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The Management of Mental Health in Primary and Secondary Care

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Introduction

The effective management of mental illness in primary care relies, in large part, on the knowledge and skills of the primary health care team, and their links with secondary care mental health professionals. According to national mental health policy, most mental health problems can, and should, be managed within primary care, whilst people with serious mental illness may require input from specialist secondary services. This chapter describes a series of educational initiatives for primary care doctors and nurses in Bedfordshire aimed at improving primary care psychiatry, and joint-working at the interface between community mental health teams and primary care teams. In 1999, this work was awarded Beacon status by the Department of Health. The educational initiatives were carried out by a team consisting of a doctor (MA), with a background in general practice who had opted to become a staff psychiatrist in the local community Trust, and a lead community mental health nurse (JB). The chapter is essentially a description of how and why the project evolved and, hopefully, it will give guidance on how to apply the same principles in other parts of the country.

The Need for Primary Health Care Team Education

At least 95% of mental health issues presenting in general practice are dealt with completely within general practice. The other 5% are referred to secondary care, but most of these will in the long term be managed by workers from both the primary care team (PCT) and the community mental health team (CMHT) working in co-operation. This represents a major

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workload for PCTs, which in a number of ways, are disadvantaged in dealing with mental health issues (Goldberg and Gournay, 1997). Firstly, most primary care workers have relatively little first hand knowledge of psychiatry. Only about one third of GPs are believed to have done a psychiatric placement as part of their GP training, and such placements are often not an ideal way of learning about the psychiatric problems they will encounter in general practice. Most primary care nurses are "general trained" and will have received very little teaching on mental health issues (Onyett et al, 1996). Secondly, although an "evidence base" exists to inform appropriate treatment decisions, thus far little has been done to use the knowledge in implementing good practice. At the same time, GPs are constantly bombarded by conflicting claims about drug treatments from pharmaceutical representatives. Our own observations in South Bedfordshire reveal that while GPs are anxious to preserve their counselling services, they are also often unsure about the potential benefits of new psychological techniques such as cognitive behaviour therapy. Finally, it has been suggested that often primary care doctors and nurses, may be likely to under-diagnose depression and other mental illness (Paykell and Priest, 1992; Kessler et al, 1999).

To address these issues, in 1997 we embarked on the planning phase of an educational initiative in South Bedfordshire. At that time, the situation in South Bedfordshire mirrored many of the problems identified above. Most general practitioners in the area relied extremely heavily on the local CMHTs for assistance in meeting the mental health needs of their patients. The consequence was that CMHTs received a very large proportion of requests for counselling services that did not fall within their remit. The exception to this was a few fundholding practices that had invested heavily in counselling services. In general, there was very little evidence of interchange of information between primary care and secondary mental health services, except in the form of letters between the CMHTs and the PCTs. There was also little evidence that there was an awareness of modern mental health care methods among primary care teams. For example, it was clear that GPs were often using tricyclic antidepressants at inappropriately low dosage; were still dubious about using selective serotonin reuptake inhibitors (SSRI); did not understand the need for the use of atypical antipsychotics; and, had no knowledge of, nor access to, cognitive behaviour therapy. The newer anti-depressants and anti-psychotics offer important advantages in terms of greater efficiency and fewer side effects. On the other hand, CMHTs had been told to concentrate on treating the seriously mentally ill, but struggled with a large number of "inappropriate" referrals. With one or two notable exceptions, community mental health nurses (CMHN) had received no training in

cognitive therapy, and were mostly seen as "depot injection nurses". Family Therapy was unavailable to families with seriously mentally ill patients.

Developing an Educational Initiative

In developing an educational initiative in South Bedfordshire, we attempted to educate the various components of the mental health system, and then to organisationally rationalise the system. This was intended to produce a more effective system that is totally integrated and capable of meeting all the mental health needs of the population in a seamless fashion. In this system, less serious mental health problems will be dealt with effectively at primary care level; while serious mental illness will draw on the resources of both primary and secondary care, brought together in a coherent way.

It was decided that an educational initiative aimed at primary care doctors and nurses would be beneficial in:

- enhancing the ability of GPs and their practice nurses in diagnosing common mental health conditions such as depression, dementia or early psychosis;
- enabling GPs and primary care nurses to be more effective in managing mental health conditions;
- creating an atmosphere wherein co-operation between PCTs and CMHTs is enhanced.

