

Modelling the Interface between Primary Care and Specialist Mental Health Services: A Tool for Commissioning

Authors: *Renata Souza, Sue Patterson, Aarti Gandesha, Maureen McGeorge, Alan Quirk and Mike Crawford*

March 2015

Contents

Acknowledgements.....	2
Executive Summary	3
1. Background	7
2. Aims	8
3. Method.....	9
4. Results.....	10
4.1 Working across the Interface of primary and specialist care: models identified in the literature	10
4.1.1. Collaborative care models	11
4.1.2. Consultation liaison models.....	11
4.1.3. Referral model.....	12
4.2. Service users' experience of accessing specialised mental health care	12
4.3. Patient groups, interfaces and integration in practice.....	15
4.3.1. Referral model.....	16
4.3.2. Shared care models	18
4.3.3. Consultation liaison models.....	20
4.3.4. Facilitated-transition model.....	22
4.3.5. Stepped care model.....	23
5. Considerations for commissioning.....	23
5.1 Historic disconnection between mental health and physical health	23
5.2 Commissioning systems and structures;	24
commodification of health care, resourcing.....	24
5.3 Scope of primary care mental health.....	24
5.4 Collaborative ethos, communication and role clarity	25
6. Information sheets about interface models: A tool for commissioning	26
Useful resources.....	27
References.....	28
Appendices	29
Appendix A: Interfaces involved in the provision and access of mental health care.....	29
Appendix B: Information sheets for Commissioners.....	30

If citing this report, please reference it as:

Souza R, Patterson S, Gandesha A, McGeorge M, Quirk A, Crawford M (2015) Modelling the interface between primary care and specialist mental health services: A tool for commissioning. London: Royal College of Psychiatrists.

Acknowledgements

This report is grounded in the experiences of people who have experienced mental health difficulties and used specialised services, and health professionals and commissioners. We are grateful to the fourteen service users who kindly shared their experiences of help seeking and service use with us, and to those who helped us organise the focus group for young people and the interviews with adult service users. We also acknowledge the vital contribution of 15 professionals who made time to answer our questions and share their professional experiences with us. These include Michael Bates, Clinical Lead and Cognitive Behavioural Psychotherapist; Nancy Küchemann, Clinical Lead; Amrit Sachar, Consultant Liaison Psychiatrist; Rob Chaplin, Research Fellow and Consultant Psychiatrist; and Linda Gask, Emerita Professor of Primary Care Psychiatry.

Executive Summary

Background

This project was commissioned by the East of England Strategic Clinical Network to inform commissioning of primary care mental health services such that people with mental health problems of varying severity needing specialised input receive quality care, tailored to meet their needs in a seamless and timely manner.

Method

We combined a selective literature review with stakeholder consultation. The literature review was carried out to identify the main models used to support professionals working across the interface of the primary care and specialist services, specifically in relation to mental health care. The stakeholder consultation involved 15 health professionals, including psychiatrists, GPs, psychologists, commissioners and team leads, and 14 service users (adults and young people) who identified as having mental health problems. Our focus in the consultation was on identifying practices being employed to work across boundaries in the East of England and elsewhere, factors influencing practice, and the experience of working with various practices.

Results

Working across the Interface of primary and specialist care: models identified in the literature

We located three relevant systematic reviews and three key papers, collectively supporting identification of three principal models of inter-professional/inter-agency integrated working around people with mental health problems of varying severity. These were (1) collaborative care, (2) consultation liaison, and (3) referral models.

Collaborative care is a term used generally to characterise a range of working relationships between organisations, within organisations or between professionals, and specifically to refer to models of care which satisfy certain (but variable) criteria. It is also used more specifically to refer to particular ways of working involving multi-disciplinary teams working in 'joined up' ways to manage the care of patients with needs requiring specialised input. Particular models of collaborative care have been associated with increased treatment engagement and satisfaction with care and symptom reduction in people with depression. However gains are modest and there is still limited evidence regarding use with people experiencing anxiety and severe mental illness.

In *consultation liaison* models (which are configured in various ways), primary care providers have access to specialist mental health professionals who provide advice and support to guide the management of mental health problems. Consultation liaison is designed to promote management of the patient in primary care and settings close to home. It can also provide a gatekeeping function with specialist mental health providers assessing the need for referral or another collaborative model of care. As with other arrangements involving inter-agency work, effectiveness of the model is dependent on clarity of roles and capacity of the services involved to meet demand. There is some

evidence that working within this model can support development of knowledge and skills and change the way primary care clinicians work', but evidence is lacking regarding patient outcomes.

Referral models involve transfer of responsibility for the assessment, diagnosis and management of a presenting problem to a specialist for the duration of treatment. In relation to mental health, referral can be made to specialist services external to the primary care practice or to specialist health professionals (e.g. psychologists or counsellors) 'attached' to primary care practices. External specialist services or attached professionals receive referrals and when accepted take over management of the presenting problem discharging back to primary care when specialist input is no longer needed.

Service users' experience of accessing specialised mental health care

Many of the service users who took part in the consultation - young people and adults - expressed confusion about 'the system' and where and how to seek help. Adults had more frequently accessed care through general practitioners than the young people for whom parents, friends and 'responsible adults' in their school were central to help-seeking. Two adults told us that it was not until after they 'changed GPs' that mental health problems were identified and they were referred for specialised help. Another significant factor identified by the adults was their GPs' unhelpful 'get a grip' attitude.

Patient groups

Our consultation identified different patient groups for whom working across boundaries may be needed. These were people with: (a) common mental health problems requiring more help than their GP alone can provide; (b) severe mental illness 'stepping back' from secondary care to be maintained in primary care after a period of intensive support; (c) serious mental illness presenting to primary care in crisis; and (d) serious mental illness gaining access to CBT etc/secondary care.

Working across the interface of primary and specialist care: models identified in consultation

Consultation with service users and professionals supported identification of five different ways of working across the primary/secondary care interface. These 'practice-based' models, summarised below, generally fit within the models identified in the literature outlined above.

- 1. Referral model:** All professionals and most service users had experience of 'referral'. Most regarded it appropriate in some circumstances, particularly where mental health needs were perceived as acute. Stakeholders reported that success of the model was dependent on the appropriateness of referrals, capacity of the receiving service to provide needed services, timely transfer of accurate information and engagement of the patient in the process.
- 2. Shared care models:** We identified two models involving shared-care arrangements. The first we describe as inter-agency shared care because it involves location of responsibility for different aspects of mental health care to health professionals located in different agencies. The key strength of this model, when appropriately enacted is clarity about the responsibilities of each service

provider such that patient care is optimised. The key challenge is that success depends on engagement of the patient so may not be appropriate for all, such as service users receiving compulsory treatment. Success also depends on the capacity of GP and specialist services, and timely, accurate communication between them, especially if the patient's condition deteriorates and changes in treatment are required. In the second shared care model - intra-agency shared care - mental health care is shared by two providers located within the same setting, who offer complementary expertise and work collaboratively to meet the patient's needs. Advantages for service users included 'normalisation' of accessing mental health care - *'like you're going for an ordinary doctor's appointment'*.

- 3. Consultation liaison models:** We identified two consultation liaison practices, characterised by provision of 'expert' advice by one practitioner to another but differentiated by the location of the specialist practitioner. In 'intra-agency shared care' a mental health specialist (consultant psychiatrist/psychologist/ counsellor) working on a sessional basis as part of the GP practice team, provides specialist advice to the GP at the invitation of the GP. In the second consultation liaison model a mental health specialist who remains a member of an external service 'consults' with a GP in relation to patients/cases satisfying particular criteria. Occasionally in consultation liaison models the specialist might consult directly with the patient but the primary therapeutic relationship remains Patient – GP. Advantages of this model identified by professionals included facilitation of collegiate relationships across the primary/secondary care 'divide' enabling sharing of complementary expertise and obviation of the need for patients to see multiple practitioners.
- 4. Facilitated transition model:** In this model transition from specialist service to primary care was facilitated, enabled or supported by a worker dedicated to the role. The interim provider (a link worker or 'navigator') might be employed by the specialist or primary care service or a third agency with the functions dependent on the level of training of the link worker or navigator. Participants in our consultation with experience of this model emphasised the importance of agreement amongst parties involved regarding roles and responsibilities of parties involved. The key advantage of facilitated transition identified by stakeholders was the promotion of continuity of care and its corollary, reduced risk of loss to follow-up.
- 5. Stepped care model:** The stepped care model involves referral of a patient to self-help interventions and/or a practitioner or service best suited to meet a patient's needs. The underlying principle is that the patient receives care of an appropriate intensity in the least restrictive, safe environment possible. Formalised stepped care is designed to regulate access to services by establishing clear entry and exit criteria for different levels of treatment.

Information sheets about interface models: A tool for commissioning

The literature review and stakeholder consultation supported the development of information sheets describing models of working across the interface between primary care and specialist mental health services (Appendix B). These information sheets describe the models, population groups for which they may be applicable, summarise strengths and limitations and outline examples of good practice specific or practical considerations pertinent to that model. The intention is that these information sheets can support commissioners and service providers by:

1. enabling identification of model(s) being employed locally and critical review of their operation;
2. informing consideration of the suitability of each model for identified local needs and circumstances; and
3. informing consideration of alternative interface models that could complement those already in practice

Please note that each model has strengths and weaknesses and effectiveness will always depend on the ways in which models are implemented. Optimum outcomes are likely to be dependent on a patient centred, collaborative ethos, clarity of roles and responsibilities and clear and timely communication of accurate information. (see principles for commissioning sheet)

1. Background

About this report

This report was commissioned by the East of England Strategic Clinical Network. The literature review and stakeholder consultation reported here supported the development of four information sheets describing models of working across the interface between primary care and specialist mental health services and development of a set of principles for integrated working. The information sheets have been designed to enable consideration of models when commissioning decisions are being made. They are the main output of the project. The information sheets can be found in Appendix B.

Ensuring timely access to high quality, efficiently delivered health care is a moral and economic imperative. Promotion of health, prevention of illness and early intervention are needed to improve public health and make efficient use of available resources. Primary care services play a central, and increasing role in efforts to improve public health and wellbeing and reduce the burden of disease¹. Primary care teams have substantial responsibilities both in direct provision of care and in mediating and regulating access to secondary care and specialist services. Multiple legislative, policy and high level strategic documents and innovations are changing the face of primary care, requiring a rethinking of care pathways and coordination of care (and thus commissioning). across service sectors and providers. The aim of delivering patient centred, compassionate and co-ordinated care as close as possible to home is at the heart of transformation of services.

Pursuant to this and enacting the commitment to adopt new models of care as articulated in Five Year Forward View, The NHS has recently (March 2015) identified 29 "vanguard" sites for introduction of new integrated healthcare models. In what has been called a radical care redesign, the models to be implemented and evaluated target different population groups but focus on people with long term conditions.

