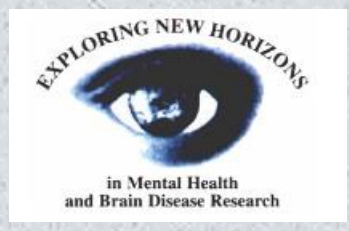

The Psychiatry Research Trust

A Witness Seminar on the History of Primary Care Mental Health in England: 1948-2019

17th June 2022

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Background

Each year, general practitioners hold around 300 million consultations with patients (NHS England, 2022) of which one third have a mental health component. The vast majority of these consultations are for people with common mental health problems, such as depression and anxiety. In an average general practice of 2000 people, around 200 adults will have a mental health problem, and that figure does not include those with dementia, children with mental health problems, those with substance and drug misuse, or those with intellectual disability.

Primary care mental health is a fundamental part of general practice (Gask et al. 2018), delivering care to many more people than specialist mental health services, and yet there is limited documented history of its development (Hall 2022). We sought to address this gap in the narrative by organizing a Witness Seminar to bring together key participants in the development of the field over the last 60 years, facilitating reminiscence and discussion of lived experiences. Our aim was to record a chronicle of memories which would become a valuable resource to anybody studying the history of mental health in primary care in the future.

The Witness Seminar was held on Friday 17th June 2022, at the Royal Society of Medicine (RSM), Wimpole Street. The day was made possible due to funding from the Psychiatry Research Trust, and Implemental Worldwide who helped to manage the logistics.

In order to structure the day and focus discussions we divided the seminar into the three stages which we introduce below.

1. Delivering primary care mental health by relationships – swinging 60s and psychoanalysis

After the end of the Second World War, and the creation of the NHS, health services became available to all, free at the point of delivery. Every individual could have their own general practitioner who acted as a "gatekeeper" to hospital specialists. Mental health care was led by psychiatrists through the provision of distant (hospital based) outpatient services, in the same way that gynaecology, or orthopaedics were delivered. About 20% of psychiatrists were doing some form of consultation-liaison service delivery with primary care, tangibly bringing psychology into the consultation room (Strathdee and Williams, 1984).

During this time society moved from post war austerity to the increasing affluence and freedoms found in the 60s and 70s. These cultural changes were characterised by free thinking, free love, and free ideas – the control, the poverty, the bleakness of post war UK was replaced by prosperity and opportunity. For general practice, this was an important time, as it became recognized as a medical specialty in its own right: The College of General Practitioners was founded in 1952 and granted a royal charter in 1972. The emancipation of general practice was described best in a publication of the time *The Future General Practitioner – Learning and Teaching* (RCGP 1972) which set out the foundations for the doctor-patient relationship. The study of this relationship became the bedrock for the success of primary care. Providing the background, the support and the evidence for the

importance of the doctor-patient relationship was the work of Michael Balint, and psychoanalysis (Balint, 1957). The principles of psychoanalysis and understanding relationships, was built into the training and development of new general practitioners (GP's); support for these new GPs was provided by the spread of Balint Groups, case discussion groups which were based on the work of Michael Balint and aimed to help GPs explore the psycho-dynamics of doctor-patient relationships.

2. Delivering primary care mental health by money – the purchaser-provider split, and fundholding

In 1991, the concept of a purchaser-provider split was introduced to healthcare. The underlying principle was that quality would be improved by competition. The NHS was re-configured to allow for competition, by allowing purchasers (commissioners at Health Authorities) to buy health care from independent providers called Trusts. Quality was not only measured by clinical outcome, but by financial efficiency.

In the 1990s a quinquennial report found that people with psychosis were under-served, and psychiatric teams were withdrawn from primary care so that they could concentrate on the "most unwell" in specialist units (Brooking and Gournay, 1994). This was seen as both clinically and financially more effective. However, the consequence of this contraction of psychiatric services into mental health hospitals resulted in a much clearer distinction between the responsibility of primary care and the responsibility of mental health services. Unlike other secondary care services, mental health teams created boundaries, or barriers to referral from primary care. Unless a patient met certain criteria, that they were sufficiently unwell, they would not be considered for advice or assistance. From a primary care perspective, psychiatric teams dealt only with psychosis. Primary care became the repository for every sort of mental health problem apart from severe psychosis. Unable to access psychiatric services, doctors or nurses, psychologists or psychiatric social workers, primary care resorted to the only two alternatives that would work for people with common mental health problems; medication or counselling. Prescribing rates for anti-depressant medication increased significantly, as did the use of benzodiazepines (Mehdi, 2012).

While Health Authorities were developing their skills to commission and purchase health care, some practices were given funds to purchase healthcare for their own populations. This was called the General Practice Fund-holding Scheme. The void left by the retraction of psychiatric services to the mental health hospital was dealt with in primary care by a rapid expansion in counselling services, aided by the fundholding scheme. However, not all practices were fundholders, resulting in a huge variety of the availability and quality of counselling services offered by different practices. This was the post code lottery of fundholding.

3. Delivering primary care mental health by guidelines – NICE and IAPT

The new millennium brought a new Government, new mental health policies (Department of Health, 1998), and a new approach to health care through the development of the National Institute for Clinical Excellence (NICE) which aimed to use guidelines to provide

both high quality care and consistent services across the country. The post code lottery that characterised fund holding was to be abolished.

At the same time, a focus on the underlying causes of long-term unemployment revealed that nearly 50% had mental health problems; not those managed by psychiatrists, but the depression and anxiety managed by primary care. (Layard and Clark, 2014) A workshop in 2004 held at Downing Street proposed that there was an economic case to be made for investing in training tens of thousands of mental health workers, who would deliver evidence-based interventions to relieve depression and anxiety, so that sufferers could return to work. (Evans, 2013) This would reduce the national burden of the long term unemployed, decrease benefits costs, and increase tax revenue, as the unemployed became employed once more. The evidence-based interventions would be based on the guidelines produced by NICE for anxiety and depression. Thus, was born the Improving Access to Psychological Therapies (IAPT) programme, created not as a necessary new mental health intervention to fill a mental health need, but an economic model to address long term unemployment.

The IAPT programme, amongst other things, provided for primary care a route to manage people with depression and anxiety. It rationalized the primary secondary care interface, that was so lacking in the 1990s. People who are severely unwell will go to the mental health services, who will provide long-term care for them. People with common and less severe mental health problems like depression and anxiety will be treated with evidence-based interventions through the IAPT programme instead of the free for all that was counselling. The primary care role was to refer the patient to the most appropriate care provider, returning to GP's acting as the gate keepers to secondary care services.

The Seminar

Each section was introduced by two key speakers, and then opened to the audience for discussion. The invited audience consisted of 23 in-person attendees, and 11 attending virtually via Zoom, and were a mixture of GP's, psychiatrists and psychologists. The ability to hold a hybrid event was invaluable, as it allowed people to attend who otherwise may not have had the opportunity to contribute. The seminar was recorded and later transcribed into this document which will be held at the Royal College of Psychiatrists (RCPsych) archives. We hope that it fills some of the gaps in the history of primary care mental health, and enables further research for those who are interested.

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Alan Cohen

Welcome to this witness seminar on the development of primary care mental health. We want to thank Tom Craig and the Psychiatry Research Trust for funding the seminar and Implemental Worldwide for managing today's logistics. And for those of you who don't know, Implemental Worldwide is a community interest company with an ambition to support an international network of colleagues who are committed to improving mental health services. The Implemental team works collaboratively with colleagues from all over the world and harnesses the expertise of an extensive network of over 200 associates who are leading clinicians, managers and scientists. Implemental have extensive experience of system change, particularly deinstitutionalization and developing community services. Before introducing Clare Gerada, I just want to remember Helen Lester who most of us will remember with a great deal of affection. A GP (General Practitioner) with enormous dedication, inspiration, research and leadership and it's a real shame that she's not able to be here now. And I'm sure, had she been here, she would have enjoyed reminiscing in a way that only she could. I'd also like to mention Professor John Hall who is the reason that we are here. John is a psychologist who was writing about the history of psychiatry and it was he who identified that there is no documented history of primary care mental health. And now I've got great pleasure in introducing Professor Clare Gerada. I have, as all good chairs should do, downloaded a quick brief biography from the RCGP (Royal College of General Practitioners) website, which I think I should probably read out. But the reality is that we all know and admire Clare, for the wide-ranging work she's done in particular primary care mental health, I'm not even going to bother to go further. So, thank you for coming to talk to us today.

Clare Gerada

Well thank you for giving me the honour of starting this, I am really in awe actually of everybody, because you're all old faces really and this is like a reunion.
I am just going to say a few words and then sadly, I will have to leave as I am going to Limerick. So, let's just set the scene, all of us in this room had some history in primary care mental health, although we didn't think of it as primary care mental health.

We just thought of it, as I thought of it, as just addressing an unmet need. And for me it started when I worked at the Whittington hospital, and I was doing A&E (Accidents & Emergencies) and, in those days, you used to get breaks. So, I used to go to the library in the hospital and they had what was called the Green journal, which is the British Journal of Psychiatry and I used to sit there in the library, reading this journal. I got fascinated with Freud. I decided at that point I was going to do psychiatry, whilst I decided this, it was unknown to me that the Maudsley only accepted people who wanted to learn about Schizophrenia. So, when I went to my interview, Robin Murray interviewed me and asked me why I wanted to learn about psychiatry. And I responded that I wanted to learn about Freud. It must have seemed completely off the wall, but nevertheless he offered me a place at the Maudsley. And it was at the Maudsley that I met my other half, and whilst he denies this, there can only be one psychiatrist in this family. So, I left and became a GP. So that's how I got into the primary care mental health world. It was really completely serendipitous and also due to love. But at the time, they were enormous gaps, my last job was in addiction services. And during these times, at the beginning of the HIV (human immunodeficiency virus) pandemic, that there were 18 months to two year waiting times for a drug user to get a prescription to get into treatment. Myself and somebody who I've scored as an inspirational North London GP. We decided to change that and we really, I think, created a specialty for primary care substance use. We developed a competency training program, which continues today. At an annual conference, we reduced the waiting time from 18 months to two weeks to get treatment. And we did an awful lot of other things and that's how I really got into primary care mental health. From there I met Alan. When I was a very, very, very large fish in a very, very small city. So, it was quite easy to get on and do things. So that's really my story. Like many of you, we just did it because we did it. We did it because we were interested. We were GPs. We were holistic. We loved patients, and we just got on with it. And so, I think we're going to hear more from everybody, about how you all got into it and how we work. We can now record what we've done in terms of transforming the world. Ironically now, despite being the lead of primary care mental health at the Royal College of Psychiatry, in 1999, I'm still the lead of primary care mental health for the Royal College of GPs in 2022. And nothing has changed. We're having exactly the same discussions as

we had. In fact, I found the agenda for a meeting in 2002 and it's exactly the same agenda. How do we reduce the gap through primary care and secondary care? How do we improve the skills of GP's and other mental health workers? How do we improve integrated care? It is exactly the same agenda today, as it was in 1999. So, thank you very much for having me.

1. Delivering primary care mental health by relationships

Alan Cohen

Thank you very much for that Clare. We are now going to move on to the first of three sessions, grandly titled: Delivering Primary Care Mental Health by relationships. Which I am going to chair. Andre is going to chair the second session: Delivering Primary Care Mental Health by Money, and Lydia is going to chair the third session: Delivering Primary Care Mental Health by Guidelines. The format will be the same for each session. There will be two or three invited guests to share their experiences and reminiscences of a period. And then we'll use their contributions to stimulate the conversation and discussion between the people who are joining us remotely and the people in the room. We wanted to bring your attention to the fact that this meeting will be transcribed, so your attendance here and your signature implies that you are aware of this. And to make the transcription easier, it'd be really good to introduce yourself before you speak. It'll make it much easier that way. We are going to limit speakers and contributions from the floor to no more than 10 minutes. Finally, we would like you to be honest, we would like you to be, where appropriate, contentious. We're not all going to remember the same thing the same way and that's fine. What we would ask you to do is if you disagree with somebody that's fine. You can disagree with it, but don't be rude, be respectful please. This transcript and all the documents that you may or may not have uploaded to the website are going to be stored in three libraries. So, we wouldn't want your unpleasant comments about Joe Bloggs to be permanently in the RSM (Royal Society of Medicine) library or the RCGP library. It really wouldn't go down very well. So, that's the introduction which you're going to get at the beginning of each session. I am chairing a session on primary care mental health by relationships, which broadly spanned from the 1960s to 1989, which is when the government started talking about delivering health care by constitution and by money. It's just worth taking two minutes to put this into context. The 1960s and 1970s came after a long period

of austerity in the Second World War, and were characterised by increasing affluence, increasing freedoms. Some of us will remember the free sex, free drugs, free living, if you were there you would remember. But there was a real development and freedom about the way that we approach things and general practice was no different. The College of General Practice was started in 1952 and received the Royal designation in 1972. General Practice started and blossomed, certainly when I joined the game as a trainee there were only three or four departments of general practice around the country. And certainly, academic general practice was a real rarity. And as a trainee, there were two books that I had to read. The first was The Future General Practitioner by Marshall Marinker and Paul Freeling, really important to talk for the first time about the doctor/patient relationship, as it being the basis of what we do. And I can remember that one of the tasks set for me in my time at Lisson Grove Health Centre was to do a whole surgery without reaching for my prescription pack, and that is something that we don't do anymore. The other book was 6 Minutes With a Patient by Michael Balint. And you couldn't be a GP without having read those two books. The whole point of this was to bring me neatly to the Balint Society and Andrew Elder. Andrew was a GP at Lisson Grove but at a different practice. And has been an enormously powerful force for the doctor patient relationship and Balint and Psychoanalysis in primary care. And Andrew was President of the Balint society. We are really glad you've been able to come here and talk to us about your reminiscences and memories of that time period. Thank you, Andrew.

Andrew Elder

Thank you, Alan, very much for the invitation. Good morning everybody, gosh you've set me a hard task to go back over 50 years. I've been scratching my head quite a lot and I hope I can contribute more informally to the discussion but my anxiety levels were such that I've actually written my 10-minute speech. But, as you say, I was basically a busy NHS (National Health Services) GP in North West London for most of my working life. I qualified in 1969 and began my career as a GP in 1972. In those days, I don't think the terms primary care and mental health had even been invented! There was Psychiatry and there was General Practice. Two very separate worlds. At my medical school, psychiatry teaching was a handful of lectures and a residency in one of the vast psychiatric hospitals just beyond the periphery of Greater London. The professor of medicine

dedicated two lectures to rubbishing the idea that there could be any connection between body and mind. And of course, there was no teaching about general practice. For GPs of my generation, if you trained at all, training wasn't mandatory until 1979, much depended on the attitudes and philosophy of your training practice. I was fortunate. The founding partner of my practice, and my trainer, Harry Levitt, had been a close colleague of Michael Balint's and had had a personal analysis. He was a founder of the Society for Psychosomatic Research, and later Chair of the College of GPs. Sitting in on his surgeries was like eavesdropping on a series of intimate conversations. If I asked him for advice about someone, he would tell me their life story. All his emphasis was on the patient as a person. Diagnoses and treatments were important, but they were episodes, chapters, not the story itself. In those days, there was much greater autonomy and freedom for GPs. Yes, there was 24-hour responsibility but within the GMS (General Medical Services) contract there was considerable freedom and considerable variation in attitudes to practice and innovation. There were surgeries without a basin in the consulting room and a neighbouring GP who removed patients if they requested a visit. This was the era of Lloyd George envelopes, often stuffed full, so-called fat files which was a diagnostic category, listing endless repeat prescriptions of barbiturates, and later benzodiazepines, mostly without consultation. In those days, the population was perhaps more reticent about presenting emotional and psychological difficulties. But Michael Shepherd's 1966 book 'Psychiatric Illness in General Practice' had already shown convincingly that general practitioners shouldered the overwhelming majority of psychiatric consultations in the Health Service. Professor Michael Shepherd fell out with his colleagues because of his conviction that better mental health care could be achieved by better training and support for general practitioners in the NHS. And so, we come to the difficult question of training and the central paradox of our subject: that family doctors who conduct most of the consultations in the Health Services concerning mental health are not usually even recognised as mental health practitioners!

Soon after starting as a trainee in 1972, I was on my way to the fourth floor of the Tavistock Clinic to join a Case Discussion Seminar for GPs. I was a member of that group, led by John Denford, which met weekly for just over four years, and it became one of the main components of my GP training. Emerging from the medical school's

insistence on so-called objectivity, it was a revelation to be in a setting which valued feelings, relationships, and the discussion of different ideas about what might be 'going on' between a doctor and a patient. Michael Balint had published his landmark book, 'The Doctor, His Patient and the Illness' in 1957 - the first of five volumes which collectively made up the Balint Research Project. In clear and memorable language, Balint articulated a new and much expanded role for GPs, which went far beyond patients' physical health to include their emotional and psychological wellbeing as well. His ideas were highly influential and strongly permeated the early architecture of General Practice. They were largely adopted by the College in its blueprint for GP training, The Future General Practitioner, was published in 1972. Balint Groups were designed as training groups through which GPs could acquire the skills and self-understanding to fulfil their new role. The focus in the group work is exploratory, not teaching, and focussed strictly on the doctor-patient relationship and its attendant interactions. The Balint's (Michael and Enid) recognised that successful training would involve a certain amount of psychological change and development within the doctor to enable greater sensitivity and responsiveness to patients' emotional needs. Their principal aim was to help GPs recognise that their own relationships with patients, if only they can observe them, are often of great therapeutic value and sometimes hold the key to a patient's distress. After Michael Balint's retirement from the Tavistock in 1961. The GP training scheme continued to run a program of weekly groups with GPs which at its height was training 50 to 60 doctors at any one time, groups were led by psychoanalysts experienced in working with GPs. Many of us continued along Balint lines and working within an environment in two of the further research groups that CHI (Commission for Health Improvement) led held posts in education and training. And this enabled those of us who became course organisers for instance, to include a Balint group as a weekly component of our half day release schemes, allowing every trainee a three-year exposure to think about doctor patient relationships during their training. When I look back on my experiences in the 1970s and 1980s, I'm struck by the extent of time and freedom to explore and do different things. Alongside being a full time, all singing and dancing GP looking after patients, I was surprised to realise that in our own practice, and this is before me, all incoming partners and most trainees through to the mid-1980s went into therapy. I attended a one-year introductory

training in group analysis at this time, where there were two other GPs on the same course. It was not uncommon for referring GPs to be invited to assessment meetings, so that they could contribute to the discussion of their patient, providing a learning experience for the GP, but also demonstrating that the GPs perspective was valued on a few occasions has led me to becoming a co-therapist in family therapy involving my own patients. And now another anecdote, a treasured memory with Anna Freud in discussion with her colleagues, about a five-year-old I had referred. In 1975, with one other partner, I undertook two additional surgeries a week running a Student Health Service at Bedford college in Regent's park. Student health perhaps deserves a small but significant chapter in this seminar story, being amongst the first examples of a primary care-based response to the mainly mental health needs of a particular population. All the early pioneers were GPs who then brought in psychotherapists and counsellors to work with them. In 1967, a paper appeared in the Journal of the College of GPs entitled, 'An Experiment in General Practitioner/Psychiatrist Co-operation'. It entailed the author spending an afternoon every fortnight at two GP surgeries, offering himself as a consultant to the doctors. Nothing similar had been carried out in the UK before.

The approach described had little to do with increasing the availability of psychological therapy, and much to do with the value of psychotherapeutic listening, being available to primary care teams and to patients who come in and out of the doctor's surgery. A compelling case was made to the importance of such expertise being available in primary care, accessibility of trusted setting, lack of stigma, value of its collaborative nature, and a large number of patients who were not suitable for onward referral or were resistant to it, and that GP's patients frequently had complex mental health problems. During the 1970s and 1980s, there was a slow but steady increase in the number of psychotherapists and counsellors working alongside GPs in practices. This represented a significant increase in the possibility of psychotherapeutic help for a great many patients from many different backgrounds. For the first time in the NHS, increasingly, counsellors and therapists became directly employed members of primary care teams and often played an important role in team development within practices. In our own service, referrals were always made in person, never written or by message, and never after only a single appointment with a patient. We never set a time limit on the number of sessions. And never had a significant

waiting list. Counsellors were able to adapt that technique and approach to their primary care setting and to consider the individual strengths and susceptibility of referrals. Referrals in primary care often arise out of tensions in the relationship between doctor and patient. GPs are the recipients of powerful projections as well as having to deal with their own emotional responses to patients. Some capacity to think about such things means that a referral is less likely to arise primarily from pressure the professional is unable to withstand. There is always tension in the growth of mental health services in primary care. Does it represent a well-integrated development, based on supporting the complex containing role that GPs play in the mental health of their patients? Or is there a danger of it aggravating the fragmentation and splitting, that is so often present in complex human situations? Perhaps that question is best left hanging in there for later discussion.

David Zigmond

Ah… I hadn't realised, Andrew, that I am an exact contemporary of yours: qualified 1969. I just want to reflect on my experience of the Balint era. It infused my professional life enormously, providing more human interest and an enduring motivation to keep going – until it was scuppered by the increasing atomization, and the kind of institutional clunkiness that we all had to put up with. I didn't actually become a member of the Balint society like you did. But I *was* in Enid Balint's group at University College Hospital for two years with the GPs, just as an observer.