In order to develop a strategy for applying our educational initiative, it was important to develop a theoretical model of what an evidence-based seamless service would look like. Essentially, communication across the primary/secondary care interface was the key to the model, and it was clear that one person would have to take on the role of being the "communication channel" between the two teams. We visited several sites where such teams were being developed and considered the evidence regarding the 'consultation-liaison' model discussed by Gask et al (1997). It was clear that the person best placed to provide the liaison link between the CMHT and the PCT was the community mental health nurse (CMHN), who was a member of both teams. In this position the CMHN could deal with the seriously mentally ill of the practice as a case manager. The CMHN could also act as a link between the psychiatrist and the GP, as well as giving advice directly to the GP. The CMHN would have access to the GP's notes and computer system; could ensure that the practice had a CPA register; and, ensure that all CPA2 patients had care plans which were known to the GP. In addition, the CMHN could give clinical supervision to primary care

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nurses who might be dealing with the less serious mental health problems in the practice. In order to do this, the CMHNs would need to be qualified as case managers, and trained in:

- risk assessment;
- cognitive therapy for psychosis (which may help modify the patient's perception of delusions and hallucinations);
- family therapy in serious mental illness (which has been shown to minimise relapse); and
- compliance therapy (which is a form of motivational interviewing to encourage patients to take their medication regularly, and so helps prevent a relapse of the illness).

It is well established that primary care nurses have a role in identifying and helping manage anxiety and depression, identifying dementia and identifying postnatal depression, as well as potentially identifying patients with psychotic symptoms (Mann et al, 1998). Thus practice nurses, district nurses and health visitors all have a potential role in mental health practice. To fulfill this role, they need training, support and clinical supervision, all of which the CMHN is well placed to provide.

In Figure 1, we have developed a theoretical model of a seamless mental health service which helps to identify the roles of each member of the PCT and the CMHT, and highlights their training requirements. It is essential that all the members of the primary care team take on a role in dealing with mental health problems, or the team will find it impossible to deal with this major burden in day to day practice. Practice councillors will also play a useful role, so long as their interventions are seen to be evidence based and effective.

The next stage for the education team was to undergo approved training in educating primary care teams. The authors were both fortunate in receiving sponsorship to join the program for training Mental Health Facilitators, which is run jointly by the Royal College of General Practitioners and the Institute of Psychiatry. The course organisers are Dr Andre' Tylee (see Tylee, 1999), Senior Fellow in Mental Health at the RCGP, and Mrs Elizabeth Armstrong, Head of the National Centre for Educating Practice Nurses on Depression. The course is run as a number of modules over a period of one year. Between modules, trainee facilitators begin to engage with practices and are given supervision of their work in the modules. It is intended that the trainees work in doctor/nurse pairs so that, in visiting a practice, they are able to engage with the whole PCT. In turn, it is hoped that the PCT will work together to develop better systems within their practice to deal with mental health problems.

In visiting practices, we found that it was often very difficult to persuade a PCT to admit to having any particular problems. However, when they did, it was then possible to enable the team to put together a plan in order to improve practice in the identified area. The facilitation team would deliver an educational intervention based on the package it had devised, and monitor progress.

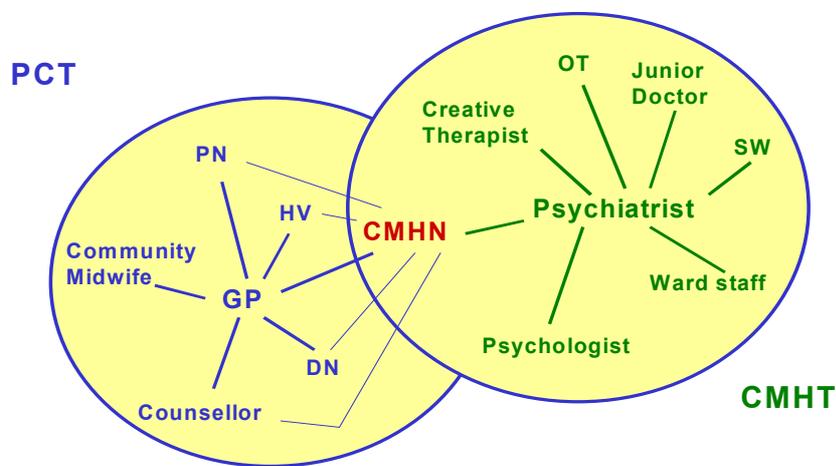


Figure 1: Liaison Model – based upon the role of the CMHN

Thus, in a range of practices, different educational interventions were delivered. These included interventions aimed at:

- the identification and management of postnatal depression;
- how to deal with aggressive patients;
- training the practice nurses to identify patients who presented with depression; and,
- showing practice nurses how to deal with problems related to anxiety.

We identified participating PCTs by writing to all general practices in the Luton and Dunstable areas to offer our services. In the first year, we visited six practices. Others were included later on. In each practice we visited, we wrote a report of our conversation with the team for our records. This

served as our assessment of the practice, and contained bullet points identifying the areas on which we agreed to work with the practice. This report was shared with the practice and used as a basis for our future work with the practice team. Figure 2 shows the work of the mental health facilitators across the primary care/ secondary mental health services interface.

