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Joint commissioning for mental health services between primary health care and social care in Wales

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Policy initiatives increasingly emphasise the importance of breaking down organizational and professional barriers in order to achieve the delivery of effective mental health services. In this context, joint commissioning is seen as providing a way forward, and GPs are now identified as having a key role to play, alongside other professionals and agencies. However, there is evidence that joint commissioning is not yet well established, and a number of barriers to its development have been identified. The study reported here aimed to inform the development of joint commissioning between primary health care and social care in Wales by first mapping progress to date and then exploring the issues involved in more detail through three case studies. After the methods used for each stage have been described, the results are presented and discussed in relation to the problems identified and potential approaches to their resolution.

Key words: joint commissioning; mental health; primary care

Introduction

The main thrust in mental health policy in Wales for the last 20 to 30 years has been the closure of long-stay institutions and the creation of community-based mental health services, delivered largely via multidisciplinary community mental health teams (CMHTs) located within the secondary care services. At the same time, national policy in the 1980s and 1990s has also placed a growing emphasis on the development of primary health care services, particularly on the role of general practice in primary care settings.

However, these two policy strands – mental health policy and primary health care policy – both fail to address the creation of an integrated community mental health and primary care policy framework. In particular, the mental health policy of the 1980s and 1990s, with its focus on the care and treatment of people with a severe and enduring mental health problem, created a significant divide between secondary and primary mental health care services, and resulted in a patchy approach to local service development (Peck and Parker, 1998).

However, recent policy initiatives would indicate that these shortcomings are now being acknowledged. Policy documents issued by the Welsh Office (1996a, 1996b, 1996c, 1997) make it clear that breaking down organizational and professional barriers is central to improving mental health in the community. General practitioners (GPs), as well as social workers, voluntary workers, psychologists, community psychiatric nurses (CPNs) and psychiatrists, are identified as having a key role to play, and these disciplines are urged to collaborate so that plans to improve community mental health are jointly owned. At the same time, a number of broader policy shifts have focused attention on the problems created by the historic fragmentation of health and social care. These include:

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- the new approach to public health, with its emphasis on inequalities and prevention;
- the social exclusion agenda;
- the recent emphasis on quality improvement through clinical effectiveness and clinical governance.

In particular, *Modernising Mental Health Services* (Department of Health, 1998) and the *National Service Framework for Mental Health Services* (Department of Health, 1999) attempt to restore some balance to mental health policy. Both acknowledge the important contribution to be made by primary care services, and indeed three of the seven standards in the National Service Framework refer explicitly to the issues of health promotion and primary care. While the National Assembly for Wales is developing its own distinctive mental health strategy, it is likely that the tone and direction of this will follow the policy direction set out in *Modernising Mental Health Services*. Finally, changes in commissioning structures also create an opportunity to address the historical divide between mental health and primary care services. Within Wales, Local Health Groups have since April 1999 begun to take on the principal role in commissioning health care services. While the commissioning of some specialist mental health services (notably forensic services) will remain a separate and centralized activity, over time Local Health Groups will increasingly become the main commissioning body. The fact that these are co-terminous with the 22 local authorities in Wales, and are required to involve the local authority in their commissioning structures, creates a significant opportunity for policy and service integration.

In this context, joint commissioning is increasingly seen as providing a way forward and offering some learning for the potential future role of the Local Health Groups. However, there is general agreement in the literature that joint commissioning is something of a 'slippery concept' (Hudson, 1997a), and that arriving at an adequate definition is not a straightforward task. Those definitions which have been put forward range from Davidson's relatively straightforward notion of two or more agencies taking joint responsibility for translating strategy into action (Davidson, 1995), to Poxton's view that collaboration – and not simply joint working – is required if resources are to be used as effectively and efficiently as possible (Poxton, 1994). Elaborating on this theme, Gostick (1994) argues that collaboration requires the same vision and values on the part of the individuals involved, and that commissioning is an 'overarching activity' encompassing both the planning and purchasing of services.