Those experiences stayed with me since that time when I realised what is quite as important as the *phenomenology* of medicine. It is the *semiotics*. What do symptoms and illnesses mean? And I think that, in a way, what's happened in mental health is the growing dictatorship of phenomenology. What *is,* or what is *defined* as what is, has utterly pushed out attempts at exploring meaning. That really matters, because what enormously keeps staff motivation and morale going is the *meaning* of work – not just dealing with things via particular procedures. I think it's that quest for personal meaning that has got lost. And why that's happened is really interesting…

Lind Gask

It's nice to see you too. I'm afraid I can't see who all the people in the room are, but you can see me. So, I'm speaking to you from Orkney. I think it's a great pity that David Goldberg can't be with us today, because my introduction to primary care mental health was

through David. In the mid-1980s, I had done one research project looking at what happened when GPs referred people and they were sent straight back to the psychiatrist simply with an opinion letter. And David Goldberg said they wouldn't like that. And Neil Kassell said they were quite satisfied. So, I went and interviewed the GPs and that was my introduction to general practice psychiatry. But I did a PhD with David and by that time, he had already done all the work looking at the particular skills that doctors needed in order to be able to acknowledge and talk with people with mental health problems. And it was a tremendously exciting time. And I have to say, I think that what really came over to me very powerfully, when I was researching in primary care was the enormous disparities between practices and the neighbourhoods in which they worked. I can remember going down to Kent as part of a research project when I was working with Tom Craig. And we were doing work on trying to help trainers to learn how to acquire teaching skills using video. And there were paintings in the consulting room that had been contributed by patients. And then you would go to Manchester, where there would be a grill at reception and one magazine being fought over by three or four people. And I think that yes, at the time, I wanted to be a psychotherapist. But I was very much aware that we had a lot to do in order to be able to help doctors to engage people with emotional problems. And there was a big emphasis on consulting skills in general practice at that time with teaching that was very much aware from people like Roger Neighbour. And so, there was a real willingness on the part of many trainers to work with us and get involved in actually looking at what skills you actually need to help people talk about their feelings. And that wasn't Balint. Some doctors were interested in going to Balint groups in Manchester, but many of them just felt they didn't really know where to begin. And I think the work we did, I think the work that David initiated, needs mentioning at this point, it grew right out of the work in the General Practice Research Unit at the Maudsley in the 1960s and it was a carrying on of that tradition.

Clare Gerada

I just want to say thank you very much for letting me speak. It's just that I'm going to have to leave soon. I mean, we became victims of our own success because I worked at the Maudsley with David Goldberg and with Michael Shepard and as we identified the fact that, if you'd like, far more mental illness was presenting in primary care. And much of it was being unrecognised and everyone

recognised it differently. So, a homeless housing issue might be presenting, but we were also missing Obsessive Compulsive Disorder, Depressive Disorder, Anxiety Disorder. We were over prescribing Benzodiazepines. In fact, I think 80% of women under 50 years of age received Benzo's and probably about 90% of our patients aged over 70s, would have a Temazepam prescription. So, we became the victims, David Goldberg's work showed the prevalence of mental health that was presenting. And also, if my memory serves right, David was quite dismissive of GPs. Actually, when he came down to London he was, because he would be dismissive of the sort of mental health problems that Andrew is describing, the sort of presenting in a different way. So, backache presenting, he would deny the fact that we're identifying it by just calling it something different. So, there was an industrialisation led by academics, and I hasten to add, including my other half, of trying to formalise and name mental illness, we can no longer call anybody "just off their feet". We were sort of mirroring what was going on in the States. We couldn't get treatment unless we had a label. So, I have to say that the romanticised era Andrew, the simpler era where you didn't need a diagnosis, you didn't need a letter, was actually driven through the academic work that chose us, in general practice, to identify and to spotlight all of the problems that we were facing and that hasn't stopped since. So instead of putting the spotlight for example, on patients presenting to accident and emergency, or even patients presenting to obstetrics and gynaecology, it put the spotlight on us. And as more of a spotlight was put on us, and so the more we had to skill ourselves up, we had to find time, we had to industrialise and we had to formalise what we were doing. And so, with this, out went the gentle consultation between you and the patient, and in came evidence-based CBT (Cognitive Behavioural Therapy). Sitting with David and his team, which my husband was part of, made me feel inferior as a GP, because I was made to feel that I was part of the problem. And if only I did it better, my colleagues did better we wouldn't have so much morbidity going around. Instead of what we now know, which is that it's not as simple as that. I just wanted to say that.

Andrew Elder

I just want to say briefly in response to Clare. That I am not in any way suggesting a golden romanticised age where there were no letters and all that sort of stuff at all. I was pointing out that occasionally there was good collaboration between the two sectors.

We started the consultation data in my practice in the 1970s. We were very aware of how much actual real mental illness there was around and we were working as GPs with it quite consciously.

Chris Dowrick

Hi there, I'm sorry, I'm not there in person. Well, I am talking very personally about me and my personal history in relation to all this. Actually, I'm starting back before my medical training because, as many of you know, I was a social worker before I moved into medicine and started medical training in 1981, when I was 29. But in the 1970s I was a social worker in London, and then in Malvern n, and then in Manchester. That's where Linda and I met for the first time, when she was a registrar and I was a social worker psychotherapist. But the reason for talking about that is that my time as a social worker massively influenced my decision to move into medicine and it was massively affected by a whole relational approach to mental health care which has, for me, persisted ever since. So, I mean in terms of specifics, in 1974 to 1976 I was working in Camden in the Family Service Unit, but I spent a lot of time actually in the Tavistock with John Byng-Hall who some of you will remember as a family therapist. In 1976 and 1977, I was doing my social work training at the LSE (London School of Economics) which was really the old psychiatric social work course. And I had a year's placement at the Maudsley where I was working with a Kleinian psychiatrist Murray Jackson and he actually had a ward to manage. And also with Robin Skinner, who was doing lots of family therapy. And then I moved to Malvern as a mental health specialist with a lot of interest in family therapy. And then 1979 to 1981 in Gaskell house in Manchester, which is where I met Linda for the first time working with Bob Hobson, who again is a name that may be familiar to many of you. Bob actually introduced me to Balint for the first time, I read his book Basic Fault while I was there. And also, a friend of mine from school, Paul Hodgkin, who is a GP who is most recently retired, like me now. He was in Manchester at the time and I remember talking with him and another friend who was a GP in Manchester, who, in the course of conversation we were talking about Balint and he said "Well of course in these days, in general practice, we diagnosed everybody with a Personality Disorder" because that was just how he was seeing things. But as I say, my switch to medicine was because I could see the sorts of things that I was doing. I was interested in the sorts of things that Linda was doing, that Bob Hobson and other people were too. I felt that personally, I could

pursue those better within the medical framework rather than within a social work framework. So, it was quite a big shift, but it worked and then if I'm going forward several years, when I finished training, the choice for me was always between general practice and psychiatry. There wasn't anything else I was thinking about, but I thought from a selfish point of view, I might pursue my career a little bit more rapidly in general practice at that time than was done in psychiatry. And then in my GP training at the Elms Medical Centre in Liverpool, the senior partner there was a GP called Len Ratoff who was in one of the first Balint groups; I'm not quite sure whether it was Michael or Enid who was leading that one. My first and most enjoyable paper that I wrote, which was called "Why do the O'Shea's consult so often?" was very much informed by the idea about relational care and it was about ideas about some mutually unacknowledged oppression between the partners and the patients. And then, when I joined my current practice for the first two or three years which I facilitated with Bill Barnes who was a clinical psychologist. I facilitated, I guess you have to call it a Neo-Balint group. It wasn't formally aligned with Balint, but it was along those lines. And we wrote a paper from which was called Sole Bearers with a deliberately ambiguous title. And really, I mean, the whole sort of Relational Approach to mental health, to primary care, to psychiatry, it's informed all of my thinking, research and writing ever since. So that's sort of the essence of what I want to say.

Maryanne Freer

Hi, my name is Maryanne Freer. I'm actually a psychiatrist, and a lifelong collaborator with general practice. I just wanted to pick up one or two points from what Claire was saying, which was about moving forwards into a kind of mechanistic point. What I'd like to say is, I was actually a medical student in the 1980s. So, I didn't get an opportunity to join a Balint group. But what I would like to say was, I was actually taught by some of the greats who are your colleagues here. Christian Water, for example, was one of my tutors in Newcastle medical school. And so, I think part of the history is also about the younger generation and how this generation of GPs, their commitment to education was so huge about passing it on to the next generation, and then on to the next generation. I was taught as an undergraduate about holistic practice, mainly through the GP grades where there was not a division between mental health and physical health. And it was about what we might call now good old fashioned family practice, which we all might long for. But

what I would say is, it's not been lost, and actually people are still practising in this room, but it's been passed on to the younger generations. And then on to the younger generations, I was always taught that teaching was a core part of being a doctor and passing on that knowledge. So, I would just simply like to say, a massive thank you, to what I call the general practitioner greats, who were there in the early days, and who really, to me, instilled all of this across all general practice, not just primary care.

Linda Gask

I just wanted to come back on a slightly earlier conversation and also comment on what Chris said. Claire said she felt that David Goldberg did general practice down. I think anyone sitting with David Goldberg used to feel slightly inferior. I certainly did most of the time I worked with him as a PhD student. But I do remember when he went out to work in South Manchester in the early 1990s. And he was doing consultation liaison work in South Manchester. I think it really came home to him the complexity of people that GPs were seeing in primary care. I remember him coming back and saying there are some really difficult problems that people are trying to sort out. I don't think that it had actually occurred to him to the same degree before that point. When he was actually out there doing consultation in Wythenshawe. And I think that many of us, yes, I absolutely agree with Claire about the way that everything has been mechanised and the five-minute CBT skills that you can learn and all of that. I can only say that, as someone who's been a patient myself, I have absolutely no doubt that relationships are key. And for me, continuity of care was absolutely key. And that continuity is something that we don't have now, that we did then. But for me, as the psychiatrist, it was also about building those relationships with GPs in the way that Andrew was talking about a little bit earlier. But in working with doctors, I got to know them and built relationships with them as a psychiatrist, so that we trusted each other and we had time together and we were able to build those relationships. And that is something that I also think has largely been lost.

Irwin Nazreth

My name is Irwin Nazareth, I was a GP until recently, until a year ago. But I'm still an academic. So, there's several interesting points raised and I've been as much a GP as an academic. So, I started the practice in 1997, in Hampstead. And so, I want to tell you about my own personal experience in the practice, which fits in with what Andrew said. But before I say that, I want to say something more

generally about therapy in general practice. I started my GP training when Balint was just getting out of fashion, and CBT was very much involved. There was also quite a backlash against psychotherapy in general. So, I think that has changed the way we work in general practice. There was also the availability of antidepressants, which was less than 10 years ago, and I think that also changed the way people are treated. But we started our practice in 1997, it was so close to Tavistock so we made connections with that stuff. And having started a practice, you're always enthusiastic to do the very best. So, we invited somebody from Tavistock to spend a session with us, which she did very unwillingly. She was a senior registrar, and she spent two hours every two weeks I think, when we brought patients to actually discuss them. And it was interesting, we started quite sceptical because we were brought up in the age of CBT rather than psychotherapy, so we were rather uncertain. And every patient we referred to the Tavistock was rejected because they were not suitable. So, we had quite a negative view of psychotherapy. But I think the two years that she was with us were really fantastic because we started getting an understanding of the psychodynamics and the consultation. She was so interested in the work we were doing, she decided to have a liaison session with us, which had never happened before and she used to work every month, I think, she used to see patients. But then she finished her job and we lost her, we never got a replacement. But I think that was a very good model because it not only educated us, it helped the patients but what she had imparted to us was useful in our application of both CBT but also getting an understanding that the CBT goes to a certain level but then you still have the same problem come back unless you have these booster doses. So that was my personal experience. And I think the point about being a researcher, I know the importance of diagnostic categorization, but we're probably going the full cycle because we now believe in multi-morbidity, not just physical and mental, but also multi-morbidity with mental health, so you may have three or four diagnoses. And I think, as much as we think things are not worse, things are also better, we prescribe less benzodiazepines, hardly any. We deal with a bigger range of problems in general practice. So, I think I would take your point that we are heading in the right direction, but there are problems. There are problems because of time, demands, admin, the computer, well lots of issues. And that's going to be a barrier to good primary care mental health in the future.

David Zigmond

I think one of our biggest problems is that we have increasingly devised systems where the relationships become unimportant, where no-one-knows-anyone anymore. So, GPs now – not only do they not know their patients, they don't know their receptionists, and the receptionists they don't know don't know either. They certainly don't know their colleagues. All these things were untrue when I first joined the NHS. I knew my hospital colleagues, I knew my CPN (Community Psychiatric Nurse), I certainly knew my receptionists, and my receptionists knew who most patients were when they called in the morning. They weren't then met by algorithmic answerphones. And it is, in my view, impossible to provide good care anytime, let alone mental health care, when working alongside colleagues that we do not know – that's absolutely vital. So, what have we done? We have developed a system with mandated industrialised packaging to replace more informal networks of people. The reason relationships are absolutely vital, is because care involves ecology, not engineering. But we've got into a system where we think that we can increasingly engineer and package everything, and that includes diagnoses. As I understand that, David Goldberg's specialty is to keep on proliferating such diagnoses and their application … and the price is high.

John Hague

Hi I am John Hague, that was fantastic. I feel you know, such a window on the world. Two things to say. I think we have allowed relationships to be lost, both with patients and with colleagues and that's a tragedy. About diagnosis, well once you get a diagnosis the service is commissioned to provide a service for that diagnosis. That's also a tragedy. And that's completely dominated my career as a GP, which I will discuss more later.

Rachel Jenkins

Thank you, I'll be very brief. But it was to pick up a couple of things. One, is David Goldberg, whenever I was meeting GPs from around the country, I met the people who David trained as medical students. This picks up the point that teachers matter, good teachers matter. And whatever else one feels about diagnosis or not, he had imbued a really good mental health understanding in students, with training. The second thing I wanted to just pick up, was because I was very interested in this attachment that you had from University College of London and I, in fact, did one of those myself as a young

psychiatrist working in a practice in Peckham. But I didn't achieve it nearly so well because I felt that I was seeing so many interesting patients that I hadn't known existed. So, it was a wonderful experience for me about what you saw in primary care. But in terms of me upskilling the practice, I wasn't. Because they weren't there with me. They were happily throwing things at me and running, you know, to their next visit, so I was doing nothing to strengthen that practice. And so that kind of weighed on my mind when I was thinking later, in the Department of Health which I will talk about later.

Jeremy Broadhead

Just a quick thing, my name is Jeremy Broadhead, and I'm a psychiatrist. And I see a lot of patients who haven't got better in primary care but don't quite satisfy the criteria for secondary care. And my lens on services is through that group, that feedback and changes over time and what I wanted to reflect some wonderful statements and you made about the complex and containing road, the relationship holding the key to therapeutic success, knowing the patient as a person, and that is what these patients I see have not been able to establish. They don't know who their GP is, I can't write to a person, I have to just put the duty doctor now. Whereas, over 10 years ago, someone would ring me up and say, look I'd be grateful if you would see this person, I have no good ideas and what do you think? So how do you do any of those things without continuity? I really don't know, and I think that one word is so key to success in this area.

Tom Burns

Hi everyone, Tom Burns I am a psychiatrist. Just to respond to Rachel's point about your attention to general practice. In the 1980s, when Paul Freeling was a Professor at St. George's. He was very clever and he got lots of money and he got half a million pounds that he had to spend on putting psychiatrists into general practice. And I was a clinical tutor and I thought that's fantastic. They were fully funded, they would go and work in general practice for six months, as part of the rotation. And the experience was amazing because the first thing was that none of them wanted to do it. They refused to go to general practice, and I had to bully, bribe and eventually forced them to. Second thing was, everyone who did it, said that it was the best job they did. And in terms of helping the GP, none of them thought they helped the GPs at all, they thought they learned from GPs. And the two things they told me that they really

learned and stayed with them, is that GPs are nicer to their patients than we are. They like them and they're liked back, we're learning there. And the second was, diagnosis is important when actually dealing with distress and symptoms, seems to be agile practice work and we think we learned a lot from that. But of course, at the end of the six months, the end of the three-year project, money went.

Andrew Elder

I just wanted to make a comment about sort of history repeating itself. Listening to Linda about David Goldberg. I didn't mention the name of the psychiatrist who wrote the 1967 paper. It was Alexis Brooke from the Tavistock and that project in the 1960s and 1970s was entirely about encouraging psychotherapists and psychiatrists to go out into practice and exactly the experience that you've just reported, is in those papers. The reluctance but then feeling that they've learned. But the history of institutions changes, I was appointed to the Tavistock in 1995, by which time the Tavistock had become an extremely entrenched and interiorized sort of institution in comparison to the 1970s, in those days, with Alexis Brooke. And I think it was me that actually fostered the connection, I think it was Joey Riley, who came out to your practice. Because I was then in the adult department saying, look, for goodness' sake there's a whole tradition at the Tavistock, so why don't you start educating psychotherapists about what goes on in general practice, and that was 1995. And that was 30 years later.

Irwin Nazreth

Yes, and she wrote a paper for the Royal Society of Medicine.

Andrew Elder

Yes, she did indeed.

Venetia Young

I'm Venetia Young, a GP family therapist that is retired and is still active. I just wanted to talk about the relationship between teacher and student because I think what I experienced at UCH was like an apprenticeship model. So, I was apprenticed to Jack Norrel, who many of the students were terrified of. But I can vividly remember one consultation, when he said "this woman has mentioned twice she's had a miscarriage and she's talking about lower abdominal pain, listen to what the patient says". And indeed, her fears were about miscarriages. And then I was apprentice to Heinz Wolf in a student's psychotherapy group and took on a patient with hysterical aphonia and for a quiet person who never dared speak, this was a perfect patient for me. I learned so much at weekly supervision and

that model is still going on at UCH today and is spreading globally. Hans' father was a GP. And then the other person was John Paul in Ipswich, I wrote lots about attachment with him, and loads about psychosomatic medicine and then went back to Ipswich to do a psychiatry job and spent every Saturday morning listening to his consultations with his patients with Multiple Sclerosis. I thought this was normal. So, you can imagine my shock when I went back to Cumbria to be a GP. To find that I was the only person doing this. I felt really apprenticed to those people. John Paul gave me some of his videotape material because he videotaped his consultations and training. And he said I want you to carry the banner for me. And so that's what I did because it was like passing the baton. It was a really moving experience. I kept in touch with him for a long, long time until he died and I'm still in touch with his daughter. So that's the model, which feels to me has got lost a bit. I've had 2 trainee GPs apprentice to me and I've tried to carry on that model.

Andre Tylee

I'm glad I'm following Venetia, because my experiences are very similar. I see it as a “both and “not an "either or". I don't want to get into the "either or" about relational and diagnostic systems because my role models were the wonderful Harold Stewart at the Tavistock who ran the Balint group that I was in in the 1980s and Paul Freeling who had been in the original Balint group and within Balint’s as well, subsequently, who was a fantastic mentor but also interested, as well as in relational medicine, in diagnostic classifications and how to how to conduct fantastic consultations. And your combination of him and David Goldberg. David Goldberg was the first person I went to when I was thinking about doing research on what goes on in consultations where somebody's depression doesn't get recognized. And when I decided I wanted to videotape 50 GPs in my locality for 20 hours each to look at this and see why some people get diagnosed with depression and some people don't. What is the difference? And it was David Goldberg, who introduced me to his research assistant or research fellow, who was Linda (Gask), who got me going on that side of things as well. So, I saw it as a “both and” so I was attending a Balint group and learning about how to, in my situation, cope with my heartsink patients you know, I had loads of heartsink patients because I hadn't done any psychiatric training at all. I'd gone straight into general practice, I’d been recruited out of the GP vocational scheme and straight into practice with a wonderful GP, but I hadn’t done any

mental health training at all. So, I was desperately running around like a headless chicken, trying to learn from as many different directions as possible. And so, David was incredibly influential in that as well as Paul Freeling and Harold Stewart so it was a combination that really helped me and I'll talk in the second session, a little bit, about how back then that helped me to construct a really good mental health team in our practice, in the fundholding era when it became possible to do that sort of thing.