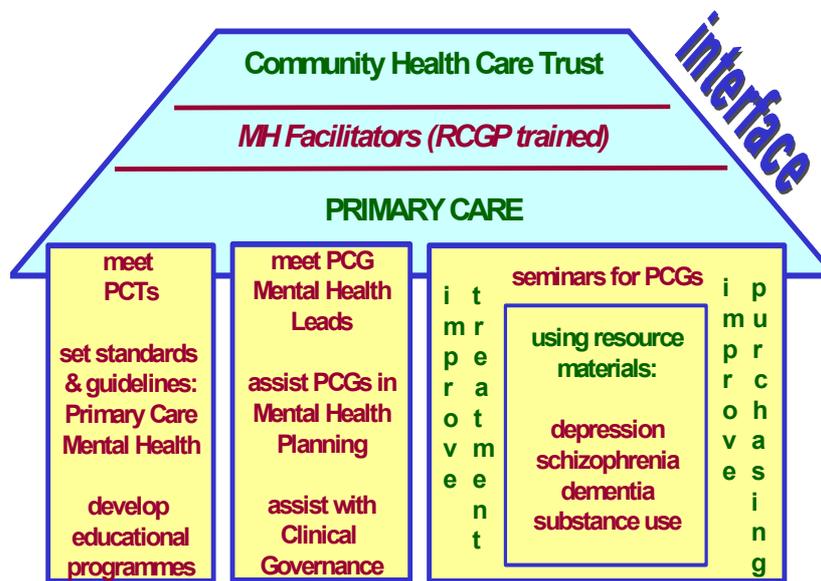


Figure 2: Clinical Governance – Across the Interface

As our practice visits grew in number, it became apparent that certain issues were arising time and again. Therefore, we began to develop packages of guidelines on basic mental health problems that we could use repeatedly. Each pack contained a set of guidelines, information from scientific papers on which they were based, and copies of the overheads which we might use in a presentation on the subject. All our packages contain information on diagnosis and information on treatment including both pharmaceutical and cognitive-behavioural treatment. The packages we have produced include:

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- The Identification and Management of Depression in Primary Care;
- Joint working between the CMHT and Primary Care in Schizophrenia;
- The Identification and Management of Dementia in primary Care;
- The Identification and Management of Postnatal Depression in Primary Care;
- Alcohol Problems in Primary Care;
- Anxiety Management in Primary Care; and,
- Information on the Care Programme Approach (CPA).

We realised that it would be a good idea to organise workshops for PCTs (both GPs and nurses) in which we could address several practices together. We used the packages described above as the basis of these workshops, and each participant received a copy of the package. We began with a series of workshops on depression, and then we added on a series of workshops on schizophrenia. More recently, we have started two more series of workshops, one on the management of dementia and one on the management of alcohol problems in primary care. By the end of 1998, we had presented workshops involving 25 practices in two primary care group (PCG) areas, including 26 GPs and 20 practice nurses. The content of our workshops is shown below.

A typical Depression Workshop will deal with:

- the recognition of depression;
- assessment of suicide risk;
- introduction to management techniques including medication, cognitive-behavioural and social interventions;
- video exercises including pre-recorded vignettes;
- co-ordination of primary care interventions and CMHT interventions; and,
- general discussion.

A typical Schizophrenia Workshop will include:

- diagnosis and natural course of schizophrenia;
- principles of the Care Program Approach;
- the role of the consultant and the CMHT;
- the role of the GP and the PCT;
- developing joint protocols;
- introduction to management with medication and psychosocial interventions; and,
- summary and discussion.

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A typical Dementia Workshop includes:

- identification of dementia;
- the different forms of dementia;
- appropriate investigations;
- screening and the over 75 check;
- medication for symptom control;
- the new drugs; and,
- the roles of nursing staff, OT and social services.

A typical Alcohol Workshop includes:

- the problems caused by alcohol;
- screening for alcohol consumption;
- the issue of dual diagnosis;
- motivational interviewing;
- the role of drugs in management; and,
- other cognitive-behavioural interventions in dual diagnosis.

At the request of a number of practices, we undertook to run an educational workshop programme for practice nurses in the Luton PCG area. In this series of workshops, lasting 5 sessions, we were able to train practice nurses to identify depression in their primary care work, and then teach them some basic cognitive-behavioural techniques such as problem solving for managing depression. Then we moved on to the identification and management of anxiety based problems. We hope to repeat the success of this course in other groups of practices.

