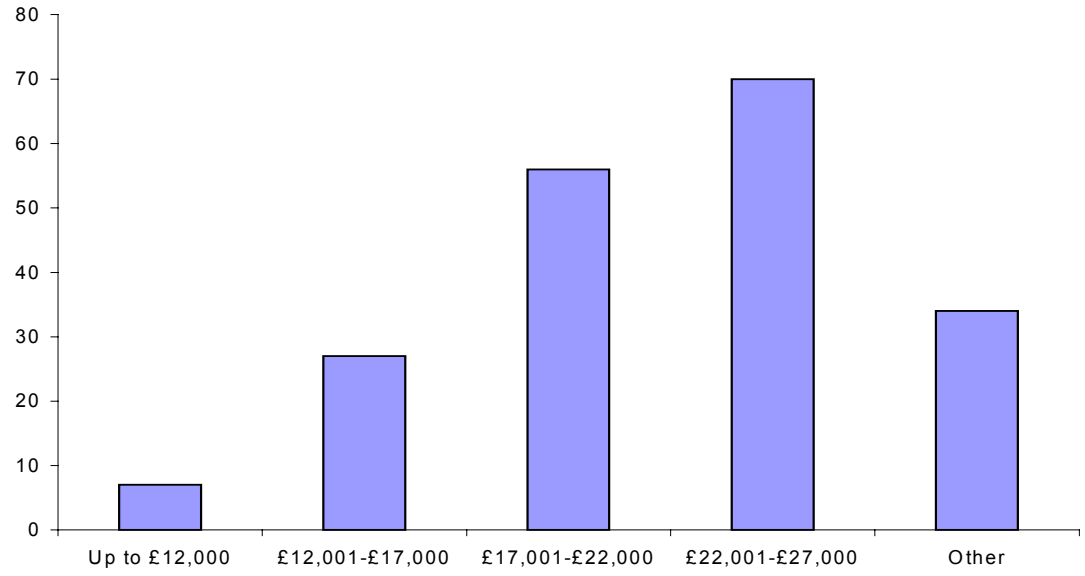
Experience of family work/couples, health promotion skills, brief effective therapy skills, group skills, health promotion and information management were not rated highly across any of the groups.

Respondents were then given the opportunity to make comments. Not surprisingly, these reinforced the findings above. The most common comment was to emphasise the importance of communication skills (25%, n=130), followed by the need for knowledge of local resources (15%, n=130), and ability to assess and identify needs of clients (14%, n=130). 12% of respondents stated that all of the skills described were more or less essential for anyone working in this field and 12% stated that professional interaction skills were 'Important'.

Salary

The next question asked respondents what salary they felt Community Mental Health Workers should receive. As Figure 3 demonstrates, the most popular answer suggested that the workers should receive a salary of between £22,001 and £27,000.

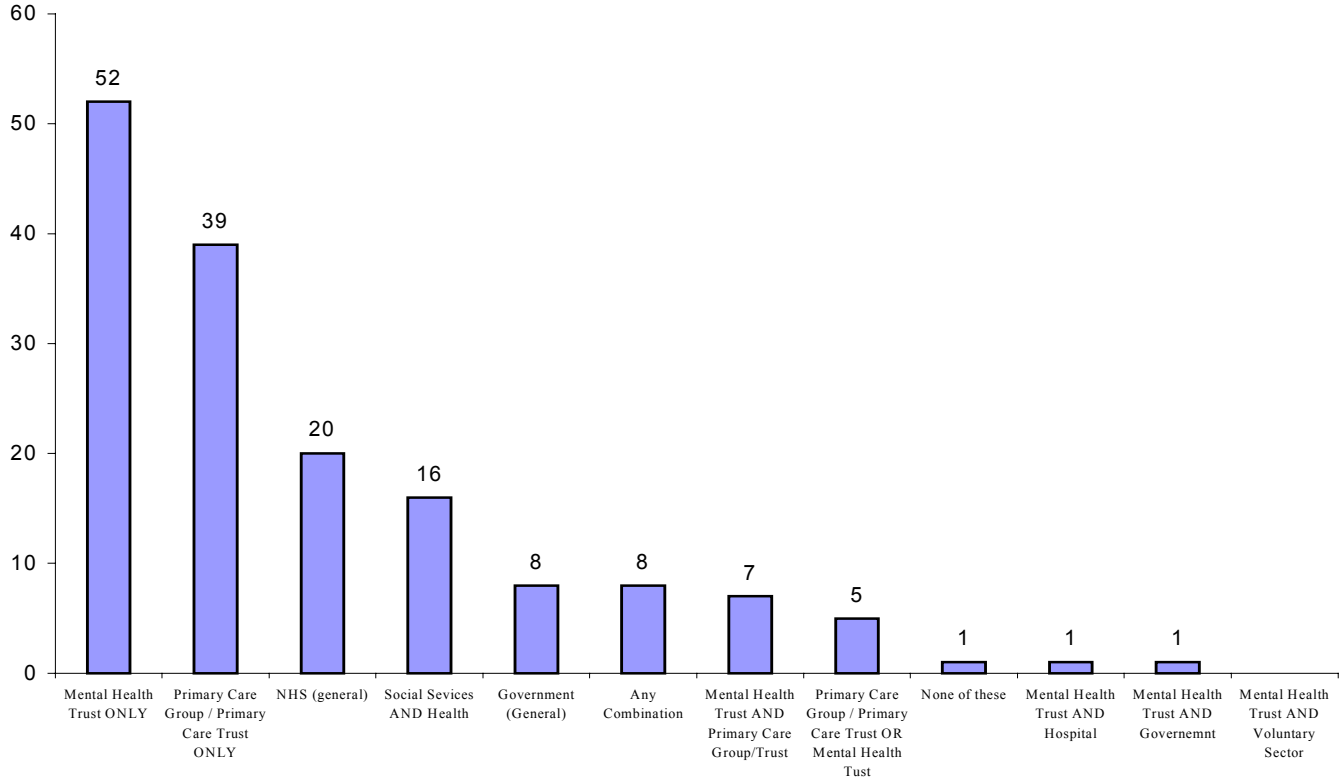
Figure 3. What salary should a Community Mental Health Worker receive?



This distribution of answers was similar throughout all the respondent groups. Other suggestions for salary included £20,000 to £25,000 (n=1), more than £30,000 (n=1), and £36,000 (n=1). 78.5% of respondents (n=28) who selected 'other' and made a comment (rather than specify a particular salary range) believed that the salary should reflect the individual's experience, knowledge and managerial responsibilities.

When asked who or what organisation should pay this salary (see Figure 3b), respondents (n=158) were most likely to propose that a 'Mental Health Trust only' pays the salary or secondly a 'Primary Care Group/Trust only'. This was uniform across all the groups. Where a combination of providers was suggested, 48% suggested that Social Services and Health should pay the salary.

Figure 3b. Who or what organisation should pay this salary?



General comments about salary:

I am leaving nursing after 15 years because I don't want to work in management and not work with patients – I cannot afford to stay…I should earn more after 15 years than I do. (Male, Assertive Outreach Worker, aged 31-50)

If you pay peanuts you get monkeys. (Male, GP Principal, aged 31-50)

A supervising 'graduate psychology primary care worker' could attract a higher salary for a greater clinical/co-ordinating role. (Female, Social Worker Supervisor, aged 31-50)

Training

This section asked respondents to rate the importance of a selection of aspects for Community Mental Health Worker training using a scale of 1 (unimportant) to 5 (very important). To simplify the report, the author again chose to combine the ratings of 'Important' and 'Very Important' as they both indicate positive feelings towards the skill in question. As Table 4 below highlights, most of the training aspects presented were rated fairly highly with the following two rated extremely highly:

- Experience of working autonomously;
- Experience of working in the community.