Lawrence Buckman

Lawrence Buckman, retired GP and current psychotherapist, both NHS and private. My NHS employer I should say is Clare Gerada because I work for practitioner health, looking after colleagues who are not able to work. Venetia started to talk about Heinz Wolf and I have to carry on. I was one of the other beneficiaries of Heinz's brilliant innovation to recruit students from the body of the student corpus to become student therapists and to just learn what it was like to be part of a supervision group and to take on patients. I was educated by who I thought was a magician at first, Irene Bloomfield. Who was an absolutely phenomenal psychotherapist who, rather like those group plays, you must know if you play bridge. You put down one card and somebody amongst the table says, well, you've got this, this and this and you're going to play that, that and that. And you'd open your mouth and say one sentence and Irene would tell you the rest of the hour's consultation, exactly what happened, who said what to whom and what the outcome was. And I used to think she must be videoing us to know accurately what was going on. And of course, she was just very experienced. And she introduced me to the fact that you can look after people who have not quite formed mental illness, who have a problem and to treat them as patients and people rather than objects with a diagnosis. And I carry that forward. I stayed in the group, both as a student and then a little bit beyond that for four years. I thought it was fascinating. I was one of the few in that group, in that cohort, not to become a psychiatrist. But I thought that the education was worth it. I learned an awful lot. And I carried it forward both in my hospital career and when I left and went into general practice. As it happens, the senior partner was one of Michael Collins, original doctors. He died a long time ago in a very psychotherapy-oriented practice. That practice was not quite anti-medication, but certainly not enthusiastic for it. And we had our own support group within the practice, it was a huge practice at the time. And I've carried that

with me. And that training was absolutely brilliant. As a grounding for making, you think there are other possibilities of ways to handle patients other than a signed prescription to get them out the door. And the idea that you could put at the end of your day with, certain limits, a patient who you would spend an unlimited time with, well up to an hour. And where you could give them the time that they needed over an extended and in theory, unlimited period. And that was a great training given to me by Heinz Wolf and his department. He was a pioneer. And I'm not sure how many other medical schools did that at the time. I was a student in this particular thing and the group started in 1975.

Alan Cohen

Before we move on, I was going to share my experience as everyone is sharing their experiences of Balint and stuff. What you need to know is that my father was a psychoanalyst. And as a child I had five or six years of psychoanalysis and I was brought up with this as a normal environment for me, so psychoanalysis and relationships troubles, this was all normal to me. So as a trainee, I was fortunate to be invited to join Enid Balint's group and this was the early 1980s. And we started meeting at the RCGP headquarters. And it was an interesting period of time, that's where I was, all the rest of the doctors, GPs in her group were experienced GPs, I was the only trainee. And one of them was Argentinian. And it was at the time of the Falklands War, and this guy had suddenly disappeared. So, we tried to understand what that might mean. And then about three or four sessions later we got slung out of the college because the College wanted the room. So, we started meeting at her own home. Again, quite interesting. And there was one session where there was, of the 50-minute session, there was 45 minutes of absolute silence. Nobody said a word. And then the final session started about 10 minutes late because she came in and said, " my haemoglobin is now four and I don't think that we're going to be able to continue this group". And all the GPs, all the members of the group had been so bothered about themselves, that we missed the fact that she was exsanguinating in front of our eyes. You can make your own judgments as to how this relates to what happened to the rest of my career and the effect it had on me. But certainly, it would be one of the methods, it's that relationships are desperately important, but they aren't the only solution. There are other things as well. Other ways that GPs need to be providing care, an exact combination is really important.

David Zigmond

Of course, but the question is, how do we apply our skilled dexterity to navigate between the objective and the intersubjective. The objective is science, it is traditional physical medicine. And the intersubjective is about personal understanding. Good doctoring, I believe, is about being able to move with great skill between one and the other, to make a weave. That's not easy at all. It's a weft that's always a delicate threading of the objective and the intersubjective. In other words, how do I understand *my* experiences and thoughts about *your* experiences and thoughts? And how do we do that? And then how do we stand back and objectively process all that? Rather than just say, 'Oh, I'll generically pack that'. And that is the tragedy: we've missed the nuance of such things because we *can* mass produce the objective. We can mass produce diagnoses, treatments, care packages and algorithmic pathways now. We've pushed out, and allowed to perish, all of the intersubjective art of practice.

Barry Lewis

I'm Barry Lewis, I only want to make some links, which have been going on in my head. And there are a couple really, I was fortunate to train with David Goldberg and Neil Kassell, crossing over with Linda and other people who have talked about them in Manchester. I then went into practice in industrial Rochdale there with a large migrant population and a fairly backward district general psychiatry department. Which sets its own challenges and I suppose it's a view from the hills of what you can do, and what you can try to do, where the resources of the Tavistock and other well established, famous and well-resourced units are there for you to link into it. And very much what Andrew did was the start of vocational training. So, I was a course organiser and introduced training in relationship training into a course which you had absolute influence over. Nobody was leaning on you to produce a course that passed the Membership of the Royal College of General Practitioner no matter what. But it was a course that actually allowed you to develop caring practitioners. At the same time, at the practice it was quite difficult to convince people that a liaison psychiatrist was what we really wanted. And the only way into that was to have a registrar, who might have an interest, who might come along and understand what we were doing as GPs, but also added to what we could do as GPs. And the final step in that was to convince patients that they would benefit from two relationships going on in their care, which was actually

quite a challenge for the patient group that we had. And that, in itself, changed the way that patients looked at us. And those relationships were built and developed on the fact that someone else may be sitting in the room or in the room next door. But we'd also be caring for them in the way that a GP is a listener so the GP would continue that and to just reflect what you've been saying. All of that is lost. The great regret is that the transactional processes are taken over from the interactional teamwork-based processes, despite all the best efforts, and I think it's just life and time moving on. But it's enormously frustrating to see that that bedrock of work that produced a very well-functioning team within a GP practice that delivered mental health care in the broadest sense, working with a range of professionals, does seem, despite best efforts, to have gone. And we shouldn't have a miserable view of where we are. But unfortunately, that is the case, that relationship-based care, does seem to have been undermined, and you see little sparks and little individuals who still commit themselves to being the named Doctor, available for their patients and providing a breadth of care that I don't see happening within family, my friends or any of the other people who tell me about the interactions with primary care or psychiatry now.

Huw Lloyd

Huw Lloyd, I'm from Wales, anybody else from Wales? I just want to take you back to when I was a little boy and my father was a psychiatrist and I was brought up in the mental hospital. And my father had a very good relationship with many GPs, GPs all knew him and he knew them. So, well. You know, one particular chap called Thomas, when I had my chance to do a four-week stint in general practice, my father asked Thomas, who was a GP locally, to take me in, it was an eye opener. I learned from him because his father had been a GP and it was all about knowing patients and having a good relationship. And he understood the fact that actually knowing people, and understanding them is vitally important. I have no specific training from my father but I did learn that I didn't want to do psychiatry as such, but I did learn that actually an awful lot goes on up here that affects what's going on down there. Then I just think that we lost some of these individual relationships. Certainly, during my career a long time ago, we did not know all the consultants in the hospital. We used to meet regularly when I was first allowed as a GP and then gradually only knew the name of the person. I think that's a very great loss. But some people still managed to make

relationships with their consultant colleagues, whether they be psychiatrists, general surgeons, whatever, and some people still maintain individual lists. In fact, I never actually met my own GP, but I do know him socially. He has an individual list, and he spends a great deal of time and trouble, or so I hear, when he is with his patients to get to know them and understand them. I'm very pleased that my daughter has taken on the role of being a general practitioner, but it's not general practice's design route. It's just, it's so different, and she doesn't like the standard. One thing she doesn't like and it's partly her own fault, is that she goes through different practices as a locum, out of choice, because she's trying to bring up a family and she gets to know some patients, but most of all, she doesn't because she's not there long enough. And I think that's a very great pity. Somebody mentioned, I'm going to finish shortly, but I want to end on a little story about heart sink patients. We've all had them, but some of them are not as much heartsink as others. I had a chap whose name happened to be Mr Lloyd and he won't mind me telling you this story because he's dead and he was very free about sharing his stories. And when he used to come in to see the GP. He did so as you might say, justifiably because he had genuine problems. And he was such an upbeat guy who always made me laugh. And he said one day, you must be so fed up of seeing me all this time, it must get you really down. So I say you know we do have patients we call heart sink patients. But you're not one of them, heart sink patients drag you down. You see, I think you're a heart lift patient. And he said oh, thank you doctor. Anyways, next time he came, there was a knock on the door which was unusual. And he says Hello Dr. Lloyd, it's your heart throb patient.

Tony Kendrick

Thank you. I've been listening with great interest to all of this. And I understand that we're going to talk later about fundholding and IAPT (Adult Improving Access to Psychological Therapies) and those things are relevant to what I wanted to say. Many of you won't know me, I'm a GP, in Southampton. I was a student under Paul Freeling. And he made me want to go into general practice in the student tutorials as a medical student. I was with Andre and Alan at St. George's when Paul was my mentor as well and with Tom Burns. Prior to that, when I first started in general practice in the mid-1980s. I was interested in mental health. I went to a conference on cognitive therapy and well cognitive theory on therapy at Oxford

when Aaron Beck came over to speak and Tim Beck who died recently and I was really struck by the possibility of applying some cognitive therapy techniques. So, what I used to do, I was in a busy practice, I was one in four on call full time GP so I was working about 60/70 hours a week. But we could do it then because it was a very male centred organisation. I had a wife at home who was looking after my children. And if I didn't get home till 7.30, I was a hero, that has changed. GPs now both male and female, do not or cannot work those sorts of hours. So, after surgery I used to see patients, selected patients, to try and help them in longer sessions. Half an hour/45 minutes using cognitive techniques. And I ran into three problems and I stopped doing it after about a year. The first was that it was difficult to know when to end because you were the patient's GP, you were responsible for their care generally, you didn't have a discharge date. And it was quite difficult to know when you had done as much as you could and therefore, they should kind of move back into a normal GP patient relationship. So that was one reason why it was difficult. Secondly, I had no supervision; I wasn't in London within walking distance of the Tavistock. Like Irwin, I couldn't easily get supervision locally. In fact, people trained in cognitive therapy who would supervise a jobbing GP to do it were very few and far apart. Obviously since then we've developed IAPT on the back of cognitive therapy and we're going to talk about that later. So, the lack of supervision was important, because clearly, I was inexperienced and I quickly came up against my lack of ability. The third thing really was that life was very busy, and patients had all sorts of problems. The more I learned about general practice, the more I realised I could be doing for them. And that's what's happened to general practice in a generation or two that we've realised there's an awful lot more that we should and can be doing for people and a lot more people get a lot more treatment now. Continuity has suffered as a result of people wanting less than full time work.

And the great demand that my generation, the baby boomer generation, has put on general practice. I've been most recently working in Stoneham Lane in Southampton in a poor part of Southampton, where we had 95% satisfaction with access and with continuity. And the reason there was it's an unusual practice: they decided to have a much higher doctor to patient ratio, which meant that the average list size is under 1800 for the full-time equivalent doctors and this allows more continuity and allows greater access.

	We don't have people waiting weeks for appointments. That's not possible everywhere. Because GPs don't want to work everywhere. And most importantly, they decided to do this by taking a much lower salary, much lower profits out of the practice. And that was the only way they could do that. And again, most people don't want to do that. So, when I started doing research at St. George's with Paul and with Tom, it struck me that the epidemiology was really important that although there were some beautiful, wonderful relationships between doctors and patients that I'd read about and was interested in, there were an awful lot of missed mental problems. And that we weren't really serving the full number of our patients. And the challenge really was, how do you square this circle? How do you provide a much better service for more people without lessening the individual excellence that you're providing to the patient in front of you? And I'm hoping today might have some historical lessons that will enable us to move forward because many of us are still working in this area. We're still producing guidelines. And I would like to learn from history.
Alan Cohen	Thank you, Tony. That was really helpful. And you're right about learning from history. I think that's the reason that we're here is to allow us to learn and for others to listen to what we've been saying and be able to draw some conclusions drawn from lessons. Having said that, have we run out of speakers for this session?
Maryanne Freer	Can I just say, I completely appreciate that. I'm also practising in that genre at that period we're talking about but can I also say that everybody's come up with a lot of things that have been lost? I'd say things changed. And I'd also say as somebody who's currently practising and has worked so closely with general practice and other psychiatrists that I see a lot of relationship medicine still going on. It's there. And I just felt I needed to say that because it felt like everybody was saying it's gone. It's changed. But I have to say I see it. I think that is core to being a doctor. I work at Newcastle Medical School; we do a lot of work with undergraduates. It's key to what we do. And still try to do.
David Zigmond	Can I counter that?
Alan Cohen	Yes, but can you please state who you are?

David Zigmond	Yes sorry, I'm still David Zigmond. I'm very pleased you're dealing with an oasis. I hope it spreads. I hope it can thrive. Yet what I have witnessed time and time again – and I have hundreds of dissatisfied people contacting me with similar experiences – is quite different. I'm not discounting the fact that some people find good fortune, or have stoical, tenacious perseverance – and then somehow manage to have relationships. But generally our pastoral healthcare has become more and more humanly eroded, and it is now almost impossible to grow adequate relationships. And we must take that seriously. And we must not be apologists about the fact that it is like that.
Maryanne Freer	I'm not saying that but I am saying that it is still possible. I think it's a core part of being a doctor.
David Zigmond	Of course, it is, but how possible is it?
Alan Cohen	Okay now Rachel, Irwin and I will go after that as well.
Rachel Jenkins	It's just to give an example, at the Welsh marches where I've retreated, and when I went there 10 years ago, my new GP, in a rural practice, spent an astonishing half hour with me at least getting to know me, which was stunning. He's always very keen that I see him. If I'm booked in for somebody else, he'll emerge from down the corridor and grab me as I'm his patient, not one of the other partners. However, eight miles down the road in Hereford all the practices have been told to go into a huge building in front of the railway station and nobody sees the same doctor; every time you just book in the receptionist, nobody sees the same GP but it must be completely impossible to have any kind of relationship with them, and I've no idea whose idea that was, why it's happened. But just to say the rural areas are very different from the urban ones.
Irwin Nazreth	Just a quick comment that's relating to the discussion you're having after this. There are serious structural problems, continuity doesn't occur because of part time working. It doesn't occur because of probably salaries being much less if you're a partner than being a locum. And time factors are enormous. So, I think ideally, many doctors may aspire to what you're suggesting, but I don't think it's happening. I sort of agree with David. It's not happening in the majority and I don't think it matters that if you were in an urban

area, I mean, I've been in my practice for 45 years. And I knew the GPs who gradually retired over the years but two of the GPs with whom I still have contact, who know me very well. I never ever get to contact them. I never see them. There's a cycle of GPs. It has changed in the last few years, particularly in the last year, well since COVID. There has been almost no physical contact, not even online consultation. So, it is the telephone. And I think we're really in trouble. If we carry on and I think increasingly GPs want to stick to telephone consultations. At the moment. It's as much as 70% of consultations and it really comes too much in terms of mental health consultation.

Andrew Elder I just wanted to speak about going back to Balint and maybe just addressing the point that it all belongs in the past. That's one thing, but also just to say the Balints were not remotely interested in something that's called mental health knowledge. And were absolutely interested in the professional relationship functioning of GPs, who they absolutely knew, who examined patients, treated them. There was no split between the relationship and the work. Absolutely not. So just to correct that if it was a cool, scrupulous examination of professional work in terms of the relationship between the patient and them. Education and every single day, you'd never get through a group within it without describing the details of an examination if you've examined the patient. And then just to say about the past, I mean, certainly I know of three practices, which are sort of, not all in London, who have sort of Balint related type professional meetings in their practices. Sort of good enough or whatever you want to call it, but a meeting of a team which looks at feelings and relationships, there are plenty around actually institutionalised. Practice has been going for 20/30 years up to the pandemic, actually, because I think the point that you make about telephone contact now is really important. And there's quite a lot of Balint groups that are around now. I know what I wanted to mention, particularly here although Clare has gone, don't forget Balint groups in our compulsory part of training for psychiatrists, introduced by Clare's husband. For the last five or six years still, modern general practice is not part of our curriculum, but it is part of the psychiatrist's curriculum. I think that point needs to be very clearly made here.

Tom Burns I just wanted to say that I wasn't aware they were actually.

Andrew Elder They have been for five or six years.

Nav Chana I am Nav Chana, I'm a GP. I started my GP training in 1989 to current day and I'm still sort of batting in my practice in southwest London. Firstly, Alan, thank you so much, to you and Andre for inviting me to this and I'm sitting amongst colleagues who've been icons in my career, so I won't name you all, but you've all had a significant influence in my training. I guess I just wanted to pick up this point about loss of relational care versus, you know, sort of fragmentation and pressures that colleagues are feeling both across all sectors. It's not just within primary care, it's across the whole piece. And I suppose what will be will be a shame is that we get into a debate about, you know, the, the sort of the benefits or drawbacks to it, what why it was so wonderful all those years ago and why it's all so horrible now, I mean, I think that would be a shame. Context has changed. I guess I would have to say the context has changed considerably. Expectations of people have changed considerably. Policy landscapes, absolutely focusing on access, do not reward any attempt on continuity and the whole influence of the pandemic and the way that that changed almost overnight. The way that kind of system started to work, I think we can't ignore the profound impacts of all of those things because actually, some of the debates that we might have, might be slightly superfluous because that is now kind of the way of the world and I suppose I want to just kind of close by saying that my practice is facing biggest demand pressures I've encountered across the 30 plus years. It is just not feasible, given the workforce that we have, and the resources that we have to do many of the wonderful things that you've all talked about in the context of our daily life. And, you know, we have our reception staff that are regularly being abused, they're being beaten up. One of my receptionists got punched in the face last week. So, I guess what I'm trying to say is that within the context of all of this it is quite hard to kind of imagine a perfect system. So, my closing point and it's just to be clear, we're just doing this increasing focus for me now on looking at populations of people and how they present and what their needs are. So quite a lot of the work that we get in our primary care service is, you know, self-limiting illness. It's episodic and it may not need, you know, as much relationship care as we would espouse, but people who have complex comorbidities and significant other needs do and it's getting the priorities right, the

balance right and the interventions, right, to make sure we target those populations in the most effective way.

Alan Cohen Is there anybody else who would like to contribute before lunch? Okay David?

David Zigmond Yes, I just want to challenge some of these notions. The problem for me isn't just that things have changed. It's *how* we adjust to that change. And our adjustments to that change are unsustainable; clearly, they are perilous. We've got this terrible crisis of recruitment and employment of staff. And of course, as you say, the public are massively dissatisfied. So, then I come back to my point – that we must acknowledge that loss and the importance of this; both for the morale of the profession and also, inevitably, for the care of patients.

Nav Chana I think we are agreeing. I think our nuances are slightly different though.

John Hague Hello, can I just go back to what Tony was saying a short while ago about their practice, having more doctors per patient than is now the norm and that enables them to practise in a different way. That's interesting. Let's just leave it at that.

Tony Kendrick I would just like to say it's easier to aspire to than to try to achieve in many places.

Alan Cohen I'm going to reflect something about the discussion around loss of relationships, and how today seems very much like a reunion. A lot of people haven't seen each other for a very long time, and it's great to renew those relationships. Even if we don't make any changes at all and we don't think we made it meaningful. It is great to see so many faces from the past and although most of us are retired, the opportunity to see you all here is really brilliant and thank you all for coming.

2. Delivering primary care mental health by money

Andre Tylee Thank you everyone for coming back. So, this second session is the next period of time, which we want to try and focus on which is

from 1989 until 2005. The underwriting picture being that it was part of the fund holding period in general practice, where the practices were or weren't fundholding that's the sort of framework that we're putting on this. For the benefits of people who are joining us, maybe on Zoom who haven't been with us, this morning, I'm going to repeat some of the guidelines for how we're conducting this and then I'll give a very small introduction about fundholding. So, the format for this session is exactly the same. We'll have three speakers this time, each have got 10 minutes to talk, and we're still going to use the yellow and the red card when the time is up, though we didn't really need it very much (so far). Just those three speakers are each going to share their experiences of that area, their reminiscences of that period, and then we'll all be able to contribute and stimulate our own memories and experiences. The whole thing as you know, those in the room, but maybe people who are joining us might not realise, is being recorded, transcribed and will be stored in the libraries of the College of GPs, the College of Psychiatrists and here at the RSM. So, it's important that we really avoid anything that's too contentious and we must be respectful of each other's opinions and each other as much as possible. When you do speak, please give your name before you speak so that the transcription tech will be able to record your speaking. It'd be very difficult to try and work it out afterwards. I think that's it; those are the things aren't they.