The centrality of Primary Care to mental health

The 2012 Health and Social Care Act enshrined the role that providers of primary care services play in commissioning NHS services with Clinical Commissioning Groups assuming responsibility for around £60 billion of public funds. The overarching aims of the reform set out in the Act were to reduce inefficiency, and increase patient choice and improve patient outcome. While important across health care, this report is specifically concerned with mental health.

The prevalence of mental health problems and mental illnesses and their impact on individuals and society underpins the Parity of Esteem Programme* which is critical to development of mental health care. Designed to ensure that people with mental health related needs receive appropriate services in a timely way, The Parity of Esteem Programme is founded in recognition that:

- mental illnesses are very common and hugely costly;
- few people with common mental illnesses (anxiety and depression) receive evidence based treatment;
- people with poor physical health are at higher risk of experiencing mental health problems; and
- people with poor mental health are more likely to have poor physical health.

*<http://www.england.nhs.uk/wp-content/uploads/2014/02/nhs-parity.pdf>

Policy endorses the view that provision of high quality healthcare requires integration of mental health and physical health strategies and integration of mental health care of varying types, delivered in various settings at different levels of the health system².

With an increasing expectation that mental health needs will be identified and, where possible, managed in primary care settings, the notion of 'primary care mental health' has emerged. While still conceptually fuzzy, there is consensus that primary care mental health involves provision of care meeting mental health needs in the community, close to home, in a minimally intrusive way. It encompasses (but may not be limited to) early identification of mental health problems, better management of chronic illness and associated mental health problems and improvements in collaborative relationship between patients, the primary care team, and other relevant healthcare providers and organisations¹.

GPs are at the centre of primary care mental health, detecting mental health problems and related needs, intervening where possible and appropriate, and gate keeping to appropriate services³. Since GPs hold comprehensive information about the patient's history and circumstances, it is argued they are key to ensuring that services are personalised. Moreover as the key service provider, GPs are responsible for ensuring transition, between primary and specialist services, is smooth and addresses patients' social and environmental, as well as physical and psychological needs⁴.

This is no simple task however: the complexity and diversity of mental health conditions, the variety of services across primary, secondary and third sectors, and contextual variability mean that a 'one size fits all approach' is untenable and various options must be explored with applicability to context critical to success.

While guidance for commissioners of primary mental health care services provides some advice identifying critical ingredients of a good service – including a knowledgeable and skilled primary care team and ensuring the interfaces between the different parts of the system are seamless and meet patients' needs – there is no standardised model 'for commissioning and provision of primary mental health care services'¹. Commissioners, obliged to purchase services that fit local contexts, require information about stakeholder expectations and experiences, and current and possible practices to inform decision making.

2. Aims

This study was designed primarily to inform commissioning of primary care mental health services such that people with mental health problems of varying severity needing specialised input receive quality care, tailored to meet their needs in a seamless and timely manner.

Our objectives were to:

1. identify conceptual and practice based models of collaborative/integrated working that could be applied to support primary care mental health, where specialist input is required;

2. describe the influences on practice across the interface likely to be operating in the East of England;
3. identify routes of access to secondary care mental health services, care pathways and transition/interfaces along the pathway;
4. describe experiences of health practitioners and service users with respect to collaborative working, transition between services and/or receipt of mental health care in primary care settings; and
5. produce practical 'information sheets' to guide consideration of each interface models identified.

3. Method

We employed a mixed-methods design, combining a selective review of primary and secondary literature with stakeholder consultation. We sought to develop knowledge that could be usefully applied to inform commissioning decisions.

Literature review

We selectively reviewed the mental health and collaborative care literature to identify the main models used to support working within and across the interface of the primary care and specialist services, particularly in relation to mental health care. We located pertinent articles and reports using Cochrane database, Google Scholar and other databases, and recommendations by stakeholders. Search terms used included; integrated, collaborative, interface, shared-care, with primary care and mental health or psychiatry.

Stakeholder consultation

We undertook an extensive consultation involving professionals and people who self-identified as having mental health problems (young people and adults). We sought to include people likely to have knowledge or experiences of delivering or receiving services 'across boundaries' from different perspectives. Our focus in the consultation was on identifying models used to work across boundaries, factors influencing practice and the experience of working with various models.

Participants were identified differently dependent on their stakeholder group: young people, adult service users or professionals. Professionals were identified by project commissioners, through Royal College of Psychiatry professional networks and as authors of pertinent papers. Potential participants were invited to take part in the consultation by a member of the study team by email or telephone. All who were invited to take part did so. The 15 participants were five psychiatrists, three general practitioners (including two involved in commissioning), three consultant psychologists/CBT therapists working in primary care settings, one nurse consultant and three team leads/project coordinators working in different health care settings including primary and secondary care NHS services and the independent/voluntary sector. Contact with the seven young people was made through a third sector agency providing social support, with which they were involved. The seven adult service user participants were recruited through an advertisement circulated through service user networks at three NHS Trusts in the East of England. All participants were advised that the purpose of consultation was to inform quality improvement and gave consent to use of information provided in this report.

Data were collected from professionals and adult service users in semi-structured telephone interviews and from young people in a focus group. Data were collected by members of the project team between November 2014 and January 2015.

Interviews and the focus group with service users explored their treatment journeys, particularly:

- access to care;
- transition between components of the system; and
- experiences of the care received generally and specifically in relation to the models of service they'd encountered.

Interviews and the focus group were recorded with permission and transcribed verbatim for analysis.

Data were analysed by the project team using narrative synthesis and the framework approach⁵.

4. Results

The results are presented in four sections. The first section, 4.1, provides an overview of models of working across boundaries being employed in mental health/primary care context, as identified in the literature. Next, in 4.2, we draw on the accounts of service users to outline pathways to mental health care, first points of contact and interfaces involved in accessing specialised care. Following that, in 4.3, we combine what service users told us with information from health practitioners to outline five practice-based models of the interface between primary care and specialist mental health services. In the final section we present four key issues for consideration by commissioners. The results presented in these sections have informed development of fact sheets (appendix B) designed to support commissioners making decisions about models of care.

A note on terminology: Many terms have been used to describe the provision of care involving more than one health professional, department or agency simultaneously or sequentially. Some of these such as 'integrated' 'shared care' and 'collaborative' have both general and specific meanings. To avoid confusion with particular models of care we use the term 'interface' as in 'working across' or 'at the interface' when referring to care which crosses boundaries between services or professionals.

4.1 Working across the Interface of primary and specialist care: models identified in the literature

Review of the literature demonstrated the challenges of provision of care where more than one health professional or service was involved, generally and particularly for people with mental health needs requiring specialised intervention or support.

A substantial literature describes multiple barriers to interface working and challenges for commissioners and service providers seeking to ensure people with mental health related needs receive quality care. Chief amongst these is the deep level disconnection between physical and mental health which has long shaped thinking and health care design and

delivery. Also identified internationally is a fundamental disconnection between acute and primary health care services and their separation from social services in funding and service delivery. Principles for good practice, grounded in various theoretical models of integration and empirical study are also clearly articulated. Systems which 'talk to each other', and health professionals who understand each other and work collaboratively to deliver patient centred care and strong leadership are repeatedly identified as critical to positive outcomes.

Consensus is that there is much talk of integrated care – “a 65 year history of statements of intent around better integrated care for people with mental health problems”⁶ – but that practice lags behind articulated commitment. As noted in an authoritative report of an inquiry into integration of care for people with mental health problems, “good integrated care appears to be the exception rather than the norm.”⁶

We located three relevant systematic reviews^{7,8,9} and three key papers relevant to the UK context^{10,11,12}, collectively supporting identification of three principal models of inter-professional/inter-agency working around people with mental health problems of varying severity. These were (1) collaborative care, (2) consultation liaison and (3) referral models:

4.1.1. Collaborative care models

Collaborative care is a term used generally and specifically. As a general term 'collaborative care' encompasses a range of working relationships between organisations, within organisations (for example involving different departments, teams or practitioners) or between professionals. More specifically collaborative care refers to models of care satisfying certain (but variable) criteria. Gunn¹³, for example, outlines four criteria, stating that collaborative care involves:

1. A multi professional approach, requiring a general practitioner/family physician plus at least one other health professional.
2. A structured management plan.
3. Scheduled patient follow ups.
4. Enhanced inter-professional communication.

Thus defined, collaborative care is not inconsistent with what has been described as 'shared care' – the joint participation of primary care physicians and specialist care physicians in the planned delivery of care for patients informed by an enhanced information exchange over and above routine discharge and referral¹⁴. Collaborative care arrangements may be relatively simple or more complicated and multi-faceted, dependent upon the numbers of agencies, professionals and interfaces involved.

Particular models of collaborative care have been associated with increased treatment engagement and satisfaction with care and symptom reduction in people with depression^{7,15,16}. However there is still limited evidence regarding use with people experiencing anxiety and severe mental illness^{7,10}.

4.1.2. Consultation liaison models

In consultation liaison models, primary care providers have access to specialist mental health professionals who provide advice and support to enable management of the patient in the primary care setting. Consultation liaison is primarily designed to promote

management of the patient in primary care wherever possible but, dependent on model and application may also serve to reduce the number of referrals made to outpatient services. While consultation may be undertaken by telephone or in writing, Bower and Gilbody¹¹ contend that good practice consultation liaison involves face to face contact between specialist mental health professionals, such as a psychiatrist, and the primary care team. It is proposed that consultation liaison working supports development of educative collegiate relationship between primary care clinicians and mental health specialists such that each party learns more about the challenges faced by the other. Success of consultation liaison is fundamentally dependent on timely consultation meeting the needs of the primary care practitioner. There is some evidence that this model 'can affect the behaviour of primary care clinicians', but evidence is lacking regarding patient outcomes'^{10,11}.

4.1.3. Referral model

The referral model involves transfer of responsibility for the management of the presenting problem to the specialist for the duration of treatment. In this traditional model, referral is made to a specialist services appropriate to identified need. Referral may be to a provider external to the primary care practice or to a specialist practitioner (e.g. psychologists or counsellors) 'attached' to primary the care practice. External specialist services or attached professionals receive referrals and practice remains essentially disengaged from primary care rather than integrated with it. Gask and Khanna¹⁰ contend that this model fits with patient and GP expectations and is supported by current health policy. They say that successful implementation is dependent on access to a sufficient pool of suitably trained and supervised therapists available to meet demand¹⁰.

4.2. Service users' experience of accessing specialised mental health care

The service users who took part in the consultation described very different personal treatment 'journeys' and experiences accessing and using services to support their varied mental health needs.