Table 4. Overall trends in groups – sorted in descending order.

Training aspects	No. rated 4 & 5	Total (%)
Experience of working autonomously	169	91.8%
Experience of working in the community	170	91.4%
Experience of working with a mixed caseload	160	86.5%
Development of self-awareness skills	149	82.3%
Experience of working with families	142	79.3%
Understanding the theory behind work with clients	141	79.2%
Experience of working with groups	107	59.1%

Respondents, however, were generally more likely to rate 'Experience of working in the community' as 'Very important' (59%, n=186), whereas the spread of responses for 'Experience of working autonomously' was much more even, with 46% (n=184) rating it as 'Important' and 46% rating it as 'Very important'. However, 63% of Community Psychiatric Nurses (n=33) rated this as 'Very important' which was a much higher relative percentage compared with the other groups of respondents.

This response from Community Psychiatric Nurses was echoed when asked about 'Self awareness'. Over half the respondents rated it as 'Important', except Community Psychiatric Nurses of whom 61% (n=33) felt it to be 'Very important'.

With regard to 'Working with a mixed caseload', respondents from all groups shared similar opinions (describing it as 'Important'). The only group to differ (albeit a very small group, n=8) were those from the voluntary sector, 75% of whom felt that it was 'Very important'.

With regard to the other training aspects, responses throughout the groups were similar. When asked to comment on 'Community Mental Health Worker training', there were 38 comments made. The most common (n=7) suggested that the topic of medication should be included in the training – including prescribing practice, side-effects etc. Community Psychiatric Nurses were the most likely group to suggest this.

The second most common comment (n=6) suggested that training should include assessment issues, incorporating aspects of risk and risk management. Four respondents felt that cultural awareness and cultural aspects of mental health (care) should be included in the training, and another four respondents felt that specific attention should be given to enhancing professionals' ability to work with other mental health professionals. Three respondents considered drug and alcohol issues necessary to the training.

Other comments suggested inclusion of:

- Anti-discriminatory practice;
- Negotiation and psycho-social skills;
- Mental Health Act issues;
- Acute mental health in-patient setting experience (hospital);
- Personal safety issues including the practice of 'control and restraint';
- Training by and from service users and carers.

General comments made (commonly n=1 or 2) included the suggestion that the 'Certificate in Mental Health' would be an ideal training background, and that training and actual experience are very different things! The need for clinical supervision was also mentioned, as was the intimation that professionals do not work with both the serious/long-term mentally ill and those with milder mental health problems. Those with a more serious mental health problem tend to be overlooked in favour of delivering care to those with a more mild mental health problem.

General comments about the new Community Mental Health Worker training:

> *Again depends on role. People do not usually work successfully with both short and long-term clients. The longer term people usually get dropped.* (Female, Head OT, 20-30)

> *The* Certificate in Community Mental Health Care, *is an excellent introduction to the skills needed* [for the Community Mental Health Worker]. (Female, Residential Home Manager, aged 31-50)

> *Mild and severe mental illness require in many cases different training…* (Female, Primary Care Counsellor, aged 51-65)

> *There needs to be a re-emphasis of interpersonal skills and counselling/psychotherapy skills, which the CPA philosophy has diminished.* (Male, Community Psychiatric Nurse, aged 31-50)

Expert patients

Respondents were asked to select 'Yes' or 'No' in relation to whether or not expert patients could be Community Mental Health Workers. As Figure 4 (below) demonstrates, *over half* the respondents felt that expert patients/service users *could* be Community Mental Health Workers.

Figure 4. Do you feel that 'expert patients' could be Community Mental Health Workers?

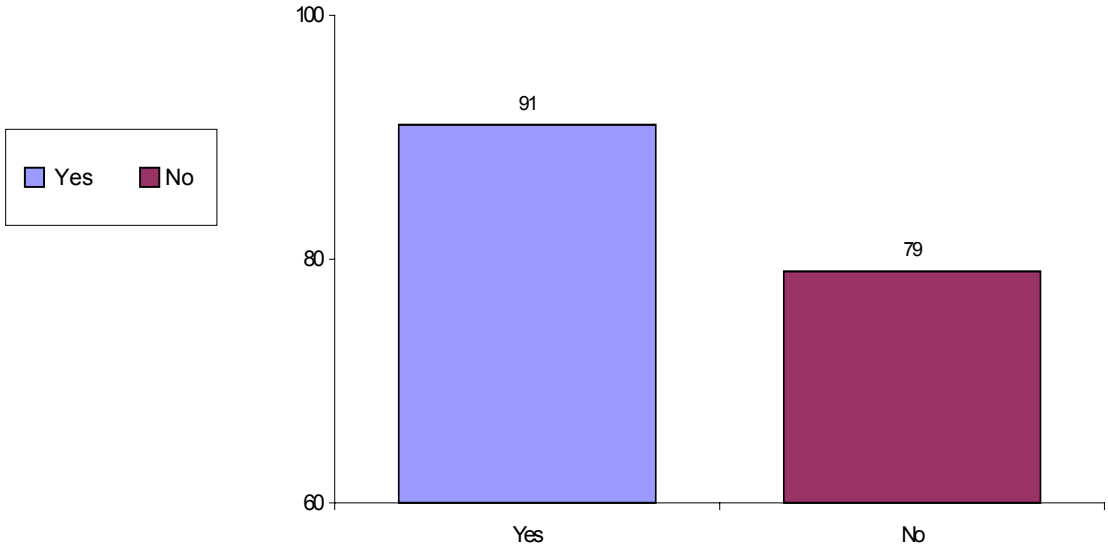
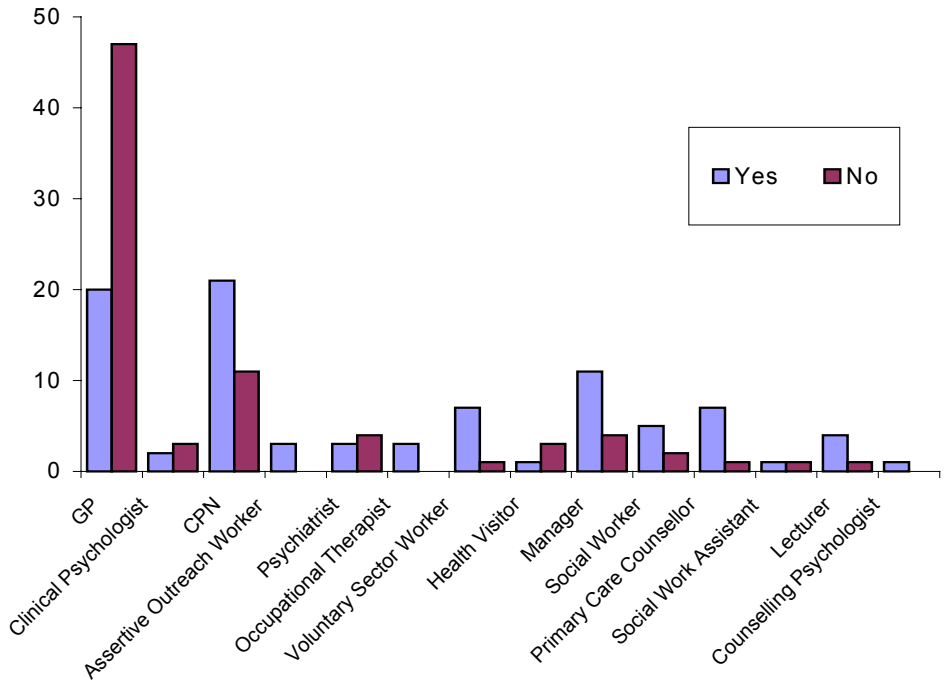


Figure 4b (below) highlights the individual group responses to this question and underlines the fact that GPs, more than any other group, stated that they felt 'expert patients' *could not* be Community Mental Health Workers.