In providing guidance on joint commissioning, the Department of Health (1995) describes the process as a cycle encompassing the following five stages:

- developing a strategic framework (the establishment of shared values and clarification of roles and responsibilities);
- strategic planning (undertaking a needs assessment and identifying the resources available);
- operational planning;
- purchasing activities;
- monitoring and review.

In addition, a number of writers point out that joint commissioning can take place at different levels (Gostick, 1994, 1995; Department of Health, 1995; Hudson and Willis, 1995; Rummery and Glendinning, 1997). These include health authority area, local authority area, and locality or practice-based levels, as well as commissioning for particular user groups and individuals.

However, it appears that joint commissioning is not yet well established between primary health and social care (Lee and Gask, 1998), although there has been some activity in certain areas of the UK where special funding has been made available. Explanations for the slow progress to date include the problems involved in jointly allocating resources (particularly when the straightforward pooling of budgets is at present illegal), difficulties in engaging GPs in the commissioning process (Hine and Bachmann, 1997), and major differences in professional and managerial accountability, with GPs acting as self-employed independent contractors while social workers are employed within a managed organizational structure (Rummery and Glendinning, 1997).

In addition, many writers view the pace of major organizational change as a factor which has hindered collaborative working. Here, Henwood and Wistow (1995) highlight the plight of Wales, where the former eight counties have recently been divided into 22 unitary authorities. Paradoxically, over the same period, the number of health auth-

orities has been reduced from nine to five. To compound these changes, in April 1999 the number of NHS Trusts providing services in Wales was significantly reduced, and in most areas mental health service provision was integrated into large, combined NHS Trusts. At the same time, April 1999 also saw the end of GP fund holding and the establishment of local health groups. These developments not only reduce co-terminosity but, more importantly, they also have the potential to impact negatively on inter-agency trust – arguably a key factor in joint commissioning (Gostick, 1994).

While the problems outlined above pertain as much to mental health as to other health and social care issues, the literature suggests that mental health presents additional difficulties. In particular, as outlined above, specialist mental health and primary care policies appear to have been pulling in different directions.

Against this background, the Centre for Mental Health Services Development was commissioned by the Wales Office for Research and Development to undertake a study of joint commissioning for mental health between primary health and social care. The study was undertaken between December 1997 and November 1998 in two stages, namely a mapping exercise to establish the current extent of joint commissioning, and a series of three case studies designed to explore the issues involved in more detail.

Methods

To determine the extent of joint commissioning in Wales, telephone interviews were conducted with each health authority commissioner for mental health ($n = 17$), each social services commissioner for mental health ($n = 22$), and five GPs who were identified by health authority contacts as being involved in GP commissioning groups. The interview schedule comprised mainly closed questions, although a number of open questions were also included. Respondents were initially asked whether they were involved in planning mental health services with other agencies. If so, follow-up questions sought further information about the planning structures in place, leadership, the level at which activity was taking place, the stage reached in the planning process, and budgetary control. Because more specialist services, such as forensic psychiatry and neuropsychiatry, are commissioned at area level, the information sought at this level was limited to whether other agencies were involved in the commissioning process.

The standardized information obtained was recorded against a check-list, entered on a database and summated. Detailed notes were taken of responses to open questions, and these were then grouped under thematic headings using content analysis techniques.

On the basis of the mapping exercise, three commissioning groups were selected for detailed case study. The criteria for selection were that a structure for planning mental health services was in place and that representatives from both social services and primary health care were involved. In addition, we were concerned to represent the geographical diversity of Wales, and the case studies were therefore undertaken in one valleys area, one urban area and one rural area.