Participants

Adult service users were diverse in relation to reported age at onset of time of illness, timing of first contact (e.g. 1973 to 'last year'), mental health 'problems'/diagnoses, service use and help-seeking behaviour. All reported having continuing contact with GPs who were more or less engaged in management of mental health, and all reported negotiating multiple organisational/professional interfaces sometimes simultaneously and sometimes over the course of their mental health problems. At the time of interview, participants were accessing a range of services in relation to mental health, with most using multiple services concurrently. One woman for example told us that she consults with a community mental health team care-coordinator regularly, is under the care of a psychiatrist, is attending a 20 week course with a psychologist, attends a day centre and has regular appointments with her GP for medication management and blood tests.

The seven young people who took part in the focus group were all female and aged 15 years or under. We did not ask about their mental health but during the course of the discussion participants described diverse personal circumstances and disclosed a range of mental health issues, including anxiety, depression and self-harming behaviour. The young

people reported using various informal and formal support networks and services to manage their difficulties. Six had first-hand experience of accessing and using mental health services and one had relied on web-based and peer support. The ways in which young people described their mental health concerns indicated an acceptance of difficulties as a 'normal' process and/or understandable experience - a function of their stage of life and circumstances. Their accounts demonstrated substantial maturity and consideration of mental health, reflection on their experiences and openness to examining, what remained for some, emotionally challenging times.

I know this sounds weird, but I wouldn't say I was ever serious enough to call it depression, like proper anxiety, but I used to have really, really bad episodes of just like sadness and wanting to be alone all the time. (Young service user)

The accounts of young people demonstrated substantial variability in duration and types of engagement with formal support. At either end of the spectrum of engagement were a participant who reported extensive ongoing engagement with a range of services (related to her role and experiences as a young carer) and another who reported managing her mental health concerns alone, having elected to not use formal services:

And I never got help by anyone because I felt like I couldn't open up to any of my family because, you know your self-harm and stuff, it's not an easy thing to talk about. So I never told anyone about it, I just kind of, it was hard so I had to try and get over it by myself. So it sort of worked, I mean I still get sad sometimes and just wanting to be alone, but I don't know, it's, I haven't had any help for it to be honest. (Young service user)

Service access - first point of contact

People who took part in the consultation reported varying pathways to specialist mental health care. Similarities and differences were apparent within and between the adults and young people. With many young people and adults expressing confusion about 'the system' and where and how to seek help (sometimes for difficulties they had not identified as mental health problems), various points of first contact were identified. One adult and several young people spoke of making contact with a range of agencies before achieving care considered appropriate and/or of struggling to have their need for service met.

I went to [named agency]... and was offered some support, not really direct or accurate to myself, and about the same time I went to my GP and it was my GP who really put the ball in motion to refer me to IAPT. (Adult service user)

Adults who took part in interviews had more frequently accessed care through general practitioners than the young people for whom social relationships were central to identification of problems and help seeking. For adults the first point of contact was typically the GP; all except one identified GP as the sole entry point to mental health care (Figure 1) but their experiences related to identification of mental health problems and their management differed substantially. While some reported a timely and empathic response to problems related to mental health, help-seeking was sometimes delayed.

First of all I didn't really know who to go to and I really, really struggled and then I went to the doctor first of all....It took me a long time to get the help I needed - was probably depressed for a couple of years before I actually went and got proper

help – before that I was just put on antidepressants to be honest, just put on them and put on them. (Adult service user)

Two adults told us that it was not until after they 'changed GPs' that mental health problems were identified and they were referred for specialised help. One of these people told us his GP's "old fashioned get a grip and get on with it" attitude was unhelpful "because I wanted answers; I wanted to know how to deal with it".



Figure 1:

Adults' access to mental health care

Parents and friends were prominent in young people's help-seeking narratives and typically instrumental in identifying needs and supporting access to services (Figure 2).

I've had depression ever since I was a child, I mean getting to the age of like 10, 11 when I actually realised I needed help, so at first my mum was the first person that I spoke to and she was the one that suggested, do you want to go to the GP and see where we can take this, and see how far we can get with the support? (Young service user)

One of my friends worried about me, so they went to the school and I've been getting help through them with the nurse and that, which we've got through NHS. (Young service user)

I went [to the GP] on my way home from school and I spoke to them about getting my friend some help...I started crying there, so they took me round into a little room and just spoke to me about it and they spoke to her how she could get help with me. (Young service user)

For three young people the first 'touch point' regarding their mental health was with a 'responsible person' at school; teachers, welfare workers, and visiting nurses had been approached when the young person recognised a need for support that friends could not provide (Figure 2).

I just spoke to my teacher and she was the one who spoke to the welfare. (Young service user)

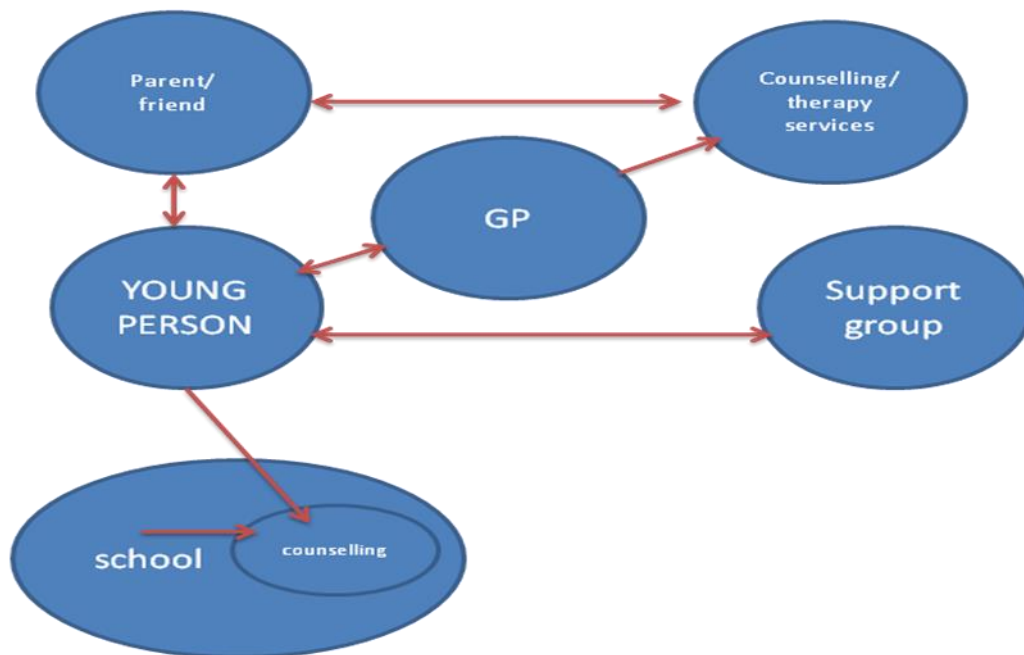


Figure 2: Young people's access to mental health care

4.3. Patient groups, interfaces and integration in practice

Our consultation identified different 'groups' of people for whom primary care mental health and interface/integrated working may be needed, multiple interfaces and a range of practices related to these population groups and interfaces.

Population groups for whom working across boundaries may be needed were people with:

- common mental health problems requiring more help than their GP alone can provide;
- severe mental illness 'stepping back' from secondary care to be maintained in primary care after a period of intensive support;
- severe mental illness presenting to primary care in crisis; and
- severe mental illness gaining access to CBT etc/secondary care.

The interfaces involved in accessing and providing mental health care are represented graphically in Appendix A. These are depicted as being centred on the GP/patient relationship. The various agencies potentially or actually involved in care of individual patients have different levels and types of connection to each other.

Based on our consultation with stakeholders we identified five ways of working across the interface between the primary and mental health specialist care. These working models generally fit within the models identified in the literature and described in section 4.1 above. They included models for traditional 'referral' (Figure 3), 'shared care' (Figures 4 & 5), 'consultation liaison' (Figures 6 & 7), 'facilitated-transition care' (Figure 8) and 'stepped care'.

In the following section we describe these models, identify their strengths and weaknesses and outline the experiences of stakeholders working with each model.

4.3.1. Referral model

The referral model (depicted here as referral from GP to specialist care, but also operational in reverse) involves transfer of the patient's care, in respect of an identified condition from one practitioner to the other. In this 'traditional' model, the patient experiencing mental health problems of sufficient severity is referred by a GP to a specialised service appropriate to identified need.

The only reason I went to my GP today was because I had another appointment for something else. I wasn't well and I just said to him about how I'm feeling and he just said 'right, you need to call your team and they'll sort you out. (Adult service user)

Referral may be made to a range of specialised services, dependent on acuity and type of mental health problem, including an Improving Access to Psychological Therapies (IAPT) service, community mental health team or an emergency psychiatric service, private practitioner, or general counselling service. Responsibility for mental health care is transferred when the patient is accepted, to the receiving service, with clear role demarcation.

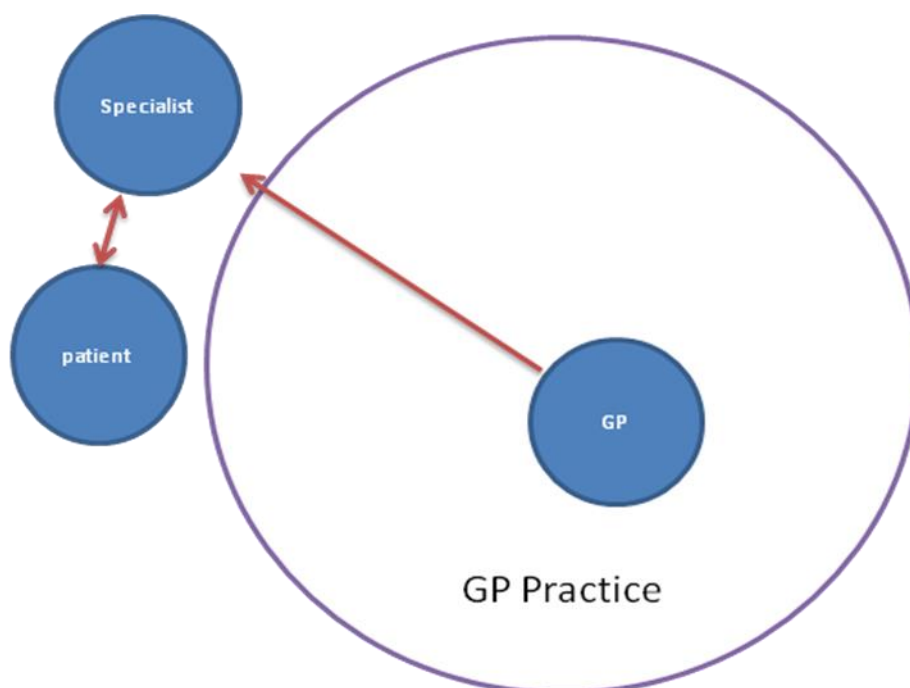


Figure 3: Referral Model

Once the patient is sufficiently well, the specialist service discharges the patient back to the care of the GP.

