Fundholding and the care of the mentally ill

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There are two distinct issues to consider in the interaction between primary and secondary services in relation to the provision of mental health care. The first is the role of specialist mental health workers in supporting primary care teams (and in particular GPs and counsellors) so that appropriate help is given to the large number of patients who do not meet criteria for severe mental illness. The second is the role of the primary health care team in working alongside specialist mental health workers to provide shared care for the most disabled people with mental illness – those who qualify for the higher tiers of the care programme approach (CPA). The former agenda is driven by the new powers of GPs as commissioners, what drives the latter?

GPs rarely have time to attend CPA or supervision register care planning meetings, even those which precede the discharge from hospital, and back into the GP's care, of vulnerable patients with complex needs. There is a real danger of modern, intensive community care acting as a primary care by-pass for severely mentally ill people in the community. This would both deny them this important aspect of social integration and might lead to their physical health needs not being fully considered when care plans are drawn up.

This lack of involvement by GPs is further emphasised by the introduction of supervised discharge. The commonest interpretation of the new legislation appears to be that the "Responsible Community Medical Officer" should be a psychiatrist and not the patient's GP. Psychiatrists thus find themselves in the unusual position of being 'hospital doctors' who assume a prime 24-hour care responsibility for patients who are not in hospital.

The importance of GPs in the care of the severely mentally ill goes beyond their role as providers of mental health care. We work in a primary care led NHS and GPs have considerable responsibility for commissioning secondary care mental health services, either as fundholders or through family health service authorities which are now merged with health authorities. Grace *et al*'s survey of Nottingham GPs (1996) illustrates a problem for specialist mental health services which, although obvious to mental health care workers, appears less so to policy makers. The CPA is the central plank of the Government's mental health policy for the severely mentally ill, and it is alarming that in October 1994, three years after its introduction, less than one-third of GPs had even heard of it. As commissioners, GPs share responsibility for the successful implementation of the repeated policy directive that specialist services target the severely mentally ill; with CPA as the vehicle. How can they discharge this responsibility when they have been so poorly informed?

A survey conducted more recently, by the College Research Unit, gathered information from psychiatrists working in 141 English trusts (76% of the national total), about the impact of fundholding on the services in which they work (details available from authors). The replies suggest that fundholding has had an adverse affect on the ability of about one-half of mental health services to care for the severely mentally ill. As a result of fundholding, 43% of trusts reported being less able to target the severely mentally ill and it has led to specialist mental health services becoming more fragmented in 24% of trusts. The commonest cause for these effects is the relocation of community psychiatric nurses from community mental health teams into the primary care health centres of fundholders.

GPs act with the best of intentions when they shift resources in this way. There is a massive unmet need for mental health care among people using primary care services. Many of these patients are too distressed and impaired to warrant the term "worried well" and many have disorders which are eminently treatable. Indeed from a public health perspective, the economic and social benefits arising from providing adequate care for this group might outweigh those from investing a similar amount of money in the care of the severely mentally ill.

These arguments, however, are not directly relevant. It is the Government's intention, and therefore NHS policy, that specialist mental health services should target the group of patients whose disorders render them vulnerable to suicide, self-neglect or acting violently and who require intensive support in the community from mental health professionals. The problem is that this policy appears to be at odds with the implementation of another policy; that of a primary care led NHS.

Reference

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