Modelling the Interface between Primary Care and Specialist Mental Health Services:

Information sheets for Commissioners

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March 2015

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[1] 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
- Practitioners are motivated to work with patients to optimise outcomes but 'systems' and structures can impede delivery of best practice care

[1] 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.

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

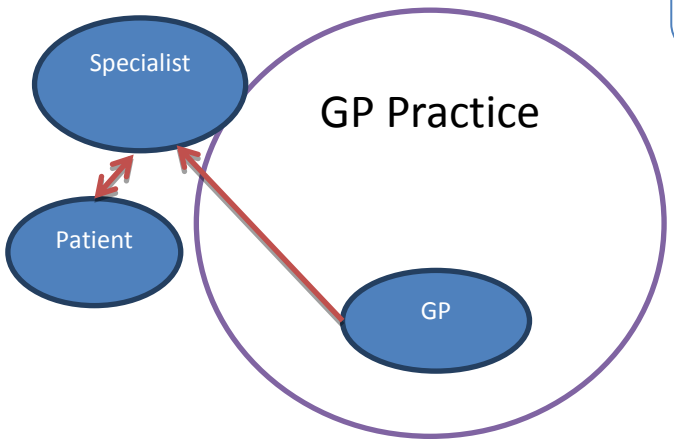
Information sheet 1: Referral Model

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

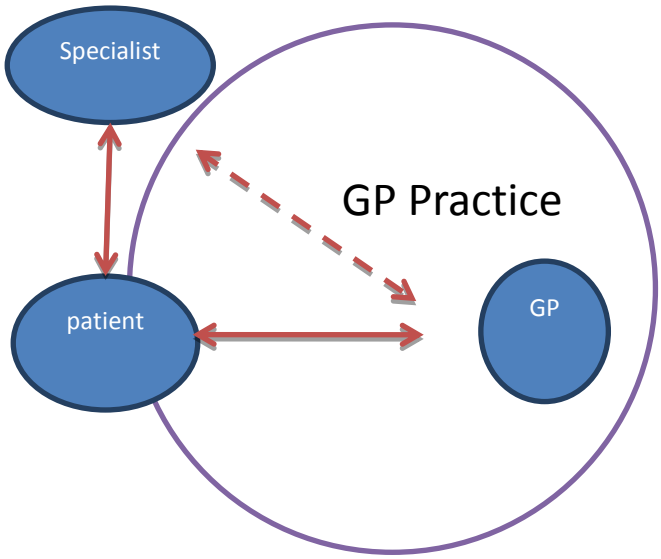
Information sheet 2: Shared Care Models

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.

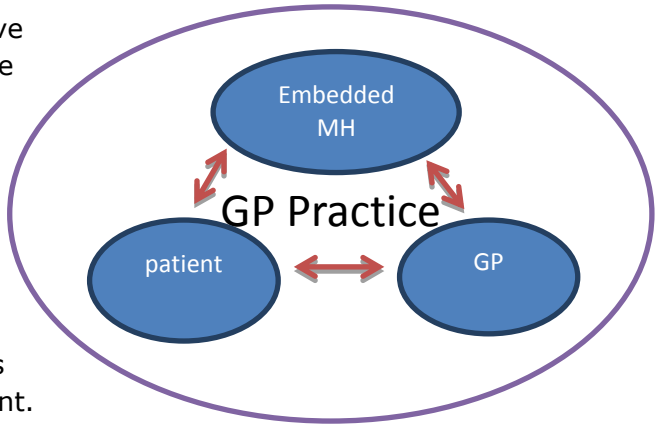


Population groups for whom inter-agency shared care might be appropriate

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[2]
- People with long-term conditions and moderate to severe depression and associated functional impairment[3]

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)

[2] *Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev2012;10:CD006525.*

[3] 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

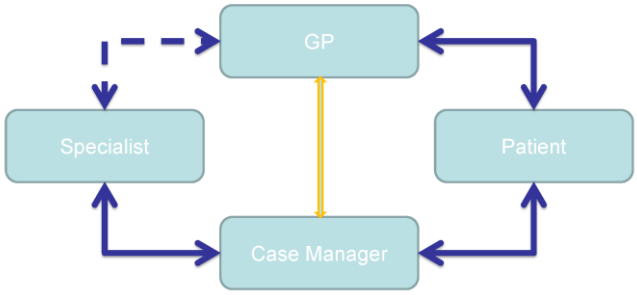
Salford primary care mental health team:

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

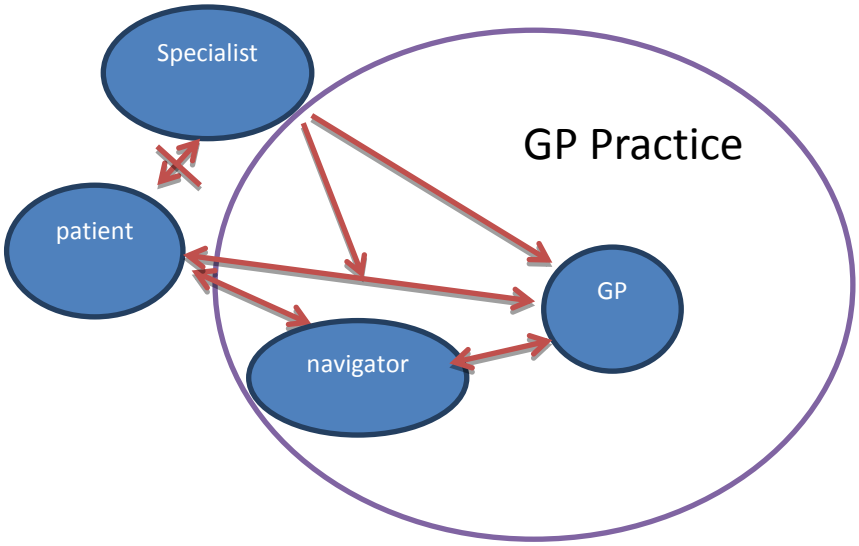
Useful resources

- 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 consultation or advice to 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)*



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

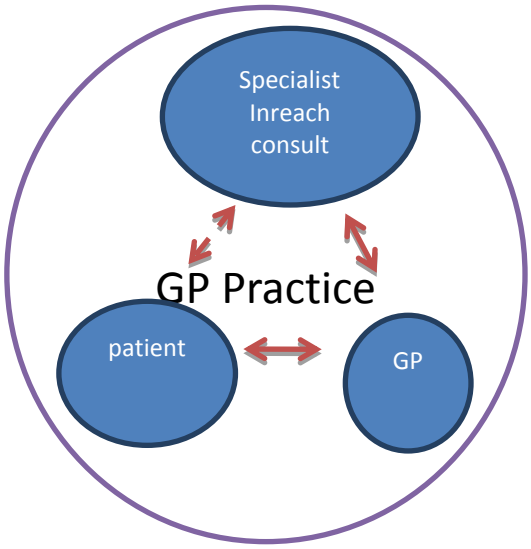
Useful resources

- 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.

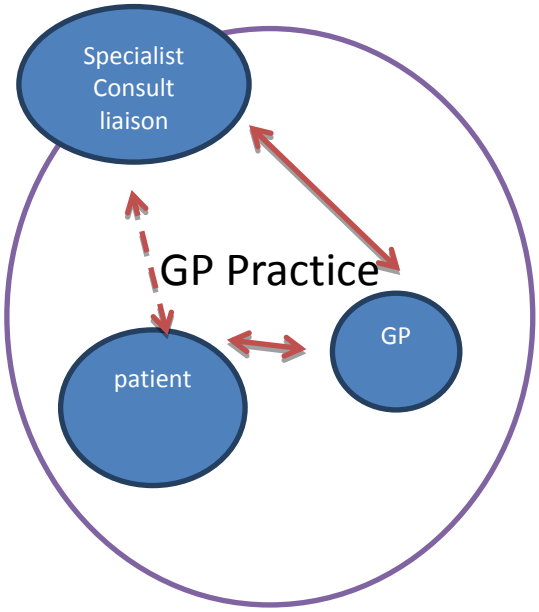
We identified two consultation liaison practices, differentiated by location of the specialist - within the GP practice or at another agency.



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.

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