All 35 members of the three commissioning groups were invited to take part in an interview, and a total of 28 members agreed to do so. Those who declined thought that they would not be able to assist in the research because the focus was on primary health and social care. Participants were interviewed using a semi-structured schedule to explore perceptions of the commissioning process in mental health, the barriers that existed, how they might be overcome, and the role of primary health care within this process. Assurances were given that any information provided would be treated as confidential, and that the participants' identities would not be revealed in any verbal or written reports. Interviews were conducted in a private room where the discussion could not be overhead.

The interviews were audio-taped and fully transcribed. Participants were then offered the opportunity to review their interview transcript in order to check its accuracy and inform the researcher of any part of the interview which they did not wish to be used. Analysis was a continuous process allowing tentative explanatory themes to be tested as they emerged. Initial coding resulted in the development of 64 data categories relating to seven themes, namely the type of locality, the group's agenda, perceptions of mental health service delivery, barriers to joint commissioning, the role of primary health care, social care and health care, and definitions of joint commissioning. Further analysis led to the development of four overarching

themes, namely the locality, the commissioning group, their priorities and the implications for joint commissioning.

Results

Before undertaking the mapping exercise, it was necessary to address the problems of defining joint commissioning that were highlighted earlier. On the basis of the relevant literature, and following discussion with key informants in Wales, a distinction was made between the planning aspect of commissioning (involving the assessment of needs and resources and the identification of priorities) and the purchasing of the required service. Thus commissioning can be defined as an overarching activity consisting of both planning and purchasing. In turn, joint commissioning requires individual agencies both to jointly plan and jointly purchase services. In reporting the results of the mapping exercise, the term 'planning' has therefore been used when those involved are doing only that and have not ventured into purchasing services. Similarly, the term 'purchasing' has been used when this activity has been undertaken without any joint planning, while the term 'commissioning' has been used when both planning and purchasing have been undertaken to deliver a service.

The results of the mapping exercise are presented here in relation to the three organizational levels at which primary health care and social services staff might potentially meet to plan and purchase mental health services, namely the health authority area, the local authority area and the locality or practice level. Although the focus is on social service staff and GPs, it is acknowledged that others, including representatives from user and carer groups, trusts and community health councils, are also members of commissioning groups.

The health authority area

As noted earlier, there are now five health authority areas in Wales. Responses to the mapping exercise indicated that whereas social services were represented in mental health commissioning groups in all five areas, primary care was represented in only three of the five areas, in all cases by a GP. In addition to commissioning specialist services, such as forensic psychiatry, the commissioning groups at this level were reported to be largely involved in producing strategies to inform localities.

The local authority area

A similar picture to that at area level emerged in relation to the 22 unified local authority areas created from the former eight counties. A mental health planning or commissioning group existed in 20 areas, with social services represented in all 20 groups and primary care in only 9 groups, again in all cases by a GP. In three areas, no representation had been invited from primary care, while eight areas reported that GPs were invited to attend but failed to do so. The nine GPs who did attend were reported to vary in their attendance and level of participation, with only five attending regularly and only one taking responsibility for chairing meetings. In addition, social service staff reported that only one of the nine GPs was actively involved in the commissioning process, while the others tended to play a more passive role.

Table 1 indicates the progress made in the commissioning process within the nine areas which had primary care representation. As can be seen, activity to date had focused on planning rather than on purchasing. In effect, therefore, no group involving both primary health and social care had yet commissioned a service in Wales.

In addition to providing this information, respondents to the mapping exercise identified a number of difficulties in joint commissioning at local authority level. Most significantly, reorganization of both the local authorities and health auth-

Table 1 Progress towards joint commissioning at local authority level in nine areas with primary care representation

Stage of commissioning process	Yes	No
Structure in place for joint commissioning	9	0
Needs assessment completed	7	2
Resources identified	9	0
Mental health strategy produced	8	1
Mental health plan produced	5	4
Service priorities agreed	4	5
Service purchased	0	9
Service evaluated	0	9

orities was reported to have impeded progress. Building trust with new people and organizations was acknowledged to require time, and joint commissioning since reorganization was still relatively new, being in operation at the earliest since 1996.