Figure 4b. 'Expert patients' as Community Mental Health Workers – individual group responses.



Respondents were asked to comment on their answer. The most significant comment (35%) was that experience and training would be essential for service users to fulfil this role.

Other comments included:

- Supervision and support would be necessary for service users to fulfil the role (n=10).
- Service users would be in a position to share experience and skills which would benefit clients (n=8).
- Service users could be befrienders/promote self-help/provide general support only (n=3).
- Concerns appertaining to the ability of service users to be 'objective' (n=6), possible illness relapse (n=5), and their lack of training (n=4) were expressed along with concern about confidentiality issues (n=4).
- Three respondents felt that service users would be 'ideal' candidates for this role. Other less frequent comments included concerns that service users would use relationships to 'benefit themselves', the 'client might not like it', it would improve integration (i.e. reduce stigma), and service users were better placed than professionals.

The general comments made about the 'expert patient':

> *What a stupid question!* [Response was 'no']. (Female, Clinical Psychologist, aged 51-65)
>
> *Absolutely not.* (Female, Community Mental Health Nurse, aged 31-50)
>
> *What better assessors and supporters can there be?!* (Male, Community Psychiatric Nurse, aged 31-50)
>
> *Expert patients should be used to create opportunities for mental health service users to develop confidence, skills and self-empowerment and earn money.* (Female, Development Worker for Mental Health, aged 31-50)
>
> *Expert patients couldn't be mental health workers due to issues surrounding risk and indemnity. Patients may still be a resource under supervision of the CMHT.* (Male, GP, aged 31-50)
>
> *They may well be using the role as ongoing therapy for themselves. They may not really* listen *to clients assuming their own experiences and material are relevant to others.* (Female, Primary Care Counsellor, aged 51-65)

Often biased by their experience and have axe to grind – would be helpful support but not do the job alone. (Female, GP Job Sharing Principal, aged 20-30)

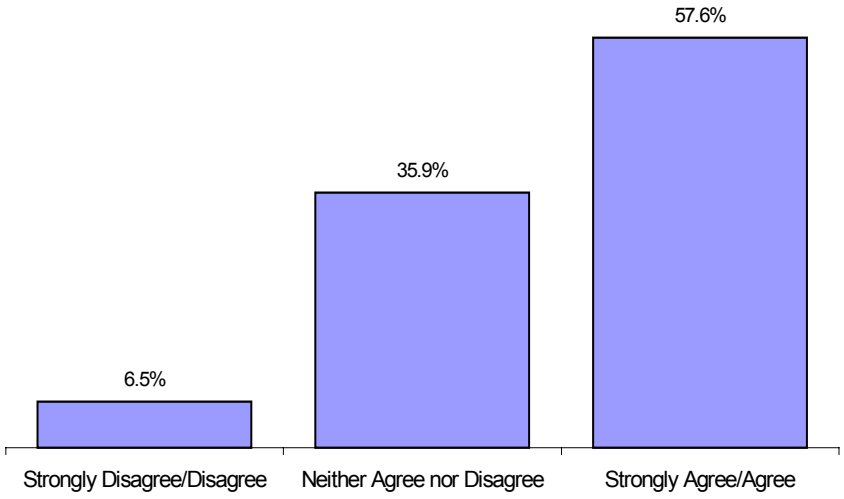
There are already workers who have been patients. Their 'patientness' is unimportant compared to their personal skills and qualities. (Male, Consultant Psychiatrist, aged 31-50)

About the new Community Mental Health Worker

Respondents were asked to comment on two statements about the new Community Mental Health Worker by stating their overall opinion using a scale from 'Strongly Agree' to 'Strongly Disagree'.

As Figure 5 (below) illustrates, over half of all respondents felt that the new Community Mental Health Worker would make a difference to those with mild/moderate mental health problems. This was similar throughout the groups.

Figure 5. Responses to the statement: I think the new Community Mental Health Worker will make a difference to the care given to those with a mild/moderate mental health problem.



One of the most common comments (n=33, 21%) was that money should be available for the severely mentally ill only. Other comments (usually singular) from the groups included:

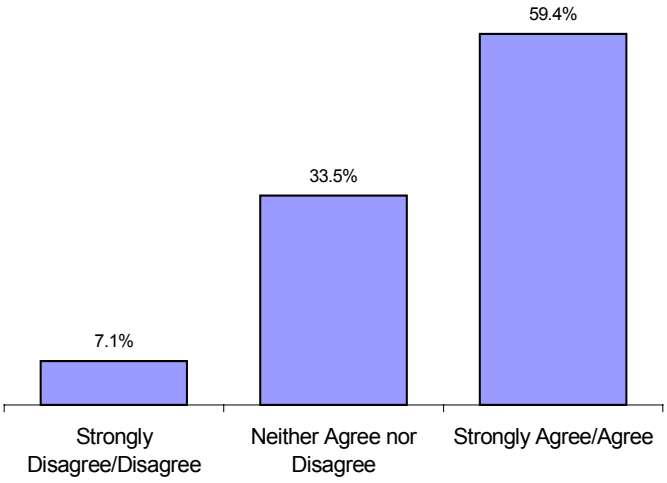
- Those with milder mental health problems must be cared for in primary care (n=5) and receive specialised input (n=4).
- The success of the new worker with regard to those with a mild/moderate mental health problem would depend on their training.
- Any extra worker would make a difference.

- This input would reduce hospital admission rates.
- There is a general need for more Psychiatric Nurses.
- There is too much available for those with less severe problems already.
- Money is too limited to make any real difference.

Figure 5b (below) shows that, again, over half of all respondents felt that the new Community Mental Health Worker would make a difference to those with a 'more severe' mental health problem – a marginally more positive result compared with the previous statement. This was similar throughout the groups.

The responses to the above two statements seem to underline earlier findings about identified gaps in service provision for both the severely mentally ill and those with less severe mental health problems. As before, however, respondents felt that those with a more severe mental illness are marginally more in need of increased input.

Figure 5b. Responses to the statement: I think the new Community Mental Health Worker will make a difference to those with a more severe mental illness.



There were 23 comments made. The most common comment (n=7) was that long-term support was necessary for those with a more severe mental health problem. The next frequent comment (n=4) was that the new workers, if working with this client group, should be within a specialist team such as a Community Mental Health Team.

Other comments included (singular unless otherwise stated):

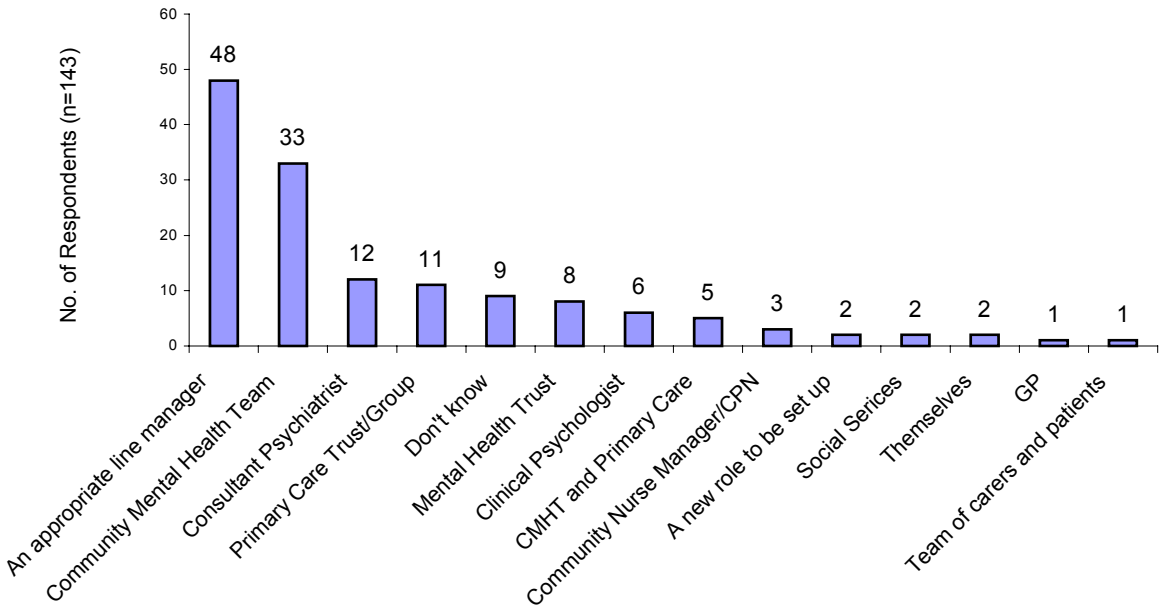
- Expressions of anxiety for the future care of those with a more severe mental illness (n=2).
- The need to provide advocacy for this group.

