Primary Care Mental Health (2002) **1**: 000–000 © 2003 Radcliffe Medical Press

Research papers

Managing mental health in primary care: a partnership approach

Huw Charles-Jones MA MSc MBBS MRCGP DCH DRCOG
Northwest Region NHSE Research & Development Training Fellow, The School of Primary Care, University of Manchester, Manchester, UK

Brian Jackson RMN MSc Dip HE
Mental Health Team Leader

Debbie Nixon RGN DN BSc (Hons)
Mental Health Project Lead

TP Saunders BSc MB ChB
General Practitioner

Heath Lane Medical Centre, Boughton, Chester, UK

David M Tanner MSc
Service Improvement Manager, Halton Primary Care Trust, Countess of Chester Health Park, Chester, UK

ABSTRACT

Primary care has been placed at the cornerstone of the National Health Service. *Shifting the Balance of Power* identifies primary care trusts as having the lead role in developing strategic partnerships to improve the health of local communities.[1] The mental health agenda is challenging for primary care as both a commissioner and provider of services. One of the challenges is to provide a model of care that offers an improved single point of access, is integrated with all components of effective care and enhances outcomes for service users. Primary care is the major provider of mental health services in the United Kingdom with 90% of patients with mental health problems treated solely in this sector.[2]

The *National Service Framework for Mental Health* outlines an ambitious programme of development incorporating seven national standards.[3] primary care organisations (PCOs) have lead responsibility for standards 2 and 3 relating to access and effective treatments.

Chester City PCO commissioned and developed a multidisciplinary mental health team in primary care capable of delivering care across the continuum of mental health problems for the adult population aged 16–65 years, which became fully operational in April 2001.

The model is organised around four groups or clusters of practices, each covering a population of approximately 25 000. Each cluster has a linked clinical team leader, deputy and support worker providing a single point of access for primary care referrals in the practices, a 'signposting' function, specialist assessment and delivery of a range of therapeutic interventions.

It would appear that such a multidisciplinary mental health team in primary care, comprising specialist mental health workers, is capable of providing rapid access, managing the continuum of mental health problems and interfacing effectively with a range of key partner organisations.

Early findings demonstrate that this model delivers measurable benefits to service users and primary care professionals and may potentially reduce the utilisation of specialist services. It would appear that the reconfiguration of the service has offered considerable scope to meet the challenging national imperatives required by the newly emerging PCOs.

Keywords: access, effective care, enhanced outcomes

Introduction

Primary care has been placed at the cornerstone of the National Health Service (NHS). *Shifting the Balance of Power* identifies primary care trusts (PCTs) as having the lead role in developing strategic partnerships to improve the health of local communities.[1] The mental health agenda is challenging for primary care as both a commissioner and provider of services. One of the challenges is to provide a model of care that offers an improved single point of access, is integrated with the components of effective care and enhances outcomes for service users.

Primary care is the major provider of mental health services in the United Kingdom (UK) with 90% of patients with mental health problems being treated solely in this sector.[2] Up to 40% of patients attending their general practitioner (GP) have an underlying mental health problem and in 20–25% of those attending it is the sole reason for them seeing their GP.[4] The most common mental health problems presented to GPs are depression and anxiety.[5,6]

Despite the high levels of mental health morbidity presenting in primary care, there has historically been a lack of resources to support appropriate management and treatment of patients with mental health problems. Limited access to counselling and psychological therapies coupled with variations in the capability of GPs to manage mental health problems has led to a greater emphasis on biomedical solutions, such as drug treatment. The majority of problems have a complex aetiology, in which social and relationship problems are often significant components and over-reliance on drug therapy may be inappropriate.

The configuration of primary care mental health services differs widely across the country. The range includes well-established multidisciplinary mental health teams working in primary care, counselling-led services and, in many instances, an outreach model from specialist services. The delivery of the latter can be particularly problematic because of the different priorities and case mix in primary and secondary care. Indeed the perceived polarisation of the agendas of primary and secondary services has frequently led to cultural and professional separation and difficulties in managing care across the interface.

The *National Service Framework for Mental Health* (NSF) outlines an ambitious programme of development incorporating seven national standards. Primary care organisations (PCOs) have lead responsibility for standards 2 and 3 that relate to access and effective treatments.[3] To achieve these, PCOs are required to:

- develop resources within each practice to assess mental health needs
- develop the resources to work with diverse groups of the population
- develop the skills and competencies to manage common mental health problems
- agree arrangements for referral and assessment, advice or treatment and care.