Practice/locality level

Four organizational arrangements can be identified through which GPs might potentially engage in commissioning at this level, namely total purchasing pilot projects (TPPs), fundholding, locality commissioning groups and GP commissioning groups.

At the time of the mapping exercise, three TPPs existed in Wales but ceased to operate after April 1999, as did fundholding. Of the three TPPs, one was reported to have a focus on mental health. Telephone interviews with a proportion of fundholding practices indicated that funds for the purchase of mental health services had been returned to the appropriate health authority.

As far as locality commissioning groups were concerned, three pilot groups were identified. All three groups reported that they intended to plan and develop mental health services but had not yet initiated the process.

Twelve GP commissioning groups were also identified. These had been established either on the initiative of health authorities which had invited interested GPs to form groups, or on the initiative of GPs who then sought health authority support. The groups generally comprised both fundholders and nonfundholders. Of the 12 groups, only two reported that they intended to plan and develop mental health services. While one had decided to focus on the elderly mentally ill, the other had not yet agreed priorities for mental health. Neither of the two groups had yet moved towards the development of services.

Overall, therefore, of a total of 18 commissioning groups identified, only five intended to develop adult mental health services. As Table 2 indicates, two of these five groups had no social services representation. Among those which had such representation, most progress had been made by the one TPP which had a focus on mental health. This TPP covered a whole locality and was reported to commission services for the locality on behalf of the health authority.

Among the 13 groups which currently did not intend to develop adult mental health services, the main reason given was that these services are not easy to define and plan. For example, one TPP had been concerned to focus on mental health, but had been unable to establish which patients currently in psychiatric hospital belonged to its catchment area. In addition, one health authority commissioner reported that mental health services were co-ordinated from 'the centre', and that it was therefore not necessary at present for GP groups to focus on mental health.

Table 2 Progress towards joint commissioning at locality/practice level among five commissioning groups intending to develop adult mental health services

Stage of commissioning process	Yes	No
Social services representation	3	2
Needs assessment completed	1	4
Resources identified	1	4
Mental health strategy produced	1	4
Mental health plan produced	1	4
Service priorities agreed	1	4
Service purchased	0	5
Service evaluated	0	5

The case studies

The three commissioning groups selected for more detailed study included a locality commissioning group in a valleys area, a GP commissioning group in an urban area and a locality commissioning group covering a rural area.

The valleys area

In this area, a mental health planning team had been in place for about 2 years. The locality health commissioner chaired the meetings which were attended by, among others, two representatives from social services and three representatives from the local trust. Although primary care was represented by a GP, it became apparent that social services and the specialist health care services remained firmly in control of the joint commissioning process. This appeared to be partly because four key members of the group facilitated action, in that they were usually members of the subgroups which pushed forward the agenda, did much of the work 'behind the scenes' and added to the cohesion of the group. In addition, however, the GP assigned to the planning team had not attended for several months, and many of the team

commented that they 'did not know what he looked like'.

In the absence of any active primary care involvement, the planning team had a single overarching priority, namely to provide care for people with severe and enduring problems, in line with national policy for the specialist mental health services. As one participant explained:

> the fact that we are trying to follow the All Wales Strategy gave us the drive, and there was a directive that we had to respond to it. The Health Authority strategic framework coming in gave us focus, it gave us a task and we knew what we had to do and could just take things forward.

A specific priority for the planning team was therefore to achieve closer working relationships between secondary health care (the trust) and social services. Indeed, the first priority of their mental health plan was to acquire a joint base and develop joint care plans between the trust and social services.