- The new workers could assist primary care workers in caring for those with a long-term mental health problem 'if deemed mentally stable'.
- The new workers could work with this client group only if they have the necessary skills.
- The new workers could help reduce the high caseloads of other workers already involved with this client group.
- More workers to care for this client group would help 'protect society'.

Management

The questionnaire next asked respondents whom they thought should manage the new Community Mental Health Workers, i.e. to whom should they be accountable and responsible?

Figure 6. Responses to the question: who should manage the Community Mental Health Worker?



The most common response was that the new workers should be managed by an appropriate line manager. This response was similar throughout the groups except for GPs – only 6% (n=47) selected this answer compared to 36% throughout the other groups. GPs' most likely response was that the Community Mental Health Team should be the workers' line manager. There were few comments made on this topic:

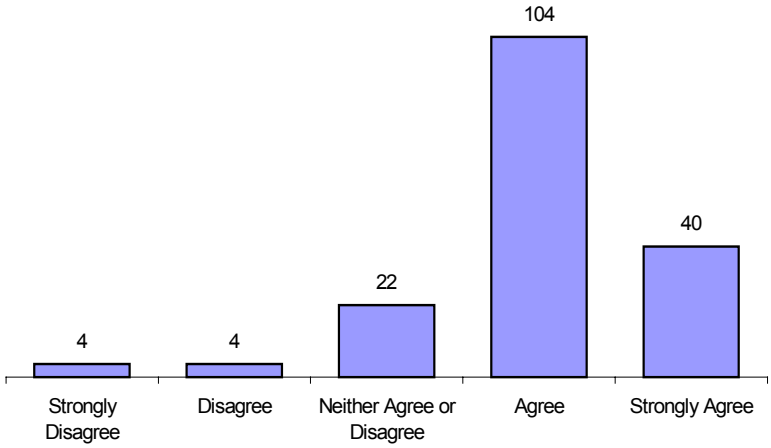
> *Depends on the focus of their work. A team of their workers focusing on users from ethnic minority groups would be better managed by a voluntary sector group representing the ethnic minority community.* (Female, Mental Health Trainer/Consultant, aged 31-50)

Should the new worker carry a caseload?

Respondents were asked to comment on the statement that the new Community Mental Health Worker *should* have a caseload, using a scale from 'Strongly agree' to 'Strongly disagree'.

An overwhelming 83% (n=174) stated that they 'Agreed' or 'Strongly agreed' with the new workers carrying a caseload. This was the same throughout all the groups, apart from Community Psychiatric Nurses. Over half of all the Community Psychiatric Nurse respondents (n=31) 'Strongly agreed' that the new workers should have a caseload.

Figure 7. Responses to the statement: the new Community Mental Health Worker *should* have a caseload.



There were over 30 comments made on this subject. The most common comment (n=8) suggested that carrying a caseload was an important aspect of the role as it ensured 'continuity of care' for clients. Six respondents suggested that these workers should carry a caseload within a 'case management framework' and four respondents suggested that these workers should have a short-term caseload only (i.e. work with clients on a short-term basis only).

Other comments included (singular unless otherwise stated):

- The worker should only have a caseload if supervised (n=3).
- The worker should carry a caseload only if they have the correct skills (n=3).
- The worker *should not* carry a caseload as it would reduce their 'availability and access' to others (n=3).
- The worker should have a caseload as a role model for others.
- The worker should have the skills but no caseload.
- The worker should support another worker with a caseload only.

Comments about why the new worker *should* carry a caseload:

As they are set up to bridge a current gap in services it would be hard for this to be achieved if they did not participate in care and treatment. (Female, Lecturer/Clinical Nurse Specialist, aged 31-50)

Not necessarily a large caseload but one in which expertise and skills can be demonstrated to other workers. (Male, Community Psychiatric Nurse, aged 31-50)

Their usefulness would be severely limited if they do not have a client caseload. (Female, GP, aged 31-50)

Comments about why the new worker *should not* carry a caseload:

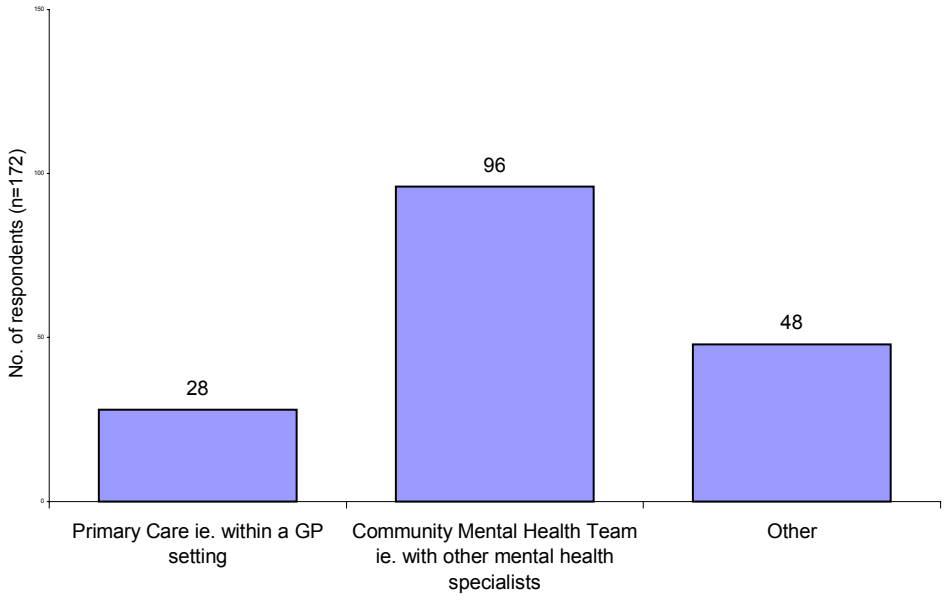
With limited funding a caseload would create a very long waiting list. (Male, GP, aged 31-50)

They should support patients or the caseload of other trained staff. (Male, Community Mental Health Nurse, aged 31-50)

Where should the new worker be based?

The final question asked respondents where the new worker should be based, either within primary care, within a Community Mental Health Team, or 'Other'. As Figure 8 (below) demonstrates, the most common response was that the new worker should be based within a Community Mental Health Team.

Figure 8. Response to the question: where should the new Community Mental Health Worker be based?



This response was similar throughout the groups. This would appear to correspond with the question concerning management of the new worker (see Figure 6) whereby respondents frequently suggested that the Community Mental Health Team should manage the new worker.

Where 'Other' was selected, the most common description that followed was that the worker should be based in both primary care *and* a Community Mental Health Team (62%, n=39). A total of 21 respondents commented that the worker should be based within the Community Mental Health Team so that they receive adequate support and another two felt that any other setting would isolate the worker.

Six respondents suggested that Community Mental Health Teams should be based within primary care and five respondents proposed that those described as having a milder mental illness should be cared for in primary care.

