Sandwell's mental health strategy is entirely based on human givens principles. The challenge now is to translate them into practice, says ***Dr Ian Walton****.*

Human givens and the NHS

DESPITE the current horrendous climate in the NHS, in which every mental health trust in the country is being forced to make cuts, here in Sandwell, in the heart of the West Midlands, known as the 'Black Country', we have managed to plant the human givens flag and are gradually embedding its base in concrete. However, it will be no easy task, and I write this article in the hope that others can benefit from our experience.

For, although Sandwell's primary care trust, social services and mental health trust have all embraced human givens principles, incorporating this approach into Sandwell's mental health strategy, anyone who works in the NHS will know that we are top heavy with strategy documents and guidelines produced by well-meaning administrators, who fail to connect with front-line clinicians. If we are to mainstream human givens into the NHS, so that it underpins practice as well as strategy, there is an enormous challenge still ahead.

Over the period that it has been in power, the Government has created a number of large organisations, including the Modernisation Agency, the NHS University and the National Institute of Mental Health in England, all costing millions and yet now defunct, to force through improvement and change. As each of these failed to produce the desired effects, it was re-branded or disbanded: the current 'change organisation' is called the Care Services Improvement Partnership. All of these organisations have produced large, long reports, toolkits for improvement and 'new ways of working' documents, which overwhelm service commissioners, who are forced to set clinicians targets related to the strategies written about in these documents. Alas, for the commissioners of services, reaching targets is all important, as their future depends on it. Indeed, the policy writers and Government are so focused on the meeting of targets that regular inspections by various agencies take place, requiring form filling and huge amounts of time: time which could have been spent focusing on local needs but instead is spent producing the documentation required by the inspectors. Though intending to force improvement, this has probably had the opposite effect, as minds are continually focused on not failing the next inspection, rather than on a broad view of improving services.

Meanwhile, clinicians have been disengaged from the whole process, and so feel powerless when they are told that they must conform to a strategy that they have not been involved in producing. Even more frustrating to clinicians is the fact that we must focus on the things deemed important by politicians in any particular year. Thus, we have less time to take a whole view of the patient and may neglect aspects of care that are not deemed to be 'targets'. Indeed, a recent study has confirmed that, as mental health was not a major focus of the new GP contract, it became neglected because attention was focused on collecting "Quality and Outcome Framework points" in the target areas, principally diabetes, heart disease and lung disease.

In the health service roughly 90 per cent of consultations take place in primary care but this absorbs just 15 per cent of NHS funding. Secondary care has soaked up the lion's share of the funds, while primary care has generally been deemed less important, because hospital medicine has always been the more glamorous and hospitals are thought of as the places where lives are saved. However, it is an alarmingly little known fact that, when there is an increase in the number of GPs, death rates fall, but an increase in hospital doctors has the opposite effect. For years, in primary care, we would plan developments of our services and, each year, our developments were pulled at the 11th hour, as secondary care overspent. I remember complaining about this to the health authority's accountant one year and being told that it had always happened this way and it always would! So far he has been totally accurate.

Balancing the books

Now, however, the Government has realised that, despite doubling of funding for the NHS in the last few years, the secondary sector continues to overspend, and it has told them that they must balance their books. Last year the acute trusts, which run the medical hospitals in the country, were bailed out in the usual manner but, as it was deemed that deficits could no longer be carried forward, mental health services, in particular, were hit hard to pay for the medical sector's overspend. Although mental ill health is a major cause of mortality and morbidity, mental health remains a Cinderella service, and there was hardly any time to decide where the cuts would have to be made. Some areas have made psychologists redundant to protect hospital beds because, in the 'new' NHS, keeping beds open will protect income for the new foundation hospital trusts. Sandwell had actually balanced its books overall,

but was still forced by the West Midlands Strategic Health Authority to bail out other primary care trusts in the area to the tune of a few million pounds.

At least our mental health trust kept its psychology services. Instead, it closed a ward of the local mental hospital sooner than planned and before we had the workforce in place to support the patients at home. The trust then transferred this work onto the primary care mental health teams, which meant that patients in primary care lost out. (Primary care teams in the medical sector have also shrunk, as nurses put into the community, and often paid for by primary care to provide local services, are pulled back into hospitals.)