National milestones are challenging and require PCOs to develop and monitor effective clinical pathways for a number of mental health problems in partnership with specialist services, develop local workforce strategies and implement audit programmes to monitor the prescribing of antidepressants, benzodiazepines and antipsychotics.

The NHS Plan in conjunction with the NSF, outlines a radical new approach to the modernisation of mental health services.[7,3] Primary care is identified as playing a key role. Proposals include the provision of 1000 new graduate mental health workers trained in brief interventions, to support and strengthen primary care, by 2004.

The Mental Health Policy Implementation Guide re-emphasises the key contribution of primary care and begins to define the role of the primary care mental health worker.[8] This will be to support individuals with common mental health problems, and also contribute to the shared care of people with severe and enduring mental illness (SEMI). The role of 'gateway workers' is also described. These workers will form part of specialist services and link to primary care providing triage, fostering multidisciplinary working and managing the interface between primary and secondary care.

PCTs will be required to consider local implementation plans in the context of existing and new mental health roles. Implementation issues relating to local needs, service infrastructure and professional supervision and support requirements will need to be developed (Northwest Mental Health Development Centre, October 2001). There is therefore a challenging agenda for primary care. *The Primary Care Key Group Report to The Workforce Action Team* (WAT) acknowledges the scale of the work programme.[9] Four domains of action are identified. These are organisational and leadership development, education and training, the development of new types of workers and a focus on systems designed to improve the quality of services available in primary care. The key objectives for primary care were summarised in a briefing by the Department of Health (September 2001).[10] These are to:

- develop integrated, responsive local services
- work towards a single point of access
- develop inclusive services
- develop multidisciplinary mental health teams in primary care.

It is in the context of these national drivers and local health needs that the Chester City Model was

commissioned and developed. This paper describes the development of a multidisciplinary mental health team capable of managing the continuum of mental health problems in primary care and delivering early and effective interventions in partnership with a wide range of stakeholders.

The Chester City Mental Health Project

The Chester City Mental Health Project began as a collaborative venture between two fundholding general practices in Chester (Handbridge and Heath Lane Medical Centres), Chester and Halton Community NHS Trust, South Cheshire Health Authority and Cheshire Social Services. The aims of the initial collaboration were to address the problems of poor access to a range of treatments, fragmentation of services and poor communication between the different agencies. The result of the collaboration was the successful development of an integrated, multidisciplinary service, which was delivered in primary care. The success of this early work was recognised by its selection as a NHS beacon site for both mental healthcare and primary care. Chester City PCO attempted to build on the principles of this early work to reconfigure the provision of mental health services for patients with common mental health problems. This work was identified as a priority area of the Health Improvement Programme (HImP) and also of the wider objectives of the PCO in achieving greater equity and delivering real health improvements for local communities. The early stages in this process have been described elsewhere.[11]

The scope of the developments

Chester City PCO is responsible for a registered urban population of approximately 100 000. There are 13 GP practices incorporating 66 GP principals. Local health needs assessment work identified high levels of mental health morbidity in Chester with specific groups such as the homeless presenting a major public health challenge.[12]

A mapping exercise was undertaken in May 1999 to examine service configurations, client needs, outcomes, and skills and capability in primary care to manage mental heath problems.

This highlighted a number of key areas for action, which included:

- there was no consistent relationship between needs and resource. Indeed in some cases there was an inverse relationship
- there was limited access and long waiting times for psychological therapies
- priorities for specialist mental health services did not always mirror those of primary care
- services were fragmented and treatment options varied widely
- there was no evidence of cost- or clinical effectiveness
- clinical capability and competence varied
- there was a lack of high-quality mental health information in primary care.