Comments:

> *It's essential that mental health is initially dealt with in Primary Care.* (Female, Community Psychiatric Nurse, aged 31-50)
>
> *Primary Care…Direct access to those who need it.* (Male, CMHT Manager, aged 31-50)
>
> *...must be attached to CMHTs for supervision, work allocation, training, support etc. Would be too isolated at Primary Care level.* (Female, Project Manager, aged 31-50)
>
> *They need to be in primary care if they are to build a relationship with primary care colleagues, so they too can be available on the first line of contact.* (Female, Community Mental Health Nurse, aged 31-50)
>
> *In this area there is the potential for* excellent *community mental healthcare if it were developed based on PCTs with more psychologists/counsellors*. (Female, Clinical Psychologist, aged 51-65)

Final Notes and Comments

At the end of the questionnaire there was an opportunity for respondents to comment generally on the subject of the Community Mental Health Worker. These comments mainly reiterated what had been stated in the questionnaire. Respondents commented that the new Community Mental Health Worker should have a clear career path with a good salary (n=4), that they should be a trained, qualified professional (n=3), and that they

should have input with those with mild mental health problems to prevent development into more serious mental health issues (n=3). A few topics seemed to reoccur however:

The debate over the need for a new role:

I believe there is a need for a new role – Mental Health Worker – which combines aspects of CPNs (Community Psychiatric Nurses), OTs (Occupational Therapists), ASWs (Approved Social Workers), Clinical Psychologists…This training should be cross fertilised with single discipline training programmes e.g. doctors. (Male, Assertive Outreach Worker, aged 31-50)

…the worker needs a range of skills which could be combined in one specialist worker. (Female, Senior Social Worker, aged 31-50)

The skills needed are a combination of knowledge of mental illness with an understanding of and access to social services – a new role in addition to those above. (Male, GP, aged 31-50)

Severe mental health and long-term mental health have an excellent treatment/support system which simply needs to be better resourced, they do not need another tier of trained worker. (Male, GP, aged 31-50)

This new role needs to be more than offering isolated sessions to individuals in a clinic. (Female, Community Mental Health Nurse, aged 31-50)

Different disciplines exist to provide holistic care – 'merging' into a 'new' worker seems like change for the sake of it. (Female, Community Psychiatric Nurse, aged 31-50)

There is another need for someone from possibly any of the above disciplines [as described in the questionnaire pp4 & p5] *to work within primary care to assist clearer gate-keeping, boundaries and ring-fencing processes to help ensure that those with the greatest need get the most appropriate help. This would be a highly skilled role requiring a sound professional background.* (Male, Mental Health Educator, aged 31-50)

GP specific issues:

Sometimes patients with 'personality disorders' or allied problems are returned to the GP to manage. This can be difficult and we can feel unsupported. (Male, GP aged 31-50)

As a GP I spend a lot of time trying to provide for these people [those with a less severe mental illness]. *I have no training in this area, very little time and no support*. (Female, GP, aged 31-50)

This is part of the GP role: albeit compromised by lack of support, co-ordination and resources. (Male, GP, aged 31-50)

GPs do their bit and provide some mental health therapy, referring as appropriate. (Male, GP, aged 31-50)

Patients who do not need secondary care have long waits for counselling and limited time with a GP. (Male, GP, aged 31-50)

General political quotes:

Constant promises of more money/improved services has not affected patients' experiences of psychiatric services enough in the last 10 years. (Male, Assertive Outreach Worker, aged 31-50)

...it does not make sense to train another profession to have the same skills, call them something different and pay them less, which appears to be the Government agenda. (Female, Bank Community Psychiatric Nurse, aged 31-50)

Funding will be essential if it is to succeed. (Female, GP, aged 31-50)

This could be a useful role provided funding is found in addition *to what is already provided.* (Female, GP, aged 31-50)

Community treatment – needs back up with sufficient in-patient beds – currently there are not enough. (Male, GP, aged 31-50)

The funding is so small that I don't feel that this worker will fulfil any of these roles within this practice. (Male, GP, aged 31-50)

The difficulty with so much emphasis on 'National Service Frameworks' and 'NHS Plans' is their agendas are politically driven. Hence priorities change with the tide. Most mental health workers are clear as to what they are supposed *to be doing. They are less clear about whether their prescribed priorities are the right ones.* (Male, Mental Health Educator, aged 31-50)

General quotes on community mental healthcare:

As someone said 'evidence-based care' simply means a new antipsychotic and some CBT. (Male, Mental Health Training and Development Officer, aged 31-50)

More community help needed – experts – going where needed. More group help needed/self-help and expert. (Female, Primary Care Counsellor, aged 31-50)

CMHT's focus should be on those with long-term serious mental illness therefore the 'new' mental health workers should be based in Primary Care to enable a clear focus on those with minor mental illness and the Primary Care needs of those with serious mental illness. (Female, Lecturer/Clinical Nurse Specialist, aged 31-50)

This is a role which could be extremely useful if done at the right level e.g. a high level. Otherwise there is much scope for serious mistakes with no improvement. (Female, Clinical Psychologist, aged 51-65)

I think it's a great idea, but I also thought it was what existing CMHT staff were meant to be already! (Female, Project Co-ordinator, aged 20-30)

I think the social model of mental health needs to be emphasised more. Also all aspects of mental health promotion need to be key to what should be provided. (Female, Mental Health Trainer/Consultant, aged 31-50)

...the workers need to have a lot of common sense. (Male, Day Services Manager, 51-65)

Respondents' descriptions of community mental health developments currently taking place in the South:

Practice-based qualified RGN/RMNs provide support for vulnerable patients. (We have a register of these patients.) Support by regular contact either face-to-face or by telephone. (Male, GP, aged 51-65)

The Mental Health Worker is a new job title, and person specification within Avon and Wiltshire Mental Health Partnership Trust. (Male, Mental Health Training and Development Officer, aged 31-50)

The team I work in is based in Social Services but supports people with common mental illnesses…Referrals are received from GPs, CMHT, children and families, Health Visitors, and vol [voluntary] *agencies.* (Female, Social Worker Mental Health, aged 31-50)

We also work very closely with secondary care in assessment, advice and information. Good practice models for the Primary Care Mental Health Service includes:
- triage service to improve access through to appropriate services and increase patient choice;
- improve provision of mental health information to patients not just in the practice but by developing links and partnerships in the community and voluntary sector and attending to the education needs of professionals and patients;
- attend to specific needs of vulnerable groups e.g. women unable to access services because of childcare, carers, ethnic community, non-compliant and 'hard to engage' young males;
- direct treatment provision. (Female, Social Worker Supervisor, aged 31-50)

Note: Poole Mental Health Primary/Support Team provides a mental health assessment and support service for residents of the Borough of Poole aged under 65 who may be experiencing common mental health problems with other social care needs. For details, contact Linda Anderson via the Social Services help desk on: (01202) 633868/69/70 or 633890.

Issues Arising

A substantial number of GPs in this survey stated that they dealt with mental health issues as an integral part of their role as a GP. However, when subsequently asked whether they had a formal mental health qualification, 73% said they had *not*. This is not to say that they are not knowledgeable about mental health.

The Government's *Workforce Action Team (WAT) for Mental Health* special report of August 2001 (which focused on primary care) reinforced this finding:

> Many GPs lack confidence in managing mental health issues, perhaps reflecting that fewer than 30% have held a postgraduate psychiatric post. Fewer than 35% of randomly selected GPs in England and Wales had undertaken some form of continuing medical education in mental health topics in the previous three years. Thresholds vary enormously and some GPs will manage in primary care the same patients whom others will refer to specialists. Effectiveness varies according to confidence, ability and experience alongside severe time constraints.