In this context, the issue of improving working relationships with primary health care was not a priority. Providing for people with severe and enduring problems was perceived to be a matter for secondary, not primary, care – and those working in secondary care believed that GPs neither wanted nor needed to be involved. GPs were perceived as 'generalists' with little expertise in mental health. In addition, it was believed that people with severe and enduring problems only consulted their GP about physical health problems. For this reason, the fact that the GP representative had not attended meetings for some time did not cause obvious concern. On the contrary, the view was expressed that if primary health care was better represented in the planning team, the team's priorities might be challenged. In turn, because GPs encountered patients with less severe mental illness on a daily basis, people with severe and enduring problems would be disadvantaged:

> I don't know if they [the GPs] would chuck it all out but I think the emphasis would be very different. The people who are currently long-term users of the service would be less supported . . . so we would be encouraged to deal with people who have less mental illness problems . . . I don't think we should necessarily be preventative.

However, when interviewed, the GP representative himself called these assumptions into question, reporting that 20% of the patients he saw with mental health had severe and enduring difficulties. So far as attendance at meetings was concerned, he explained that he had a two-partner practice and his partner had been ill, with the result that he was unable to attend meetings after the morning surgery because no one else was available to cover home visits.

The urban area

Unsurprisingly, a different picture emerged from the urban area selected for study, where the focus was on a GP commissioning group and the active involvement of primary care was therefore not in question. Here, however, exploration of the commissioning group's priorities highlighted the differing agendas of those working in primary health and secondary care.

The commissioning group had identified mental health as a priority for the current year, and had therefore formed a mental health subgroup about 5 months previously. Membership consisted of a GP, a practice manager, a commissioner and a nurse from the health authority, a principal officer from social services, and a nurse team leader from the community mental health team. Given the recent establishment of the group, it appeared that individual roles still had to be established, and that agreement about the development of mental health services had yet to be reached. Nevertheless, it was clear that primary health care was concerned to influence the commissioning process.

However, as in the valleys area, the health authority and social services had followed specialist government policy in directing mental health resources towards patients with severe and enduring problems. Thus both the local CMHT and social services staff saw this group as their priority, as a representative from the health authority explained:

> the community mental health teams are specifically supposed to look at the serious mental health patients, the more serious cases . . . social services would play a significant factor in the actual dealing with these patients as well.

In contrast, primary health care members of the

group believed there were other needs in the locality. For example:

> one of the priorities was looking at the late teens, those with depression, who were single . . . who are clearly becoming depressed as a consequence of social factors . . . and economic aspects that go with it, they haven't got an awful lot of money, they can't go out that often, they are tied because of children . . .

From a primary care perspective, these differing views of need posed particular problems in a context where resources were scarce:

> in an ideal scenario . . what would happen . . . GPs would have access to a wide variety of support agencies within the community. Social services would play a significant factor in the actual dealing with these patients [the less severely ill] as well. But obviously, there is a difficulty within social services, in that there are resource limitations, as with the Health Authority.

In addition, as the GP representative indicated, something of an 'us and them' situation currently prevailed so far as patients with severe and enduring problems were concerned. In his view this was a result of misunderstanding on the part of secondary services about the role of primary care:

> we feel there is a serious communication issue about us and them. . . . They don't perceive what we do. . . . The perception of mental health services is that you do not have to involve primary care, because the GPs don't have anything to do with those people [with severe and enduring problems].

The GP went on to provide an example which illustrates his different perception of the role of primary care:

> we were asked as GPs to see a patient of mine. The psychiatrist, the social worker and the CPN who turned up, none of them knew the patient. And there was a sequence of events that had triggered it off, and they called us up just to finish off signing the section papers. . . . The GP on call realized that this was not quite right and that the patient probably did not even need sectioning, so rang me and I went to see her and said 'look, she is always like this'. So they all trailed off home again. Now what should have happened was that as soon the CPN saw the patient, they should have rung us first. We were the ones who knew the patient, but because the communication lines are towards a hospital sort of base, so they triggered a section assessment.

In this area, therefore, primary health care members of the planning team were not only concerned with the needs of patients with less severe mental illness, but in addition they wanted to be more involved in the care of patients with severe and enduring problems, and to improve communication with the specialist services. However, the extent to which these concerns could be encompassed within the joint commissioning process remained unclear, as a result of the different priorities and perceptions of specialist care team members.