So, this period is about fund holding. In my practice, we were too small to go into fund holding when it first started in 1989 because we only had about 5000 patients at that time and

we were really disappointed t because the one thing that we really wanted to do as a fundholder was to set up a really good mental health team. That's what we did later with fundholding, we constructed what we wanted. And we'd been frustrated over the years that we hadn't been able to have counselling psychologists, relationship psychologists, clinical psychologists, therapists coming into the practice. And also in our particular situation, we were on the boundary of two boroughs. So, we had two lots of social services, two lots of mental health teams. The advantage of having two lots of mental health teams was that we could see that one of them was incredibly relational and was in and out of the practice, we knew them really well. They popped in and out of the practice, they let us use their premises for our practice meetings because we didn't have a big enough meeting room. So, when we did eventually

become fund holding, we managed to just have one mental health team. So, the team, let's say that was less relational, less available, we actually shifted all the patients into the other team to help manage that. And so, we then had to consider a consultant who was in and out of the practice all the time, on the phone all the time. And we had a lovely CPN (Community Psychiatric Nurse) who was similarly in and out all the time, but we were able to employ a relationship counsellor, a counselling psychologist who's sitting over there, my wife, Sue, and Noelle, a clinical psychologist. And we really constructed a very good team and did practice training together as well. So, we did shared training, bringing in the health visitors, bringing in nurses, bringing in everybody to learn to work together. That lasted for quite a long time. Until I can't remember if it was an FCP (Family Practitioner Committee) or a precursor; it must have been an FHSA (Family Health Services Authority) back then, decided that that was inequitable, that we had too much of a Rolls Royce service. And everybody got pulled out of our practice and spread across the whole borough, which diluted the service incredibly for our patients. So having had a good service for our patients, which we loved. That was the only thing we did with fundholding. We didn't fund a swimming pool or physio or anything else. It was used for good mental health because that's what was really important to us. And we lost it, this wonderful team that we had. And we didn't have the same access that we had before. So that's my personal perspective. Tom was very much around our area and Tom was the medical director at St. George's. So, we have a very close relationship with Tom, who's going to speak second. But first, Rachel, I'd like to introduce Rachel Jenkins. Who needs no introduction. Rachel, who I'm very grateful to, was instrumental in getting me over from St. George's to the Institute of Psychiatry with Anthony Mann and David Goldberg, which was absolutely the best thing I ever did. And so, I'm very grateful to Rachel who at the time was professor of epidemiology and social psychiatry and is the director of the WHO (World Health Organisation), Centre for Mental Health, doing incredible mental health work all around the world, chiefly often in low- and middle-income countries. But also at that time, was the principal medical officer for mental health at the Department of health.

Rachel Jenkins Partially yes, it was in series not in parallel.

Andre Tylee It's a pleasure to hear Rachel's perspective, as a psychiatrist, as a top civil servant. Looking after mental health and her work around the world as well, working with general practices.

Rachel Jenkins And thank you very much Andre for the introduction. Yes, I was going to talk about four phases and really the time at the Michael Shepherd's General Practice Research Unit, which has been mentioned, a brief period at Barts (St Bartholomew's Medical Centre) running the liaison service, a decade at the department of health and then subsequently the WHO Collaborating Centre, because they've all kind of built on each other.
But they've all built up in prevention, which I think is probably the same with a lot of us. So, in the General Practice Research Unit, Michael Sheppard, obviously in the 60s conducted that study showing the extent of psychiatric morbidity in general practice, not just standalone but also how associated it was with physical illness and social problems as well, which totally underpins everybody's efforts to be multiaxial and this is something that we kept moving and I just wanted to flag that up. There were other people in the general practice research unit studying attachments of social workers and attachments of psychologists and I was very fortunate to be helping Anthony Mann who I want to pay tribute to. He may be on the Zoom, but he was a wonderful researcher to kind of learn from, during my research training. And we did the study of the 12-month outcome of people with common mental disorders in general practice, and we found after years, half of them were better than half weren't. But then we went back about 12 years later and examined the case notes and to our horror a lot of the people who thought were better, weren't anymore. And some of those people had been consulting once a month over that 12-year period. So, the burden for the health service is just huge and these repeat consultations with people who haven't been properly assessed and managed. And one that comes to mind was this young woman in a wheelchair in a local authority flat in Stratford on Avon, who had used her GP as her social life really. She was going in every month, because of low level depression and her totally impoverished social environment which had not been fixed. So, I was very aware of this huge burden of repeat consultations, which is the consequence of not getting good multiaxial assessments and management. The other interesting study that, like I said, that got me involved at the time was Marshall Marinker's idea that we would use, what Michael

Shepherd would call" blue chip GPs" and do an observational study of the way they made diagnoses. And what became very clear was that these blue-chip GPs were in fact being multiaxial, that's what they were actually doing in practice, but the current diagnostic recording systems didn't allow them to reflect what they were seeing in the proper way. So, I'm all for classification and diagnosis. But I want it to be multiaxial and not uniaxial in its approach. So anyway, I've mentioned my earlier attachment to a practice in Peckham when I was a Senior Registrar, which was subsequently influential in my thinking. I felt that I hadn't been able to strengthen the GP skills while I was there as the GPs had just referred rather than shared and discussed the consultations. And the other thing is when I got into the Department of Health and I talked to Donald Acheson, the then CMO, he said that you can't give a psychiatrist to every general practice, this hadn't actually dawned on me before, the logistical issues of how you get equitable support to every general practice. While I was Liaison psychiatrist at Barts, I made a good relationship with Sian Griffiths who was a public health doctor there, and we were then collectively thinking of how to best support primary care in Hackney and in the City. And so, I continued to work quite a bit with her afterwards, when she was Regional Director of Public Health at Southwest Thames, and when I was in the Department of Health trying to forge those relationships between primary care and public health. So then, yes, I was headhunted from Barts into the Department of Health at the end of 1987. My first Secretary of State was Ken Clark. And we also had Edwina Curry. But the other thing is that the Chief Medical Officer and the Permanent Secretary had a kind of conspiracy to try and stop Edwina from taking the BMJ home every weekend, because she would come back on Monday morning with something else she needed to prevent. But the good thing was that for the first time, she got us all thinking about prevention. I was commissioned to produce this paper on prevention in psychiatry, and nobody in DH had done that before. And I remember my senior administrative officer Assistant Secretary saying we prevented syphilis, what more do they want?!
Anyway, what I realised when I arrived at the Department of Health, was that the Department of Health had commissioned all of this research on primary care, but it had no policy on primary care; all of the policy focus was at the hard end of forensic psychiatry. It was all focused on regional secure units. Nobody was thinking about primary care. Michael Shepherd's General Practice Research Unit,

which was funded by DH, had been producing all these wonderful research papers but there had been no subsequent policy follow up on the research findings. So, I then approached Geoffrey Rivett for advice, who I thought was going to be here, but I owe him a great deal because he was very wise, I asked him how to push the mental health and primary care agenda. And he said, do a series of conferences Rachel and some pilot projects. So that's what we did. We had some national conferences on counselling and primary care, depression, and primary care, and on prevention in primary care. So, you know, 100 or so people, GPs came to each one and there was a lot of discussion. Often a lot of initial anger directed at me, and I felt I was carrying the can for things that Ken Clark and others were doing which has nothing to do with me. But those conferences started a lot of helpful dialogue. And then I went and talked to the then President of the RCGP to get his views on next steps. He said that it's always really helpful to set up some GP fellows to take the lead as well as to conduct some pilot projects. So I will describe the pilot projects first, which I set up with Anthony Mann. I don't know if you remember GP facilitators who started off helping the practice buildings, and then they helped with cardiovascular disease and general practice. So, then the facilitators were chosen from expert nurses and, health visitors. And we found a brilliant one, Liz Armstrong, who was a generic nurse. We set her up as a GP facilitator in Kensington and Chelsea with six intervention practices and six control practices. She helped the intervention practices, from the outside, to systematise better what they were doing on mental health. So better assessments, working out what were all the relevant charities around them that they could refer to and so on. And, also getting to know their psychiatrists so they could do better referrals and so on. So, she evaluated this and it worked basically, it improved assessment and management compared with the control practices. That study was published. The other one we did was to give a practice in Bath an extra practice nurse, and we compared that practice with another control practice in Bath which was not given the extra nurse. And what happened in that first year was that practice nursing nearly died because all the GPs just threw everything at her, and you can't throw out a third of your consultations at one nurse. And although that practice did get to a better place, it was not the preferred model to put somebody inside the practice as this results in GPs offloading the clients on the additional person rather than the GPs strengthening their own skills.

The conclusion from these pilot studies was that it was better to give external facilitation to improve working practices rather than to add an internal person to take all referrals, as one third of GP consulters have a diagnosable mental health condition.
I then come on to the Fellowships we've had. Andre Tylee was our GP fellow, the national lead in educating GPs about mental health, trying to work through the regional structure as I recall, and so it was a bit of a top-down cascade method. But nonetheless, it was getting a lot of good stuff out there. Liz Armstrong became the RCGP fellow in educating Practice Nurses. And we set up a former occupational doctor from Marks and Spencer's as the Faculty of Occupational Health National Fellow on educating occupational doctors about mental health, and I'm pretty sure but I can't remember her name (Ruth Chambers), was established as the RCGP Fellow working with the RCGP on stress and GPs, which of course research has identified is a big thing. Then just before I left the Department of Health, the WHO asked me in 1996 to host some meetings developing the first WHO primary care guidelines on mental health so then, after I left DH to direct the WHO Collaborating Centre, I was asked by WHO to bring these international guidelines to the UK, so we adapted them for the UK, and developed the two editions in 2000 and 2004 and also for prisons in 2002 . And the final thing I did a few years ago with the RCGP was we did a document after a week's workshop on mental health promotion for GPs, the possibilities for promoting mental health in every consultation.

Andre Tylee

Thank you, Rachel, we'll just move straight on and then we'll get the comments from everyone else. It's an absolute delight to have Tom next talking, Tom Burns is an Emeritus Professor of Social Psychiatry at Kellogg's College, Oxford, having been there for many years since he was originally at St. George's as has been mentioned. But I am very grateful to him because he was an excellent Supervisor of my thesis back in the 80s, early 90s with Paul Freeling. And they were a great team to have as research trainers. Tom, at that time, was a community psychiatrist professor. And has always had a huge interest in good management of psychosis in the community. And has done some very big trials, recently, over the last few years before retiring, on intensive care in the community and compulsory care in the community.

Tom Burns

Thanks very much. Tom Burns, moving on from Rachel, at the time in question. I was the Clinical Director of the general adult services in what was ludicrously called Pathfinder, which was the St. George's Mental Health Trust, which covered Wandsworth and Mitcham and when I heard that fundholding was coming in, I have to tell you, my heart sank in my boots, and I dreaded it. I'm going to give you a parochial and slightly negative view. Why did my heart sink? Well, a very practical, selfish reason was the thought of all those contract negotiations. Filled me with horror. Absolutely. And I had 3 a year, one with Wandsworth, one with Mitcham and one with whoever the general practice health authority was. The thought of having to do 15 of those was just horrendous. The other important point was that the way we run our services emphasised two core principles, which I thought were challenged by fundholding. The first was a strong integrated CMHT (Community Mental Health Team), which was responsible for the whole pathway of general adult mental health patients, outpatients, inpatients discharge, and across the diagnosis of a strong integrated team with everybody knowing each other quite small. And the other principle was of equity. We felt it was very important in our service that each team was equally configured. Equally configured and equally resourced, with the same population program. Now the reason for that, obviously, if you want a moral one, I think the strength of the NHS is equity. We're all in this together, and we share the risk. The other was slightly more pragmatic. As a clinical director, I learned that you can't tell your consultant colleagues what to do. It just does not work. But if you have each team equally configured, equally burdened, you can turn to Joe Bloggs and say you know, Joe, you're overflowing your bed numbers and keeping people in very long, much more than the guy next door to you. And he would give you all sorts of explanations and say well if you're really struggling with it, perhaps I can get him to come in and explain to you. So that equity was very important, not just morally but practically. I was concerned, we were concerned that that was going to be broken down. And we went to the high-profile initiatives which didn't inspire me. One was a practice who spoke about bringing a consultant psychiatrist in once a week and all that sort of stuff. And what I knew that meant was that a really enthusiastic general practice and in the nature of things, probably in a decent area, with less ill patients, was getting more resources. I did not like the idea and it also corroded this concept of integration of the CMHT, it's not just about how many people in the team, they all

have to be working together. I was unhappy with that and also, you mentioned David Goldberg everyone has to in this meeting. And Goldberg had published those two papers on CPNs who had been placed down for general practice, remember that? And showed that very quickly, they lost focus and drifted away from people who were mentally ill. So, there were lots of reasons why I didn't want it. Our chief executive Duncan Selby, much more pragmatic, said Well I better find out what the GPs think of them. And so, he did a survey, and he did a survey of the GPs in Wandsworth and Mitcham and the results weren't exactly reassuring. The Wandsworth GPs said that they would probably stay with Pathfinder, the Mitcham GPs said we're off, the moment we get a choice, we're out of here. So, we thought well what can we do? And we talked to them a bit. There were probably two things, in response to what they said. Interestingly, two things that were already happening in our service, but weren't widespread. The first is, we rearranged our catchment areas on to general practices, so that each general practice only related to one CMHT. It caused some problems in border practices, particularly for us people that needed sectioning and things, it's a nightmare. But there's a smaller number of patients, and that seemed to be helpful. And the other thing we did, again, something we've been doing for years in two or three of the teams, is we mandated for our teams, is that the consultant would meet the general practice once a month, or once every six weeks, face to face, not just for a crisis, but on a regular basis. And that was initiated, and we did the survey a year later and we were relieved that those ones in Wandsworth were definitely going to stay with us. And believe it or not, Mitcham was going to stay with us. So, in a way, although I didn't like it, it forced us to introduce a change that was sort of bubbling along but had not been mandated across the whole service. And I don't know if anything ever changed. I had one last comment to make. But what was thought of when Alan first approached me was what was my memory of this and this is an old man talking but I thought Potemkin villages these changes look great from 100 miles away, but actually don't change an awful lot. And I think my experience was that many of the changes didn't make a big difference. But after the discussion we had this morning about the things that have gone wrong in psychiatry and in general practice today. It's worse in general practice because of the level of micromanagement is really very excessive. But I think the reality is, there are a lot of mental health services where people do, do it

relationally because frankly, if you don't believe in relationships, then being in psychiatry is a mad choice. It really is. And in my experiences, there are lots of young doctors, I mean the nurses without a doubt all of them in my experience. But lots of young doctors, particularly as we're now increasingly female, who find the rewarding job is in talking to people. But as I experienced working at the Royal College of Psychiatrists briefly, empty vessels make the loudest noise, and it's the hard-working people doing this who often don't get heard. Now on balance I think there's a bit more of it going on than we think. So that was my memory of it. And the other memory of course, was Alan telling me what to do, but that hasn't changed.

Andre Tylee

That's wonderful. Thank you. Yeah, I ended up in a total purchasing pilot of about 30 practices so I know what you're talking about. So now it's wonderful to have you here as well. Now Dr. Nav Chana who, as we said earlier, is still working as a GP in a very busy practice in Mitcham who has also, he's very modest, he won't tell you that he was the head of the National Association of Primary Care for four years as well and has been instrumental in quite a lot of recent government policy. Not least primary care networks if I'm not wrong, so we really want your reminiscences about the period that Tom and Rachel have just been talking about.

Nav Chana

Thank you, Andre. Thank you very much. And thank you again to everyone for listening to what I've got to say on this topic. So just from a personal point of view, I started up my practice as a partner in 1991. And as Andre said in his introduction, we came into fundholding a little bit later than a lot of practices, partly because of size, but partly also because of the philosophical objections and that kind of notion of you know, equity versus inequity and postcode lottery and all that kind of stuff. But having been a GP for three years, by the time I think we went into fundholding, and one of the challenges that I faced then and as I do now is that Merton is not a homogenous place. It describes a London borough like many of many of you will be familiar with such as parts of the country where, actually the geographies are not homogeneous and population is not homogeneous and I guess the reason that's important to me, as it was then as it is now, is that East Merton where my practice is, is literally one and a half miles away from Wimbledon Village, but you can imagine the kind of social, political, environmental, and poverty

divide along that journey. The average life expectancy of a man born in Mitcham in 1991, when I was a GP, compared with somebody born in West Merton with 7.7 years life expectancy difference. Sadly, it's gotten worse, not better, in the 30 years I've been a GP and it's not my fault before anyone comments. I just say that because notwithstanding all about, you know, advancements in healthcare and technology and everything. Things for me, got worse, not better in terms of health inequity. And I think that's quite a sad reflection as I ponder on my life in that area. So, the reason I'm stressing that is of course that you know, parts of my practice boundary, communities who live in neighbourhoods' of 10/15 streets, have a significant level of health need, largely driven by social environmental housing, lack of jobs, and a number of factors that you're all very familiar with to have a significant influence on health and wellbeing. And on this point about equity versus inequity. When you look at risk allocation of resources, and of course, you kind of start to think well everyone must get the same but actually my argument would be that people who live in households in four or five streets might need something completely different than those who live in you know, a block of flats over there or in a detached house over there. And they're all these things they juxtapose. And I kind of think that the commissioning of healthcare has always failed because it never goes granular enough, because we always default to the easiest points of decision making. So, I'm sorry, sorry to contradict anything that was just said, it's just a personal view. So, my experience of GP fund holding, there was a very young, vigorous, enthusiastic GP colleague I met in a practice not too far away from us, called Alan Cohen, who is now an absolute champion for mental health care provision, and suggested to me and my colleagues that perhaps we could do something together as two practices, although not geographically co-located, but near enough to be able to interact with each other. And we shared the weekend on-call rota at the time. And the design was just as you said Andre was to kind of design and deliver a mental health team that could fit within our kind of vision of what good access to mental healthcare would look like. But very specifically targeting the populations that I've been talking about and the need that we were unravelling as we did our day-to-day jobs. And these are things which are not always easy to describe, but we're talking about substance misuse. We're talking about alcohol problems. We're talking about domestic violence, we're talking about long term mental illness, we're talking about, of

course, mild to moderate mental health issues, but there's a whole raft of other things that are going on here. So, the team had to be interviewed to be able to kind of deal with some of these issues. And with our pooled £50,000 for the two practices that we had allocated for mental health care, Alan, I think went along to the aforementioned chief executive and had this conversation which was, what can we get to 50 grand given the nature of challenges that we were facing, what would be feasible and realistic. And because of Alan's kind of sharp sense on all this, we managed to get six full time equivalent community psychiatrists, a social worker, a CPN, a mental health OT (Occupational Therapist), and we had access to psychology services, as well. And the key thing here for me was that that team was co-located within their practices. So, it wasn't about someone popping in once a month. And having a chat. You know, these colleagues were there visible, you can touch them, you can actually, you know, feel them if you wanted to. You could knock on the door after a consultation and have a chat about something. And I'm just going to focus a little bit on the clinical experience for me, as a very young GP at the time, not well trained in mental health issues, had very little awareness of some of these things. But to be able to go on a home visit with a consultant psychiatrist and go visit a problem family together and discuss it on the way back. Kind of think about what that meant, in the context in which people live their lives, for me was an absolute revelation, absolute revelation. And then the ability to do that with a CPN or a social worker or any combination of the above was absolutely outstanding. We noticed, didn't we Alan, some significant outcomes. Because I think your referring has an actual impact on secondary care. Some of our patients and our families were using any services 50, 100, 150 times a year. The default option is phoning an ambulance or coming to see the GP on a daily basis. We were able to moderate some of that. Because actually the right interventions were going into place, people understood the context in which they lived, social environmental factors were being considered and so on and so on. And, you know, I have never had a happier time as a clinician, as I did in those three years before it was abolished. Because after that, I've always been on the backfoot and always struggled to get the right service, the right response. Not the “no we don't do alcohol; you have to refer” to that. The usual “no too old”, or “no too young”. It's all just absolute, forgive me, nonsense. And I'm closing my reflection before the yellow card comes up. Whilst we

talk about equity, I just want to make sure that people understand that what matters to people is where they live, how they live, and the relationships that they have. And I think that if we could start to think about mental health service provisions which can accommodate that, rather than just getting big all the time, it might help us a little bit with some of the challenges that we face.

Andre Tylee Thank you Nav, that is very interesting. Now all three speakers have been, Irwin?

Irwin Nazareth I guess it is very interesting. Because some of this history is very much close to my heart. I just wanted to raise an issue that there are big structural changes that have occurred. And you mentioned fundholding, fundholding came to an end when the government changed, you remember the Tony Blair government came in in 1997. And then a year later, we had something known as a PCG (Primary Care Group). That lasted for a few years before we became a PCT (Primary Care Trust) that changed over to the CCG (Clinical Commissioning Group) and now on the first of July, we're going to have the ICP (Integrated Care Provider), what I see as an integrated care pathway. And there are only going to be 42 of those in the country. So that's been an issue. The other issue is psychiatry has also changed. As much as you have the teams that Tom described earlier. It's now become diagnosis dependent to refer a person with psychosis to the team. There will still be assertive outreach, early intervention teams. But the management of the person that has multiple diagnoses, which is often the case in psychiatry because they have to move from one group to another and they work quite separately. I still think we have a problem in terms of systems and unless these systems are changed, and maybe history will teach us that, we sort of go back to where we started about 50 years later. But maybe that's the value of today's meeting because it's quite interesting, you know, recollecting the past and I agree fundholding, which we never became a fundholder well, because by the time we started our practice it was gone. And then I think the GPs are also struggling with delivering care in this system.