Developing a primary care mental ealth team

The PCO has commissioned and developed a multidisciplinary mental health team in primary care capable of delivering care across the continuum of mental health problems for the adult population aged 16–65 years. This service became fully operational in April 2001. The new investment required was approximately £180 000. The team comprises four whole-time equivalent (wte) clinical team leaders (three community psychiatric nurses, one occupational therapist), two wte deputy clinical team leaders (registered mental health nurses), one wte primary care mental health worker (assistant psychologist) and three wte support workers. Interventions provided by the team include:

- individual care packages for anxiety and depression
- access to a range of high-quality self-help materials and liaising closely with user and care groups
- a rapid access assessment and triage service
- an outreach service for the homeless population
- anxiety management, stress management and postnatal depression support groups
- shared care packages for clients with SEMI
- a benzodiazepine withdrawal service that includes individual and group interventions
- delivering support and rehabilitation packages that utilise the skills of support workers within the team.

The team is responsible for increasing both the capacity and capability in primary care to manage mental health problems. It does this in the following ways, by:

- expanding the role of the primary healthcare trust (PHCT) to treat and manage mental health problems by providing clinical supervision, shadowing opportunities and mentorship

- providing skill-based learning programmes for practice teams
- utilising a case study approach in practices and protected learning time to improve the appropriateness and effectiveness of referrals and treatment
- supporting the lead mental health GP in each practice
- liaising with local statutory and non-statutory organisations in the locality and developing a resource directory
- enabling a 'signposting' function into a range of statutory organisations
- developing and evaluating new roles in primary care including the primary care mental health worker and support worker functions.

The model

The model is organised around four groups or clusters of practices. Each cluster covers a population of approximately 25 000. Each cluster has a linked clinical team leader, deputy team leader and support worker. GPs provide all the medical support to clients. The team provides a single point of access for primary care referrals in the practices. These referrals are discussed at a weekly practice meeting that involves GPs, community psychiatric nurses (CPNs) from specialist services, practice counsellors, psychological therapies and other members of the PHCT especially the health visitors. The model utilises the existing skills of the PHCT to integrate the physical and psychological components of care, especially for clients with SEMI. This has required a review of existing roles and ways of working and refocused core skills and competencies.

Cases are considered in the context of locally agreed clinical pathways for the range of presenting problems and allocated accordingly. These pathways have been incorporated into an electronic mental health template available to every GP in Chester. This provides GPs with the option of referring electronically to the mental health team, enabling access to more consistent and standardised information. Acute referrals for specialist services can be sent directly by the GP based on presenting clinical need.

Improving equity and access to skills and resources

The PCO was committed to improving access to skills and resources across the locality. Through early fundholding initiatives, practices had commissioned a range of interventions including practice-based counselling services and in some cases psychological therapy support from local trusts and independent providers. In total, approximately £160 000 had been invested. This resource was reconfigured based on a resource allocation methodology developed by the PCO and South Cheshire Health Authority. This enabled the allocation of practice-based counselling services and access to a wider range of psychological therapies across the clusters. The clinical team leader acts as a central referral agent and co-ordinates service provision. The range of available therapies includes:

- brief interventions for a range of common mental health problems
- cognitive behavioural therapy
- group therapy including anger control
- family therapy
- couple counselling
- problem solving approaches.

Managing the interface

The primary care mental health team (PCMHT) liaises closely with a range of statutory and voluntary sector services and has a key role in supporting the care co-ordination process with specialist services. Interfaces include;

- community mental health teams (CMHTs)
- clinical psychology
- 16–19 service, which focuses on the mental health needs of service users across the transition
- eating disorder service
- mental health services for the elderly
- team for the homeless.

The interface is managed through the practice based allocation meetings and regular shared peer clinical supervision sessions. The clinical team leaders are invited to attend allocation meetings in the specialist trust to facilitate case discussion and manage care across primary and secondary care.

Performance monitoring and evaluation

Central to the delivery of the model has been ongoing monitoring and service evaluation. This has comprised a combination of qualitative and quantitative measures. An intrinsic part of the evaluation has been