Data indicate that success of the referral model is dependent upon the capacity of the receiving service to provide needed services (linked to appropriateness of referral), timely transfer of accurate information and active engagement of the patient in the process. Its application may be restricted to people with clearly defined, discrete problems. Success of this model is dependent on referrals being appropriate, that is, meeting the criteria set by

the receiving service, timely response to referral and effective communication between services.

People who have mental illness such as anxiety disorder or depressive illness, may also in parallel have another axis of mental disorder, i.e. they might also have a personality disorder, they might also have a substance misuse problem. In those cases just referring to a psychiatrist in the traditional fashion in secondary care actually achieves nothing, because a psychiatrist, just using pharmacotherapy is not going to get very far. (Professional)

Participants in the consultation (service users and professionals) emphasised the importance of patients and practitioners being clear about when and how to re-engage with the specialist service if needed after discharge back to primary care.

Because my experience of re-accessing services was wholly unhelpful, I think I should have been given a discharge care plan – what to do in a crisis. (Adult service user)

4.3.2. Shared care models

We identified two shared care practices, defined as such because they involve sharing of responsibilities for mental health care between primary care and specialist providers. They differed in respect of the location of the specialist practitioner.

The first of these we described as **inter-agency shared care** because it involves health professionals located in different domains or services having responsibility for different aspects of mental health care.

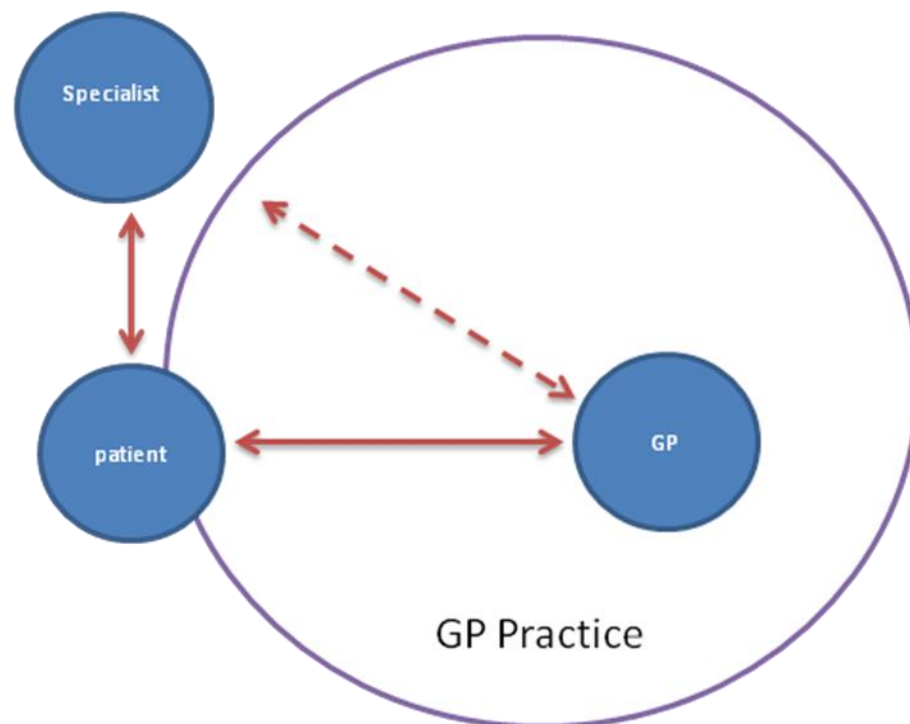


Figure 4: Inter-agency shared care

Inter-agency shared care practice involves the identified patient having ongoing clinical/therapeutic relationships (related to mental health) with both a designated GP and consultant psychiatrist/community mental health service or other specialist provider (e.g. psychotherapist). Shared care is typically but not always, formalised with each professional having particular responsibilities, agreed by all involved. Such arrangements may be at the service rather than practitioner level. Where this model was employed in practice, it typically involved a psychiatrist based in a specialist service maintaining responsibility for psychotropic medication, monitoring and management of adherence, response and side effects, with the GP undertaking mental health monitoring and assessments as agreed, and attending to routine health care. If the specialist provider is another specialist (e.g. psychologist) then responsibilities would be agreed accordingly. Because the model is dependent on active engagement of the patient, shared care arrangements are best suited to patients diagnosed with severe mental illness who are psychiatrically and socially stable, who are generally functioning well but need specialist support with particular concerns.

In **intra-agency shared care**, mental health care is shared by two providers co-located within the same setting who offer complementary expertise and work collaboratively to meet the patient's needs. In contrast to inter-agency shared care where the patient 'goes

between' services, in intra-agency shared care, the services are provided in a single facility and there is an ongoing collaboration between practitioners. The patient has therapeutic relationships with both GP and specialist provider and both address mental health concerns, according to a jointly developed care plan.

It was brilliant the way the GP and counsellor have worked together – she called me back and made sure that I was OK and made sure that I'm taking my medication, and the effects of it as well and the time as well that he spent with me. (Adult service user)

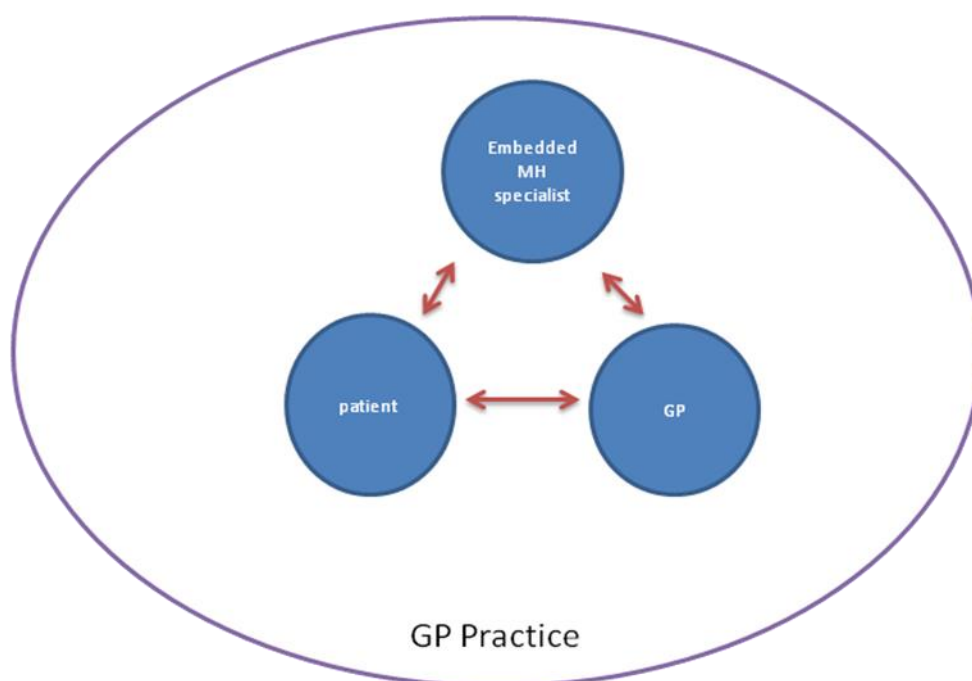


Figure 5: Intra-agency shared care

Advantages of intra-agency shared care models are grounded in the provision of care in the least restrictive and least stigmatising environment possible. Service users reported 'normalisation' of accessing mental health care - 'like you're going for an ordinary doctor's appointment' - avoidance of stigma associated with attending specialist facilities and convenience related to reduced travel time to attend appointments. Additionally service users reported that receiving service from a specialist and GP in the same setting built confidence in providers and trust in care because the different people involved in providing were seen to be working together.

Another variant of shared care, described as collaborative care by those using the model, involved the referral of a patient experiencing mental health difficulties to a case manager located within the GP practice. The case manager, working under supervision of a specialist mental health professional, then worked with the GP and patient to develop and enact a care plan.

4.3.3. Consultation liaison models

We identified two consultation liaison practices, characterised by provision of 'expert' advice by one practitioner to another, but differentiated by location of the specialist within the GP practice or at another agency.

In the first practice, shown in Figure 6, a mental health specialist (consultant psychiatrist/psychologist/counsellor) working on a sessional basis or employed as part of the GP practice team, provides specialist input to GPs to support best practice care of practice patients. While the specialist may consult either separately with the patient or with the patient and GP together, the primary relationships are between GP and patient and GP and specialist. Responsibility for care remains with the GP.

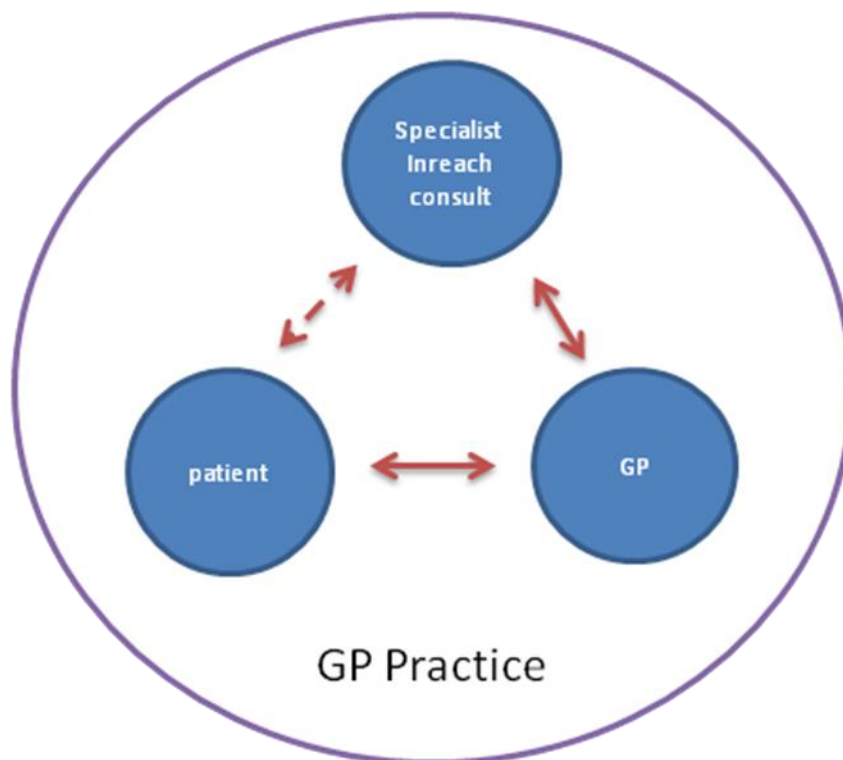


Figure 6: Consultation liaison- specialist embedded in GP practice

Consultation liaison was described as being applicable and useful for patients with diverse needs. Collocation of health professionals with different and complementary areas of expertise allows for 'corridor conversations', potentially facilitating increased understanding of the contributions different professionals can play in supporting care. Use of shared patient records was also described as helpful in promoting continuity of information.

