



The Neglected Majority

Developing intermediate mental health care in primary care

Introduction

Mental health problems are common. In the average primary care trust (PCT) of 200,000 people there will be about 22,000 people who each year have some sort of mental health problem, of whom about 500 people will have a severe and enduring mental health condition such as schizophrenia or bipolar disorder (manic depression).

In line with the National Service Framework for Mental Health (NSF) (DH, 1999), specialist mental health services (which provide community mental health teams, acute and crisis services) appropriately prioritise people with severe and enduring mental health conditions.

This, though, leaves some 21,800 people in each PCT who are not eligible for specialist services. They are supported entirely by primary care services.

Yet people with mental health problems do not slip neatly into one or the other category of care: those with common mental health

problems (mostly depression and anxiety) managed entirely in primary care, and those with severe and enduring mental health problems managed entirely by specialist mental health services.

The reality is that there is a group of people whose problems cannot be managed with confidence in primary care, but who are not appropriate for secondary care services. This group has the following characteristics:

- they have continuing mental health difficulties despite several treatment options from primary care, but do not have a severe and enduring mental health problem as described in the National Service Framework;
- their employment or accommodation is frequently at risk;
- their physical health, or other long term condition, is frequently worsened by their mental health problem.

This group of people cannot be managed with confidence in primary care, and yet are inappropriate for specialist mental health services – they are the Neglected Majority.

How many people?

The evidence for how many people fall into this group is mixed. Few studies have focused specifically on this group. There is however national and international data from which some inferences can be drawn, associated with the practical experience of work being carried out by the Sainsbury Centre for Mental Health (SCMH) and others to offer support to this group.

Table I outlines the total number of people affected by the main types of mental health problems in any given week.

According to National Institute for Health and Clinical Excellence (NICE) guidelines for depression (NICE, 2004a) 20% of individuals with depression are still unwell two years after diagnosis. Even after multiple

treatments, 10% still remain unwell. The guidelines also review studies of 'resistant' or 'refractory' depression: by which it refers to people "whose depression symptoms had failed to respond to two or more antidepressants at an adequate dose for an adequate duration given sequentially." The review indicates that between 10% and 20% of patients with depression fall into this category.

Work being carried out jointly by SCMH and Ipswich PCT indicates that 1 in 18 people with a common mental health condition will fall into the group of those who need more than conventional primary care can provide.

For an average sized PCT of 200,000 people this means that there will be 1,177 people whose care cannot be managed with confidence in primary care but who are inappropriate for specialist services.

Table I: The weekly prevalence of mental health problems

| | Weekly prevalence per 1000 adults of working age | Weekly prevalence in adults of working age, per PCT of 200,000* | Weekly prevalence in adults of working age (pop 50,000,000)* |
|--|--|---|--|
| Depression | 28 | 3,528 | 882,000 |
| Mixed anxiety and depression | 92 | 11,592 | 2,898,000 |
| Anxiety Disorder | 47 | 5,922 | 1,480,500 |
| Other neuroses (OCD, PD, phobias) | 38 | 4,788 | 1,197,000 |
| Psychoses | 4 | 504 | 126,000 |
| Total of all common conditions (as these often co-exist) | 173 | 21,798 | 5,449,500 |

*assuming that 63% of the population are of working age.

OCD = obsessive compulsive disorder

PD = panic disorder

(ONS, 2000)

Levels of care

Current government policy is to use the Kaiser Permanente or United Health Care models for the care of people with long-term health conditions. Both models espouse “risk stratification” to ensure that individuals receive the appropriate level of care for their individual need. Figure 1 shows the “pyramid of care” developed by US health provider Kaiser Permanente which identifies the population of patients with long term conditions into three distinct groups based on their degree of need. This figure was reproduced in the Department of Health policy document *Supporting People with Long Term Conditions* (DH, 2005).

The intention is that people with different levels of risk or severity receive different types of intervention. For diabetes and

coronary heart disease this is an obvious, and already implemented, process. Not everybody with angina is immediately offered coronary artery bypass graft. Not everybody with diabetes is immediately started on insulin.

For severe and enduring mental health conditions it could be argued that the structure of mental health teams also already reflects this approach, with CMHTs providing a less intensive form of support compared to assertive outreach teams, which provide a more intensive service to people with very severe problems.