Despite extensive press and media coverage about funding for new Community Mental Health Workers, little more than half of the respondents in this survey had heard of the possible new post, with 63% of GPs completely unaware of the proposal.

The most common description for the new worker (where respondents had heard of the term) was a 'generic mental health/social care worker', although much popular media coverage and debate has been given to:

- A 'Primary Graduate Care Worker' – a graduate (possibly from a psychology discipline) to assist GPs in the primary care setting to treat common mental health problems using brief therapy techniques.
- A 'Support Time and Recovery (STR) Worker' – an unqualified support worker to deal with clients' everyday needs. This worker will not provide clinical or medical treatment.
- A 'Gateway Worker' – a worker employed to work with GPs, Primary Care Teams, A&E departments and NHS Direct to respond to those who need immediate help.

Respondents in this survey felt that Community Mental Health Workers already existed in the form of Community Psychiatric Nurses or unqualified support workers. It was also stated that the new worker should work primarily with those with a long-term mental health problem, although there were gaps in service provision for clients with less severe mental health problems too.

The emphasis from the Government concerning the new proposals for improving the nation's mental health is on strengthening primary care mental health. The findings from this survey suggest that, in order to do so successfully, additional support is required for those long-term service users who are neither receiving sustained input from the secondary services nor adequate input from the primary care services.

This is again similar to the findings of the *Workforce Action Team Special Report.* It detailed that certainly those with more serious mental health problems are not always managed by specialised services. Indeed 'for those with severe and enduring illnesses the GP is the most frequently consulted of any primary or secondary professional' (Workforce Action Team, 2001). This is an interesting conclusion considering the first finding of this survey, which stated that 73% of the GP respondents had no mental health qualification.

Similar to nation-wide findings (specifically the findings of the Workforce Action Team who purport that mental and physical states should not be managed separately), respondents felt that the physical health of those with long-term serious mental health problems was poor.

A recurring theme throughout the questionnaire responses was that regular long-term input was required for those with long-term mental health problems.

Respondents felt that the mental healthcare of those described as having a less severe mental illness was satisfactory. Service provision for this client group was therefore seen to be better than the attention given to the physical healthcare needs of the severely mentally ill. However, it is perhaps worth commenting that the Workforce Action Team reports that 'between 30% and 50% of presentations of depression are undetected by GPs' (Workforce Action Team, 2001).

Responses to general aspects

With regard to general aspects of mental healthcare, there were varied responses ranging from satisfactory to unsatisfactory:

Client access to talking therapies

According to the WAT report, 'services in the south of England are generally more numerous than those in the north' (Workforce Action Team, 2001) referring to psychology services and counselling. This would not seem to be the case according to respondents. Indeed, this service was rated least favourably when compared with the others, raising issues such as waiting lists, waiting times and access to services.

Communication between services

Again, similar to the aforementioned report, occasionally respondents recorded significant communication difficulties between service providers.

Delivery of appropriate client care

This was not rated highly by respondents. The reasons cited for this were multifaceted, including the lack of long-term input for those with a more severe long-term mental health problem, and the unhelpful use of descriptive terms such as 'mildly mentally ill' and 'severely mentally ill'. These terms were considered to be misleading and underlined the disparate nature of primary and secondary care approaches to mental health, incorporating the disregard for holistic approaches to health and disease. Unsurprisingly, these findings echoed those in the WAT report.

Who could be a Community Mental Health Worker?

One of the issues raised was that the role of the new worker should not be added to an existing worker's role. Instead, it should be independent of other team roles and responsibilities or, if it was an established professional, they should be relieved of their current responsibilities. Respondents were quite clear that, at present, healthcare staff had barely enough time to fulfil their current roles.

Recruitment, selection and training

The following findings may assist in the recruitment, selection and training of new workers.

Respondents stated that the five skills they felt were most important for the new worker to have were:

- communication and listening skills;
- knowledge of local health services;
- ability to assess and identify needs;
- ability to work with others who may be involved in the client's care;
- ability to build therapeutic relationships.

The two aspects of training rated most highly were experience of working autonomously and experience of working in the community. The ability to work in a holistic manner was also rated highly, which would correspond

with the WAT report highlighting the need to view both physical and mental aspects of healthcare concurrently. Other similar findings include the need for promoting client self-help skills, drug treatment issues and risk management.

Suicide was *not* referred to by any respondents, despite it being the main cause of premature death in people with mental illness and the subject of the Government's White Paper *Saving Lives: Our Healthier Nation,* which set the target to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010. There were no questions appertaining to suicide in the questionnaire, as this important aspect of mental healthcare was outside the remit of this particular project.

Overall, compared with the recommended content of a primary mental health course by WAT, respondents in this survey did not seem to identify similar features for skills and training of a mental health worker. It could perhaps be argued that the skills and training for mental health workers, new or otherwise, need to be identified at a local level to meet the needs of both clients and staff within that area.

With regard to the salary of the new worker, respondents made it quite clear that they felt the new worker should have a salary to reflect the work they do in terms of their role and management responsibilities. The inference being that, for the job to be done efficiently and effectively, the new worker must have the correct skills, training and expertise – such a person needs to be attracted financially to such a role. Respondents mostly suggested that a Mental Health Trust should finance the role.

The WAT report cites service users throughout its document. Though it does not refer to service users being involved as 'expert patients', it does infer their role in advocacy, education and training, service development and commissioning. Over half the respondents in this survey felt that service users could be Community Mental Health Workers, which addresses the issue of integration to a far greater level than that suggested by the WAT report! It was notable, however, that GPs were more likely than any other group to state that service users could *not* be Community Mental Health Workers.

Respondents were most likely to state that the management of the new worker should be led by 'some appropriate line manager'. The WAT report comments that 'a primary care mental health lead facilitator should be established in each PCT' (Workforce Action Team, 2001) but does not directly infer a particular management set up for the new workers. This appears to be in accordance with the respondents in this survey. It would

seem prudent not to prescribe a particular manager for all workers nationally, given the differing natures of the proposed new worker's roles. For example, graduate primary care workers would perhaps be better managed by their psychology colleagues and STR workers by social services managers. If each locality determines the role and remit of a new Community Mental Health Worker, it would seem sensible for each locality to decide who their manager should be.

The WAT report describes strengthening mental health service provision in primary care, and suggests the establishment of Primary Care Mental Health Teams, among others. Respondents in this survey stated that they felt the new worker should be based within a Community Mental Health Team, although another common response was that they should be based in both primary care and a Community Mental Health Team. Support, supervision and liaison were reported as essential for the new worker, thus respondents were aware of the isolation that can be felt by primary care workers dealing with aspects of mental healthcare.

Project Outcomes

The project seems to have achieved the expected outcomes as described in the rationale.

- Respondents have identified a clear need for another worker in mental health, but not necessarily a new role.

- Respondents described the need for improved service provision for those with a milder mental illness *and* those with a more serious mental illness. Clients with more severe mental problems, however, are more in need of enhanced services on a long-term basis. The physical health of such clients needs particular attention. Clearly, primary care workers are involved with clients experiencing the *whole* spectrum of mental health and mental ill health – not just those with less severe mental health problems as the literature previously suggested.

- Respondents stated that the Community Mental Health Worker should be managed by an appropriate line manager from within a Community Mental Health Team but with close links to primary care.

- Respondents identified particular aspects of training and skills that were felt to be crucial to the role.

- Respondents did not suggest at any time that the role of a Community Mental Health Worker could not be fulfilled by one person. Indeed, this person should be capable of addressing a wide range of mental or physical health/ill health issues and social care aspects such as housing and welfare.

References

ALLEN, C. (2000) Great Expectations. *Mental Health Practice*, 4 (3), 4.

ALYAS, Z. (2001) Letter: The continuing debate about cardiotoxicity of antipsychotics. *British Medical Journal*, 20 May 2001.