Linda Gask Hi, I'm going to reflect about the 1990s as well, but from geographically quite a bit further north if that's alright. I was appointed as the general adult psychiatrist, Senior Lecturer in community psychiatry in Preston in 1992. And I could have been in

1892 compared to what you're talking about. It was a very, very different world. There was the closing asylum. There was a truly awful relationship between the GPs and the consultant body. So bad that when myself and my fellow new consultant went to meet them, I'm just amazed that we managed to kind of survive the sheer anger with services really, which was nothing to do with us. We were supposed to be the solution, but the things had been truly terrible. And I think it's really important to be honest about how bad things were in some places around Britain at that time, and still are to some degree in some places. I set about trying to make relationships with the GPs. And there was one practice in particular, which was quite antagonistic towards me as an incomer and fund holding actually changed that. Because what fund holding meant was that we had to go and talk face to face, and I ended up spending half a day a fortnight in that practice. And having a really good relationship with them. So, we went from an atmosphere which was really quite poisonous at times, to them being massive fans of me which was quite sort of striking really. And while I was working there, I mean, I attempted to engage general practice in lots of other ways. One thing I did was the GP registrar training course. For those who hadn't done any psychiatry, in their training, that Francis Creed started in Manchester. I was able to bring that up to Preston, and Barry Lewis, who was there, was able to help provide the funding for that which was great, and we ran that for over 20 years. And I got to know some of the practices through the trainees. I got to know many of those who went on then to become GP leads in mental health around that part of the world. But also, what I was doing was working at the Primary Care Research and Development Centre in Manchester as a psychiatrist, and we found ourselves with a contract to evaluate fundholding and total purchasing in mental health. So, I then had an opportunity to travel around the country and actually talk to GPs and to primary care trusts and everyone about what was going on. And our findings really supported that, that a lot of the changes that took place were not through the details of contracts, they were through the relationships that were built between clinicians primarily talking about what they needed. Of course, a lot of that then disappeared afterwards. But that relationship building was certainly key. On the other side, however, one of the things that I wrote up that came out of that was the absence of any kind of real governance over what was being purchased. And there was a sense that it didn't really matter what

you did about mental health, as long as you thought it was good and as long as someone else thought it was good. The evaluation, things were being purchased. And I know Andre and I've talked about this in the past, I think things were being purchased by some people who did not have any evidence base at all. It was fascinating, how clinical governance of mental health in primary care just seemed to be something that didn't happen. You couldn't do harm by talking to people. Well, of course you can. If you're not supervised and if you're not actually trained in something. So, it was interesting, a very fascinating period to be evaluating primary care. And I look forward to the next bit when we come on to talk about IAPT, because IAPT is where I went next, when I went to Salford. So, each of these periods is a period in my career. Thank you.

Ian McPherson

I'm Ian McPherson, a long-time clinical psychologist working in primary care. At this point of fundholding, I'd gone over to the dark side, because I had a chief executive and I kept telling him everything that was wrong with things we've done. He said, well if you're so full of ideas why don't you do it. Fortunately, there are good HR practices who can stop this from happening anymore. But rather like Tom, I was director of mental health in North Warwickshire when fundholding came in and my reaction was very similar to Tom's. I was worried about the fragmentation of relatively recently established community mental health teams. Fortunately, however, when we went out to talk to the GPs, I think echoing Linda's point, we had conversations about mental health I'd struggled to get the whole time I was there. When we set up community mental health teams we would move around knocking on GP's doors, asking them why they weren't referring in, we were trying to get referrals. And this was in the poorer part of Warwickshire and most of them actually wanted counselling they just didn't really want to organise it themselves. So, we undertook to coordinate counselling for them, supplying counsellors where they didn't have them, and working with the well-established counsellors that were already there. And that was what you were looking for. We then quickly got into a situation that the demand was massively exceeding the amount of resources they had, and counsellors obviously were coordinated with community mental health teams which meant that when people came in who needed more intensive support, we could do that. But what it did mean, for the first time other than when I was working in primary care as a

practitioner, I got the chance to talk with GPs about mental health. And there weren't many Andre's and Alan's in North Warwickshire but we actually found people who did get it and actually were doing amazing things in rural and deprived areas. And I just suppose that although there were lots of things wrong with fundholding, I think we were able to give a reasonable service for the money. And the thing that I got out of it, and others, was established having regular dialogue with GPs of the communities we were serving, which hadn't happened.

Graham Ash

Thank you. Really just another tale from the northwest really, I'm a psychiatrist. Although I'm mainly interested in the history of psychiatry nowadays. I think before I go any further, I should say I owe a debt of gratitude to Linda because she was the university representative when I was appointed as a consultant and was very glad to get through that day. I trained in Manchester in the late 1980s, early 1990s. I became a consultant in 1994. And this was in a district that was immediately to the south of the one you just heard about and it was Preston. I worked in a town called Ormskirk. When I started in my job, I had been led to understand that we would be working as community mental health teams, although that wasn't quite so. The mental health service was sectorized and what was obvious was that the relationship between psychiatry, if I can call it that in general practice, was quite different between sectors. There were different demographics between sectors, the nature of the practices was also quite different between the sectors. At the same time, our managers were very concerned about implementing something called the Care Program approach, which I don't think we've mentioned so far, or it's usually just called CPA. And the particular problem that we had was that although we had to invite just about everyone in the world to what we call CPA reviews and it still continues, the particular problem was how to engage our GP colleagues. Their attendance at CPA meetings was very infrequent. So, we decided to really form hit scores. And what we did was to contact the practices and ask if we could come to the practice and hold the review in the surgery. And in fact, we often did that in the GPs offices. Actually, it was very popular with both the GPs and the patients and was quite productive because we were talking mutually on matters of mutual interest on both sides, because often the patients were very challenging. And that practice worked very well for a number of years. But eventually when we were sort of formally

placed in CMHTs, our managers felt we ought to be doing other things and it just dwindled. I think one of the issues that comes up from my point of view is I am very aware of all the theory and the practices that were going on and that were reported about. In fact, what we were doing was our attempt to sort of integrate some of some of the practice elsewhere into local practice. And I'm just wondering really whether there was more diversity nationally, than perhaps has been suggested. Thank you.

Tony Kendrick

I can remember being invited by Linda up to Preston to give a talk on the work that I was doing supervised by Tom Burns on people with long term mental health problems and structuring regular care for them, which was a forerunner of the system incorporated into the contract later. And I remember getting in my car in the south in the sunshine, about six o'clock in the morning. And in my short sleeves as much as I am now, it was a day like today. And as I drove north, the weather changed. And by the time I got to Preston, and I'm not kidding, there was horizontal rain, battering my car, and it was only about 50 yards from my car to the door of the unit. And I got absolutely drenched at that time and I remember, I apologise for my terrible Preston accent, but I remember the ladies who let me in and I said, Gosh you've got more rain here than in Manchester and she said, Manchester they know nothing about rain in Manchester. And they were really proud that they had a much higher rain level per annum than Manchester. It has a point, which is about inequity. And thinking more broadly about distribution across practices, across communities. I put in the chat, a reference to a study that Bonnie Sibbald led on and Doug Brennaman did most of the legwork for, and I was privileged to be part of that and write it up for the BMJ where we did a survey, a national survey of English and Welsh general practices and found that mental health professionals who were working in them tended to cluster together in larger training practices and it was very unevenly distributed. And I think one of the problems with fundholding was it was just those very practices, who had the time and space to lift their noses from the grindstone high enough up to see over the parapet. And eventually it was shut down. of course, because fundholding stopped. It was perceived, I think, partly to increase disparity. And the Inverse Care Law is all about that. And you know, I was coming from leafy suburbs west of London and I was working in a large training practice at the time, and we were able to do a lot with our patients but we had a

consulting rate, which was about one and a half to two consultations per patient per year. And in the sharp end of the boroughs in London, it would be three or four consultations per patient, per year. And now it's even more, over many more practices. So unfortunately, the Inverse Care Law was actually exacerbated I think by fundholding. And some of these lovely examples that we're hearing about were great, but they needed to be levelling across practices who were facing more challenges.

Maryanne Freer

Hi, I am doctor Maryanne Freer, I'm a psychiatrist. I kind of came into this scenario around about 2000. And I was invited in as a psychiatrist into a GP postgraduate education unit set up by Chris Drinkwater GP. I was the only psychiatrist working with a big group of GPs who were working across all areas. So, it was integrating mental health and physical health specialist's work. I, the specialist, was asked to work as a generalist and to understand generalist evidence base and knowledge. And actually, to take all of that on board. The two bits of this unit, which linked into fundholding were surface development, and education. And I was brought in, I was called a cross-border worker in that I worked across pathways into different cultures, general practice and also specialism.

The bit that I want to say about the education was extremely important, about the engagement of very hard-pressed GP colleagues in service development. So, we found that actually, if we put out a service pathway, you know, come along and discuss this pathway we want, everyone complained. However, if we did something which was about education and saving frequent attenders, then we would get a huge turnout, in which we were helping people develop skills for the generalist consultation, not based on generalism. And all of that knowledge base is not about translating specialism and asking GPs to be mini psychiatrists. If we did that, then we could actually then do the service developments which gets back to health inequalities. This was in Sunderland where I was asked to work with fundholders PCG and went on to CCGs. w. And I actually became, believe it or not, as a psychiatrist, the GP mental health lead for South Tyne CCG and have a very strong role in education as a way to further service development at the GP end of things. I just want to mention that in this new era, we had National Trailblazers. There'll be a number of people here who went on Trailblazers. Yeah. Trailblazers again were very important because it was working across the divide with pairs of people, a generalist

and specialist (GP and psychiatrist, practice nurse and CPN etc) looking at service development project, which usually had an educational element to it and obviously Andre was our lead, was our hero in the National TrailBlazers circle (in most English regions). So again, I'm sure trailblazers will be mentioned further and about their impact which was evaluated and a way of engaging people at the frontline at the coalface, the jobbing GP, the jobbing CPN, the jobbing psychiatrists to try and make that difference in the microcosm.

David Zigmond

I think we have to look at the soil. I don't think we can get very far by trying to only improve the seeds. And the fact is that doctors now increasingly don't know people, they don't know their patients, and also, they don't have the headspace or the heart-space to develop healing relationships and meaningful encounters with patients. And I don't think that by infusing the system with all kinds of clever devices and projects and so on, we can succeed until those issues of personal disconnection are dealt with. And so we've got to do something about it. Otherwise, the seeds will never take, they will never flourish.

Alan Cohen

There were a couple of points, one Nav was very kind about the way we work together. But I think it's worth trying to remember what the context was like. Where the opportunity to improve the quality of care, improve the way your practice worked and to improve care for your patients has never been offered again. All sorts of terrible things about fund holding. Absolutely. And all the things that you know, Tony said, were absolutely right. But there was still an opportunity that if you wanted to improve the care of your patients, you had to grasp, and we were faced with a terrible decision. We could have not grasped and not improved service for our patients or do we swallow our morals and ethics and do something about trying to improve our practice? And to miss that bit of it, misses the context of what general practice was like at the time. So, it's like mostly, it's never quite a black and white decision. It's actually much more complex than that. The other bit that is fascinating. What we all seem to have completely forgotten is when the government, the Labour Party then abolished fundholding and I had to remove all the fundholding benefits from Nav's practice. Take him for a pint of beer, as if that was going to make any difference to telling him that all the extra staffing he had got was going. It got replaced by something

that we have all completely forgotten, just as well, is practice based commissioning and the amount of money being pummelled into the NHS for practice-based commissioning, sounds very much like primary care networks now. And Tony talked in the first session, about him learning from the mistakes we've made. It sounds as if governments actually haven't heard very much about learning from the mistakes and seeing it didn't work. And now I will end my rant.

John Hague

So, four things. First of all, fundholding was about relationships. And I think it was almost a leadership incubator for the next 10 or 20 years. Through fundholding I met Alan Cohen, Geraldine Strathdee, and so on. And then tremendous influence on the whole landscape of mental health over the years because of that, it was the first time for a long time that stakeholders, patients and GPs and others were actually listened to and had some ability to change things. And it's enabled innovation. So, let's look at it as an incubator, as a steppingstone to the future rather than as an end in itself.

Andrew Elder

It's really following on the last few points really, there is a grievance relationship somewhere deep in the unconscious of the GPs and hospitals. I think we need to just touch on that and remind ourselves about it. I completely agree, actually, that being given the possibility of shaping services from a primary care point of view, it was a seriously important opportunity. My personal memory is of absolute misery. And it split our practice absolutely down the middle, endless political partnership meetings. And one shouldn't forget the wider political context, even what you maybe thought was a good idea, might be quite difficult to support. I can remember hours and hours and hours of it. And eventually it split our partnership because the keenest member of our practice. Most of us were ideologically cautious, I would say some sort of a bit ambivalent, I can see the advantages that some were basically cautious about it because of some of the reasons that have been mentioned. But when it eventually led to a bunch of stuff, and the partner who was curious about it went off into single handed practice. And I don't know the figures but there were quite a lot of partnerships that split, I think, around this time. Looking back and reflecting on it now, I realised that the whole business of equity and inequity was terribly important because we were in a very fortunate position. We had moved into our Health Centre in 1979. After living for what was 10 years in sort of lock up shops, temporary flats, because the building

wasn't ready, etc. So, we were in the Lisson Grove Health Centre, from 1979. Possibly more important, we also had the Academic Department of General Practice in the same building. So, we had more political leverage. And in that area of London suddenly a new health centre was quite an interesting focus for our colleagues in the community as well. So, we were very fortunate and we, before fundholding, had successfully fought some battles. Which may not seem so important now, on things like making sure all of our nursing staff were practice based and not area distributed. I'm sure that's all gone now, but actually it's enormously important to have the same group of professionals working together who are looking after the same group of patients. We had battle after battle after battle with our nursing officers and won the battle. So, we always had practice-based staff. We also had a local authority social worker, I can't remember the title now but there was a very influential book written around that time about social work in general, which I can't remember. But we managed to negotiate with Westminster and so we had a full-time local authority social worker working in our practice. I want to mention my partner Brian Jarman , who hadn't at this stage become professor of general practice, but was already very, very aerated about inequity, all sorts, and I can't easily forget him going down to talk to GPs in the Exeter roundabout probably the early 1980s and coming back and being incensed by the difference of the quality of professional life in Exeter, compared to where we were at Lisson Grove, and beginning his work on what eventually became the underprivileged, the UPA score, which began to redistribute resources to practices according to their deprivation indices. Jeffrey Rivett, actually used to visit and discuss some of these things, that's a name that is interesting to be reminded of. And also, brilliant man that he still is, he had designed a computer system. You might remember this, whereby patients could come in and check their benefit entitlement. It was a new computer system. It was in relation to the Department of Health and in the evenings, you saw somebody, and they could check whether or not they've got absolutely all their allowances. So, we were in a very fortunate position. I think I already had a very good functioning primary care team, regular weekly meetings, people coming in to employ counsellors, a psychosexual counsellor actually came from the Margaret Pike centre, a social worker and so on. We were very, very fortunate and would meet each other every week and have a group to discuss our cases. So, I think we sadly, let rip on all the political

and ideological stuff that came with fundholding without making a proper appreciation of its value, but we were basically really opposed to it.

Venetia Young

Okay I was in a group of Trailblazers in the Northeast, which I think was probably where I met Marianne, and then in New Zealand as well. And so that apprenticeship model of psychiatrists working with GPs got embedded in me. And I ended up doing family therapy training in 1989 and wrote a letter to context for a journal and I finished by saying, where are the GPs that think like this? But I got several responses, Brian Lance, Peter Thompson and David Thompson. And we met at a Counselling in Primary Care conference. It must have been one of Rachel's projects. I've got two of the brochures from there and we formed a group called Thinking Families. And spent the next few years going around visiting each other's surgeries, watching each other work, putting on educational programs. Teaching them how to do family trees, think differently about their genders, which were really well thought of and well attended. And culminated with John Law who was part of the group. And Dave Thompson and Sarah Barracks, so it was a really flourishing group. And we met up again recently to have a reunion and to do another edition of where we all got to. I think I was in my own little bubble in Cumbria because we had no university and no medical school. So, this was heaven to me, to be with like-minded people. So, I wrote a book called 10 minutes for the family on therapy interventions in primary care, so it was really quiet a sort of productive time. And then, I joined PRiMHE , which I can't remember what year it started. And again, it was putting on conferences. All sorts of different people came to talk. It was a fabulous time, but then 2005 is when things started to fade because IAPT came in, but that’s somebody else's business. That's the next step. I thought Chris Manning was going to be here today. Because he was instrumental in setting up, getting a family oriented mental health focused way of thinking. And an MSc in Primary Care Mental Health at a university which ran for a few years. I actually just joined to help with the conferences and meetings.

Barry Lewis

Well first of all, Tony it's not just Preston that has horizontal rain, they know nothing about it compared to Rochdale. I am just thinking through the threads again and coming back to your starting point, Rachel. What was influential for me was being one of the

Regional Mental Health Fellows being led by Andre and a whole group of us who spent a lot of time drinking wine which Frank Smith kindly produced, well just a taste, only a taste. But seriously, it was an interesting time in terms of that going on, the Defeat Depression Campaign, almost in parallel with fundholding, and led to lots of debates with Nav and with Lawrence about the ethical and moral meaning of fundholding. But led also to Linda, really believing that I was the magic money tree in terms of the conviction that you could actually do a lot of the change management of what was delivered by general practices in primary care through education and training. Which is where you are coming from and it meant that working within a postgraduate Deanery and when postgraduate Deans have the freedom to do with their budgets what they felt they could do was influencing in that direction. So, producing trainees who have done a mental health skills training course that the likes of Linda and Richard Morris would actually put on and deliver along with GP teachers at the same time as the Defeat Depression Campaign. Opening the doors to all sorts of practices that hadn't previously thought of considering training and recognizing that they had the will or the ability to become training practices, undergraduate or postgraduate, introducing them to university medical schools. And starting the ball rolling, and then spreading those skills out into the workforce, as those trainees then graduated as fully fledged GPs. And it was a different way of approaching what fundholding could produce it's probably not all relevant to this meeting. But we tried exactly the same thing with improving the care of renal failure in primary care and we did the same in heart disease in primary care with some of the commercial support that came with it, because there was undoubtedly a commercial element to that. But also, with the education and training and the engagement of cardiologists and oncologists in understanding what GPs could do with the comorbidities that they were handling during their everyday practices. And that's the alternative way forward and primary care networks and all the rest of it will mean that money drives the process. But it's a shame because education and training could in fact, do the same if people were allowed the freedom to do so.

Nav Chana

It’s Nav Chana speaking, for the record and I guess Andre I just wanted to kind of, if it's acceptable, we've sort of lumped a lot into fundholding into this conversation. And I think for me the broader issue is how do you commission and/or provide services for

populations with needs, whether their populations with mental health needs or populations with comorbidities, or frailty, or wherever? And I think fundholding was an experiment, which, as we said, did have lots of problems, but also arguably some benefits. Since 1991, I've written a paper on this. There have been 14 reforms, which have brought a tighter target to primary care provision, with a focus on two elements. One is around the practice development which includes the broader skill mix and increasing use of technology and all that kind of stuff, but with a very strong focus on access, but perhaps missing out the continuity element we've been highlighting earlier. But even now, everything is very much targeting those sorts of things. And the second is a population health improvement setting or suite of interventions or targets, which might be immunisation, it might be better management of long-term conditions and so on. But that's essentially what all those policy narratives are around and the reason I say it's 13 is because the policy changes every two to two and a half years. And why that's important, is because we never quite get to evaluate these things. So total purchasing, there were one or two papers that came out which started to show that there was some potential benefit, but only one or two and then it was just axed. No one really evaluated primary care groups and what they did, no one really evaluated any of the subsequent commissioning policies because they just change every year. So, I just wanted to highlight for the record, we can debate fundholding all we want but actually the broader issue for me is the commissioning, contracting you know, the models that we're using to do the services.

Rachel Jenkins

Yeah, I was going to say something a bit similar in a way, which is that I had lunch with somebody who turns out to have been the person in Treasury who first imposed budgets in primary care which in this time had to be submitted to the same financial disciplines as the specialist services. So, we can all blame them for that. But I mean when I arrived, we were all trying to struggle with making mental health work within a purchaser-provider split environment which had been imposed by, if you remember, Alan Waters and Margaret Thatcher. And I remember being at a meeting with Donald Acheson where he was supposed to be explaining to us what all this meant. And he said he could only tell us what they had written in the Times that morning, he knew no more. They were not consulting him or anybody else in the Department of Health. And so, I think I

want to say a lot of these changes come from some external point. And the people you'd expect to be influencing them have not had an input, you'd expect previous experience to be feeding in, and it hasn't, and we'll come to that with IAPT. So, a lot of the time people, like myself, were running to kind of make something work within a new structural change that we had had no hand in, as it were. And often the people in the Department of Health could understand surgery, knees, and hips, but they didn't really understand mental health, geriatrics and all that. That the bulk of the morbidity that most people are dealing with, had not been thought through in relation to these specific changes. So that was one thing. Second thing somebody raised the point about educating commissioners this was a big, big problem for us in the mental health field. Because the commissioners, it was like being given the car keys without a driving lesson, you know, there was no education for it, no understanding of the epidemiology. And you found that there was no provision for those few people who needed 24 hours care etc. So, a lot of people are falling by the wayside because they hadn't been thought through, nobody had looked at the spectrum of epidemiology and what you have to provide for in a population of more than a few thousand. The other point I just wanted to flag up which Nav mentioned, this idea of a one stop shop, which I've always thought and John Reed thought at the time, that it was a very good idea. So, to make it much easier for patients to access their physical health care, their mental health support, their benefits, help for their housing difficulties, help with domestic violence, etc. If you can have a bit more of a one stop shop, it would be so helpful for them. You know, if you're a woman with three children, how are you supposed to negotiate with all these different agencies? So, it's just not to lose sight.