I think that [approach] has worked well because of the close relationships between the professionals your surgery and you can talk to them and discuss referrals and they can give you direct feedback. They also use our computer systems so they can look at patient's notes and see what else is happening. (Professional)

Advantages of this model identified by service users were similar to those of intra-agency shared care - 'normalisation' and ease of access to specialist mental health care. The maintenance of a single therapeutic relationship with the GP was also appreciated because it reduced the need to repeatedly share information.

In the second consultation liaison model (Figure 7) a mental health specialist (from a secondary mental health service) 'consults' with a GP in relation to patients/cases satisfying particular criteria. While the specialist may consult either separately with the patient or with the patient and GP together, the primary relationships are between GP and patient, and GP and specialist. The explicit goals of this model are to 'gatekeep' secondary mental health services and develop the capacity of GPs to manage patients with moderate-severe mental illnesses. As described by a psychiatrist:

When I get the referral from the GP my secretary would liaise with their secretary to arrange a joint consultation meeting where I would be sitting with the GP in the GP's consulting room seeing this patient who's been referred by the GP together...We'll ask the patient to wait in the waiting room, we'll discuss actually what the problems are, what the sources or source of the problems happen to be, and what can we do to help. (Professional)

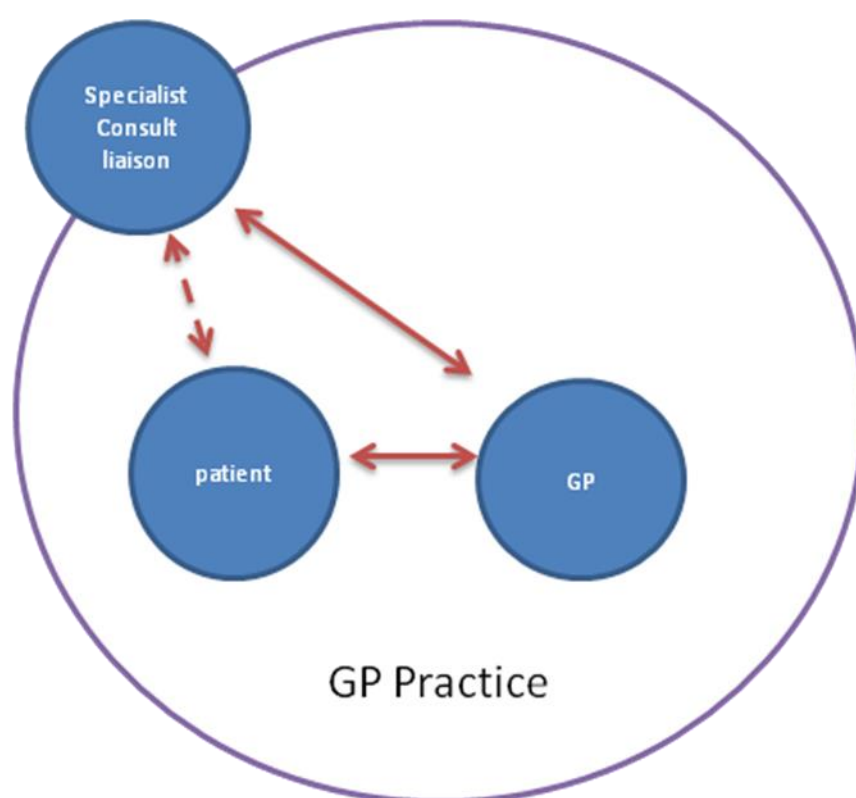


Figure 7: Consultation liaison - specialist attached to community mental health team (or other service provider)

Advantages of this model identified by professionals included that it helps build relationships and helps increase GPs' confidence.

The GP, over a period of time, becomes more and more confident about, if you like, the basic theoretical learning on mental health they have received. (Professional)

4.3.4. Facilitated-transition model

The facilitated-transition model involved provision of support to enable engagement of a patient being discharged from a from specialist service to GP care by an interim provider. The interim provider (a link worker or 'navigator') could be an adjunct to the specialist service or a separate third sector agency. The role of the navigator may be restricted to supporting the patient to establish a relationship with the GP who has assumed legal responsibility for care, but may also involve supporting the patient to integrate socially. The manager of a navigator service described how they support patients' transition to primary care.

Once the person is discharged [from a specialist mental health service]... a meeting is then set up between the navigator and the patient, and that is done in our office... which is an ordinary office, so nobody knows what they're walking to... Then the navigator will carry out... sort of an interview about the person, and obviously it will touch on the mental illness but it will also look at what it is they want to get out of the project, what we can actually do and what we can't do. So they get a really clear picture around the things that we will support them with, and I must say that generally speaking in the first instances it is around benefits, quite often, it can be around debt, money matters of any sort, it can be around their housing situation, the confusion that, because there's still a perception in mainstream services that once somebody is discharged from secondary care they are well. (Professional)

A navigator service may also facilitate self-management.

We [navigators] try and make that first appointment with the GP as soon as possible because a) it's all about communication, and b) it's all about relationships, and the dependency that the clients have had in secondary care has got to be switched, if you like. Well, actually, we're trying to get non dependency. We're working towards the person being self-realised and being able to manage their own mental health. (Professional)

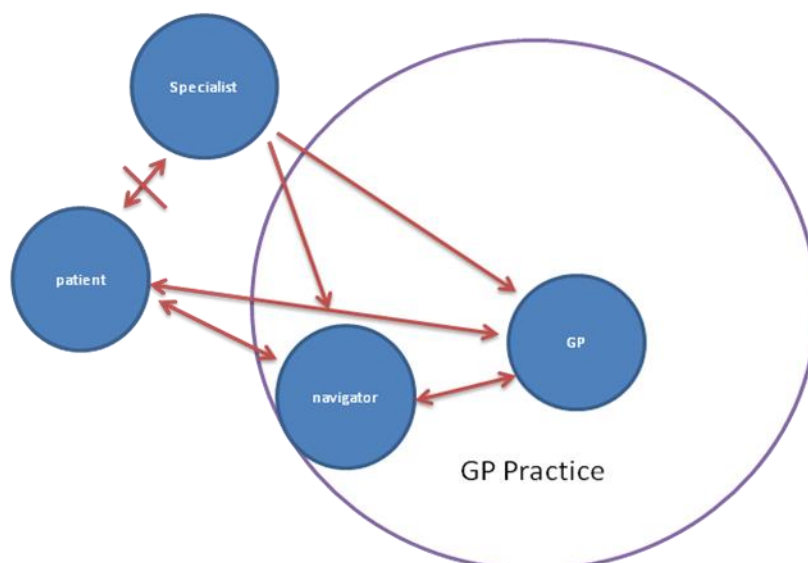


Figure 8: Facilitated-transition model

Participants in our consultation with experience of this model, emphasised the importance of agreement amongst parties involved regarding roles and responsibilities and the capacity of the parties to meet responsibilities. Without clarity and capacity, patient care could be compromised.

We were, out of hours, trying to get the particular team [specialist team] to contact her [service user] by telephone, and speak to her, and do an over the phone assessment, which they wouldn't do. They felt this was because she was discharged, that it was the GP's responsibility... So those are the barriers that we encounter because we can be left holding the baby, if you like, and that is not a position we should find ourselves in. (Professional)

4.3.5. Stepped care model

The stepped care model involves referral to a service or practitioner best suited to meet a patient's needs. The underlying principle is that the patient receives care of an appropriate intensity in the least restrictive, safe environment possible. It aims to regulate access to services establishing clear entry criteria to different levels of treatment. Formalised stepped care programmes involve assessment of need at specific points on the clinical pathway.

We have a system now that allows [people to be] seen for an initial assessment within that IAPT service, and indeed at either step two or step three, if it was felt at that point that in fact this patient's needs were better served by secondary care services then they would be immediately stepped up to one of the mental health teams dealing with that side of thing. (Professional)

Stepped care has been presented as a separate model but arguably can be combined with the previous models described in this section¹⁰.

5. Considerations for commissioning

Key issues identified in developing and delivering primary care mental health and connected practice were:

5.1 Historic disconnection between mental health and physical health

The impact of separation of mental and physical health was a key influence on services. Service users expressed the desire for holistic care, and professionals described the entrenched separation of mental and physical health, and services as a fundamental challenge to defining and establishing primary care mental health and integration of mental health care in primary settings. The artificial separation, described as pervasive and operating at all levels (policy, education, commissioning, practice) was often accepted as 'the way things are', but nevertheless as something that could cause "anxiety on both sides":

Psychiatrists, for years have worked, technically with GPs but across, if you like, a huge gulf, where planes, taking the shape of letters posted would be passing across the seas and oceans. And therefore there is a lot of worry, hesitancy,

anxiety on both sides as to what the others are like and what are they going to do to us. (Professional)

A critical manifestation of the disconnection was the separate commissioning of different parts of the health service system (see below). Problems associated with separation of mental and physical health were further compounded by divisions between primary, secondary and acute care services and the arbitrary separation of social and health care with the former seen as a central component of primary care mental health.

5.2 Commissioning systems and structures; commodification of health care, resourcing

Everything has a price, everything costs. (Professional)

Consultation with professionals highlighted the complexity and fragmentation of commissioning structures as a fundamental impediment to development of primary care mental health and connected working. Concerns were expressed that the ways in which services were funded meant that services were forced to compete for funding (leading to cost-cutting measures), diversification where potentially inappropriate and restrict service provision.

And the tariffs are too tight...you haven't got enough money in that to address the time you ...So there's structural problems in terms of how it's organised. If you do have competition, have proper competition, not one. And the second one is the pricing structure is too tight but the government will see that as efficient. (Professional)

Or expressed from the service user perspective:

That's the bit that I find quite worrying is that somewhere there is somebody higher up sitting in a big leather chair making the decisions on how much someone can be helped. (Adult service user)

5.3 Scope of primary care mental health

The diversity and variability of mental health problems and related needs, a key concern for health practitioners, was evident in accounts of both adult and young service users. The consensus was that a range of services offering differing levels of support was essential to ensuring needs were met in a timely manner.

I haven't been told how many places in line for the one to one. As far as I'm concerned I'm still waiting. (Adult service user)

I understand that it's not just me that needs help, that there are a lot of other people, but sometimes the waiting list could be quite long and I would have to wait, I don't know like 12 weeks and it seemed to me by the time that I actually got the counselling that I needed and the help and support, I'd probably done it myself, and I wouldn't really need the support anymore. (Young service user)

While acknowledging the central role of GPs in managing and providing mental health care and gatekeeping access to specialised services, stakeholders also emphasised the need for patients to be able to self-refer to some services. The key role of non-health agencies, particularly schools and third sector support groups was evident in accounts of young people.