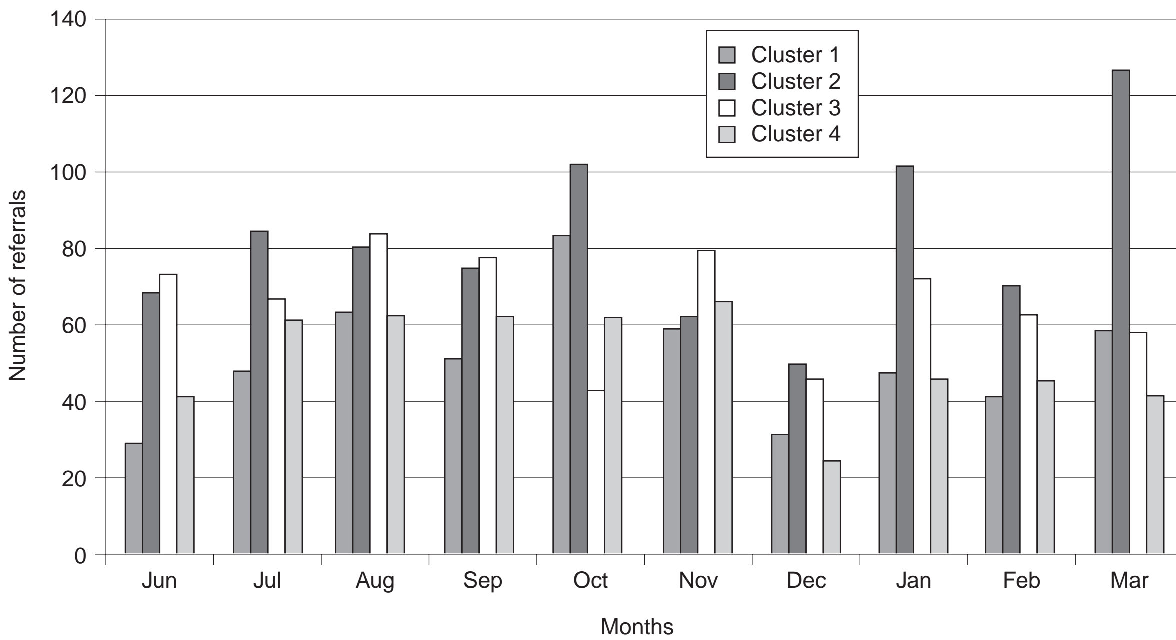

Figure 1 Total number of referrals by practice cluster grouping

to obtain the views and experiences of both service users and professionals/referrers using the service.

Regular monitoring data collated every three months comprises information about service flows and throughput at both practice and practice cluster levels, including the utilisation of specialist mental health services (see Figures 1 and 2).

Collated information about referrals to specialist services currently includes only those that have been 'signposted' via the PCMHT, which may account for the low referral rate per thousand of population. Other access routes into specialist services include direct referral by the GP, from an accident and emergency department or the GP out-of-hours service. A prospective audit, monitoring throughput from all these service areas, is currently underway to inform local planning and service delivery across the system.

The referral data highlight the variations in both perceived need and demand across the constituent practices (see Figure 3).

This chart shows a ranked distribution of individual practices, cluster groupings and the whole primary care group (PCG), for referrals to the PCMHT. It is expressed as a rate per 1000 of the relevant population