Tony Kendrick

Yeah, so leading on from what Rachel has just said, I was involved in talking to our services, from the practice in Chertsey and I had some education in psychiatric epidemiology. David Goldberg's work and I was aware of the different levels of need in different subgroups and subpopulations of people with mental health problems. And yet, we weren't able to make very much progress in changing what were essentially block contracts between the provider and the local practices. Because we couldn't break them down. We couldn't break them down by diagnosis. We couldn't break them down by need, by disability. These things were not well measured, and there was no

obvious currency by which you could trade off one priority against another. That's still the case. I think, even with the mental health minimum data set. We're still doing work, I'm on a national group looking at trying to develop this mental health currency for different conditions and levels of need. And so, a lot of the actual work that was done on the ground and I think, unfortunately, is still the case, but maybe colleagues will correct me if I'm wrong, was actually to do with particular teams and their preferences for who they would let through the referral system and who they would concentrate on and trying to shift the status quo came up against a huge amount of inertia. And if you weren't able to do any fine grain analysis of case mix and provision, it was very difficult to do anything but accept what they'd been doing for years. Now, things may have changed. And I've not been actively involved in commissioning in recent years. But it does seem to me, my wife works as a clinical psychologist in a community mental health team, I obviously see what happens in an inner city, Southampton. I'm fairly well informed about IAPT. There is a gap, a particular gap between people who can be helped by IAPT and people who can be helped by a community mental health team. And GPs often say that they have some really quite challenging interactions with people who qualify for neither or have tried both and not been helped. People with a mixture of chronic depression, substance misuse, personality disorder, so called, who don't fit necessary referral criteria, but still have needs. When I was asked most recently by the Primary Care Network in Southampton, what they should spend extra money on. My suggestion was case managers. They're not case managers linked to any particular set of diagnoses but case managers who would take on the care of people who fall in these gaps, and act as coordinators as liaison between primary and secondary care and as care managers/medication managers. It's been shown to be cost effective, at least for the people who enter into trials for a number of conditions and yet it's not being implemented. And one of the problems is, I think, this lack of a currency, this lack of ability to define needs in a more refined way, and then negotiate with services who may find it very difficult to change, but they need to change.

Tom Burns

I just wanted to comment and go back to championing equity. I think in the discussion that has gone on since then, I think equity sounds like it's been interpreted as uniformity. Now I don’t think equity is incompatible with innovation from variation, there was plenty of

that in a trust that I was describing. Indeed, the innovation that budget holding forced us to do had already been going on for 10 years, but it wasn't equally spread. So just wanted to make sure I hadn't misled you, all of our equity was about ensuring a minimal standard for medical costs. But people did it in different ways, some were very innovative, and some people sitting around here collaborated on some of those innovations without any money but thank you for the money.

Lawrence Buckman

Yes, as well as references being made to some of the things I did, I suppose I should also say that a lot of the changes in primary care between 1977 and 2013 were at least partly laid at my door whether for or against. I'll come out as, it's no secret, I did not support fund holding. I was in a minority. Many people supported fundholding, nothing to do with the morals, they supported it because it was their chance to get their hands on the levers, which I entirely understood. But as Nav rightly said, it's actually about commissioning. It's not really about this mechanism or that mechanism. And of course, the particular kind of Tory government that brought in fundholding wasn't really bothered about equity. They were bothered about other things instead. And I've never criticised the GPs for going with the flow, when it was pretty obvious that going with the flow will, at least in the very short term, get you more of something whether it's money or facility. As a non-fundholder, I was involved in commissioning mental health services, mainly because I gave a speech at the Maudsley where I said that where I practised, in fact, if you had a mental illness of any kind, you're better off going privately than you were trying to access any conceivable mental health facility. And the day after I gave that speech, I got a phone call from the chief executive of the Mental Health Care Trust. Asking what was I doing? And I said, well actually you read the transcript, he was very upset. And I said, well actually I watered it down. I would have said something else if I'd known you were going to listen. And after discussion, we have a pseudo total purchasing thing where the whole of Barnet was given access after what I'd said had upset them so much that a bespoke Mental Health Access Service which meant, to the GPs in our area, which was a lot of practices, some fundholding and some not. It meant that we got part of a consultant psychiatrist who came with a mental health access worker who had previously been a proper mental health social worker, and the social worker sorted out all the patients and

where they should go. And the psychiatrist provided in-house, it was actually in our house, but it was also for all the GPs locally to receive mental health care services. It was completely equitable, and there was one big advantage: we'd made the issue that our biggest ethnic minority were Farsi speaking, and that we needed a Farsi speaking psychiatrist. And surprise, surprise, they found one. It's a bit of a shame he had to come all the way from Oxford to work. But he did it for ages until the funding ran out, and he provided an absolutely exemplary service, both to our Farsi speaking and non-Farsi speaking patients. I just wanted to touch on two other things. One is the issue about where people practise and this one stop shop thing that always appeals to politicians. Because there's a great photo opportunity. The biggest issue for most GPs, whether they rent or they own practices are the premises and the land on which they stand. And that determines the way practices develop. So, a practice in Bermondsey, for example, develops in a particular way, and a practice in Taunton develops in a completely different way. It has nothing whatsoever to do with the ambition of the medical practitioners or the needs of the patients. It's everything to do with land price, and the cost of reinforcing premises, enlarging them, what you could only do if your premises were twice the size and what you could only do with that. So, when we get examples of one stop shops that are wonderful, and I don't mean to be unkind to those people. I always ask, who funded that? How was that funded? And the best one stop shops, I'm afraid, are differentially funded, and people inside the department know that.

And I think, as I finished, I just want to say that governments do not learn the lessons, whenever you hear the phrase lessons will be learned, you know for sure, they will not be learned. And they will not be learned for one reason. Because they are based on a false premise that they go after a wise agreement, negotiations between the government and, in my case the BMA (British Medical Association), are about a wise agreement and the civil servants whether medical or lay, and the doctors and our lay negotiators are set on the wise agreement. Then they have to go back to their own sides to sell it and you always say the enemy is behind you, never in front. Talking to the departmental officials, they're not the enemy, the enemy are not in the room. And the enemy have already made up their minds, both sides have made up their minds of what the outcome is going to be before you even leave the room. And this myth that somehow you can come to a wise agreement which will

actually happen and be checked up on and somebody will have input data later on that will that will inform whether you carry on doing that or not, has in my experience of 12 NHS reorganisations, but I accept Nav now says it's 14, rejiggering of primary care, the myth has never ever happened. Never. And it's a bit of a laugh between the two sides. Actually, we know that when it goes back to the principles, it was my case the GPs and in their case it was ministers and others. It's already been decided. And what you don't know is that there is a parallel department for each department in the treasury and those people a very small number of extremely clever people make the decisions. They have decided for the Department of Health, because I used to meet them, what is going to happen next. And when you say oh, we just agreed this, they say oh no we're not doing that, we're doing this. And we'd say but we just agreed that, they say oh no, we're not doing that. And that process of political iteration is what actually happens. So, when we say we like one stop shops, or we like fundholding, you know it won't be evaluated. I'm sorry to say this at length but I just think I'm trying to inject reality into the fantasy that we can improve mental healthcare, we can only improve it by imposing the wise agreement on those people on both sides who will not listen.

David Zigmond There is a big theme, but I will try and keep it punchy. I think that beneath everything we're talking about are massive cultural assumptions in this direction. And it comes from our living – as we all do now – in an advanced industrialised society. We are very good at engineering things and so, very often, we lose sight of our ecology. It is an absolutely massive problem. And I see all of these things as part of a macrocosm. We commodify, and then we do so at the expense of communities. We are very good now with proliferating generic diagnoses, and then we do not hear or understand personal stories. And we are very good at being short term expedient … and then find that whatever we have manufactured is not sustainable.

Huw Lloyd It's true now a lot of different places now have different ways of approaching things. It took me back to, I think it was the World Health Organization they asked me to go speak, I said I don't know that much about mental health, but I'll do my best, and at least it was about education which I knew a little bit more about. The speaker who was before me was a gynaecologist from the states and

he was saying how they will have to learn about mental health, because all women would go to their gynaecologist about everything no matter what. So therefore, this is why they had to learn about mental health issues. But the next one after me was somebody who was representing the World Health Organization, who had said that they had to adopt different methods in certain parts of eastern Africa because they had no doctors. And what they would do is they would find the local witch doctor and say, you know, what have you had trouble with recently? And they'd say well have you ever tried this method? And introduce this to them. And it is interesting to me because I was thinking it isn't just about witch doctors because I went two or three times to go teach doctors there, there weren't many of them, about primary care mental health. And one guy came in and was saying, you know, I don't deal with people who are mentally ill, I have to have them tied up first. So, there was a bit of a culture gap there which you had to manage? And when I was assessing him at the end, he said I can't wait to go and tell my friends you don't have to tie people up. So, I thought that was a bit of a success story. The reason I'm telling you about it is because I think you know; we've talked a lot about the differences in one part or another of this country. And as you've probably noticed, I come from Wales. And actually, a lot of what you've been talking about is irrelevant. It didn't happen in Wales. Of course, we did have mental illness there. But the thing is, it does make a lot of difference where you are and who's in power. And I don't know but when I was chairman in the college, I was invited to go out on health stuff and talk to people and all the rest of it. And then the penny dropped, when I was talking to really nice people, that they were dealing with stuff that won't even affect my patients at all. And when I went out and started stuff up David Shiers and David Clark and a lot of other helpful people, we set up a network in Wales to deal with bringing people and interest in primary care together. And we were very lucky that we had a minister who was in favour of what we were doing and funded us to help conferences and get people in we got psychiatrists, we got GPs, we got community psychiatrists, we got various people from the charities, and then we would discuss how we would take things forward. And it worked really well and we were quite enthused. But then it was a change of politician, they didn't like it and that sort of initiative. So, one of the things I'm saying is, I've seen so many changes over the years and we've all seen these things. What I feel is interesting is looking back

at history. So that what we can steal from that history, helps us think, that is the essence of what is important. And I think the word has been used quite a bit, relationships are actually a hugely important thing. Relating to your patient, relating to your colleague, and how that transpires into what we do generally with when we have fun, we're learning or whatever other literals you want to use. But I think we need to try and think about what we lost. We've still got a lot and we have to think about how we can build up that, to adjust to our present-day needs. Because things have changed.

Rachel Jenkins

Can I just say something very quickly? It's just, it was touched on, but it is this problem with ministerial turnover, as well as what you're saying about people in the backroom. Ministers have a lifespan of somewhere between six months and two or three years, if you're lucky. And so that's a problem. Governments don't always last. And so, as well as what you're saying about wise agreements. There's also the problem of the research evaluations because you commission some research, and it takes about a year to get it going and dialogue within the Department of Health and the academics about what would be a really good way to do it. And so that runs for three years and then you take a year to do your research and then write it up, so it's like five years when it comes back in. And by that time all those people have long gone, all those policy ideas long gone. It's a major headache for us really, and I don't know how you solve it.

Alan Cohen

I was actually going to say something very similar, but from a very much an individual GP perspective. Because I was really struck by what you were saying. It's really powerful, really important, about negotiations at the national level, I had no idea and I'm fascinated. But it makes no bloody difference to what I do with Joe Blogs sitting in front of me in a consultation. And I think the only way I can square this circle is to think about the only thing that works, which is actually not to keep changing policy. If we just keep the same system going, anything beyond about three years, that would be such a major success. We can actually learn to do something sensible, one lesson. If we just stop fiddling.

3. Delivering primary care mental health by guidelines

Lydia Thurston

Welcome back everyone to the third and final session of the day. For those of you who I haven't introduced myself to, I am a psychiatrist with a special interest in the history of mental health in particular. And I'd like to say thank you to John Hall who introduced me to Alan and Andre, that's how I got involved in this project and I am really grateful to be here. So, the third session of the day is about delivering primary care mental health by guidelines, with a focus on IAPT, so 2005 to 2019. For this session we've got two speakers so firstly, David Zigmond who is a retired South London GP psychotherapist.

David Zigmond

Well, I will share a bit of embarrassing self-disclosure first of all. I was invited to do this by Andre, and I suggested that rather than doing a 'presentation' – because I hate formal presentations – can you just talk to me, and then we can have a discussion where we open it out to everyone? Anyway, there were a lot of emails exchanged, and these reminded me of how I get aggravated having to work with anyone else's different format! And this is why I have great difficulty having personal satisfaction when attempting to work creatively in the NHS. We'll come back to that in a minute.

Now look what I have just found – here and now – in the Royal Society of Medicine – a teabag: this is worse than you think, this is a *plastic* thing, look! It is dangerously unsustainable. It really is not sustainable. It insidiously damages the environment. Why do they sell it to the Royal Society? Because they can, they can market it: because both parties can cut immediate costs by using plastic rather than paper teabags. Those are the kinds of difficulties we are now facing in our NHS.

Now where to start? Before I qualified, in about 1967, I went to Monmouth for a GP elective. And there – mentoring me – was a lovely man called Dr Gibson who worked there. He was a very strongly vocational, old-school GP. He was kind, he was patient, he was very clever, and he was evidently committed to his work. He worked in a partnership. And he told me about something he had just been reading. As he showed it to me he said, 'This is a wonderful book, David. It's so deep and makes so much sense of my working life'. Anyway, it was Balint's book. And he was one of the people who encouraged me to go into general practice because I then saw it was a wonderful mixture of science and art: a dance of

the generic and personal. It was about understanding key *medical* formulations *and* getting to know *people* better and better. And building trust, and all the rest of the things we've been talking about. And I realised that this group of GPs were really happy with their work. So, I thought I'd like to do that. I then decided to train in general practice and in psychiatry.

In psychiatry I first worked in a mental hospital. I was there for a few years working with another lovely man: Gerald Goldberg; he was warm, thoughtful, gently ironic, deeply committed to his work. He lived with his family in a rambling Victorian house in the hospital grounds. And he'd known many of his patients for years, he knew the GPs, he knew not just the patients but also their families, their neighbourhoods and so on. If he was asked by a GP to visit Maisie who was going hypomanic, he would go to visit Maisie, and she would recognise him. But then most local professional people knew one another and their patients. So Gerald knew the local GPs. What happened then? If Gerald wanted to admit Maisie, he could call up the ward and say, 'Sophie, do we still have a female bed available? … Can you contact Jeanne, the secretary, and arrange an ambulance – so maybe we can get her in this afternoon?'. That's how it worked, right? Short, direct lines of communication. Gerald knew the GPs, the GPs knew the patients. Larger communities, right? He had his smaller community in the mental hospital with his secretary, his nursing staff, his OTs, his psychologists … they were a team.

Now the psychologist … let's talk a little bit more about psychology. I remember the ward psychologist used to do projective (Rorschach) tests. What's a projective test? Well, it's certainly about what *I* make of an ambiguous picture. But it's also what *you* make of my response to ambiguity. Both are ambiguous. In other words, the test is some kind of view into the way that our minds might be working. Now that's a subtle art, but we have, intolerantly, replaced it with specious science. But nevertheless, then, skilled psychologists bridged this whole extra dimension – psychology was an allied yet alternative discipline which infused medicine with nuanced psychological insight, and so offered extra perspectives or meaning into our work. Now, be mindful of what's happened in subsequently clinical psychology, because it's gone the opposite way. It's not that medicine is now infused by a psychological understanding of what we're doing. It's rather that psychologists have become medicalised.

So, they too now think in terms of closed packages, clusters of diagnoses, clusters of care pathways – all things we think we can manufacture and mass produce. Those erstwhile projective tests – representative of the erstwhile art of psychology – have long gone.

Later on in my profession, what I found so damaging was that people in the service knew one another so much less. When I was at University College Hospital I worked for a deeply thoughtful and empathic consultant called Roger. And I talked to Roger about what I was seeing on the ward: a man who shortly after his retirement went into heart failure. He was admitted to the hospital and became unprecedentedly manic: he was exposing himself to the nurses, pulling out his drips and saying he wasn't who they thought he was. Anyway, what happened was this: I talked to this man about his life and all his regrets and sorrows and feelings of shame and grief. It was all very poignant and interesting. But it turned out that it was those conversations that most settled his heart failure as well as his mania. As I talked to Roger about it he said, 'Oh, you should write this up'. So I did. That was the first thing I published – *The Medical Model – its Limitations and Alternatives*. *How humanism may synergise biomechanism*.

In a way, that's where I'm stuck. I've not progressed very much beyond that! I still think it is the overuse of the medical model that has led us into the kind of perils that we have – because we think that we can manipulate and control and engineer and design our way out of all our all-too-human blights of distress. Well, the truth is, with physical illnesses we *can* very often; with orthopaedics we can, with eye surgery we can. But we *can't* with functional illnesses, and we can't very much with mental illnesses. We're talking about conduction when we talk about treatment. So, what's happened, is that we've used that model – of conductive curative treatments which have been dramatically successful with, say, surgical conditions – to try to model mental health services. So that we feel we can *cure* mental illnesses; no, we usually cannot. To extend a metaphor for what we *can* do: we can provide an anchor and harbour, we can provide buoyancy-aid, we can help navigate, even sometimes provide an outboard motor, but rarely can we cure mental illness. But we can do something else: we can *heal* by enabling people's immunity and capacity to growth and repair, and that's different. That's all inductive, not conductive. And we've got

to stop thinking so much about decisive treatments and think more about the potent vagaries of healing.

Now, I voluntarily surrender to the next speaker.

Lydia Thurston Next is John Hague, so John is a retired GP, he's been active in mental health commissioning in Sussex for 20 years. And from 2008 till 2011 was an IAPT clinical lead.

John Hague Thank you, I'm desperate to avoid the red card, I'm not going to manage it. So, first of all, Lawrence is completely right about the funding and that's a really important thing to keep in mind during this time. During fundholding I began to be responsible for, partially at least, the commissioning of the town of Ipswich, in terms of mental health commissioning. We look back and most GPs have Tricyclics, and the SSRIs (Selective serotonin reuptake inhibitors), if you were brave enough to prescribe them at the time. And whatever Balint type skills they'd acquired or hadn't acquired in their training. Referral just wasn't available, by and large, even for moderate problems. Panic Disorder and PTSD were invented in 1980, I remember after the Falklands war desperately trying to get help for people with PTSD. "We were not commissioned for that service." And that's what we were told at the time. And that phrase is my Blackpool rock. Secondary services were at a time quite adept to assessing patients and discharging them as not fit for the service, despite them being unable to be treated in primary care as well. And that's the tragedy. So, what we did was, in partnership with a very farsighted psychiatrist, we cooked up a scheme using the freedoms of the new GP contract to run a pilot with a couple of psychiatric nurses, a psychiatrist, a therapist, a social worker who was from MIND to help with employment issues, and a couple of other workers as well. And let's connect the whole town, and in return for that, we expected GPs to deliver the beginnings of standardised care. So, use a rating scale to help diagnose the severity of illness, we used the Australian DASS (Depression Anxiety Scale). You've got to do training, we trained all of the practice nurses, most of the GPs. And we had standardised computer templates to record care and standardise risk assessments. So, we were trying, through improving services and improving education, to raise the bar and the standard of treatment which was available. We

looked at how many people were not suited to primary care but were also not suited to secondary care. And that was, every week, 194 people in Ipswich, it was a town of 160,000. So huge unmet need, despite that, we face constant problems. We couldn't find finance, couldn't find premises, couldn't get staffed, and the project lasted less than a year before it was terminated. But at the same time, Richard Layard and David Clark were standing in a queue to get a cup of tea and they got talking and cooked up this scheme called IAPT, Improving Access to Psychological Therapies. Richard Layard is a professor of economics and David Clark is professor of psychology at Oxford. And between them they cooked up the idea of IAPT. So, my first learning point is networks really matter and who you know really matters. And I've really benefited from the people I've learned from. The second thing is that nothing matters but money. And if you happen to have a friend who's called Gordon who happens to be Chancellor of the Exchequer, then you're probably going to get the policy through. And that's what happened with IAPT. And that's where we are now, the ability to influence the politics at Treasury level and get an idea through the hoops in order to get national funding is what led to IAPT. And I think in many ways, it's been a tremendous force for good and I will argue about why it wasn't, later on as well. So, during the time of the pilots, I co-wrote a book with Alan Cohen called The Neglected Majority, which describes trying to develop a service for those 194 people a week, but on a bigger scale. But nonetheless, IAPT happened, our project got pulled. I was fortunate enough to be working for the Sainsbury Centre for Mental Health at the time, as was Alan. And I also worked on the expert reference group for IAPT, and then moved on to the regional lead. What's IAPT about? It's about single consultation, advise and move on. And/or the three underlying principles of delivering evidence based psychological therapy at the right dose, at the right time. So, if someone is likely to be helped by low intensity rapidly accessible treatment, give it to them. Don't wait two years for the right psychologists to be available, because you might get them better, a lot sooner. And we developed that into referring someone to Living Life to the Full, so they can actually leave my consulting room, sit in the waiting room, and instantly access low intensity CBT if they wanted to. An appropriately trained and supervised workforce, so two entirely new workforces had to be invented and university courses developed and so on to develop both the low intensity workers and the high intensity workers. And