The rural area

Although the third case study of a locality commissioning group again raised questions about the extent to which the primary care perspective can be encompassed in joint commissioning, it also highlighted the potential for an alliance between primary and social care in addressing the needs of patients with severe and enduring mental health problems.

In this rural area, primary health care led the commissioning process, in as much as a GP chaired the group's meetings. Other members included a second GP as well as representatives from the health authority, social services and the local trust.

Since its establishment 18 months previously, the group appeared to have followed a demanding learning curve. Those who were involved had had to learn the process of commissioning from scratch, and there was no precedent in Wales for a GP chairing a locality commissioning team. Moreover, the GP concerned acknowledged that he had little experience of formal committee work, and that the vision he initially brought to the role was not shared by the other members. A key example concerned the first task of the group, which was to write a mental health plan for the locality. Because the GP chairperson himself was concerned to develop a nurse-led service attached to primary health care, this had become the focus of the document. However, when the document

was drafted, the discrepancy between this individual GP's concerns and those of the other members, including his GP colleague, became apparent:

> GPs said you know this is unworkable . . . it would have worked in his practice but it wouldn't have worked in, say, my practice . . . the trust said this is unworkable and we don't want this, and so we had to go back and rewrite, and you know we rewrote and rewrote it, and kept consulting with the main players until eventually we came to a document that was accepted by all the organizations.

Although the process of redrafting and consultation described by this participant had led to a plan which was more acceptable to the other group members, it was apparent that the compromise which was reached in fact embodied only the secondary care perspective, with priority given to patients with severe and enduring problems:

> now it has moved from a nurse-led service attached to primary health care . . . to a huge change really . . . it's quite obvious the difference now is the CMHTs are the hub.

In effect, although the GP chairperson had significant influence within the team and had attempted to bring a different, primary care-based perspective to the development of mental health services, this perspective had not prevailed. In addition, the issue of responsibility for patients with severe and enduring problems had not yet been resolved, and in some respects a similar pattern to that seen in the previous case studies also emerged here. Thus the health agency representatives in the group clearly perceived themselves to be the experts with regard to treating and caring for those with severe mental illness in the community:

> GPs . . . you know they've obviously got loads of patients . . . mental health is only a small part . . . whereas we are working with it daily and we're much more in tune with what is currently best practice in mental health.

Equally, as elsewhere, these members of the group believed that primary health care services had little contact with patients with severe and enduring problems:

> my own experience is that the only time that the primary care team have anything to do with the severely mentally ill is when they see them for their sick-notes.

However, as in the previous case studies, primary care representatives themselves held a different view:

> if we are prescribing for patients we're technically responsible for them . . . we're also involved in quite a lot of decisions as to whether they're admitted or whether they are reassessed.

Among social care representatives in the group, too, there was a view that primary care had a greater role to play in the care of patients with severe and enduring illness. As this participant suggested, it appeared that the lead role taken by primary care in the commissioning process had led to greater understanding of the contribution primary care could make:

> the primary care focus is a strong one, and I think it's really helped relationships on the ground.

From this new perspective, one social care representative observed that in the absence of shared responsibility with primary care '. . . everything becomes a crisis, because that's the only facility.'

The same participant went on to describe the value of a shared approach in more detail:

> if you take an individual and their needs, then it's in order to support their life and their achievements so that they make a life of their life . . . it may be that there are episodes where they require out-patients and hospital services, but that's not their whole life . . . and to see somebody within different contexts not just the one – the psychiatric context – is important and primary care has a vital role to play.

A similarly holistic view was held by the following primary care representative:

> I think the secondary care sector considers serious mental illness to be mainly one of diagnosis and surveillance. Many patients go to acute psychiatric units for expert care when that is inappropriate. What they need

is respite from their home situations, relationships or their own mental state.