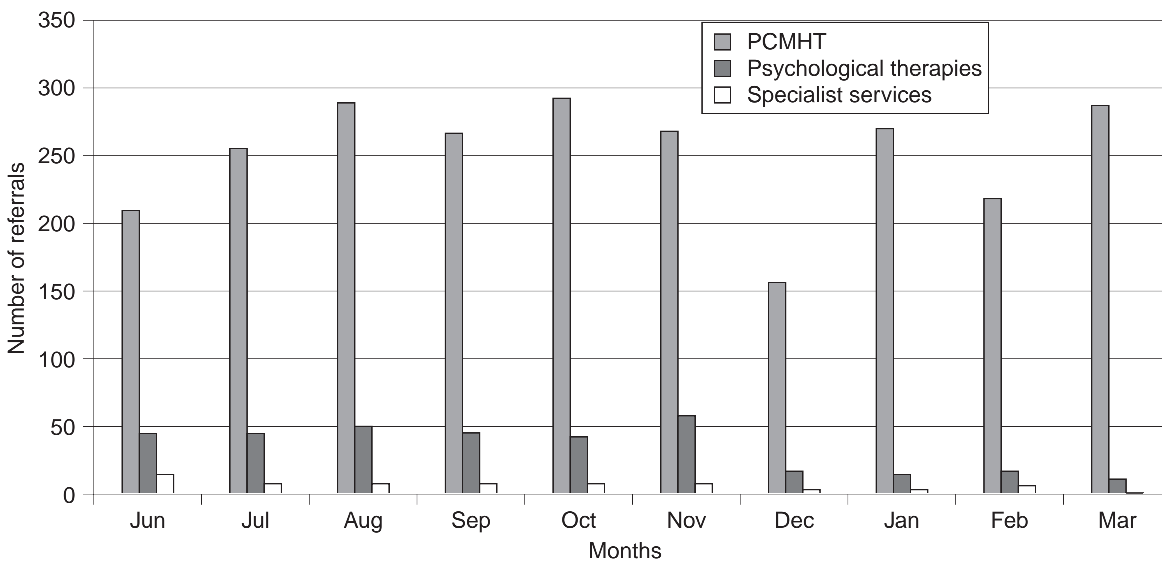

Figure 2 Total referrals to all services

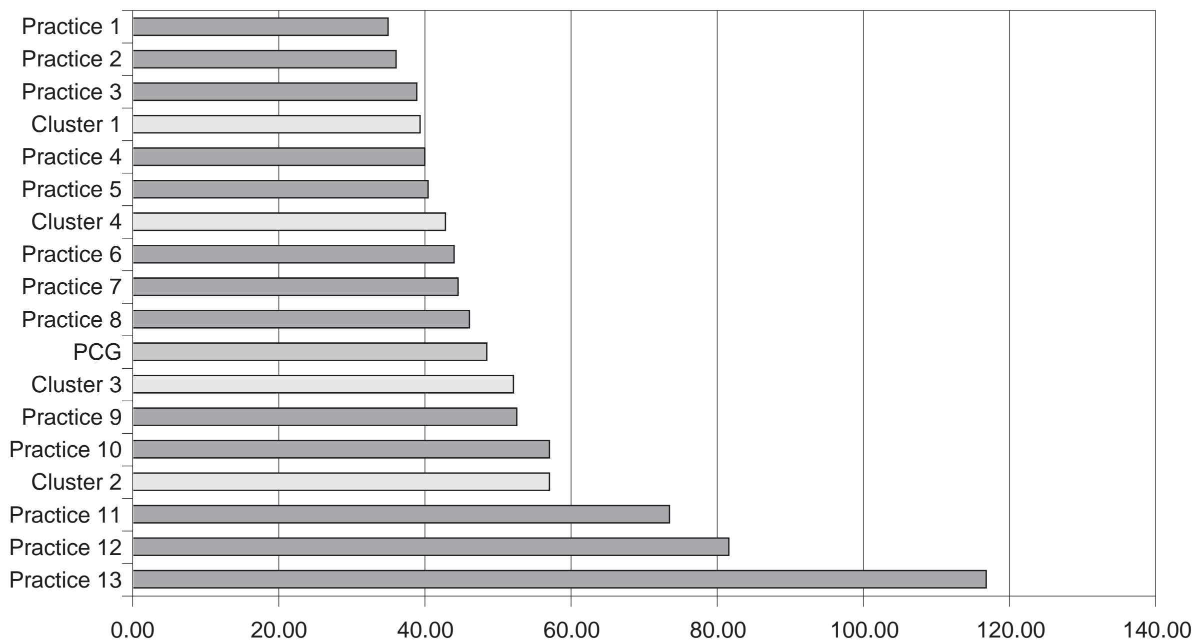

Figure 3 Referral rate per 1000 relevant population per year by practice and cluster grouping

projected for the full year based on the eight months' data collected so far. It illustrates the wide variation between individual practices and cluster groupings.

These referral patterns are not always consistent with the distribution of mental health morbidity across the locality. This may demonstrate the complex interrelationship between the capacity and capability of individual professionals to identify and manage mental health problems and the initiation of a referral. The development of clinical pathways has aimed to standardise clinical referral criteria. This process is supported by the ongoing programme of education, learning and development described earlier.

Access to services has remained within the agreed 14-day standard. Although this is an overall standard there are priority categories within this. The mean waiting time from referral to first contact is 10.8 working days. This was calculated on a random sample of 200 clients drawn from the four practice cluster groupings.

Clinical outcomes are measured using The Hospital Anxiety and Depression (HAD) Scale. This is performed at assessment and again following intervention at approximately eight weeks. Figure 4 shows the mean starting and final HAD scores of a random sample of 100 service users diagnosed with anxiety or depression. It illustrates the significant reduction achieved as a result of individual or group intervention.