There is strong evidence that the same process should be applied to the way that care is provided for common mental health conditions. That evidence is summarised in the NICE guidelines for depression and for anxiety (NICE, 2004a, 2004b).

Figure 1: The ‘risk stratification’ model

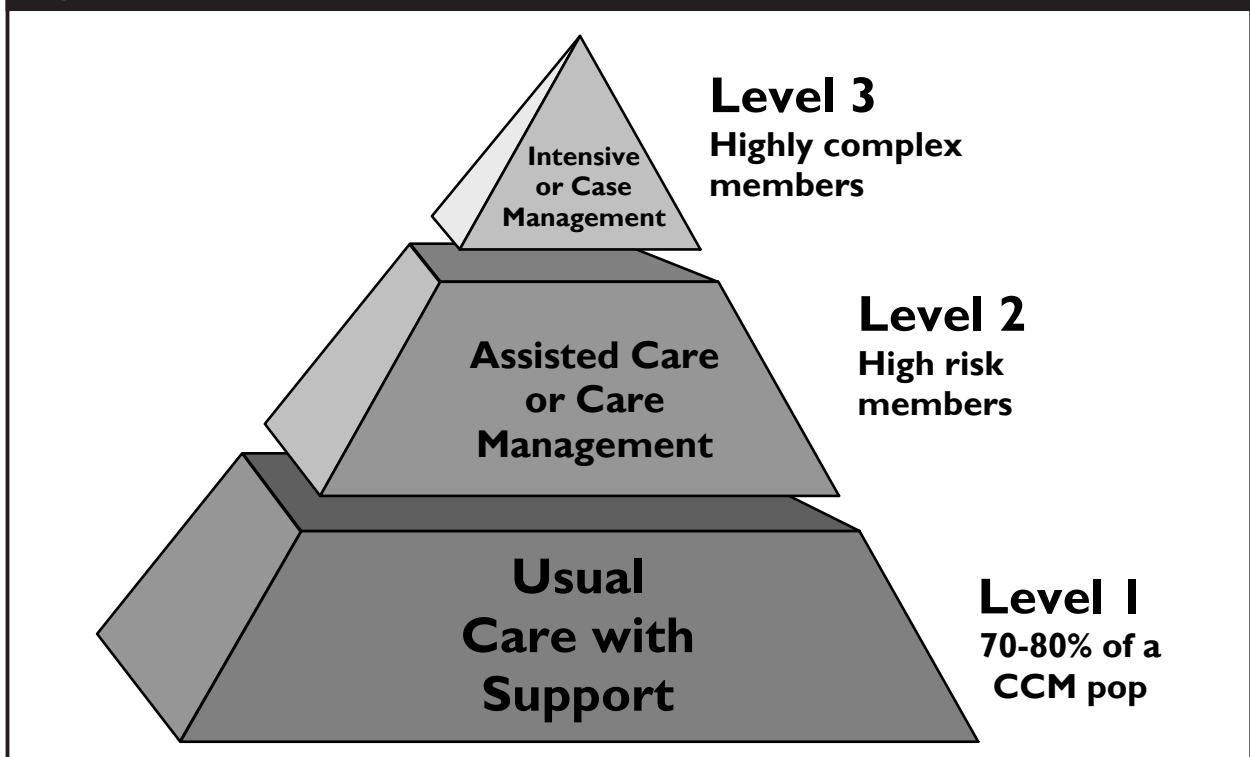


Figure 2: The stepped care approach

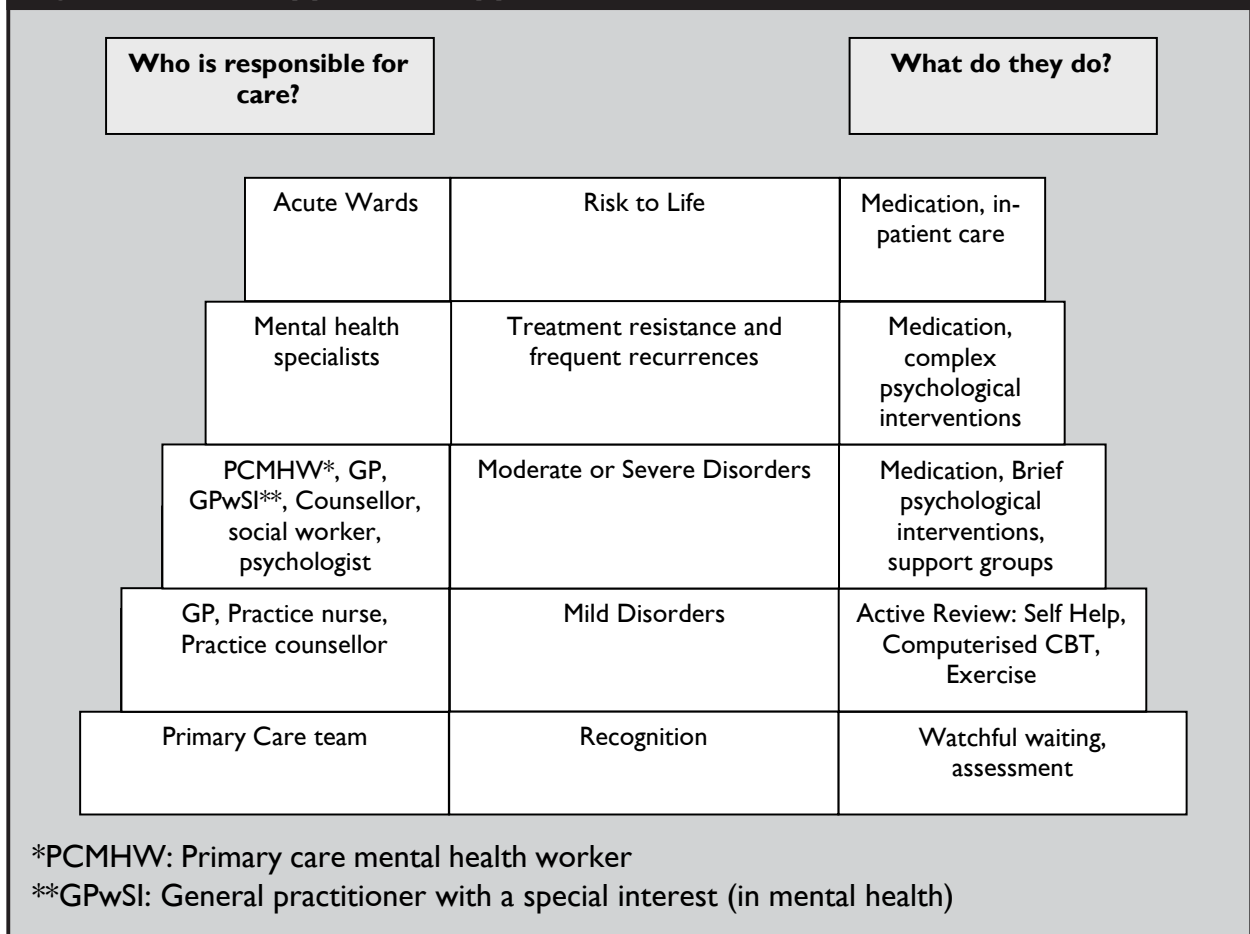


Figure 2 illustrates how the NICE guidance could be applied in the context of mental health services.

This stepped care approach reflects the need to assess the severity of the problem and to match the intervention to the assessed severity.

Currently mental health trusts provide care for those in the top two layers, and primary care provides care for those in the bottom two. Care is not provided for those in the middle layer.

The middle layer is the group of people who have not responded to treatment provided

by routine primary care, who need more intensive support and treatment, including cognitive behavioural therapy (CBT), and who frequently have co-existing physical health complaints and/or social problems such as housing and unemployment.

The Government has indicated that it will invest in a significant expansion in the availability of talking therapies like CBT on the NHS. This is an important step forward for mental health care in England, but it must be targeted appropriately towards those who need it most.

A significant proportion of people with depression get better with medication. A

further proportion will improve with treatment and support/advice from the primary care team, including short courses of counselling. The provision of increased talking therapies (particularly evidence based CBT) should thus be provided for those who do not improve, and whose employment or accommodation is at risk because of their mental health problem.