In this area, therefore, representatives from both primary and social care shared the view that lower key services provided outside the secondary sector were needed. The case study therefore highlights the new dynamics which can emerge when primary health care takes a greater role in the commissioning process. As suggested by participants in the valleys area, it was apparent that the primary care perspective on the development of mental health services represents a challenge to the focus of specialist services, and policy, on patients with severe and enduring problems. However, there were indications here of an emerging alliance between primary and social care in asserting the need for a shared, more holistic approach to the care of this group.

Discussion

For methodological reasons, the results reported above need to be interpreted with caution. For example, although the use of telephone interviews for the mapping exercise yielded an 100% response rate, it has to be remembered that respondents' perspectives may alter over time, and that the results therefore represent a 'snapshot' taken at a certain point in time. Further progress in joint commissioning for mental health services through the vehicle of Local Health Groups may also have been made since the mapping exercise was completed.

With regard to the case studies, it should be noted that the primary health care perspective represents the views of only four GPs and one practice manager, because this was the extent of primary care representation in the three commissioning processes examined. However, the fact that the findings are consistent with the literature and that similar themes emerged from all three case studies lends support to the results.

Turning to the results themselves, the mapping exercise indicates that true joint commissioning of mental health services between primary health and social care does not yet exist in Wales. Where the two agencies have started to draw up joint plans the process is in its infancy, with no evidence that the commissioning cycle has been completed. Health authorities, trusts and social services dominate the process, leaving primary health care largely on the periphery.

More detailed evidence to support these conclusions emerges from the case studies. In the valleys area, primary care played no active role in the joint commissioning process, and priorities therefore exclusively reflected national policy for the specialist services. Even in the other two areas, where primary care played a more active part, the needs of patients with less severe problems were not being addressed, and the contribution that primary care could make to the care of patients with severe and enduring problems was questioned by mental health specialists, particularly secondary care representatives. However, in the rural area there were indications that a high-profile primary care presence might have the potential to influence social services representatives at least, as a result of a shared perception of the need for a more holistic approach.

This potential notwithstanding, the study highlights a number of obstacles to the development of joint commissioning for mental health services by primary health and social care. Most significantly, historical conflicting policy drives on the one hand towards a primary care-led NHS, and on the other towards a specialist mental health emphasis on severe and enduring illness, mean that primary and specialist care representatives come to the joint commissioning arena with widely differing agendas and priorities. Given the recent establishment of Local Health Groups in Wales, and the development of the public health agenda with its focus on prevention, this situation will only be resolved if the different strands of government policy are realigned. The broader perspective of primary care, including prevention, and the needs of patients with less severe illness, will have to be accommodated alongside the current strategic focus of specialist mental health policy. This has important consequences for the development of the new All Wales Mental Health Strategy, expected in 2000. In addition, this broader perspective must also be incorporated into emerging guidance on, for example, partnership between health and social services. At the moment, there is no indication that primary care funding (e.g. GMS funds) can be included within the new flexibilities that are envisaged. If this is the case, this will perpetuate the divide between primary and secondary care mental

health services. Broader policy initiatives, such as the introduction of clinical governance, can also be grasped to support the delivery of integrated care across the primary and secondary care divide.

At the local level, too, a significant obstacle to joint commissioning is presented by uncertainty about the role of primary care in providing a service to patients with severe and enduring problems. Certainly the four GPs who took part in this study felt that their contribution was underestimated, and their view is supported by previous research which indicates that the GP's role can be central for this group of patients (Nazareth *et al.*, 1996; Lang *et al.*, 1997). In addition, treatment at a primary care level can also be the preferred and least stigmatizing option for patients (Peck and Greatley, 1999). The solution here may lie in facilitated discussion aimed at clarifying misunderstandings and developing a local approach to shared care. As a starting point, the model put forward by Goldberg and Gournay (1996) might prove useful. As Table 3 illustrates, Goldberg and Gournay identify deficits in current approaches to different categories of mental health problems and provide recommendations about alternative approaches. Using this model as a framework, clearer roles and responsibilities can be allocated to the primary health care team and specialist services, as well as to the voluntary sector, thus assisting the development of a more holistic approach to the commissioning of services.