5.4 Collaborative ethos, communication and role clarity

The data we collected demonstrated that no matter what model is employed, efficient working across boundaries and positive outcomes are dependent fundamentally on effective communication underpinned by a shared collaborative ethos. Problems with inter-agency communication were described as a key challenge to connected practice. Health practitioners noted that the various stakeholders used different record keeping systems to manage patient information and recorded different types of information in different ways. For service users this can manifest itself in having to explain yourself “forever and over again to so many different people”.

It becomes difficult explaining yourself forever and over again to so many different people and then it's just, it causes even more stress and you just start, you just shut down... In my experience it's better to have someone that you can confide in and knows your situation and knows what you feel on what you go through ... and then it's been communicated with a team, it's better off than, you're just every five minutes meeting someone new and ... I find that a lot in [named hospital] I don't see the same person and then they're asking you questions and inspecting and all of a sudden they're prodding you and it's difficult. (Adult service user)

The importance of clarity about roles and responsibilities when managing care across boundaries was also a recurrent theme in our consultation. This was a particular concern where patients are being treated on a compulsory basis and potentially pose a high level of risk to themselves or others. Key to role clarity and cooperative working however, were understanding the ways in which ‘others’ worked, particularly constraints on practice and recognition that the knowledge and expertise of various stakeholders were complementary. As noted by several participants, whilst some specialist knowledge may be needed in particular circumstances, primary mental health care involved making mental health everybody’s business and clinicians of whatever discipline delivering more holistic and rounded care for patients.

6. Information sheets about interface models: A tool for commissioning

The factsheets presented in Appendix B about the five practice based interface models are the main output from this project. They have been designed with commissioners in mind and are intended as a tool to inform commissioning decisions.

We have produced one factsheet per model. Drawing on the results of our literature review and consultation, each factsheet presents a SWOT analysis for the particular model along with examples of good practice. They will support commissioners and service providers by:

1. enabling identification of model(s) being employed locally and critical review of their operation;
2. informing consideration of the suitability of each model for identified local needs and circumstances; and
3. informing consideration of alternative interface models.

Useful resources

Case study of a collaborative primary care model implemented in Sandwell

<http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Case-study-report-on-Sandwell.pdf>

Evaluation of the Esteem Team - Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service

http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/sandwell-esteem-team-coordinated-care-case-study-kings-fund-aug13.pdf

Collaborative care model implemented in Salford

<http://six-degrees.org.uk/our-approach/>

Evaluation of the City and Hackney primary care psychotherapy consultation service

http://www.centreformentalhealth.org.uk/pdfs/Managing_patients_complex_needs.pdf

Psychological therapies and parity of esteem: from commitment to reality

http://www.bacp.co.uk/admin/structure/files/pdf/13801_bacp%20psychological%20therapies%20and%20parity%20of%20esteem.pdf

Capturing the lived experience of mental health service users in Essex

http://www.healthwatchessex.org.uk/sites/default/files/555_report_final_300914_web.pdf

A commissioner's guide to primary care mental health

<http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf>

Guidance for commissioners of primary mental health care services

<http://www.jcpmh.info/wp-content/uploads/jcpmh-primarycare-guide.pdf>

Closing the gap: priorities for essential change in mental health

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

Improving integrated care for people with mental health problems: improving integrated care for people with mental health problems

<http://www.mentalhealth.org.uk/content/assets/PDF/publications/crossing-boundaries.pdf?view=Standard>

The Big White Wall – online support for people experiencing mental health problems

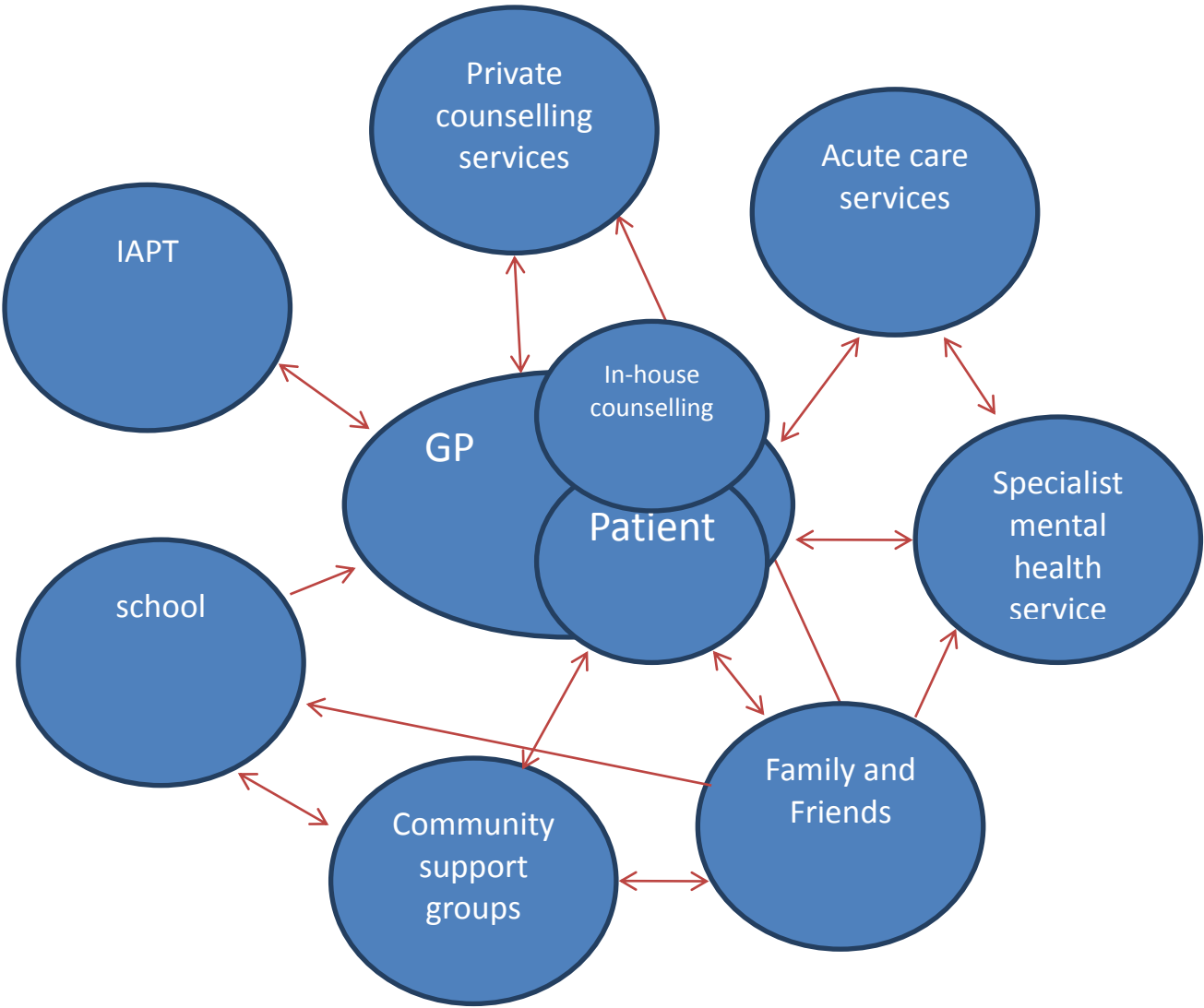
<http://www.bigwhitewall.com/landing-pages/landingv3.aspx?ReturnUrl=%2f#.VOTI4vmsWao>

References

- ¹ Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners of primary mental health care services. Volume two: practical mental health commissioning.
- ² NHS (2014) A Commissioner's guide to primary care mental health. Strengthening mental health commissioning in primary care: learning from experience.
- ³ Gask L, Sibbald B and Creed F (1997) Evaluating models of working at the interface between mental health services and primary care. *BJPsych*, 170:6-11.
- ⁴ Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point (2012) No Health Without Mental Health: Implementation Framework.
- ⁵ Gale NK, Heath G, Cameron E, Rashid S and Redwood S (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*; 13:117.
- ⁶ Mental Health Foundation (2013) Improving integrated care for people with mental health problems: improving integrated care for people with mental health problems.
- ⁷ Archer J et al (2012) Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*, 10:CD006525.
- ⁸ Smith S, Allwright S and O'Dowd T (2007) Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. *Cochrane Database Syst Rev*, 18;(3):CD004910.
- ⁹ Reilly S et al (2013) Collaborative care approaches for people with severe mental illness. *Cochrane Database Syst Rev*, 11:CD009531.
- ¹⁰ Gask L and Khanna T (2011) Ways of working at the interface between primary and specialist mental healthcare. *BJP*, 198:3-5.
- ¹¹ Bower P and Gilbody S (2005) Managing common mental health disorders in primary care: conceptual models and evidence base. *BMJ*, 330:839-842.
- ¹² Lester H (2005) Shared care for people with mental illness: a GP's perspective. *BJPsych Advances*. DOI: 10.1192/apt.11.2.133.
- ¹³ Gunn J, Diggins J, Hegarty K and Blashki G (2006) A systematic review of complex system interventions designed to increase recovery from depression in primary care. *BMC Health Serv Res*, 6(1):88.
- ¹⁴ Hickman M, Drummond N and Grimshaw J (1994) A taxonomy of shared care for chronic disease. *Journal of Public Health Medicine*, 16:447-454.
- ¹⁵ Unützer J et al (2002) Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. *JAMA*, 288(22):2836-2845.
- ¹⁶ Richards et al (2013) Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*, 347: f4913.

Appendices

Appendix A: Interfaces involved in the provision and access of mental health care



Appendix B: Information sheets for Commissioners

This package contains information designed to guide thinking about commissioning of primary care mental health services where the aim is to enable timely, effective management of patients experiencing mental health problems in the least restrictive environment possible with clear clinical pathways.

The information sheets contained in the package are based on work commissioned by the East of England Strategic Clinical Network[†] to inform commissioning of primary care mental health services. None of the models is inherently good or bad – each will work well for certain population groups in certain circumstances. Our information sheets describe the models of care identified in literature review and consultation with stakeholders. Success of each model is dependent on adherence to the principles and practices set out below.