A programme of longer-term follow up is being considered, to include monitoring of relapse/re-presentation rates and administration of the HAD Scale at 12 months.

Evaluation of the service by service users is assessed by a questionnaire administered following intervention which examines access, satisfaction with the therapist, perceived outcome and suggestions for improvement. In addition a series of in-depth interviews were undertaken. Of the 77 service users who completed a questionnaire, 22 agreed to be interviewed. Service users were contacted by an audit facilitator and asked if they would like to participate in an interview to elicit more in-depth views of the service. Twenty-two service users agreed to be interviewed. They comprised a spread of opinion covering both sexes, an age range from 20 to 70 and were from a variety of localities. The following observations were made:

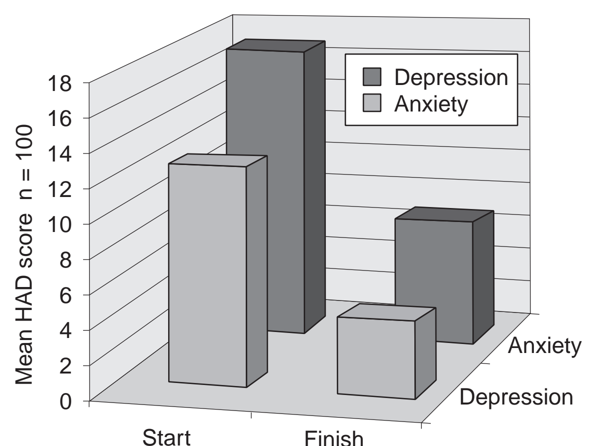

Figure 4 HAD Scale analysis

- the convenience of being treated locally and seen promptly was perceived as a considerable benefit
- access to a range of skills in primary care was valued highly with particular reference to the support worker role
- positive attitudes engendered in group situations were highly valued, although some service users felt individual therapy would have been more beneficial
- some service users were uncomfortable with letters headed 'mental health' and did not like leaving messages on the answer phone
- poor access to clinical psychology was noted.

The outcomes of this have been considered in the ongoing planning and delivery of the service.

Regular liaison with referrers is also central to the model. This occurs quarterly at practice cluster meetings with the mental health lead from each practice. This enables the monitoring of trends within and between practices, highlights priorities for service delivery and measures overall satisfaction with all aspects of the service.

Discussion

This paper describes a method of delivering mental health services in primary care.

The data presented have been produced locally through a programme of audit to support and monitor local implementation. Its generalisability is therefore limited but it begins to highlight areas worthy of further research. The process of implementation is important in terms of the lessons learnt for newly emerging PCOs and explores an innovative approach to meeting the challenging modernisation programme outlined in the NSF and *The NHS Plan*.[3,7]

It would appear that a multidisciplinary mental health team in primary care, comprising specialist mental health workers, is capable of providing rapid access, managing the continuum of mental health problems and interfacing effectively with a range of key partner organisations. This has directly increased capacity in primary care to co-ordinate and manage the care of clients with common mental health problems and provide packages of shared care for clients with SEMI.

Access to services has remained high in relation to both early interventions and an increased range of therapeutic modalities. Over a 12-month period, all clients referred to the PCMHT have been assessed and offered an appropriate intervention within the 14-day standard set. Despite differences in demand, this approach has ensured equity of access to skills and resources for all constituent practice populations. The single point of access for primary care mental health services provided by the clinical team leader has almost certainly contributed to this outcome by managing demand across the PCO. In addition it has prevented fragmentation and duplication of services and it has enhanced clinical communication between agencies.

The extended range of treatment options now available in primary care may be reflected in the apparently low referral rate to specialist services. This is being explored in more detail however across the system, in the context of locally agreed clinical pathways, clinical priorities and health and service improvement plans.

The grouping of practices into four clusters has needed a considerable programme of organisational development for primary care. This has challenged traditional models of provision where practices have historically worked in isolation from each other. It has involved practices sharing resources, working more formally in partnership with a range of mental health providers, developing shared plans for service improvements and jointly reviewing performance.

This has required action in a number of domains including; changes in culture and ways of working, training and development of the PHCT, and a review of communication systems within and between the constituent practices and key partner organisations. Chester City PCO has commissioned a qualitative piece of research to explore the benefits and barriers that may exist when groups of practices work together, and the impacts upon service delivery. Early analysis of the first phase suggests that GPs and the PHCT recognise the benefits of the new service.