But of course this only saves money in the short term and for the hospital trust, not for society as a whole. If we in general practice do not have the expertise in our local team, we often have no choice but to refer to the hospital, inconvenient for the patient and expensive for the country. If we want to reverse this situation, we need a whole-system, not a piecemeal, approach. We have already shown in Tipton, one of the most deprived areas in the country, where I am a GP, that a relatively low level of investment in general practice and the community sector can produce major health gains and reduce referrals to far more costly secondary care.

For the last six years, I have had the privilege of leading the Tipton Care Organisation that we formed to bring all the local GP practices together. The Government was steering resources towards deprived areas and, with funds that we received to compensate for the shortage of doctors in the area, we showed how we could greatly improve outcomes for our patients, simply by asking the patients and those working at the coalface the best way to invest the money.

We have found that the most effective way of improving services has been by education, particularly the way that we impart information to patients. For instance, we discovered that 76 per cent of our diabetics did not understand why they needed regular blood tests and what the results meant. Also, we needed better communication between agencies, so that services augment each other, rather than work alone.

Perhaps most importantly, we measured and audited outcomes of care. It may seem incredible to outsiders that this is relatively new to the health service but, in general, things have always been done in the way they've always been done. Mental health is even slower than other specialities to measure outcomes, as there is no simple way to do this. It has been very satisfying to know that we have a number of diabetics who, but for the extra care we put in by paying chiropodists to do and chase up foot checks, would have required amputations. Our death rates from heart disease have significantly declined, which is especially satisfying, as part of our area had the highest rate of cardiovascular disease in England. Sadly, at first, we were seen as a threat by our primary care trust because, instead of following their directives and guidelines, we did what we felt would be most effective for the patients, treating them as individuals and focusing on empowering them to learn about their illnesses and lifestyles, and then proved its value. Because we had outcome measures, eventually they had to take notice and later they took our work as a model to spread to other areas of Sandwell. In these kinds of ways we can stop the ever-increasing drain of resources into secondary care. I plan to continue to provide evidence that investment in mental health and wellbeing has both health and cost benefits for all patients, and that is why the human givens approach is the foundation of our strategy. When our patients have their needs met, it is not only their mental health that improves but their physical health too.

Needs met

This is the message that we really need to get through to the Government. We have already researched a wellbeing programme introduced in my practice, in which the top users of the service, including people with diabetes, hypertension and asthma, were taught mental health skills to enable them to take more control of their lives. We have demonstrated significant improvements in both their mental wellbeing and their physical health that continued to increase for at least two years after the course was completed (the time when our follow-up for the study ended). The results show clearly that, when patients learn the mental skills to be able to steer the direction of their lives, even if burdened with illness, they get better and better at doing it. Not only that, but their use of health services significantly declines, which was not the case for the control group, those who declined our invitation to participate in the programme.

It is a major breakthrough for us that, as laid down in *Everybody's Business: Sandwell's Mental Health Vision 2006–2015*, commissioning on mental health will for the first time be linked to outcomes. A major part of our investment in the human givens approach to therapy will be research to ensure that our investment is effective and that outcomes for our patients do improve. We expect that we will see reduced need of hospital services in both the mental health and the medical sector. And it will be in the medical sector where the most significant gains should be made. For a generally little known but very important fact is that half of the patients seen in hospital outpatients' departments have medically unexplained symptoms. These are the patients who won't do the right thing and get the diseases written about in the medical textbooks! They are not, of course, making up their suffering, but tests and scans fail to show up physical illness.

Most of us accept that a headache is most likely to be due to underlying stress or life circumstances. Our brain itself can't hurt as we have no pain receptors in the brain; the brain can even be operated on without anaesthetic. Yet it seems that,

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as a society, we do not want to accept that aches and pains in other parts of the body could also be psychosomatic, despite the rise in illnesses such as irritable bowel syndrome, now affecting up to five million people, and chronic fatigue, for which psychological approaches have now become treatment of choice. It is well known that you are twice as likely to be depressed if you suffer from diabetes, but recent research shows that depression causes metabolic changes that are often the precursor to type two diabetes. So depression may be a cause of diabetes and not always the other way around.