Principles and assumptions

- The patient's experience is fundamental to quality of care and a key outcome in and of itself
- All treatment decisions should be made in partnership with patients
- Patient information must be managed in accordance with legislation and in such a way that the patient's rights to privacy and confidentiality are upheld. Patients should at all times be informed, before information is provided about who will have access to what information, and when. Patients should always be informed about circumstances in which confidentiality might be breached and processes related to this.
- Care should be provided wherever possible in community-based primary care services close to the patient's home
- Care should always be provided in the least restrictive environment
- Commissioning should promote, as far as possible, continuity of care and minimise the number of professionals and services with which a patient has to engage
- Commissioning arrangements should minimise the number of transitions between services and providers made by patients
- Commissioned services should work in patient centred ways
- Practitioners bring complementary skills, knowledge and expertise to the care of the patient
- Practitioners must have access to supervision and support commensurate with the treatments they are delivering and the patient groups they are seeing
- Commissioning should minimise the burden on patients related to travel between services and provision of information
- Commissioning should ensure a complementary mix of services appropriate to population needs including interim supports which patients may access whilst awaiting access
- Commission for co-operation – services should specify how they work internally to promote team work and with other services
- Whichever model is employed, optimising outcomes is dependent on timely communication of accurate information and a collaborative ethos

[†] Souza R, Patterson S, Gandesha A, McGeorge M, Quirk A, Crawford M (2015) Modelling the interface between primary care and specialist mental health services: A tool for commissioning. London: Royal College of Psychiatrists.

- Practitioners are motivated to work with patients to optimise outcomes but 'systems' and structures can impede delivery of best practice care

Practicalities

- Collocation of service providers provides opportunities for development of collegiate relationships and facilitates information sharing and learning
- Service providers must articulate referral and entry and discharge criteria and referral processes
- Clarity about roles, responsibilities and accountabilities is critical to effective collaborative working
- Where clinical pathways are involved and care of a patient will be transferred or shared, commissioners should ensure that plans for communication of patient information and confidentiality are clearly articulated and that commissioning arrangements include reporting of compliance
- Where information is to be shared between multiple agencies, commissioners should ensure that appropriate memoranda of understanding and protocols are in place to allow timely and appropriate communication of clinical information
- Commissioners should consider establishing formal mechanisms for review of interagency function that include feedback from people who have used local services

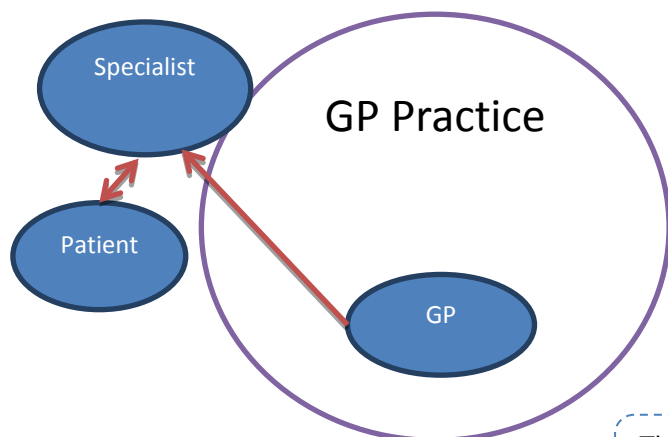
Information sheet 1: Referral Model

About this model: The referral model involves transfer of the patient's care from one practitioner to the other, in respect of a particular component of care or condition. In this 'traditional' model, the patient experiencing mental health problems of sufficient severity is referred by a GP to a specialised service appropriate to identified need. Referral may be made to a range of specialised services including an Improving Access to Psychological Therapies (IAPT) service, community mental health team or an emergency psychiatric service, private practitioner, or general counselling service dependent on identified need, urgency, patient preference and availability of services. Responsibility for mental health care is transferred, when the patient is accepted by the receiving service, with clear role demarcation; the specialised service delivers care to meet needs set out in referral or identified on assessment. Once the patient is sufficiently well for care to be managed in primary care, the specialised service discharges the patient back to the care of the GP.

Population groups for whom referral might be appropriate

- People experiencing common mental health problems requiring more help than their GP can provide
- People presenting with a first episode of a psychotic disorder
- People experiencing an acute relapse of a severe mental illness for which specialist care has previously been obtained
- People experiencing mental health crisis
- People seeking access to specialist therapy e.g. CBT, or to specific services e.g. secondary care

"The only reason I went to my GP today was because I had another appointment for something else. I wasn't well and I just said to him about how I'm feeling and he just said 'right, you need to call your team and they'll sort you out.'"
(Adult patient)



The figure illustrates referral from GP to specialist care, but the model also operates in reverse.

Strengths

- Clear lines of responsibility and accountability
- Specialist workers benefit from belonging to a specialist team enabling access to appropriate supervision, clinical support and administrative support

Weaknesses

- Service, rather than patient centred care
- The patient is expected to 'move' between services, potentially disrupting continuity of care; may oblige patient to tell their story several times to different agencies
- Risk of 'falling through the gaps' when problems with referral/intake process
- Risk of stigma attached to use of specialist services
- May not fit patient's understanding of their condition or expectations of care

Good ideas

- To increase patient awareness of availability of specialist services and the potential for referral, GP practices should display posters and have leaflets in their waiting rooms about locally available mental health supports.
- Consideration should be given to management during 'referral period' especially where it is expected that there will be delay in access to the receiving service. GPs should consider signposting people to forms of self care for the interim, e.g. a local support group or on-line service such as the Big White Wall.

Points to consider when implementing this model

- Optimum functioning relies on GP knowledge of the service options, eligibility criteria and referral processes
- The success of this model is dependent upon the capacity of the receiving service, timely transfer of accurate information and engagement of the patient in the process.
- Referral processes and entry criteria for specialist services should be clearly articulated and publicised.
- Specialist services need to have clear access criteria and publicise these.
- Communication pathways and timetables should be agreed between agencies. These should specify what information will be included in a referral, where and how the referral is to be 'sent', what will happen when it is received, what feedback will be provided to referrer and patient and how the outcome of referral will be communicated.

Useful resources

- A commissioner's guide to primary care mental health

<http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf>

- Guidance for commissioners of primary mental health care services
<http://www.jcpmh.info/wp-content/uploads/jcpmh-primarycare-guide.pdf>
- The Big White Wall – online support for people experiencing mental health problems (can support patients during waiting times for therapy services)
<http://www.bigwhitewall.com/landing-pages/landingv3.aspx?ReturnUrl=%2f#.VOTI4vmsWao>

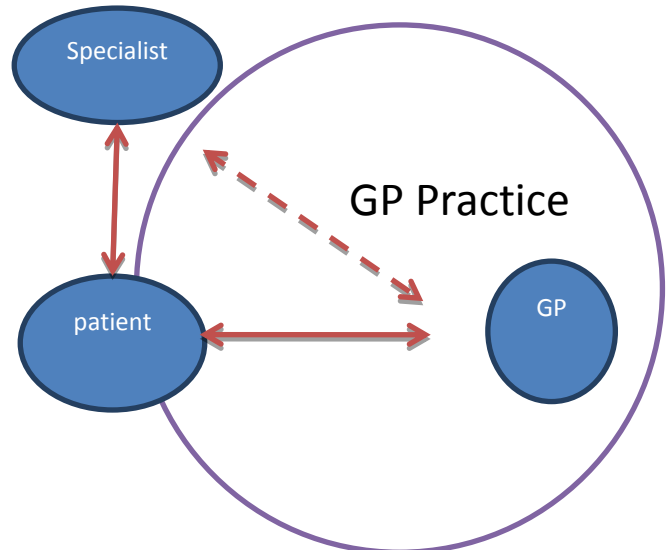
Information sheet 2: Shared Care Models

About this model: Shared care models involve formal sharing of responsibility for mental health care with primary care and specialist providers being accountable for different aspects of care. In shared care models, the patient has ongoing clinical relationships (related to mental health) with both a designated GP and mental health specialist provider (consultant psychiatrist/ community mental health service, psychologist or other specialist practitioner e.g. psychotherapist). The practitioners involved or their employing agencies enter into formal arrangements which specify the responsibilities of each party and communication arrangements.

We identified two types of shared care practices being employed with different patient groups.

Model 1: Inter-agency shared care

This model involves sharing of care by health practitioners employed by different agencies – a GP and a specialist service. Patients who had been receiving treatment through a community mental health service for a severe mental illness were sufficiently well that they could be discharged back to primary care but the specialist service was obliged to continue contact (e.g. to monitor medication response). In this circumstance the patients attended their GP for routine check-ups including monitoring of mental health and attended the specialist provider at specified intervals for required review.

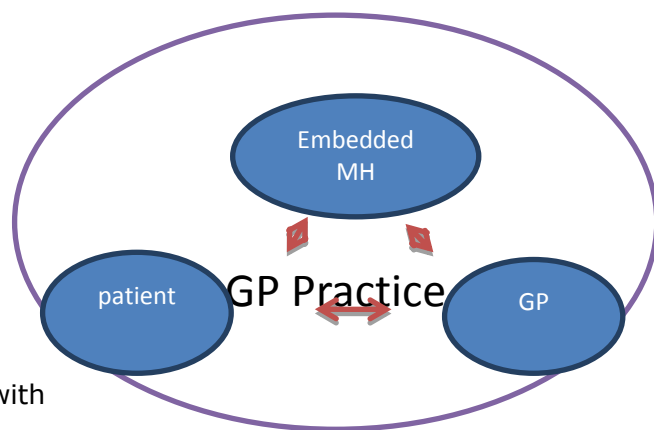


Population groups for whom inter-agency shared care might be appropriate

Patients diagnosed with severe mental health problems who are psychiatrically and socially stable, and have capacity to engage with multiple services, but need to continue contact with the mental health specialist (for example for management of medications or legal reasons)

Model 2: Intra-agency shared care

In this model of shared care, patients receive mental health related care from two or more providers located within the same primary care setting. The providers offer complementary expertise and work collaboratively to meet the patient's needs with each reinforcing the input of the other as per a shared treatment plan. The patient has therapeutic relationships with both practitioners and the practitioners communicate with each other and the patient.



Strengths

- Promotes sense of 'joined up working' for patient
- Collocation can promote informal contact building mutual respect and understanding between practitioners
- Patients report that receiving services from a specialist and GP in the same setting builds confidence in providers and trust in care because the different people involved in providing were seen to be working together
- 'Normalises' accessing mental health care – *"like you are going for an ordinary doctor's appointment"*
- Can reduce burden of travel to additional services

Population groups for whom intra-agency shared care might be appropriate

- People with depression and anxiety[‡]
- People with long-term conditions and moderate to severe depression and associated functional impairment[§]

Good ideas

- Holding joint consultations where the GP and specialist meet the patient together at the GP practice may work well for some patients.
- Specialists can provide primary care with formal training e.g. diagnosing personality disorder, while GPs can share learning specialists about holistic healthcare.
- If a GP practice is employing a lone-worker mental health specialist, robust professional and practice supervision arrangements must be in place

"It was brilliant the way the GP and counsellor have worked together – she called me back and made sure that I was OK and made sure that I'm taking my medication, and the effects of it as well and the time as well that he spent with me."

(Adult patient)

[‡] Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*2012;10:CD006525.

