

# The CPN liaison service

**To provide a seamless mental health service across the primary/secondary care interface, it is necessary to look at the needs of modern primary care and community mental health services. A theoretical model can then be developed which integrates services and clarifies the resources, both human and training, needed in such a service.**

**I**t has been suggested that between 20–25% of consultations carried out by GPs on a day-to-day basis concern mental health problems. Yet, a large proportion of patients who present with depression to their primary care team (PCT) are not diagnosed as suffering from the condition.<sup>1,2</sup> In an average practice list of 1900 patients there will be:

- ◆ 7–12 with severe mental illness
- ◆ 60 with moderate to severe depression
- ◆ 140 with mixed anxiety and depression
- ◆ 100–200 with neurotic symptoms.<sup>3</sup>

However, most patients who are treated with antidepressants in primary care are not treated for a sufficient time according to current guidelines. Furthermore, most patients prescribed tricyclic antidepressants by their GPs are prescribed sub-therapeutic doses.<sup>4</sup>

Primary care in England must shoulder the major part of the burden of mental healthcare, and manage most of it without referral to secondary care services. This task is a great one and GPs need the support of their team and a programme of ongoing education to enable them to deal adequately with the mental health workload generated by their practice lists.

Within secondary care it has become policy, following an Audit Commission report, to assume that community psychiatric nurses (CPNs) and community mental health teams (CMHTs) should reserve their attention for the care of the seriously mentally ill.<sup>5</sup> This has led to the withdrawal of CPNs and CMHTs from involvement with 'less serious'

cases who, however, continue to be referred to CMHTs by GPs who feel that they do not have the necessary expertise. Thus, there is a risk that some patients might find that neither primary nor secondary care feels able to deal with their problems.

The advent of new antipsychotic drugs, the training of CPNs in advanced psychotherapeutic skills such as cognitive therapy and family therapy, and the adoption of more effective Assertive Outreach techniques do make CPNs more effective in dealing with severe mental illness in the community. Despite this, the effective use of the Care Programme Approach (CPA) should involve GPs and the PCT in the management of the seriously mentally ill. The involvement of general practice in the care of the seriously mentally ill (especially when dealing with physical symptoms) has been emphasized by the recent publication of consensus guidelines.<sup>6</sup> Burns and colleagues have also demonstrated that practice nurses can monitor the progress of the seriously mentally ill.<sup>7</sup> These advances offer great promise for the improvement of the mental health of our patients, provided that:

- ◆ Sufficient resources in finance and manpower are available in both primary and secondary care
- ◆ Appropriate education is given to enable primary care doctors and nurses to carry out their role in the field of mental health, and education in cognitive and family therapy techniques (such as the Thorn Course) are made available to CPNs
- ◆ A clear structure is established to ensure the close relationships and cooperation of PCTs and CMHTs is maintained and that this strategy is pursued effectively.

The first attempts to link PCTs and CMHTs devolved outpatient clinics into primary care. However, psychiatrists who run outpatient clinics in general practice surgeries often fail to integrate into the PCT. Recent articles by Gask and coworkers,<sup>8</sup> and Burns and Bale<sup>9</sup> have described consultation-liaison attachments of psychiatrists to PCTs. However, the number of psychiatrists available throughout the country is insufficient to provide such a system for all general practices.

We have recently developed a system which takes advantage of a third model also described by Gask and colleagues.<sup>8</sup> CPNs, who are part of the CMHT, are aligned with general practices, and this is developed into a full liaison service between PCTs

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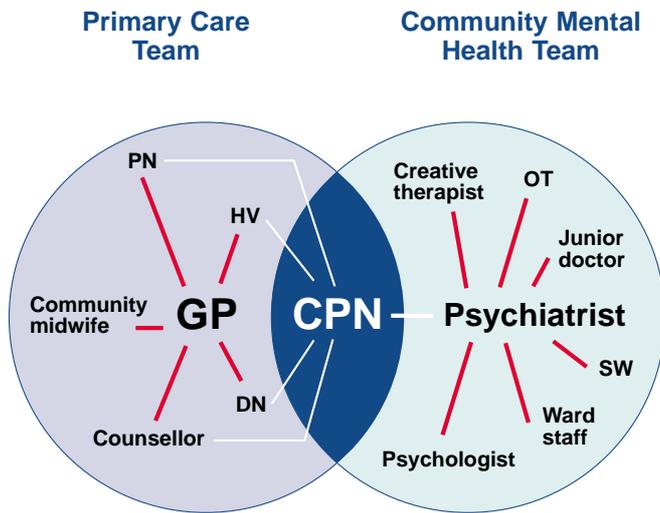
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**Figure 1: CPN Liaison Model**

and CMHTs (see Figure 1). The CPN belongs to both the CMHT and the PCT, and in this way, can fulfill the roles of:

- ◆ Acting as liaison link with the CMHT, giving advice to GPs on the management of mental health problems, and referring to the consultant psychiatrist as necessary
- ◆ Giving cognitive therapy and family therapy to the seriously mentally ill within the setting of the GP surgery
- ◆ Ensuring the full involvement of the practice in the CPA, acting as a keyworker, and encouraging the establishment of a CPA register
- ◆ Offering clinical supervision to practice nurses, district nurses, health visitors and counsellors.

It is clear that for this liaison role to be implemented, there must be sufficient number of CPNs available to cover all the practices in an area. CPN attachments to practices should be for an indefinite time and only be changed rarely, in order to ensure continuity of care. The value of this form of CPN liaison is graphically illustrated in the interim report of IRIS,<sup>11</sup> which suggests that in cases of early psychosis, the attached CPN is probably the one person in the practice who is able to collate all of the available information on the patient.

Given proper medical supervision by the practice CPN, it is possible to mobilise all types of primary care nurses to help in the management of common mental health problems (advocated by Goldberg and Gournay).<sup>16</sup> Mann and colleagues<sup>12</sup> have shown that practice nurses can monitor depressed patients and encourage compliance with treatment. Mynors-Wallace and coworkers<sup>13</sup> have shown that practice nurses can be trained in basic cognitive skills, such as problem-solving, to use with depressed patients.

In addition, health visitors are able to identify postnatal depression and to treat it using cognitive, problem-solving or counselling strategies.<sup>14,15</sup>

Training the PCT is critical to making the model work. A team of multidisciplinary trainers trained after the fashion described by Tylee<sup>16</sup> is based in Luton<sup>17</sup> and visits PCTs to help increase their preparedness to deal with mental health problems. After visiting the practice and assessing the current practice, the team writes a report giving advice and expertise. It runs workshops for PCGs offering evidence-based guidelines to deal with common mental health problems. The team also runs workshops to train practice nurses in the identification and management of depression anxiety. The full implementation of this model is a challenging task which will take many years of education and innovation, with regular audit. However, there seems little doubt that the full integration of PCTs and CMHTs, using the CPN as the link worker, presents the best chance of taking advantage of all the new developments in psychiatry of recent years and achieving a fully integrated community psychiatric service. ■

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