As we understand more and more about mind–body links, so it becomes more and more apparent that, for good health, we have to look at the whole person. This is something that has been lost in secondary care, as our hospitals become increasingly specialised in looking at less and less of the individual. A recent audit showed a decline in hospital referrals by GPs in Sandwell but, overall, outpatient appointments increased, as consultants refer between themselves, each looking at a different part of the person. It is not uncommon for the patients then to be sent back to us, totally confused after seeing a number of specialists and angry at being told that there's nothing wrong with them, although they still have the symptoms and may actually be feeling even worse.

Increased capacity

Another reason that we need the human givens approach in Sandwell, and throughout the country, is that mental health specialist services are at capacity. This means that, even when a patient has an urgent need to be seen, there may be difficulties getting them into the system. Some of this lack of capacity in the specialist mental health services is due to the fact that, once you do get into the system, it is very difficult to get discharged from it. Our service mapping has shown that there are a number of reasons for this, including a common belief that those with "severe and enduring mental illness" can only be maintained and not cured, and that they may need a fast route back into the system, which they may not get if they are discharged. Another reason is that a major national measure and target for mental health services is reduction of suicide. Though devastating, suicides are fortunately relatively uncommon, yet every suicide is closely scrutinised by the public health doctors and blame apportioned. There is, therefore, a reluctance to discharge from secondary services and many patients are even brought back to outpatients every few months to ensure that they are all right – though I would have thought that continually reminding people that they are mentally ill might have the opposite effect from that desired. A final reluctance to let go of patients is accounted for by the secondary services' lack of faith that GPs have the correct skills to manage mental health, even though GPs deal with the vast majority of mentally ill patients who are seen in the NHS (about 93 per cent). It should also be noted that about a third of those with the more severe mental illnesses – generally thought to be the province of secondary care – choose to stay with their GP. They prefer a family doctor whom they already know and trust, who may not be as experienced in dealing with their illness as psychiatrists but who, they know, will seek help and advice if needed.

Skilling up primary care

Once diabetes, blood pressure, raised cholesterol and asthma were the preserve of hospitals; only the specialist was seen to have the skill to treat these conditions properly. Since the treatment of these problems has been transferred mainly to primary care, the standard of treatment across the country has improved, because, through training, we have created the capacity in the primary care team to carry out 90 per cent of all NHS consultations. By giving primary care the skills it needs, through training and education, and by moving services into the community, we can create the same capacity in mental health. This means providing effective counselling services and training psychiatric nurses to work alongside GPs and their teams. In Sandwell, we now plan to have link workers trained in the human givens approach, who can assess any patient the GP is concerned about, advise the GP on how to treat if appropriate, direct to the appropriate agency in the community or to counselling, or get rapid help when appropriate from secondary care.

One of our inspirations has been a visit to Hartlepool Mind, which I undertook along with the chief executive of the Sandwell Mental Health Trust and the chair of the Service Users Group. Here we saw for ourselves how human givens *is* the recovery model, which in theory the NHS is signed up to. We have a model now to copy, and we plan to pilot it by opening a wellbeing centre in Smethwick,where patients can self-refer, or to which we can refer. It will have its own therapists, and, if successful, we will expand it to the other six towns in our area. This should solve the problem of how we get patients out of secondary care services and rehabilitate them into the community. (For an account of the way that Hartlepool Mind works, see "The road to recovery" by Ian Caldwell in *Human Givens*, vol 11, no 1.)

There is still a very long way to go. Without one commissioner in particular, who has battled away almost single-handedly, we could not have achieved what we have achieved so far. (It was her brainwave to run meetings where service users met commissioners and were able to help us shape the future of mental health services.) Yet, without my being on the team, she would have got stuck long ago, as I frequently have to bulldoze us through dead ends she runs into, because she is not a medical practitioner and so can be ignored by clinicians and managers.

We also still have the challenge of winning over

the psychologists and psychiatrists. Dr Farouk Okhai, chair of the Human Givens Institute and consultant psychiatrist in psychotherapy for Milton Keynes Primary Care NHS Trust, gave a talk to the psychiatrists. The junior doctors loved it, but the consultants have not really fed back. We have had three human givens training workshops, at which we offered free places to any staff that the mental health trust wanted to send but, despite promises to work with us and to release staff for training, there have been significant numbers of no shows. The trust has promised to look into this, but we have varying support from their different departments. Meanwhile, some of the psychologists say that training has to concentrate on cognitive-behavioural therapy, as this is the recommendation from NICE guidelines, and they have a limited number of training days. We will plough on regardless because, with every training, we win new supporters.