In addition, Peck and Greatley (1999) highlight the value of a development process which they successfully used to engage primary and secondary care providers in London. The four-stage process – diagnosis, action planning, sharing of learning and dissemination of findings – allowed participants to make progress in resolving long-standing operational difficulties between primary and secondary care providers. However, they also highlight the critical importance of a number of key factors to support such initiatives at a local level, including:

- sufficient senior level support for the process;
- sufficient capacity for local follow-through;
- respect for the contribution of all local stakeholders;
- appropriate brokerage of relationships to ensure a 'win-win' outcome;
- linkage between the process and local decision-making bodies, leading to a real change in investment strategies and local practice.

A further obstacle concerns the difficulties involved in engaging GPs in the process of commissioning mental health services, and this may require organizational changes beyond the devel-

Table 3 Alternative approaches to mental health care (adapted from Goldberg and Gournay, 1996)

Diagnostic group	The status quo	Alternative approaches
Group 1 Severe mental disorders (e.g. schizophrenia, manic depression, severe eating disorders)	Care poorly co-ordinated, may be duplicated, inefficient, poor physical care	Shared care – CMHT involved, family treatment, voluntary agencies involved
Group 2 Mental disorders treatable by drug or non-drug treatments/regimes (e.g. anxiety disorders, depression)	Many cases missed despite effective treatments being available	Care within primary care – not necessarily by GP. CMHT only if no response
Group 3 Mental disorders responding mainly to non-drug treatments/regimes (e.g. fatigue states, phobias, milder anxiety states and eating disorders)	Many cases missed, patients may not present symptoms, drugs work less well than non-drug treatments/regimes	Care within primary care – can be by nurses or retrained counsellors; supervised by CMHT
Group 4 Need passage of time (e.g. grief reactions)	Need supportive care – transient adjustment disorders may consume large amount of resources	Supportive care – nurses, voluntary agencies, self-help, counsellors

opment of a shared strategy. On the one hand, it is clearly important to recognize the time constraints within which GPs operate, and to arrange meetings accordingly. On the other hand, this study suggests that only those GPs who have an interest in mental health are likely to engage in joint commissioning. Some form of remuneration specific to mental health work, as suggested by the General Medical Services Committee (1997), might therefore be needed to generate and reward greater interest. In addition, problems in obtaining accurate, up-to-date information, such as those reported in this study by one TPP, also need to be resolved if GPs who do have an interest in mental health are not to be deterred from engaging in the commissioning process.

In conclusion, therefore, this study of joint commissioning for mental health in Wales has highlighted the problems involved in bringing together primary care, social service and secondary care perspectives. Although a primary care-led process may have the potential to stimulate a more holistic, shared perspective with social services staff, solutions also need to be found to the current tensions in national policy, to the prevailing uncertainty about the role of the primary health care team, and to the problems of engaging GPs in the commissioning process. The development of a new national mental health strategy for Wales offers a unique opportunity to resolve these tensions.

As suggested above, facilitated focused discussion at the local level and the introduction of incentives for GPs might offer useful ways forward. The research undertaken by Peck and Greatley (1999) with general practitioners and a range of primary care practices in London found that general practitioners were both able to acknowledge the need to improve their commissioning skills and to accept the importance of collaboration with the statutory and voluntary sector to deliver integrated care. They were also willing to engage in developing their own practice and delivering integrated care when they were able to influence the development agenda. This implies that the advent of Local Health Groups should create a climate in which GPs can be sure that they will influence the agenda.

However, in the absence of some resolution at the national policy level these are likely to remain only partial solutions. Last but not least, the process of change requires time, and an evolutionary approach and a period of greater stability will therefore be required if joint commissioning for mental health is to become a reality.

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