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Service innovations: developing a specialised (tertiary) service for the treatment of affective disorders

Although the majority of people with mental health problems have their treatment needs met within local services, the Department of Health's *Specialised Service National Definition Set* (Department of Health, 2002) outlines areas that are thought to require specialised services. Complex and/or treatment-resistant disorders (including severe and/or complex affective disorders) are one of ten mental health areas identified.

This article describes the background, context and experience of setting up a specialised service for affective disorders in Manchester and briefly describes the service. Our experience highlights current issues surrounding specialised services generally, and those for affective disorder in particular.

What are specialised services?

The Department of Health describes specialised services as those:

> 'with low patient numbers but which need a critical mass of patients to make treatment centres cost effective. Particular challenges for these services include training specialist staff, supporting high quality research programmes, and making the best use of scarce resources like expertise, high tech equipment and donated organs. Specialised services are subject to different commissioning arrangements than other NHS services.' (http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en)

These are distinct from supra-regional services (Department of Health, 2003) which are defined as 'very specialised services' that need to be provided in a small number of centres and planned and funded on a national basis, and are for conditions whose rarity is such that the national case-load would normally be less than 1000.

Specialised services therefore cover a wider area than that served by a local service or trust and include 'tertiary' services taking patients from secondary services. How wide an area should be served by such a tertiary service is not defined and will differ for different disorders. Areas are probably considerably smaller than those covered by supra-regional services since specialised services deal with more common conditions. The last few years have seen a major reorganisation of the National Health Service (NHS), including the devolution of commissioning to primary care trusts (PCTs) and the transformation of commissioning health authorities into strategic health authorities (Department of Health, 2001). This change has had major implications for commissioning arrangements for the development and maintenance of tertiary services; the potential threat to funding has been pointed out by the Academy of Medical Royal Colleges (2002). The local focus of PCTs, combined with strategic health authorities who have no direct power to resource specialised services, threatens 'strategic' or non-local planning. The mechanism of so-called collaborative commissioning by groups of PCTs is highly dependent on local priorities, arrangements and expertise.

Developments in mental health provision have put great emphasis on the primary care treatment of 'common' mental illnesses, such as depression and anxiety, with secondary care moving towards the treatment of more severe disorders with an emphasis on psychosis. Despite the publication of the *Specialised Service National Definition Set* (Department of Health, 2002) there is little guidance about what specialised/tertiary services are needed regionally and nationally. Recently, Professor Appleby, Director of Mental Health for England and Wales, has set up a National Development Group for Specialised Mental Health Commissioning to look into the need for specialised mental health services. The group plans to produce a report on needs and commissioning arrangements in the near future.

Tertiary affective disorder services

Our experience has been that there is a lack of recognition of a need for tertiary affective disorder services because these disorders are simply seen as part of the remit of secondary care. We believe that tertiary services do have a clear role to play.

First, a significant minority of patients with affective disorders are resistant to conventional treatments and continue to suffer chronic or relapsing illness (Judd *et al*, 1998, 2002). Considerable experience, expertise and resources are required to assess and treat these patients effectively and coordinated multidisciplinary input is

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needed (Porter *et al*, 2001). Most general psychiatrists cannot be experts in severe and resistant affective disorders as this requires keeping up to date with and involved with research developments, seeing sufficient patients and having the integrated multidisciplinary resources to manage them. In line with this, the depression guidelines published by the National Institute for Clinical Excellence (2004) state that, 'When a patient's depression has failed to respond to various strategies for augmentation and combination treatments, referral to a clinician with a specialist interest in treating depression should be considered'.

Second, a tertiary service, as an expert resource, can provide training, education and consultation for general clinicians to help them manage their own patients more confidently and effectively.

Third, tertiary services with strong research links can provide, evaluate and integrate into practice new psychotherapies, drugs and physical treatments.

We would argue that these factors are compelling reasons in favour of the development of specialist tertiary affective disorder teams. Despite this we know of only three such services in the UK (in Newcastle-upon-Tyne, London and our own fledgling service in Manchester). There are of course consultants with expertise and interest in affective disorders in other areas but they usually offer local expertise rather than a more comprehensive service covering a wider geographical area, which is implied by the term 'tertiary'.

Manchester Specialist Service for Affective Disorders

It became possible in 2001 for medical and psychology personnel to dedicate time to setting up a specialised service with general support from within our trust but no extra resources for staff or equipment. Financial support was obtained from industry and a private hospital which also wished to develop a service specialising in the treatment of affective disorders. The appointment of a senior nurse manager for the service enabled the setting up of a tertiary out-patient clinic to provide second opinions and support for patients with complex and treatment-resistant affective disorders.