Intermediate care

This paper has focused on a group of people for whom existing service structures do not work. To provide for them, and to make best use of new investment in talking therapies, an intermediate care team is required.

The Neglected Majority (SCMH, 2005) sets out the details of how such a team could be developed within a PCT area.

One PCT – Ipswich – has already begun to do this: its intermediate care team began operation in January 2005. Some others are in the process of setting their teams up. From that experience, we know some of the characteristics of an effective team.

The team needs to target that group of people who have a disabling mental health condition who:

- have not responded to two evidence based treatments for their mental health condition, or
- have not responded to one evidence based treatment for their mental health condition AND accommodation or employment is at risk because of their mental health problem, or

- have not responded to one evidence based treatment for their mental health condition AND their long term physical health is significantly affected by their mental health problem.

The team covers the same population numbers as a community mental health team (CMHT), but targets a different set of people with a different set of problems. It is not a 'step-down' for people who have used CMHT services.

The membership of the team can reflect local need, and local resources, but in general they will draw on the human resources and personnel that are already working on mental health issues in the community, but not in specialist services. In this way, the existing workforce is better used by focusing more specifically on an 'at risk' group, while the staffing and membership of community mental health teams is not denuded to staff the new team.

Members of the team could include the following:

- General practitioner with a special interest in mental health
- Counselling psychologist
- Primary care social workers
- Employment advisers
- Practitioners who can deliver CBT
- Accommodation advisers
- Benefit advisers
- Users of the service
- Other voluntary sector organisations that provide care.

Using the current workforce to provide a different, more targeted, service lies at the heart of the modernisation agenda, as it uses the existing expertise in the most effective fashion. Since these personnel are already working in this area, and there are no new professional posts being created, the costs associated with setting up a new team are not excessive, although it would not be realistic to expect there to be no 'start up' costs.

Expected Outcomes

There are a number of expected outcomes as a consequence of introducing this service. These outcomes, and how to measure them, are dealt with in more detail in *The Neglected Majority* (SCMH, 2005). In brief the expected outcomes are:

1. Improved mental health – a measured improvement in symptoms and signs of mental health problems. This will be associated with more appropriate use of specialist mental health services.
2. Improved physical health – a measured improvement in symptoms and signs of long term physical health conditions. This will be associated with more appropriate use of acute health care services.
3. Improved employment opportunities – that users of the service have access to all the opportunities that are available so that they can make the best individual choice as to when, how, and what sort of rehabilitation will be most appropriate for their individual needs.
4. Improved housing security – that service users are given support to maintain their tenure.

Intermediate care can also bring some financial benefits. However, the immediately realisable savings may not come to the PCT, as savings associated with employment or housing will be experienced by the Exchequer as a whole and not at a local health level.

Further information on outcomes, including a detailed analysis, are available on the SCMH website at www.scmh.org.uk.

Conclusion

There is now clear evidence that with the many successes of the National Service Framework for Mental Health, significant work remains to be done.

The national director for mental health's five-year review of the NSF acknowledged that more progress had been made in supporting those with severe mental health problems than for those with common conditions (Appleby, 2004). Lord Layard's influential work on talking therapies has likewise pointed to the need to invest in support for those whose depression and anxiety prevent them from pursuing ordinary lives (Layard, 2004). He went on to add that mental health was now 'Britain's biggest social problem'.

Intermediate mental health care is a means by which this social problem can be tackled by the NHS. It not only offers a structure for providing talking therapies to those who most need them but also addresses the social aspects of those people's lives by helping them with work, benefits and housing. With national support, it could be a major step forward in improving the mental wellbeing of thousands of people.

References

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The Neglected Majority: Developing intermediate mental health care in primary care

This publication provides a step-by-step guide to setting up an intermediate care team in primary care which brings together workers from the health, social care, housing, employment and voluntary sectors. Their aim is to promote recovery by supporting service users in all aspects of their lives. It draws on the experiences of the Sainsbury Centre for Mental Health's collaborative work with PCTs across England to develop this way of working.

The Neglected Majority is available from the Sainsbury Centre for Mental Health, priced at £9 + 15% UK p&p. Contact us on 020 7827 8352 or visit our website at www.scmh.org.uk for further details.