In order to gauge the level of support by primary care nurses for training in mental health topics, our team, in conjunction with the Audit Department of the Trust and the Bedfordshire Audit and Education Group (BAEG), distributed a questionnaire to all practice nurses, district nurses and health visitors in South Bedfordshire. The results of this activity showed that:

- health visitors wished for more training on post-natal depression;
- district nurses wished to know about dementia;
- all three groups wished for training on depression and substance abuse;
- all three groups wanted advice about when to refer patients; and,
- most primary nurses did not know about the CPA process and did not know the liaison CMHN attached to their practice.

Funding has been sought from the Bedfordshire Consortium to provide training on all these aspects of mental health care. In South Bedfordshire, our team has been able to distribute registers of CPA2 patients to all practices via their liaison CMHN every three months, and so to involve practices in the CPA process. In order to support our programme, we are developing computerised audit packages for use in both primary care and the CMHTs to audit the management of depression in primary care and of schizophrenia and depression in the CMHTs. This is a local development of a major audit of schizophrenia in the CMHTs undertaken on our behalf by a commercial organisation.

All these audit and training activities feed into the cycle of clinical governance (see Figure 3). Primary care mental health facilitators will have an important part to play in clinical governance across the primary/secondary care interface. Specific issues can be identified through a joint meeting between a primary care group and the local CMHT. Specific standards and practice guidelines can be agreed. These guidelines can be established by an educational seminar for the local practices, and baseline audits can be carried out at CMHT and PCT level.

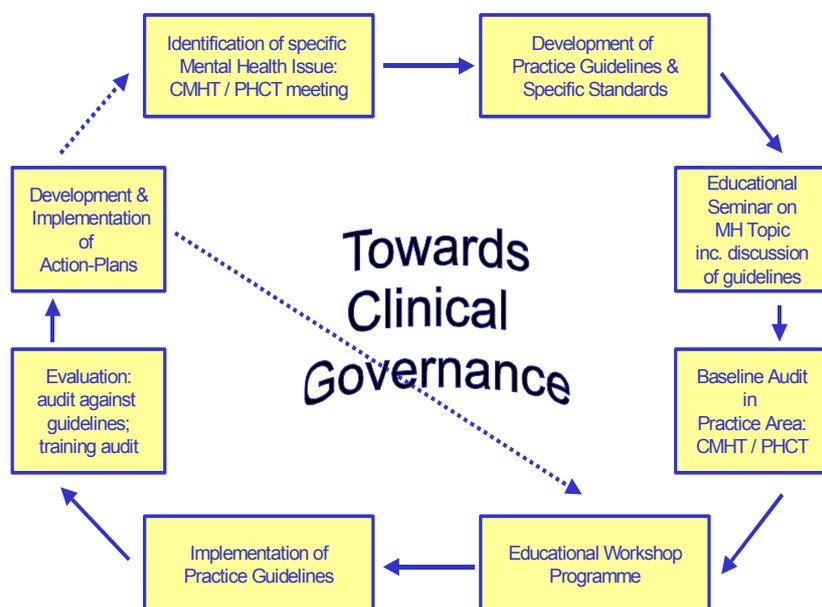


Figure 3: Towards Clinical Governance

The educational workshop leads on to the implementation of practice guidelines. Subsequently, evaluation of the results of the training can be carried out by further audit, and the action plans deriving from this can lead to identification by the PCG and the CMHTs of further issues. Then the cycle can be repeated. One hopes that the educational activity with PCGs will enhance GPs' knowledge of modern mental health issues and, therefore, will both enhance primary care practice and PCG commissioning.

Conclusion

In conclusion, we have produced a robust series of initiatives to improve primary care psychiatry, and the interface between primary and secondary care in our area. It was timely that we began to face up to this challenge when we did. The years between 1997 and 1999 have seen the end of fundholding and the development of primary care groups. This has meant a major increase in the responsibility of GPs to manage their own services effectively and to begin to commission mental health services. These years have also seen the development of clinical governance, as an evidence based and audit based tool for assessing and enhancing clinical performance, along with the publication of a national service framework (DoH, 1999). The national service framework is essentially a major systematic review of what constitutes good mental health practice with a set of national milestones that prescribe how mental health services are to develop.

The initiatives, so far, have been of an educational nature, but have also included audit activities. It would not have been possible to target the initiatives properly if we had not first developed a model of how all the members of primary care and community mental health teams should work together. As we have adopted a whole system approach to improving primary and secondary mental health care, we still have a great deal of work to do in order to completely modernise mental health services in Bedfordshire. However, substantial progress has been made, and our team was awarded NHS Beacon status in 1999. We look forward now to completing the work begun in 1997 when we started training as mental health facilitators.

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