Contact at this stage with Manchester Health Authority/Shadow Strategic Health Authority and PCTs to discuss the mechanisms and possibility of funding for a specialised service was frustrating. There appeared to be neither the mechanism nor will to take this initiative forward. As our service was not included in block contracts with neighbouring PCTs or trusts, from mid 2002 we had to charge for patients seen from outside the area covered by our trust. This requires funding on an individual patient basis and is a laborious process taking up a considerable amount of administrative time and instituting delays in being able to offer appointments. The service continues to be dependent on one-off funding and the good will of, but no direct financial support from, the local trust. However, an increasing proportion of costs is now being met by service activity. We are slowly becoming recognised and included in block contracts and are restarting the process of negotiation for recognition as a specialised service with PCT commissioners and the strategic health authority.

Overview of the service

The core of our specialist service is an out-patient tertiary clinic which provides structured assessment and advice for those aged 18–65 who are diagnosed as having difficult-to-treat depressive and bipolar disorders. We have run a cognitive–behavioural therapy group for prevention of relapse and treatment of residual depressive symptoms in patients with unipolar depression and are in the process of developing and evaluating group psychological treatments for patients with bipolar disorder, initially concentrating on a psychoeducational approach. A helpline for advice to professionals has just been started and links have been made with local voluntary groups. There is a website (http://www.ssad.man.ac.uk) with resources available for patients and professionals. Educational activities include a monthly teaching session with a private hospital, involvement with a local educational group, the Affective Disorders Group North West, and we have organised a well-attended conference on resistant affective disorders in 2003. In terms of research, clinical data and 6-month outcomes are collected, the service is involved in a trial of transcranial magnetic stimulation for depression and is embarking on a drug study in treatment-resistant depression.

The multidisciplinary team is slowly increasing and currently consists of a full-time senior nurse manager and secretary with sessional input from two clinical academic consultants (amounting to five sessions), specialist registrars in psychiatry, an administrative assistant and a psychology assistant. We are in the process of recruiting a part-time clinical psychologist and have input from an academic clinical psychologist with expertise in bipolar disorder.

Owing in part to limitation of resources, but also the recognition that the most effective way to improve treatment and outcomes is to enhance local management, the tertiary clinic concentrates on careful assessment and detailed evidence-based advice. Referrals are usually only accepted from psychiatrists. Assessments take a whole afternoon, including case note review, questionnaires from referrers and patients (covering mood, physical health, quality of life and personality), relevant physical examination, blood tests and a semi-structured interview with the patient and a relative. The team discusses the case and the assessment is fed back to the patient. A handwritten letter is immediately sent to the referrer followed by a full standardised assessment and recommendation letter, with a copy also sent to the patient. Although patients are not usually 'taken on' for treatment by the clinic, a shorter follow-up appointment is offered after 6 months to review progress, the implementation of recommendations and to make further recommendations if necessary. (For details of the

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assessment questionnaires and process please contact the authors.)

Referrals have been mostly from outside the local trust, with over 40% from outside Greater Manchester (ranging from Birmingham to Cumbria). There is the expected predominance of women (two-thirds) with over half of the patients having unipolar depression and about 40% bipolar disorder. Attendance rates are high and this is a group of patients with severe illness, as indicated by the high proportion who have received electroconvulsive therapy (about 50%). Patient satisfaction is evaluated routinely after each assessment and is extremely high.

Conclusions

Our experience highlights a number of points relevant to the issue of specialised services for mental health within the NHS. There is a lack of guidance centrally, and knowledge locally, about the need for specialised services. There has been a low priority given to the issue generally, and politically driven topics such as secure forensic provision have dominated thinking. It would appear that the expectation that PCTs would be able to 'take on' commissioning specialised services by an ill-defined collaborative process was over-optimistic and did not take into account the competing and often perverse incentives operating. Our experience has been that it has been difficult to find the right people and organisations to talk to in order to make our case and present a business plan. In addition, the present difficult financial climate for NHS trusts means that developing even a potentially self-supporting service comes up against difficulties caused by the nature of NHS accounting and the needs of the local financial recovery plan. The future is looking reasonable at present for the service developed so far, but our ability to develop further remains uncertain and will depend on being able to offer more on-going care and increasing the clinical resources.

It may be that these difficulties will be resolved as the new system beds in, the role of the strategic health authorities is clarified, PCTs gain expertise, the Department of Health gives clear guidance and the Government provides adequate resources. Then again . . .

Declaration of interest

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