also, routine outcome monitoring because if the treasury's spending billions on your program, you need to prove it works. And so right from the get-go, IAPT has been about routine outcome monitoring, using structured monitoring tools. Without very strong push from the treasury, very strong push from civil servants, this would not have happened. And the likes of James Seward and his team really pushed very hard to make this happen. And also, the agreement of national bodies, so really threatening to psychiatrists, psychologists, GPs, counsellors, and what have you. The use of a partnership was an agreement between all these different professionals to get this going, and that played a large part. We had GP leads in both PCTs PCGs and regionally to help actually get things going, to change GPs' attitudes to talking treatment to try and help bring professional groups together and so on. And that's been really important, but GPs had to become used to changing their treatment, a bit less medication, treating along with guidelines, people saying I want my own practice psychiatrist, I want my own practice CPN, my own practice counsellor, well you can't do one size fits all, this is the way it is. You can't treat people over the telephone. Which is ironic now, isn't it? Lots of people saying you can't treat people over the telephone, whereas there's studies showing you can very effectively and safely do that. But the battle is still going on really?
Patients, what do the patient's want in all of this. We haven't really talked about patients very much. Patients expect counselling, whatever that is in their minds, and don't necessarily expect a low-intensity treatment which means they do the work. And that's really quite challenging. So huge innovation throughout IAPT, not necessarily being provided by NHS providers, but having charities provide services in some areas, was quite disruptive, which was good and helped to move things on. Self-referral, a really silly idea lots of people thought at the time, to give patients the power to refer themselves to talking treatment. But actually, people who self-refer are just as sick or sicker than people who were referred by GPs and respond just as well. And they more closely reflect the ethnic background and the demographic mix of the area they come from. And people are actually pleased with both. So, in balance, it's a good thing. Long-term conditions, medically unexplained symptoms, a lot of work on integrating physical and mental health, and long-term conditions are now part of the system. Which means that my local chest clinic or diabetes service have named workers who work with them and have ways into IAPT directly from their services. That's a

good thing. So, lots of good has come out of it. And if I had to do it again tomorrow, I would do because I think it was really important. We had lots and lots of motivated, professional people who I felt were at the top of our game, doing this and achieved an awful lot. And very supportive administrators, there was time allocated to educate colleagues, and change culture and practice. IAPT helped millions of people, you can't doubt that. I've got the numbers to give in just a second. It's given reality to holistic health care. But at the end of 2019, it was funded for 25% of the suffering population. So, a GP sees 10 patients with depression, they recognize half, refer them all to IAPT, only two or three are ever seen, one recovers. Now 90% of the need is still unmet with current funding, and that's a bit of a problem. And also, I'd like to reflect on how we de-skilled primary care, because there's now a valid referral route that doesn't need to include GPs at all. As people can now navigate, can refer on to IAPT, so how has that de-skilled primary care, especially with universal crisis services you can refer yourself to as well. Has this freeing up of mental health capacity actually contributed to the decline in primary care numbers and staffing and primary care? Because mental health is being taken care of by IAPT, even though it's not necessarily as I have just said. Coupled with that, we got a decline in numbers in mental health services that the BMA document I was reading in the restaurant downstairs tells you about, so we haven't exactly been over endowed with new mental health services either. Unless you want a Crisis Team or Early Intervention Team or something which bleeds good quality workers from the current CMHTs and what have you. Have we contributed to the pathologizing distress and unhappiness? Is social prescribing really the answer to that? But in 2021, IAPT employed 13500 workers from nothing 15 years before, and saw over a million people, 600,000 were treated annually. 300,000 recovered and another 150,000 benefited significantly. Thanks.

Linda Gask

My apologies for having my hand up early, I'm going to have to leave shortly. I'm very pleased to hear John defend IAPT. I've worked with IAPT since its inception in Salford. And I'm still a non-executive director of a third sector organisation that provides a step-two service. We were one of the first Pathfinder sites in Salford and I was working then in Salford and trying to set up a primary care mental health service, and we absorbed the IAPT funding and the workers to provide that service. And I provided supervision to a step-two

team for several years, one morning a week. Does it need a psychiatrist? No, it doesn't. But we were setting up a service. And there was a great deal of containment and anxiety and connection to be made between our service and primary care. But we didn't do it in quite the way that we were supposed to do it. Because I'm a great believer that if money comes along, you try and deviate it to what you actually wanted to do in the first place. What I wanted to do was to set up a collaborative care service, because I spent a year working in Seattle with Wayne Katon and Anne Wagner, finding out about improved depression care, and how collaborative care actually has the largest evidence base for that. For those of you that haven't come across it, collaborative care is about a mental health professional supervising a case manager who works directly with primary care, and the mental health professional talks both to the GP and supervises the case manager. And it's quite systematic and it produces consistently good outcomes. And we did two large trials in the UK. I worked on the CADET (Collaborative Depression Trial) study with Dave Richards which was three centres and on the COINCIDE (Collaborative Interventions for Circulation and Depression) study which looked at people in primary care with coexistent cardiovascular and/or Diabetes. And so, we actually set about developing IAPT into a collaborative care service where there was also liaison between me and the GPs, so I provided support and backup for the team. I went out and visited all the GPs with the pharmacist from the PCT. We had a team that was more than IAPT on its own. It was a bio-psycho-social team with a considerable psychological element. And I have been really disappointed that we have gone down the route of a purely psychological intervention, which is standalone, when I think we could have done much more than that, and actually have collaborative care. So, I did that for several years.

When I first went to Salford the waiting list for psychology was two years, I was actually told by the head of psychology in primary care that people were prepared to wait for a good quality service. And I said well that's all very well but I wouldn't like to die while I was waiting. Needless to say, that didn't go down terribly well. But I do think there's an issue about you know, do you wait? And what are you waiting for? And what I certainly found when supervising an IAPT step-two service, was that there were a lot of people we could help. But we were also picking up people with early psychosis, people with bipolar disorder, the carers of people who were getting

care or not getting care in the mental health service. The GPs liked the fact that we were out in general practice and that we were using the same case records as they did so they could read very briefly what was going on and how people were doing. And they had my phone number so they could ring me if they wanted advice on medication. And I was also available as a backstop in terms of risk. And I did that job for several years until I retired. And I'm still involved with the service. I think it's very easy to play down IAPT and I think one of the big problems we had locally was that the Mental Health Trust, decided that because we had IAPT they would defund a lot of our extremely good dynamic psychotherapy service, which was absolutely brilliant. And which we really needed as well as IAPT because we had a number of people who really needed much more than IAPT could offer. And that was really tragic. But some of those people have now come to work with Six Degrees, which is the organisation we set up. We also used the opportunity of becoming a social enterprise when we could no longer be provided by the PCT. We didn't wish to be absorbed into the Mental Health Trust because we thought that they would simply do away with us. I provided supervision alongside a GP, Tom Tasker who also worked with the organisation. And he was someone that I had trained to be a GP with a special interest in mental health. So, we were able to provide physical health care inputs as well. And I think it was an absolutely brilliant service and it's still going on. The final point I want to make is we're talking about IAPT and I know Huw is here from Wales, there is no IAPT in Scotland, there is no purchasing and providing in Scotland. Scotland still has health boards, that's where I live now. So, I think it's really important to be aware that there are perhaps several histories of primary care mental health in the UK, not just one, which is England. Things are really quite different in Scotland, and I now work with a third sector organisation. I'm the chair of a trust that provides care and we are also very closely linked in with people's GPS as well. So, I'm going to stop there, and I have to leave you soon. To go and get something witnessed and signed.

Andrew Elder

Andrew Elder, GP. My remarks about IAPT follow very much what Linda was saying about collaboration really. I think it's also worth bearing in mind that Lord Layard was basically an employment economist. And I don't know what the results of IAPT have been in terms of getting people quickly back to work. But that was a very important component. I'm going to talk about unmet need and

those people that don't have GPs, or they're not registered. And I'm also very interested in, in fact I've got in front of me, The Depression report, written in 2005 by Richard Layard. It's sort of scarred into me, at present there are two sentences in his report about general practice, which we spent quite a bit of time this morning talking about as the major provider in the NHS of mental health care. Two sentences: At present, two to three quarter million patients come to GP surgeries each year with depression and anxiety. Most received drugs or nothing. Now, I was very interested in the introduction and I attended three, at least, meetings listening to David Clark and Richard Layard. And I could see the great strength of what they were talking about in relation to greater availability of CBT. But my problem was how it was to integrate with the rest of the health sector. And on three separate occasions, two of them written, I invited Richard Layard to come and sit in on an ordinary primary care team meeting so that he could actually understand a little more about the reality of what GPs face, how they deal with it, how they think about it. And I have to say I hate to admit to meeting a failure, but he never came. And that sounds to me a huge contrast to a lot of the other innovations that have been made in mental health in primary care over the years, which start with a sort of what's going on, maybe I could sit in? Should I just visit the practice? People/psychiatrists said oh, gosh, what Tom was talking about, I learned more about mental health by doing that. So, for me, it was a disappointment that actually there were only two sentences about primary care. And the people out there, incidentally, talked to David Clarke about exactly the same thing, they showed no interest whatsoever in understanding what goes on in general practice. And perhaps I have been a bit over the top, I'm sorry, but they didn't seem to share any interest.

I mean, I think it's a fantastic innovation. But I don't understand why it needs to be built on general practice. It's not really interested in what the work of GPs is. I suppose because I knew this was going to come up to my own practice, just recently before coming, we have two IAPT therapists working there. And as I was saying earlier, we have a long history of counsellors, most of whom, of course, got decommissioned after this and in the workforce that IAPT brought in and the costs directly or indirectly led to the decommissioning of 70% of practices in this country, which had psychological therapists working alongside GPs and growing in their collaborative understanding of what actually goes on in primary care. And I said to

them, what about the IAPT therapists? They said they've been okay, you know, they helped. I said, do they come to the practice meeting? No, they never have in seven or eight years or whatever it is. They've never once, maybe it's not in their terms of employment. Alongside those people working in my old practice, there is every single week, a primary care team meeting where all the clinicians discuss their problems. The IAPT therapists never attended. And I think that's a tremendous weakness of the service. I can see its strength, and everybody can hear that I'm slightly impacted on this subject, but the degree of collaboration and the degree to which it was built on an understanding of what was going on in primary care at that time, was laughable.

Ian McPherson

Forgive me Andrew, but I actually suggest that some of the things you're assuming aren't necessarily the case. I was involved in the IAPT program at the National Institute of Mental Health in England, which was charged with the initiation of IAPT. And there was a lot of mythology about Richard Layard and David Clark, they have undoubtedly had a very big impact, but in reality, there was very strong primary care involvement, not from Richard, it would have been good if he had. It was the guy who did the 1964 sit in with GPs to see how mental health presents itself to GPs, I suggest every person who works in mental health should do that.
The reality is, though, that you heard from Linda, how she and colleagues created a collaborative care arrangement with IAPT resources. My thought had always been that we got the shot where the money had been approved and we had to come up with a plan to implement it. And we looked around the room to see who was there and we brought together people who had a passion and interest in mental health and very much in primary care. So, the fact that there hasn't been a certainly, very appropriate response locally and from David and Richard, doesn't mean that there wasn't from people like Andre, Alan and John. All made a significant contribution and I'm delighted that John has spelt out some of the issues that IAPT hasn't addressed. The decommissioning of services was nothing to do with IAPT. It was an excuse to take money out. IAPT was new money, to be consistently new money, and local commissioners or mental health trusts or whoever who did that, who approached the service, because many of them, as you rightly say, decommissioned the counselling services and other services. There was no need to do that. And I think it comes back to what

we're talking about the quality of commissioning, I think that's why it's incredibly important that GPs and other colleagues come together and actually say this is what's working and what's not. And that's heart-breaking on top of everything else.

As far as the employment thing I had to say the Treasury didn't buy that, it was never going to be evidence of return to work and return to work is often used to knock IAPT. IAPT in some places, again, has not been used appropriately. It wasn't the Treasury that says we're backing it, what it was that Gordon Brown got the chance to listen to those discussions and was given this massive amount of money and that has actually been repeated by every government that's come in since. Which is very interesting because Alan made a very good point earlier about how they keep just starting things. But the funding for IAPT has continued to grow. And I personally think that it has been a good shake up. It was a wake-up call, any clinical psychologist who suggested it's okay to have a two year wait, because people will wait, well they won't, and it will damage them. It is disgraceful to suggest that that is an outcome. I now work for a Mental Health trust that provides IAPT services.

So, I suppose what I'm suggesting is there is a sense that we've been done to, and I think we need to take back our own ability to create, whether it's IAPT or any other initiative, because people have rightly said, this is about relationships and there are enough people to want it to happen. I am also passionate for alternatives to IAPT. IAPT does now incorporate other forms of therapy, including those therapy's that haven't historically existed and has got new ones coming in that I think are going to be interesting. It doesn't have to be just CBT, even Balint acknowledged that CBT only works for about 50% of people who experience it. And should we not be designing services where there's choice, where if CBT is the only thing that is available locally then we actually are required to provide alternatives?

Finally, I think it's important to realise that people are passionate enough to take back control. And I do think that somebody up there can clearly see the difficulties faced by those working in each department. And the department I think has shown that it's given responsibility over to local levels, because people like John and others picked it up and made something happen. So don't just complain about the nature of the system. We are the people; we should try and do this. And I hope the learning will be that you

should not have these things be done to you, you should be taking back control.

Maryanne Freer

Yes, IAPT fantastic and life changing for many people. I have to say however, I was also a GP mental Health Lead involved in the commissioning during IAPT. And basically, we'd set up primary care mental health teams and they became IAPT. So again, relating to what you were saying, it didn't have to be that way. And then we also have this complex patients' group which was very important. So just to sort of say some of the things I was involved in. Part of the thinking I think is about epidemiology and pathways and I think you know, at this point, the way we were tackling this nationally and also in northeast England. Trailblazers was very important in this because we were actually looking at service developments with really senior practitioners, generalists and specialists. Looking across the pathway from the patients' perspective, not getting into silos of services, is IAPT any good or whatever. And that goes back to relationships. So, I do want to flag that up and thank people. In the Northeast I worked with Dave Thompson, who was absolutely instrumental in this, and nationally with Andre, Venetia and other people, David Shiers in the West Midlands. So, really, really, really important and goes back to relationship. We could do a lot when we got a GP together with a very experienced CPN. We could change people's minds with that. You know, it's important not to get really fixed on everything as money. The second thing I'd just like to say is about the epidemiology and needs. And that's the next bit of my career. I began to work with the Charlie Waller Memorial Trust, and we looked at the epidemiology and it was young people we began to focus on. And that was actually about prevention, because we can never deal with the needs as they stand at the moment. I was just saying to Rachel before, we can't get into it now but look at COVID and the additional needs that we have now. So, we began to look at young people's mental health with a preventative agenda, and began to focus the work on education, GP consultation using generalist models, not specialist models, but focus on those young people who present, because we know 50% of mental health problems and illness present by the age of 15. And young people do go to see GPs alongside other professionals. So that felt really important about taking a long view, which does fit into the IAPT service development agenda about actually dealing with some of the needs on a preventative basis. And last thing I want to say is also

some work I did with David Shiers over in the West Midlands, a GP many of us will know. His big thing is severe mental illness and psychosis. So, when we look at this complex group, the forgotten group through prevention, we did a lot of work, which was actually about facilitating GP colleagues to be able to engage with this very, very difficult patient group to get help early, to stop that patient group moving on years later to use people like me, a psychiatrist, and NHS specialist services. So, I think just in summary, I think IAPT is fantastic but overall, it has to go back to people and actually what the needs are and looking at an integrated care pathway, and for us, it was actually trying to help the younger generation. Trying to get this through from the history to the next generation and to be able to carry that forward. And I'm sure we've all made a contribution, in different ways, to that agenda.

David Zigmond

Yes, okay. When you say it's fantastic, I think it's more mixed. That package might suit some people but it's going to miss an awful lot of others. My experience is very different. I'm not at all discounting the fact that that kind of packaging is often helpful in challenging the way some people think, but I think there are even more people who want and need something very different.

Now, let me give you a small survey of what happened in my own practice. I used to, for many years, employ my own counsellors; it wasn't very expensive. I had a series of them. We had a very good rapport; I would meet with them regularly. The satisfaction rates were very high and as far as I could tell those counsellors were usually very therapeutic. This small-scale excellence then got taken over by IAPT. I protested strongly. And I was told: NO, we're just going to provide everyone with a standardised (IAPTS) service. And then it got relocated and centralised at the Maudsley, where Andre was working. Very fortunately, I had a manager who perceived flaws in the system. But to begin with the patients still had to go to the Maudsley; so, what happened first were a lot of DNAs, and then many people didn't like it, then they would come back to me describing how they were just asked lots of questions, but there was no adequate address of their personal problems. So, there was something clearly wrong. Fortunately, the manager I complained to understood: she carefully chose more suitable practitioners and put them back to work in our practice premises. And that worked much better.

But it seems to me that the bigger conundrum is this: that we're using a lot of public money, and therefore there has to be public accountability, to subsidise things that are actually – by contrast – very intimate and nuanced. These mental health consultations are, or should be, very intimate and bespoke encounters. But we have come up with this specious idea: that we can change people's lives by bombarding them with a series of generically packaged techniques … often we can't. And the misassumption is that mental healthcare relies on conduction. In other words, we think we can change people procedurally from the outside rather than relationally from the inside. And that reductionism has been responsible for most of the therapeutic endeavour – and folly – of IAPT. And also, psychiatry generally, as well as CMHTs. One of the major indices of that is when I ask people. 'What's the name of the counsellor or psychiatrist you last saw?' And they don't know the name of the practitioner. Usually, the answer will give me a good predictor of whether they're going to be helped. And that's the kind of personal meaning and bonding that has been discarded.

Alan Cohen

Before you were talking about one of the major problems about fundholding being the inequity. And one of the bits that was, one of the consequences of fundholding, was that GPs were much more involved with the commissioning of mental health services. Their knowledge and their experience had increasing influence both good and evil, GPs were always involved. We were then faced with an enormous lump of money and a system with a potential service that was not inequitable. It was going to be delivered across the country equally. And that is extraordinary, we shouldn't get away from that. And absolutely, there are pros and cons as to whether CBT is the best system or whatever. But the idea that we're moving from an inequitable service to a service that would be fully funded across the whole country, which primary care could be involved and was involved is something that we shouldn't ignore. If there is one major flaw in the IAPT service, it's actually not the IAPT service, but the Mental Health Services who failed to address the 50% of people who don't get better. And we shouldn't you know, it's terribly easy to knock IAPT and say, oh, it's not very good for this, it's not very good for that. What about the people that it doesn't help? Where are the mental health services that we need for them?

Because what you get from the Mental Health trusts are they aren't ill enough. They haven't got psychosis, they aren't in acute crisis, we're not going to see them. And yet again, you have a significant number of people who have no access to treatment, and that's what we should be jumping up and down about! Okay, yes CBT isn't right for everybody. Absolutely. Andrew, you and I can argue that, but it's not right for everybody. Our patients will tell us, it's not right for everybody. But we've got to provide an equitable complete service and we're not doing that. And that's another lesson to take away from this. I have a really evil pitch to add about the voluntary sector providing IAPT services. I am the vice chair of Oxfordshire MIND; we have been providing services since 2005/2006. And I don't mind this being put down, transcribed and sent to the Chief Executive of Oxford Health Foundation Trust. The Chair of the Trust had made our existence so impossible, that we had to withdraw from the contract. I'm very happy for this to go back to the Chief Executive and the Chair as it might actually get them to move, thank you very much.

John Hague

Okay, so four quick things. The IAPT Services are good enough and achieve 50%. Some IAPT services are considerably better. And we really, really ought to try and learn the lessons from those really good ones and push them on to the services that aren't good enough because some are up to 70%+ recovery in many cases, and that's an achievement. We can't discount, the talk about fundholding and about defunding and what have you. There was I believe, a 20% cut across the board on the NHS around 10 years ago. And that was, certainly in our area, applied to mental health services and caused damage that continues to this day in terms of reduction in service and availability of services to patients. And I think that it will be wrong to point the finger of blame at IAPT in the context of the 20% or whatever it was. I have never met so many high-quality patient centred, hard-working people as the people that worked in IAPT. And it's been tremendous how they've said, we came across this problem with this service. We just fixed it. That's okay, isn't it? And that's what I'd like to see happen. And that's what certainly was happening locally towards the end of my tenure, and I'm wanting to emphasise about the GP IAPT leads that are led nationally and then all over the place. GPs were involved at every step of the way, in helping to introduce IAPT and helping to make sure it was as relevant to primary care as it could be. And we

certainly had IAPT workers working in our practices for many years until other things happened, but primary care really was involved. It's not perfect, but heck we're helping an awful lot of people. It's not IAPT's fault if you like, as Alan says, we've got people who aren't helped, and we need services for them too for that to lead the Neglected Majority.