APPLEBY, L, SHAW, J, AMOS, T, THOMAS, S, FERRIER, N & LEWIS, G. (2000) Sudden unexplained death in psychiatric in-patients. *British Journal of Psychiatry*, (176), 405-406.

AUTHOR UNKNOWN. (2001) *Health and social care bill: the basics*. The Guardian Unlimited Archive, Monday 12 March, 2001. http://society.guardian.co.uk [accessed 15 July 2003].

BARR, W. (2000) Characteristics of severely mentally ill patients in and out of contact with community mental health services. *Journal of Advanced Nursing,* 31 (5), 1189-1198.

BBC NEWS ONLINE. (1998) *The origins of care in the community*. Wednesday, 29 July, 1998. http://news.bbc.co.uk/1/hi/health/default.htm [accessed 24 July 2003].

BBC NEWS ONLINE. (1999) *Mental Health Care: Quality not quantity*. Friday 25 June. http://news.bbc.co.uk/ [accessed 15 July 2003].

BBC NEWS ONLINE. (2000) We want friends not medicine. Monday 13 March. http://news.bbc.co.uk/ [accessed 15 July 2003].

BELMAN, J. (2000) *The NHS Plan: Summary and Key Issues for Voluntary Organisations (August 2000)*. LVSC, London. http://www.nccalliance.org.uk [accessed 15 July 2003].

BOURNEMOUTH UNIVERSITY/DORSET HEALTH CARE NHS TRUST. (2001) *Diploma in Professional Psychosocial Interventions in the Management of Psychosis and Associated Problems*. Course Definition Document, January 2001.

BOWER, P, MEAD, N & GASK, L. (1997) Primary Care and mental health problems. *Nursing Times,* 93 (18), 58-59.

BOWERS, L. Community psychiatric nurse caseloads and the 'worried well': misspent time vital work. *Journal of Advanced Nursing*, 26 November, 5, 930-936.

BROWN, S. (1997) Excess mortality of schizophrenia. A meta-analysis. *British Journal of Psychiatry*, (171), 502-508.

BROWN, S. (1998) Review: patients who have schizophrenia have increased mortality from all causes, natural causes, and unnatural causes. *Evidence-Based Mental Health* (1), 91.

BROWN, S, BARRACLOUGH, B & INSKIP, H. (2000a) Causes of the excess mortality of schizophrenia. *British Journal of Psychiatry*, (177), 212-217.

BROWN, B, CRAWFORD, P & DARONGKAMAS, J. (2000b) Blurred roles and permeable boundaries: the experience of multidisciplinary community mental health. *Health and Social Care in the Community,* 8, 425-435.

BRUGHA, TS, WING, JK & SMITH, BL. (1989) Physical health of the long-term mentally ill in the community. Is there an unmet need? *British Journal of Psychiatry*, (155), 777-781.

BUCKLEY, NA & SANDERS, P. (2000) Cardiovascular adverse effects of antipsychotic drugs. *Drug Safety*, 3 (2), 215-228.

BUTLER, P. (2001) *The NHS Plan: The issue explained.* Guardian Unlimited. 19 March 2001. http://society.guardian.co.uk/nhsplan/ [accessed 24 July 2003].

CHONG, SA. (2001) Psychotropic drugs and sudden death. *British Journal of Psychiatry,* (178), 179-180.

CRAIG, TKJ & BOARDMAN, AP. (1997) ABC of Mental Health: Common mental health problems in Primary Care. *British Medical Journal*, 31 May, (314), 1609.

DAVIDSON, S, JUDD, F, JOLLEY, D, HOCKING, B & THOMPSON, S. (2000) The general health status of people with mental illness. *Australasian Psychiatry,* 8 (1), 31-35.

DAVIDSON, S, JUDD, F, JOLLEY, J, HOCKING, B, THOMPSON, S & HYLAND, B. (2001a) Cardiovascular risk factors for people with mental illness. *Australian and New Zealand Journal of Psychiatry*, 35 (2), 196-202.

DAVIDSON, S, JUDD, F, JOLLEY, D, HOCKING, B, THOMPSON, S & HYLAND, B. (2001b) Risk factors for HIV/AIDS and Hepatitis C among the chronically mentally ill. *Australian and New Zealand Journal of Psychiatry*, 35 (2) 203-209.

DAVISON, L, CURTIS JENKINS, C & MELLOR CLARK, K. (1998) *Clinical Effectiveness and Primary Care Couselling.* National Network of Counselling in Primary Care Service Providers. November.

DEPARTMENT OF HEALTH. (1997) *Executive Summary: The New NHS Modern, Dependable* (CM 3087). DoH, London.

DEPARTMENT OF HEALTH. (1998a) *Your NHS, The Nation's Health Service. The NHS Today – understanding the NHS*. www.nhs50.nhs.uk/nhstoday-understand-gov.htm [accessed 15 July 2003].

DEPARTMENT OF HEALTH. (1998b) *Green Paper: Our Healthier Nation*. DoH, London.

DEPARTMENT OF HEALTH. (1998c) *Executive Summary: Modernising Mental Health Services: Safe, Sound and Supportive*. DoH, London.

DEPARTMENT OF HEALTH. (1999a) *Saving Lives: Our Healthier Nation*. http://www.ohn.gov.uk/ohn/intro.htm [accessed 15 July 2003].

DEPARTMENT OF HEALTH. (1999b) *White Paper: Our Healthier Nation*. DoH, London.

DEPARTMENT OF HEALTH. (2000a) *Commissioning arrangements in the new NHS: Guidance. The NHS Plan.* DoH, London.

DEPARTMENT OF HEALTH. (2000b) *The NHS Plan - A plan for investment. A plan for reform* (CM 4818-I). DoH, London.

DEPARTMENT OF HEALTH. (2000c) *The NHS Plan - Breathing new life into the health service.* DH News Desk: Inside Story. www.doh.gov.uk/newsdesk/ inside/october [accessed 15 July 2003].

DEPARTMENT OF HEALTH. (2000d) *The NHS Plan – An Executive Summary*. DoH, London.

DEPARTMENT OF HEALTH. (2000e) *Examination of Witnesses Memorandum*. Wednesday 24 May. HMSO, London.

DEPARTMENT OF HEALTH WEBSITE a. *National Service Frameworks*. http://www.doh.gov.uk/nsf/about.htm [accessed 15 July 2003].

DEPARTMENT OF HEALTH WEBSITE b. *The NHS Plan*. *Mental Health.* http://www.gov.uk/about/nhsplan/priorities/mentalhealth.html [accessed 15 July 2003].

DINAN, T. (1999) The physical consequences of depressive illness. *British Medical Journal*, (318), 826-826.

ELLIOTT, L, CROMBIE, IK, IRVINE, L, CANTRELL, J & TAYLOR, J. (2001) The Effectiveness of Public Health Nursing: A Review of Systematic Reviews. Scottish Executive Publications, Edinburgh. ISBN: 1-84268-906-1.

GALUSKA, DA, WILL, JC, SERDULA, MK, EARL, S & FORD, MD. (1999) Are health care professionals advising obese patients to lose weight? *Journal of the American Medical Association,* 282, 1576-1578.

GOFF, DC, HENDERSON, DC & AMICO, E. (1992) Cigarette smoking in schizophrenia: relationship to psychopathology and medication side-effects. *American Journal of Psychiatry*, (149), 1189-1194.

GOLDBERG, D & GOURNEY, K. (2000) Maudsley Discussion Paper No. 1: *The General Practitioner and the Burden of Mental Health Care.* Institute of Psychiatry, King's College, London.

GOURNAY, K & BROOKING, J. (1994) Community Psychiatric Nurses in Primary Health Care. *British Journal of Psychiatry* January, 165, 231-238.

GOURNAY, K & BROOKING, J. (1995) The community psychiatric nurse in primary care: an economic analysis. *Journal of Advanced Nursing* October 22, 4, 769-78.