The role of the GP mental health lead in each practice has been essential in terms of facilitating communication, disseminating good practice and sustaining the momentum of change. This role has succeeded without the provision of protected time or additional resource and appears to reflect high levels of commitment amongst the constituent practices.

The flexibility of the PCMHT has been demonstrated in a number of ways. The team has been able to develop a shared care programme for clients with SEMI, supporting the physical care of this client group with other primary care professionals. A depression management pilot is currently underway with the elderly population utilising the skills of the district nursing team. Shared care packages are delivered with health visitors for a range of problems including postnatal depression.

Models of service that are developed in primary care appear to offer considerable scope for the delivery of integrated and multidisciplinary care. Chester City PCO is aiming to build upon this work to include an assertive outreach service for the homeless population

and provide a shared care pathway for service users who experience problems with substance misuse.

By developing new roles and new ways of working, this collaborative approach has enabled the PCO to begin to address the requirements of *The NHS Plan* and the WAT report.[7,9] The approach has involved the refocusing of existing roles and the development of new roles in primary care. Health visitors for example, have reported the benefits of working as part of a mental health team, which include having increased confidence to manage and work with clients with mental health problems.

The capacity and capability of individual professionals working in primary care is a considerable issue and has been well reported. This new way of working has enabled greater integration of the psychological and physical components of care, reduced duplication between healthcare professionals and avoided unnecessary referral.

Capability building has been provided in a number of ways. This includes multidisciplinary work-based education and training opportunities which have been effective in ensuring high levels of uptake and reducing the burden of 'time out' of practice. The PHCT has been able to develop skills and competencies within their practice teams facilitating clinical communication and extending good practice. This, combined with a framework for clinical supervision provided by the PCMHT, has led to measurable clinical improvements.

A detailed evaluation of the primary care mental health worker role is being proposed in conjunction with a number of other sites in the northwest. Anecdotally, benefits include a focus on brief interventions, expertise in assimilating audit and evaluation data and a comprehensive knowledge of the current evidence base that has underpinned the development of clinical pathways. The support worker role appears to be valued by service users and is based around the concept of support and social recovery. The PCO is keen to explore the future interface of this role with that of the proposed support time recovery workers outlined in the WAT report.[9]

Early findings demonstrate that this model delivers measurable benefits to service users and primary care professionals and may potentially reduce the utilisation of secondary services. It would appear that the reconfiguration of the service has offered considerable scope to meet the challenging national imperatives required by the newly emerging PCTs.

REFERENCES

1 Department of Health (2001) *Shifting the Balance of Power*. Department of Health: London.
2 Goldberg D and Huxley P (1992) *Common Mental Disorders; a biosocial model.* Routledge: London.
3 Department of Health (1999) *National Service Framework for Mental Health: modern standards and service models.* Department of Health: London.
4 Goldberg D (1991) Filters to care: a model. In: Jenkins R and Griffiths S (eds) *Indicators for Mental Health in the Population.* HMSO: London.
5 Mann A (1995) Depression and anxiety in primary care. In: Jenkins R, Newton J and Young R (eds) *The Prevention of Anxiety and Depression*. HMSO: London.
6 Office of National Statistics (1992) *Key Health Statistics from General Practice*. ONS: London.
7 Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. Department of Health: London.
8 Department of Health (2001) *The Mental Health Policy Implementation Guide*. Department of Health: London.
9 Mental Health Workforce Action Team (2001) *The Primary Care Key Group Report to The Workforce Action Team*. Department of Health: London.
10 Department of Health (2001)
11 Nixon D, Saunders TP and Tanner DM (2000) Managing mental health in primary care. *Journal of Clinical Excellence* (2000) **2**: 175–81.
12 South Cheshire Health Authority (1999) *Annual Public Health Report*. Department of Health: Chester.

ADDRESS FOR CORRESPONDENCE

Debbie Nixon, Heath Lane Medical Centre, Heath Lane, Boughton. Chester CH3 5ST, UK. Tel: +44 (0)1244 348844; fax: +44 (0)1244 351057; email: debbie.nixon@cmhsde.org.uk

Accepted July 2003