[§] NICE. Depression in adults with a chronic physical health problem. The NICE Guideline on Treatment and Management. National Clinical Practice Guideline 91. British Psychological Society and Royal College of Psychiatrists, 2010.

Shared care in Practice

Integrated collaborative care

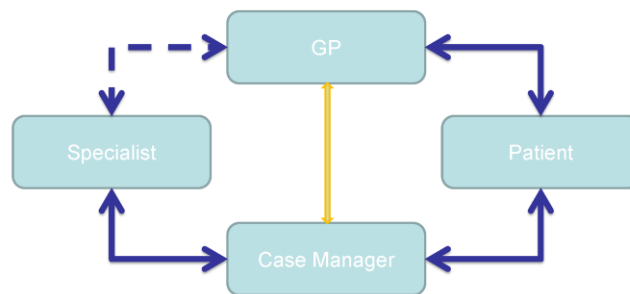
Salford primary care mental health team:

Multi-professional approach to patient care provided by a case manager working within the GP practice. Case manager receives regular supervision from specialist mental health clinician(s).

A structured management plan of medication support and brief psychological therapy.

Scheduled patient follow-ups.

Enhanced inter-professional communication patient-specific written feedback to GPs via electronic records and personal contact.



Professor David Richards, University of York, UK

Useful resources

- Intra-agency shared care: Evaluation of the Esteem Team - Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/sandwell-esteem-team-coordinated-care-case-study-kings-fund-aug13.pdf
- Collaborative care: <http://six-degrees.org.uk/our-approach/>; <http://www.ncbi.nlm.nih.gov/pubmed/25687344>
- Evaluation of the City and Hackney primary care psychotherapy consultation service:
- http://www.centreformentalhealth.org.uk/pdfs/Managing_patients_complex_needs.pdf

Information sheet 3: Facilitated-Transition Model

About this model: This model involves facilitated transition from specialist service to GP care. The interim provider (a link or liaison worker or 'navigator') could be a member of staff of the specialist service, attached to the primary care service or employed by separate agency. The precise role and responsibilities of the 'navigator' are a function of the position and qualifications of the worker or service. Where the navigator is part of a specialist service and a clinician is employed in the role, 'navigation' may involve provision of clinical care to the patient, provision of GP or other primary care staff as well as social and administrative support needed to effect smooth transition of care. Navigation services may alternately provide only practical and/or psychosocial support (e.g. assisting with transport, making or attending appointments, advocacy). In some instances navigation may involve coordination and/or linking the person with agencies other than GPs (e.g. social care) to meet needs.

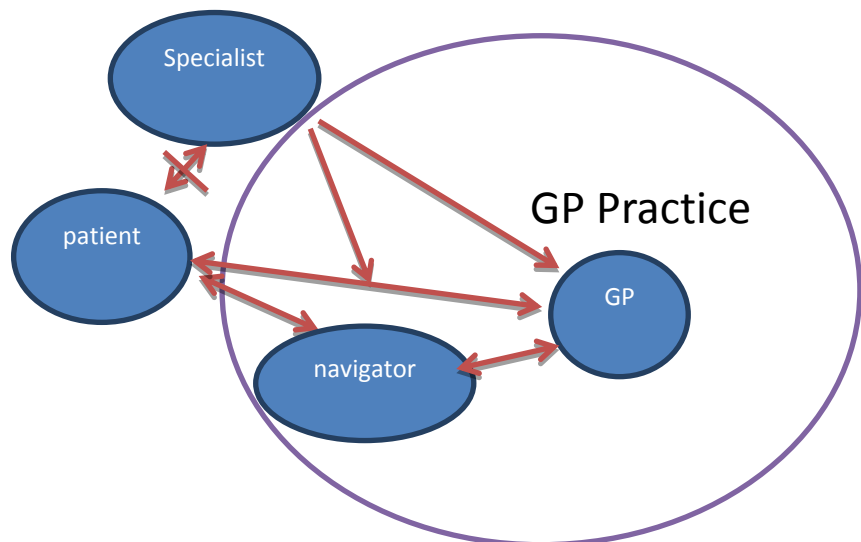
"We[navigators] try and make that first appointment with the GP as soon as possible because a) it's all about communication, and b) it's all about relationships, and the dependency that the clients have had in secondary care has got to be switched, if you like. Well, actually, we're trying to get non dependency. We're working towards the person being self-realised and being able to manage their own mental health."

(Professional)

consultation or advice to

Population groups for whom facilitated-transition might be appropriate

This model is particularly appropriate for people who have experienced severe mental health problems, 'stepping back' from secondary care to be maintained in primary care after a period of intensive support. Facilitated-transition may be particularly useful for people who have complex needs and lack informal social support



Strengths

- Can support transition from specialist services to primary care, enabling timely transfer of information while an appropriate therapeutic relationship is established thereby reducing the risk of loss to follow up
- Where clinicians are employed, can support development of partnerships between primary and secondary care services
- Timely transfer of information
- Reduces the risk of patients feeling 'abandoned' by specialist particularly where they have been receiving care from specialist services for extended periods
- Navigator can act as advocate for patient, sharing important clinical information thereby enhancing therapeutic engagement of GP and patient

Points to consider when implementing this model

- Participants in our consultation with experience of this model emphasised the importance of agreement amongst parties involved regarding roles and responsibilities and they stressed that the skills of the parties involved. Without it, patients' care could be compromised.
- GPs need to know where and when they can seek specialist input as needed
- Ensure navigators have quick and easy access to colleagues in primary and secondary care

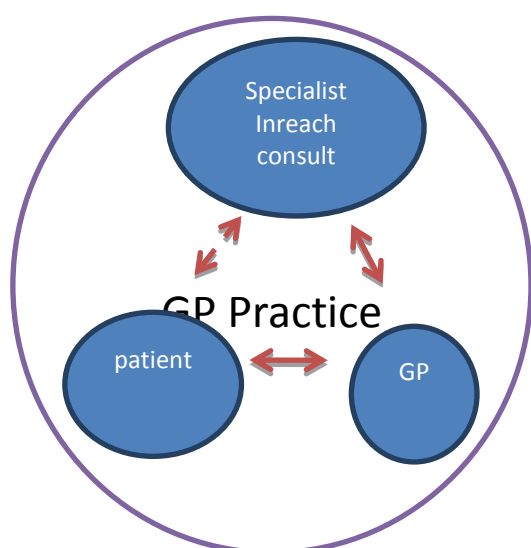
Useful resources

- NIHR School for Social Research (2012) Identifying what good care and support looks like for people with complex needs
http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/Findings_1_complex-and-severe_web.pdf
- <http://bristolmentalhealth.org/media/654252/november-2014-newsletter.pdf>
- <http://www.candi.nhs.uk/services/services/dementia-navigator-service/>
- Evaluation of the Esteem Team - Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service:
- http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/sandwell-esteem-team-coordinated-care-case-study-kings-fund-aug13.pdf

Information sheet 4: Consultation Liaison Model

About this model: Consultation liaison is a collaborative arrangement whereby a specialist provides advice in respect of patient's care, under a formal agreement. While the specialist may consult with the patient, responsibility for care remains with the GP and the primary therapeutic relationship is between GP and patient.

We identified two consultation liaison practices, differentiated by location of the specialist - within the GP practice or at another agency.

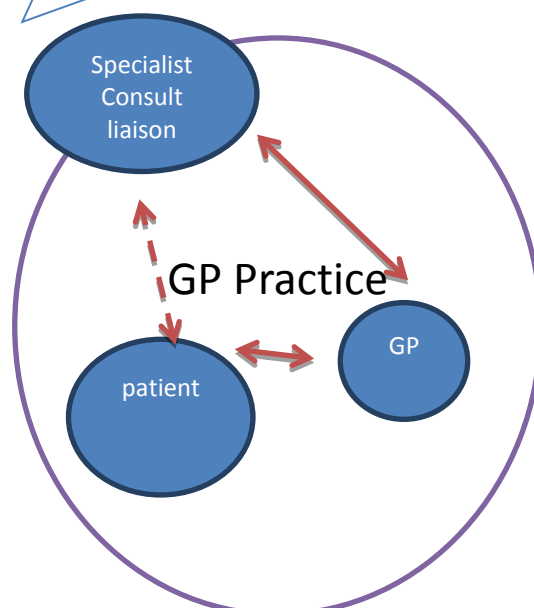


Model 1: a mental health specialist (consultant psychiatrist/psychologist/counsellor) working on a **sessional basis** as part of the GP practice team, provides specialist input to the care of patients registered at the practice.

"[The approach] has worked well. Because of the close relationships between the professionals your surgery and you can talk to them and discuss referrals and they can give you direct feedback. They also use our computer systems so they can look at patient's notes and see what else is happening."

(Professional)

Model 2: a mental health specialist who either works independently or represents another service (such as a specialist mental health team) 'consults' with a GP in relation to patients whose presentations satisfy particular criteria. The consultant in this model may also function to gatekeep access to specialist service, providing advice about when referral may be appropriate.



Population groups for whom consultation liaison might be appropriate

Any population group in circumstances where GPs feel competent in maintaining responsibility for care but require specialist advice

"When I get the referral from the GP my secretary would liaise with their secretary to arrange a joint consultation meeting where I would be sitting with the GP in the GP's consulting room seeing this patient who's been referred by the GP together... We'll ask the patient to wait in the waiting room, we'll discuss actually what the problems are, what the sources or source of the problems happen to be, and what can we do to help."

(Professional)

Strengths

Both

- Designed to reduce the number of referrals and increase the appropriateness of referrals made to specialist services by enabling management in primary care settings
- Potential for upskilling and building capacity of primary care as advice leads to learning
- Potential to reduce demand on specialist services
- Development of collaborative working relationships

Model 1

- The maintenance of the relationship between GP and patient as the primary therapeutic relationship reduces the need for patients to repeatedly provide information and for miscommunication
- Co-location of primary care and specialist workers can lead to greater levels of informal contact increasing mutual respect and understanding

Good ideas

- GP practices can pool their resources to employ a 'consultant' (e.g. clinical psychologist or other specialist) to provide advice across practices

Points to consider when implementing this model

- The limited evidence available suggests that consultation liaison models can develop skills and knowledge of those involved but evidence related to patient outcomes is lacking
- Success is dependent on GPs having access to the necessary specialist input within a timeframe that enables a prompt response for patients
- Success can be promoted by team building that fosters understanding of respective roles and professional differences

Useful resources

- Gask L and Khanna T (2011) Ways of working at the interface between primary and specialist mental healthcare. *BJP*, 198:3-5.

Royal College of Psychiatrists' Centre for Quality Improvement
2nd Floor • 21 Prescott Street • London • E1 8BB

The Royal College of Psychiatrists is a charity registered in England and Wales (228636)
and in Scotland (SC038369)

© 2015 The Royal College of Psychiatrists

www.rcpsych.ac.uk