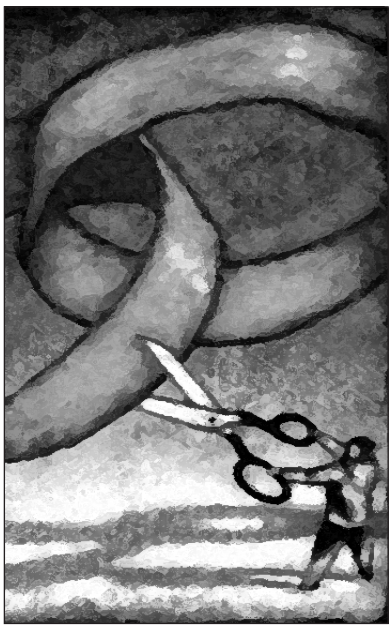
The human givens trainers have not found it all easy either. The service users, key to forcing through our redesign, have insisted on attending the training. They tend to be an angry bunch, as many feel that they have been let down by the services in the past and are still desperately seeking help and see the training as a possibility. Similarly challenging are those medics in the audience who ask about the evidence base for human givens. To fully win over the NHS, I think it is vital not so much to challenge existing practice as to concentrate on showing how the human givens approach can meet NHS needs. I plan to do this by demonstrating that human givens is the key to rehabilitating and discharging patients from secondary mental health services into the community and is an effective means of treating those with medically unexplained symptoms. This should help produce the evidence base that NHS medicine insists on. We already have two studies on the go in Sandwell. One, on the effectiveness of the rewind technique, is being led by Vinny Kumar, a community psychiatric nurse in one of our primary care mental health teams, and a second is being carried out with Stafford University, on the effectiveness of human givens for the treatment of depression. These should lead on to further studies.

I believe we are past the point of no return, and that is exciting. I have been fortunate to work in a primary care trust whose chief executive had the vision to support the development of primary care mental health services and who has allowed me the resources to do so. In the latest shake-up, he has been replaced, luckily by another chief executive with the same vision. Currently, we have identified 19 general practices in Sandwell keen to spearhead and research investment in primary mental health services with a human givens approach. We have a couple of protected learning days planned, where we close the practices for the afternoon and can concentrate on finding out what other further training and resources are needed and how to deliver them.

So it is an exciting and challenging time for us, and potentially a coming of age for the human givens approach within the NHS. If we prove it to be as successful as we expect, MindFields College will need to have the capacity and the flexibility to cope with the increased demand for training. A frequent criticism from the human resources departments in the NHS is that MindFields College courses are not validated by a recognised body, such as a university. (I know Ivan Tyrrell, Principal of MindFields College, is looking into this.) And we can expect continued resistance from the psychiatric and psychology establishment, which we will continue to need to win over. But experience has told me that there are a large number of clinicians out there desperate for the training and the tools to help them help all their patients. If we add the human givens model, which seeks to cure ill health by meeting unmet human needs, to the medical model, which seeks to cure ill health with surgery and medication, then the medics will have added a powerful tool to their toolkit.

Speaking out

Sadly, there are only a few places in the country where mental health is a priority for health service provision. Through Primhe (Primary Mental Health and Education), a charity which I chair, we have started to train specialist primary care practitioners – mainly GPs but also some nurses, commissioners and voluntary sector workers. We need leaders in primary care to be able to lead the commissioning and development of improved mental health services through 'practice-based commissioning' (the latest directive and direction for the health service), an initiative in which GPs will hold 75 per cent of NHS funding and so manage a large proportion of the finances of the NHS. Many psychiatric nurses working for the mental health trusts are frustrated with the current system and are keen to change things, but are afraid to speak out, as this would be seen by their managers as denigrating the services they work in, and could result in their being disciplined. They need leaders such as those we are training to speak out for them. As a self-employed GP who cannot be sacked for speaking his mind, I can tell the truth, call a spade a spade and say when the emperor has no clothes on.



Until our service is focused on patients' individual needs and can continually be challenged with regular audit of outcomes, which is certainly not the case in mental health services at present, it will frequently look pretty naked to many of us. n