GRAY, R, WYKES, T, PARR, AM, HAILS, E & GOURNAY, K. (2000) The use of outcome measures to evaluate the efficacy and tolerability of antipsychotic medication: a comparison of Thorn graduate and CPN practice. *Journal of Psychiatric & Mental Health Nursing*, 8 (3), 191-196.

GRIFFITHS R, (1988) *Community Care: Agenda for action*. London, HMSO.

DEVAUL, RA, FAILLACE, LA & STICKNEY, SK. (1978) Physical illness presenting as psychiatric disease. *Archives of General Psychiatry*, 35 (11), 1315-20.

HAMBRECHT, M & HAFNER, H. (2000) Cannabis, vulnerability, and the onset of schizophrenia: an epidemiological perspective. *Australian and New Zealand Journal of Psychiatry*, 34 (3), 468-475.

HARRIS, EC & BARRACLOUGH, B. (1998) Excess mortality of mental disorder. *British Journal of Psychiatry*, (173), 11-53.

HONIG, A, POP, P, DE KEMP, E, PHILIPSEN, H & ROMME, MA. (1992) Physical illness in chronic psychiatric patients from a community psychiatric unit revisited. A three year follow up study. *British Journal of Psychiatry*, (161), 80-83.

HOYER, EH, MORTENSEN, P & OLESEN, A. (2000) Mortality and causes of death in a total national sample of patients with affective disorders admitted for the first time between 1973 and 1993. *British Journal of Psychiatry*, (176), 76-82.

KENDRICK, T. (1996) Cardiovascular and respiratory risk factors and symptoms among general practice patients with long-term mental illness. *British Journal of Psychiatry*, (169), 733-739.

KORYANI, EK. (1979) Morbidity and rate of undiagnosed physical illness in a psychiatric clinic population. *Archives of General Psychiatry*, 36 (4), 414-419.

LANG, CL. (1982) The resolution of status and ideological conflicts in a community mental health setting. *Psychiatry*, 45, 159-171.

LORI BROWN, S. (1996) Editorial: Lowered serum cholesterol and low mood. *British Medical Journal*, (313), 637-638.

MANN, A, PLUMMER, S, RITTER, S & GOURNAY, K. (1998) *A randomised controlled trial to detect benefit from training practice nurses in the detection and management of psychological distress in patients attending their clinics.* London, Department of Health.

Maudsley Hospital. (1997) *Research Report 1997-1998*. Research Group – Primary Care, The Maudsley Hospital, London. http://iop.kcl.ac.uk/main/ResRep/Chapter3/Pcrecfin.htm

MIND PUBLICATIONS. (1999) *Mind Factsheets: A History of Mental Health and Community Care.* www.mind.org.uk/Information/Factsheets/History+of+mental+health/ [accessed 15 July 2003].

MURPHY E, SMITH R, LINDESAY J. (1998) Increased mortality rates in late-life depression. *British Journal of Psychiatry* 152, 347-353.

NHS EXECUTIVE BRIEFING NOTES. (1998) *Modernising Mental Health Services – The new mental health strategy.* BN No. 34/98.

NORTHERN AND YORKSHIRE REGIONAL NHS MODERNISATION PROGRAMME WEBSITE. *Mental Health: Modernising Mental Health Services.* http://www.nyx.org.uk/modernprogrammes/mentalhealth/mental.html [accessed 15 July 2003].

OSBY, U, BRANDT, L, CORREIA, N, EKBOM, A & SPARen, P. (2000) Time trends in schizophrenia mortality in Stockholm Count, Sweden: Cohort Study. *British Medical Journal*, (321), 483-484.

OUR HEALTHIER NATION WEBSITE a. *Return to National Priorities: Our Healthier Nation Target.* http://www.ohn.gov.uk/ohn/priorities/mental.htm [accessed 15 July 2003].

OUR HEALTHIER NATION WEBSITE b. *Return to National Priorities: Modernising Mental Health Services*. http://www.ohn.gov.uk/ohn/priorities/mental.htm [accessed 15 July 2003].

PARAHOO, K. (1993) Questionnaires: Use, Value and Limitations. *Nurse Researcher,* 1 (2), 4-15.

PETIT-ZEMAN, S. (2000a) *Implementation and assessment of the mental health NSF.* The Guardian Unlimited Archive, 4 December 2000. http://society.guardian.co.uk [accessed 15 July 2003].

PETIT-ZEMAN, S. (2000b) *How the NHS Plan aims to improve mental health services.* The Guardian Unlimited Archive, 4 December 2000. http://society.guardian.co.uk [accessed 15 July 2003].

PHELAN, M, STRADINS, L & MORRISON, S. (2001) Physical health of people with severe mental illness. *British Medical Journal*, (322), 443-444.

POLIT, DF & HUNGLER, BP. (1987) *Essentials of Nursing Research*. Lippincott, London.

POLLOCK, L. (2000) *Recruitment net widens*. Thursday 9 November 2000. http://society.guardian.co.uk [accessed 15 July 2003].

POYNTON, A & HIGGINS, P. (1991) Role of General Practitioners in care of long-term mentally ill patients. *British Journal of Psychiatry*, 159, 703-706.

ROBERTS, A. (1981) *Mental Health History Timeline*. www.mdx.ac.uk/study/mhhtim.htm [accessed 15 July 2003].

ROYAL COLLEGE OF GENERAL PRACTITIONERS. (1997) *Summary Paper: The New NHS Modern, Dependable.* December 97/15.

ROYAL COLLEGE OF GENERAL PRACTITIONERS. (1999) *Information Sheet No. 8: The Structure of the National Health Service*. June.

RUSCHENA, D, MULLEN, PE, BURGESS, P, CORDNER, SM, BARRY-WALSH, J, DRUMMER, OH, PALMER, S, BROWNE, C & WALLACE, C. (1998) Sudden death in psychiatric patients. *British Journal of Psychiatry*, (172), 331-336.

SECKER, J, PIDD, F & PARNHAM, A. (1999) Mental Health Training Needs of Primary Health Care Nurses. *Journal of Clinical Nursing,* 8 (6), p643-652.

SELECT COMMITTEE ON HEALTH. (2000a) *Provision of NHS Mental Health Services. Fourth Report.* Command Paper 4888. House of Commons, London.

SELECT COMMITTEE ON HEALTH. (2000b) *Provision of NHS Mental Health Services HC 373 July 2000. First Report.* Government Reply Command Paper 4888. House of Commons, London.

SHORE, K. (2000) Attack on the phrase 'the worried well'. *Protecting Psychotherapy: Managed care and beyond.* The National Coalition of Mental Health Professionals and Consumers, Inc.

STEELE, L & PETIT-ZEMAN, S. (2001) *Mental health national service framework: the issue explained.* The Guardian Unlimited Archive Tuesday, 13 March, 2001. http://society.guardian.co.uk [accessed 15 July 2003].

THE SAINSBURY CENTRE FOR MENTAL HEALTH. *An executive briefing on the implications of the NHS Plan for Mental Health Services*. www.scmh.org.uk/website/SCMH [accessed 15 July 2003].

TYRER, P. (1999) Editorial: The National Service Framework: a scaffold for mental health. *British Medical Journal*, (319), 1017-1018.

WEBB, Y, CLIFFORD, P, FOWLER, V, MORGAN, C & HANSON, M. (2000) Comparing patients' experience of mental health services in England: a five Trust survey. *International Journal of Health Care Quality Assurance,* 13 (6), p273-281

WORKFORCE ACTION TEAM. (2001) *Special Report*. 1 (4), March.

WRIGHT, A. (1996) Unrecognised Psychiatric Illness in General Practice. *British Journal of General Practice*, 46, 327-328.

Appendix A

The Questionnaire