Andre Tylee

Yes, I was one of the national leaders for IAPT as well as, as a multimorbidity lead nationally, helping David Clark and colleagues. I worked in our local IAPT for many years co-running multimorbidity groups with one of our senior staff, which went down very well. I think if IAPT is integrated with GPs and psychiatrists, and I thought Linda's example was fantastic, that was just amazing, then things should be good. But we suspected in our IAPT that there was this large cohort of patients that weren't being helped by IAPT. So, I managed to get some research funding and we looked at consecutive attenders to our IAPT in South London and we weren't at all surprised to find that about half of them were far too complex to have been referred to IAPT. They should never have gone to IAPT in the first place. Chiefly because they had histories of childhood abuse, all sorts of complexity, psychiatric multimorbidity, but chiefly abuse in childhood. It was very, very common. And so that really highlights that, they should, as Alan says, be working closely with the secondary level psychology services which luckily, we did have at the Maudsley. A good psychodynamic, psychotherapy team, although that's been depleted, partly because of IAPT thriving. But they need to be working together. So IAPT needs to be working with tertiary and secondary psychological services, psychotherapy services, and psychiatrists and GPs. And if they're not, then why aren't they? Because the others should be getting their act together and getting in on the act, like Linda describes so well.

Clare Hilton

These comments about the Treasury not really considering people, but people would go back to work as an outcome of IAPT. I beg to differ with my old age psychiatry hat on because old age psychiatrists were furious when there was a definite cut off age of 65 which was because of pension ages and not because of ability to benefit. I'm also a little bit uneasy about the fact that we've really overlooked older people's mental health, in particular, the dementias today. And I think in terms of protocols and guidelines, I just wonder how much, when the acetylcholinesterase inhibitors

were introduced, how much that de-skilled GPs from the dementia side because they've had to be prescribed through secondary care. We've also spoken about preventative medicine. I'd really like to see more CBT taught in schools as a self-help thing. And finally, I think if we're going to, with my history hat on, if we're going to look at change and look at the effect of history, I think we need to go back even further, and I think it's important that the first NHS reorganisations between 1948 and 1974, in many ways, that was the heyday of change in terms of creativity, in terms of clinicians leading the development of new practices in mental health.

Rachel Jenkins Thank you. Well, first of all, the uncontentious point is that I support the emphasis on prevention and health promotion. And I think they'd be subject to a lot of discussion. Now, what I wanted to say about IAPT as an observer from Mars as it were, having left the Department of Health and almost the UK before it came in. To me, it's been something of a disaster. And what I see is a shift, present company excluded, because you have the enthusiasts here who know how to implement things and do it with enthusiasm and make it work. But generally, it feels to me as if the GPs who I knew and loved and so on and felt were really getting strong on mental health have become deskilled by IAPT, and that it's become a case of saying oh yes, a lot of mental health problems here, we will refer, if that doesn't work, we go on to specialist services. But the idea that you would do good multiaxial assessment, diagnosis, and management in primary care, and that the buck stops here, and that yes, you'd refer if you have to, but mostly, this business is our business and will do it here. That seems to me to have gone overboard. And often, when I talk to GP friends, they get very cross with me and they're saying all the time, well how can you expect me to do mental health stuff when I'm so busy? How can you expect that, it's not reasonable? And whereas 20 years ago, people weren't saying that, now it feels to me as if people are becoming doctors from the neck down, and that they think that's reasonable. And I don't think it is. I totally take the point that specialist services are horribly fragmented, all these different teams. I hear from all my friends who know people with mental illness, that they fall in between the cracks. Yes, absolutely. But at the moment, our discussion is on IAPT. I just want to be the person who said, I don't think this is right. And one of the reasons I mentioned that pilot project was because I think the epidemiology shows us these mental problems are highly

associated with physical and social problems. So, it seems to me that both the assessment and management needs to be highly multiaxial. And young psychologists are not doing that, they're in one axis, they're not across 3 axes. So, for me, that is a big, big problem. And I've talked to David Clark about this twice really. Once was at the beginning, I was invited to the Cabinet Office meeting with him, Richard Layard and David Miliband, who was in the chair, but unfortunately David M shot off halfway to something more important. And I was trying to talk about these previous projects, which had shown, I thought, that if you put somebody inside primary care, they'll drown with all the referrals. Instead, you want a strengthening sort of facilitation approach. Well, this wasn't what David Clark wanted to hear. The next time I met him was in the queue at the Maudsley, I think having lunch or something and I was trying to talk about the problems of the association between physical and social problems and he said, well it's alright Rachel, because we've now redesigned IAPT so that we deal with asthma as well. As if asthma was the only physical problem, you could possibly get that was associated with psychological issues. I'm not happy about it. And a further problem I think, is you might remember Charlie Brooker's survey of CPNs. Do you remember that? He showed that 80% of the CPNs in general practice were not seeing anybody with psychosis at all. So, you've got this highly specialised resource going in to deal with people with fewer, less complex symptoms. And the specialist services have lost a very important resource to look after all those people with psychosis in the community. To me psychology is very important. It's a brilliant therapeutic resource. But I think much of it should be retained in a specialist service.

Ian McPherson

Sorry but it is being retained. I think you're describing something which is completely unjustified. I think we just listened to some of the colleagues here who were actually directly involved. Andre just described the comorbidity/multimorbidity work which has been done, and there are so many things there. I'm only suggesting that, given what John said, you're giving this notion that IAPT is responsible for all these things. While IAPT has been not well used, and it has been misused and there has been collusion by mental health providers. But the investment that came in, is the largest investment that mental health has ever had.

Rachel Jenkins

I think it could have been used differently. My point is not to negate the good things I've heard in this room, which are very, very good. I'm trying to take a national perspective from just a bystander now and saying it looks to me as if severe problems have resulted.

John Hall

First of all, just to say, I'm delighted that this day has occurred. It did occur through a conversation I had with Alan. I've got to know Alan over the last five years when we were co-trustees of Oxfordshire MIND, and I've been planning a book to be called the Mental Health Tribes, looking at the contribution of different professions and paraprofessional groups to mental health which I will talk about in a moment. And then when I began to look at the history of general practitioners, I realised there was a hole in the literature, and I think very little has been written about the history. And I think this workshop, this seminar will be extremely helpful, both in filling up some of those gaps and also, I hope, leading to some other research work in this field. I said I was concerned about this and his next thing was to send me a list of emails of seven of his mates and he said they're all expecting to hear from you John. And I've spoken to several of them here and that's been very helpful. So, before this day started, I had a framework, but I knew what some of the issues were. I just want to comment on the three of them because I think they're quite important. The first one is we've actually heard a lot about David Goldberg. I met David Goldberg on a number of occasions, and he is a force to be reckoned with. What nobody has referred to specifically, there are a number of his key books which have been referred to Michael Shepard's book 1986, but nobody's actually referred explicitly to Goldberg's and Huxley 1980 Mental Illness in the community, which I think is a key book. Now it is of course co-written with Peter Huxley. I met Peter Huxley about a month ago and had a very illuminating conversation with him. And I think the whole issue of their model of services helping people move through services, which are fragmented organisationally, in site and in funding is an extremely important one. I think it's a very powerful concept. And it ties up with the points a number of people have made about gaps in the system where discharge criteria from one service don't match up with acceptance for another and somebody falls into a black hole. That's a serious issue. And I would suggest that Goldberg and Huxley, if we are identifying key books in this, that's a real must read. And some of the later manifestations to that. I want to make two other points. This last session has been

called Living in Primary Care by Guidelines. And we've particularly made it around IAPT. Now what none of you know is I've known David Clark for 42 years. He was a young PhD student in Oxford when I arrived there as the head clinical psychologist. I'm not going to go down that road, I have very strong views about it. I'm not going to reveal those at the moment, only to say what's surprising about this discussion is that you're delivering primary care by guidelines. There's a whole set of other guidelines which now affect practice, which we haven't mentioned at all. And the most obvious are of course, that under the Labour government's National Service framework a whole series of detailed policy and practice guidelines were issued which when I was clinical director in Oxford, rejoiced in the name of PIGs (Policy Implementation Guides). And my life as a clinical director was led, armed by every year we would have an audit of these things as well, 30 of them all together, and we checked all these. Another thing of course, is NICE (National Institute for Health and Care Excellence), which we haven't talked about at all. I want to introduce another concept because if we put these two together, forget all the details about IAPT. If we put together these sorts of approaches, we're looking at the change in regulatory culture. And in some other work, I'm doing some historical work at the moment with a very interesting social anthropologist who's introduced me to this concept. Huw Freeman when he was writing about pre-1974, he said exactly this, there was clinical freedom. And if you had a good idea, and you could sway your local agency, there was autonomy and those innovations without constraints. And I think this concept of regulatory culture is again quite a useful thing to get our head around the whole tension between quite proper improvement of clinical practice, but also allowing autonomy and clinical practice. And clearly listening to all of you, it relates very much to the whole question of agency and locus of control. Do we have power in making these decisions? That's the second one.

And the third one, again, has been floating around all the time. It relates to IAPT, as I say with Alan, we've been running this IAPT Service. I have been a volunteer for Oxfordshire MIND for 10 years in one of the day centres there and we have a procession of young psychology graduates and students from Oxford University, all desperately wanting to be clinical psychologists. And I've known a number of these people and they've been recruited as IAPT practitioners. But one of the main personal reasons why they're

doing it is that it's a brownie point to help them get onto a clinical psychology course. So inadequate thought was given to the whole question of workforce sustainability. Nobody's talked about graduate primary care mental health workers, remember them. There's been a whole series of new groups of workers who have come in and for a number of these people, after seeing the GP, the first person they see will not necessarily be a psychiatrist. In fact, it's quite unlikely that they will be. And one of the things I took from the previous interviews with your colleagues was this whole question of the view which is encapsulated in Goldberg and Huxley that the GP is the first point of contact; they are the filter. Actually, a whole set of other people are now controlling referrals and decisions, and I think a very important aspect of interfaces between primary care and secondary care as well as mental health services is the whole question of having a sustainable and adequately competent workforce. And that's a big issue and one of the most interesting things is how people are flexible now. So, your professional origin now no longer dictates the work that you will do. So, I think that in this whole question of primary care and mental health, the whole question of alongside the actual doctor is who the other people are? And are they sustainable? Do they have the right competence? Do they actually see a career in front of them? Because actually, IAPT practitioners do not see a future in front of them, because they get out as soon as they can be a clinical psychologist.

Venetia Young

Okay, I won't go into the IAPT rage, my experience in Cumbria was very different from Linda Gask's, I helped her teaching graduate mental health workers in Preston, and she was very accepting of a systemic point of view. I was dismissed from helping with the IAPT service in Cumbria because it confused people talking about family trees.

What I wanted to talk about was QOF (Quality and Outcomes Framework) because I think that's quite important. Because I decided with my practice nurse that we would do the QOF survey on mental illness, and we did it. We got 95% attendance in the first year. And my reflection at the end of that year was these people don't complain enough. Can we make that our goal for next year that we start to get these people to complain about the care they get or are getting in terms of medication? And we achieved that slowly. One patient said oh, I don't want you to tell the psychiatrist about this discussion we've had about my side effects education,

because it will make the psychiatrist cross if you do that. So, she wouldn't let me the first year. Second year we progressed, and she would, and he was cross. So, we've had a sort of interesting journey. But the QOF for dementia, as you've mentioned, it was really, really important that we managed to get our diagnoses straight up to what they should have been for our area and getting appropriate treatments to people on antipsychotics. We did quite well at that. I wouldn't have done it if hadn't been for Hillcroft. Though I thought the tick boxes were pots and pans. We just did them because that's what you had to do to earn money. But we decided to add something to give an extra benefit to what we did. Then tried to get an article I wrote on what we did published. You can't get things from primary care mental health published. And then the other thing I wanted to say is that we were told we have to use PHQ-9 (Patient Health Questionnaire), which was designed by Pfizer. And more of them research things that increase the prescribing of anti-depressants. My practice nurses didn't want to use the holy two questions for cardio-vascular disease. So, they used a different set which was longer because they liked it. Because it involved "I" statements and it also addressed post-traumatic stress and suicidal thoughts. And we had a pathway for dealing with the different responses. I gave a selected group of 10 users and carers all the different assessments on primary care to look at. And all but one person said the same negative things about the PHQ-9, they liked things with "I" statements because they would be more honest, and I don't know whether that work ever got done. And then I did do a frequent attenders audit, which again, took my colleague about 20 different versions to get it published and we reduced our frequent attenders to a quarter in one year by probably mainly focusing on continuity of care, and I achieve continuity of care with my patients who needed it even though I worked part time.

Andrew Elder

I'll be brief, I do just want to mention babies and children and families in a day about primary care, general practice, antenatal care, everything going on and mental health. A key area is post-natal depression, antenatal health, the mental health of children. Absolutely. We adults are incredibly greedy of this sort of attention that we give. Now, I would relate that to something else, which is a sort of institutionalised intellectual split between medicine and psychological understanding. So, attachment work, there is a huge amount of knowledge now in attachment theory, barely ever

acknowledged, little understood within the institutional areas of medicine. Huge problem. Rachel earlier mentioned I think hard end bias, which struck me as a phrase, and in general practice well in representing politically, things which are very clearly defined. Everybody minds about cancer, suicide, all the rest of it. But there's great difficulty in representing the complexity of the work that actually goes on in a lot of GP practices and primary care, and until there is a bit of a shift, so that some of the knowledge that actually comes from attachment work and all sorts of other areas as well is incorporated, it's not all just medical model diagnostic driven, we will continue to have problems. Lastly, a really good friend of mine, a GP professor at King's used to, in his practice, have a diagnostic coding which they wrote in the notes TMFTN which was Too Mad for the Maudsley, that was the catch phrase. And this represented, as all GPs know, a huge number of people who come in and after GP surgery, to a certain extent are modified by the relationship they have with somebody who knows about their life, knows about the tragedies that have befallen them etc. etc. Really, really valuable but not easily treatable. Going back to this morning, I remember you mentioned Jack Norrel, he used to say life is not a treatable condition. Very, very common phrase. And that really brings me to all clinicians have to cope and deal with what cannot be done either themselves or for other people. It's extremely painful. It's an advanced professional skill, and there's nowhere where it is felt more acutely than in general practice. People coming in and out absolutely every 10 minutes. It is the most acute interface between need, want, desire and reality. Very, very difficult place to live. And one of the things we do as GPs and I reflected on this a lot when working, is sometimes we recommend a treatment because actually it really is in the patient's best interest. Very often we recommend treatment because we can't stand it any longer.

David Zigmond

I will have to be punchy and brief. You said something about how we'll work together. There's a new thing coming up called the Integrated Care Service. It all sounds good, doesn't it? 'Integration', I can't argue, that sounds good. 'Care', sounds comforting. 'Service', everyone wants that. Right? But it's a little bit like a lot of mental health services, because what actually happens is that we develop such enormous services that people struggle to know one another. Yet – as I keep saying – we can't provide good care if people don't know one another. Practitioners have got to know not just the

patients, but their staff and the colleagues that they refer to. Otherwise, it cannot be meaningfully integrated; it's not possible to personally integrate merely with algorithms and institutional protocols. It never is.

And these are the kind of things that have undermined, in my view, mental health services. What I call the *4 Cs*: competition, commissioning, commodification and commercialisation. So that's a *marketized system*. Then we have a *policed system*, which is really REMIC: remote management inspection and compliance, where we try to control everything – as if we are functioning and directed by an air traffic control centre. Everything then becomes more digitally directed. And then we have *Gigantism*, where we now sacrifice whatever we can to bigger and bigger units. And that of course, accentuates the remoteness of the nature of what should be essentially very personal encounters. That is, in my view, what mental health is mostly about: personal context, meaning and struggle.

So we must beware when lured to industrialising and mass production in mental healthcare.

Thanks.

Tony Kendrick

I think running through what's been said through the whole day really is the tension between them being person centred on the one hand and being evidence based on the other. Practising as an individual GP trying to do your best for the person in front of you, trying to interpret what will help them as exemplified by the sort of Balint approach versus thinking about your practice population as a whole. Where can you make the best impact by using the best evidence? Which is a kind of NICE approach. I've been involved in NICE guidelines over the last 12 years or so. And prior to that was involved in the QOF which was interpreting NICE guidelines. And the NICE guidelines come with the implicit potential for reward through the QOF or sanctioning if you don't follow them or are shown in a case where something's gone wrong not to follow them. Neither the entirely person-centred approach nor the evidence-based approach is satisfactory. We were criticised for the first iteration of the Depression guideline a couple of years ago and we went back to look again at patient choice because we were being fairly traditional

in thinking about only the evidence base. The revised NICE guideline on depression is coming out at the end of this month, and we've tried to square this circle which is a difficult one and meet this tension with an approach that says patient preference is important, evidence base is important. Patients should be given a menu of potential evidence-based treatments and information about them to empower them to try and make a choice. Obviously, at the moment, choice is severely limited because there are waiting lists for standard treatments, let alone the less standard treatments which might need to be developed. But that's the approach that we're taking in the new NICE guideline. And I think that's the approach that we're going to have to take in order to try and cope with this tension between trying to do your best when the person in front of you has their own ideas about their problems and their preferences, whilst at the same time not wasting resources on things which have not shown to have an evidence base.

Lydia Thurston Thank you, that brings us to the end of the session.

Andre Tylee I just want to say thank you Tony. I think that was a very good summary, actually, very helpful. Engenders loads of optimism there as well. I look forward to seeing that NICE guideline. I'd love to thank everybody who's been here today. You've all come most, a lot of you have come huge distances to be here. So, thank you so much. And I get a real sense from today that there's a Gestalt. We've got this picture now that we didn't have at the beginning of the day. Which you've all contributed to. And you've all reminded me about so many things that I've forgotten about, along the way the last 30/40 years. And it's been such a valuable discussion. I think we're going to have a very good result here. As John said earlier, this will be a fantastic transcript. I hope that historians, maybe policymakers, even hopefully the Treasury get to read and learn from it… So, thank you so much. It's been brilliant and I hope you'll enjoy reading the transcript in due course. Thank you so much to Implemental so, Tracey, Jonathan and Morgane, for making this possible and making all of the arrangements for today. Thank you to Tom Craig, who's actually funded this out of his chairman's funds for the Psychiatric Research Trust at the Maudsley. Tom has a personal chairman's fund, which is to be used over 2 accounting years. So, a big thanks to Tom for making this possible.

List of Attendees

Those in italics attended virtually via Zoom, and those in blue were part of the Implemental Organisation Team.

Alan Cohen
Andre Tylee
Andrew Elder
Barry Lewis
Chris Dowrick
Claire Hilton
Clare Gerada
David Zigmond
Graham Ash
Huw Lloyd
Ian McPherson
Irwin Nazareth
Jeremy Broadhead
John Hague
John Hall
Jonathan Rolfe
Lawrence Buckman
Lydia Thurston
Maryanne Freer
Morgane Gaschet
Nav Chana
Rachel Jenkins
Sue Tylee
Tom Burns
Tracey Power
Venetia Young

The following people were unable to attend but contributed to the online bibliography:

Carolyn Chew Graham
Gabriel Ivbijaro

Some contributors submitted biographies which are available to view online at The History of Mental Health in Primary Care - Datashare

Photographs from the event

Photo 1: Some of the attendees, from left to right: Ian McPhereson, John Hall, Venetia Young, Claire Hilton, Lawrence Buckman, Andrew Elder, Huw Lloyd, John Hague, Barry Lewis, Andre Tylee, Lydia Thurston, David Zigmond, Alan Cohen, Rachel Jenkins, Jeremy Broadhead, Nav Chana and Sue Tylee.

Photo 2: Venitia Young, David Zigmond and Andrew Elder.

Photo 3: Lydia Thurston, Andre Tylee, Tom Burns, Alan Cohen

Abbreviations

A&E	Accident and Emergencies
GMS	General Medical Services
GP	General Practitioner
NHS	National Health Services
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatry
HIV	Human Immunodeficiency Virus
RSM	Royal Society of Medicine
IAPT	Adult Improving Access to Psychological Therapies
CBT	Cognitive Behavioural Therapy
CPN	Community Psychiatric Nurse
CPA	Care Program Approach
FHSA	Family Health Services Authority
FPC	Family Practitioner Committee
WHO	World Health Organisation
Barts	St Bartholomew's Medical Centre
CMHT	Community Mental Health Team
OT	Occupational Therapist
PCG	Primary Care Group
PCT	Primary Care Trust
CCG	Clinical Commissioning Group
ICP	Integrated Care Provider
CCT	Certificate of Completion of Training
BMA	British Medical Association
SSRI	Selective serotonin reuptake inhibitors
DASS	Depression Anxiety Stress Scales
PHQ	Patient Health Questionnaire
NICE	National Institute for Health and Care Excellence
DOJ	Department of Justice
QOF	Quality and Outcomes Framework
CADET	Collaborative Depression Trial
COINCIDE	Collaborative Interventions for Circulation and Depression

Bibliography

The bibliography and supporting grey literature is available to view online at: The History of Mental Health in Primary Care - Datashare

Acknowledgements

We would like to thank Professor Tom Craig at the Psychiatry Research Trust and Implemental (https://implemental.org) for their financial and logistical support. Implemental Worldwide Community Interest Company is a social enterprise with an ambition to support an international network of colleagues who are committed to improving mental health services. Their work includes promoting good mental health and mental wellbeing as well as developing and improving services and support for people who have mental health problems. They work with governments, providers of health and social care services and employers in the public, private and voluntary sectors in many different countries.