Advancing the Shared Care Approach between **Primary Care** and **Specialist Mental Health Services**

A GUIDANCE DOCUMENT

Prepared by the
HSE Working Sub Group on Mental Health in Primary Care

FOREWORD
MENTAL HEALTH IN PRIMARY CARE

A Vision for Change recognises the essential role played by our colleagues in Primary Care in the provision of mental health care in Ireland. 90% of mental health presentations remain in a primary care context and account for over 5 million occasions of care each year.

Chapter 7 of Vision introduces a number of models for collaboration with a preference for the *Shared Care* model. This can improve service access, efficient use of specialist mental health care services and facilitate early discharge and return to primary care. The importance of maintaining the physical health of long term mental health service users is also supported through this shared care approach.

As Primary Care Teams continue to expand throughout the country it is now necessary to provide additional guidance. This document recognises the various phases of development within the Teams and acknowledges that there can be variation in the preparedness of some Primary Care and Community Mental Health Teams for this shared role.

With the additional investment in Community Mental Health Teams this document provides timely guidance on how the essential links with primary care colleagues can be maintained.

This document is one of a suite of resource materials prepared by the National Vision for Change Implementation Group. This group includes and values the expertise of multidisciplinary mental health professionals and the lived experience of Service Users.

It is easy to overlook the benefits of peer to peer communication, the spoken word and relationships between mental health and primary care. These are still pivotal to providing high quality, community based mental health care. In a busy practice and complex fast moving environments, simple protocols and straightforward engagement are the most powerful tools.

This document endorses the use of electronic communication and while this is still in development in the health context in Ireland, we felt it was important to anticipate the widespread use of ICT tools which can greatly enhance the delivery of services in a timely and comprehensive way.

A survey conducted in the preparation of this document greatly informed the work and took place as many primary care teams were being established. Thanks to those who contributed and gave feedback as part of this Guidance document development.

Practical recommended actions have been placed to the fore of the document to highlight the importance of the immediate actions that can best effect change in collaborative working at local PCT/CMHT level.

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INTRODUCTION

This Primary Care and Mental Health Group was established as a subgroup of the Vision for Change National Working Group (2010) (See Appendix I for list of membership). The working group engaged in a process of consultation with key stakeholders including Service Users. The group was tasked with examining the recommendations laid out in Chapter 7 of a *Vision for Change* (2006) (see Appendix II) and to develop a guidance document to promote collaborative working between specialist mental health and primary care services. This document will act as a 'road map' to support collaborative working between Primary Care and Specialist Mental Health Services in the delivery of a comprehensive programme of care with the Service User.

A key objective of the HSE is to integrate health care between the community and hospital services (DoHC, 2001(a)) so as to enable the best possible patient care. Whilst there is an acceptance that it is best for health care personnel to work together to ensure the best possible clinical outcomes for the patient/client, in practice this poses many challenges. Findings from a survey of current collaborative working amongst primary care and mental health service practitioners conducted by the working group showed that the level of integration between the mental health services and primary care is inadequate in relation to what is necessary to best facilitate the patient's journey and to support the professionals providing care for patients.

This document was developed to support staff working in Primary Care and Specialist Mental Health Services to achieve a more integrated approach to patient care utilising a shared care approach. The Working Group is hopeful that this document will help to advance the shared care approach to mental Health in Primary Care.

The lay out of the document is designed to highlight the recommended actions that support the collaborative working between Mental Health & Primary Care through a shared care model.

RECOMMENDED ACTIONS

Introduction

Shared care is at the core of what health service delivery is about. A key challenge for the health services is to achieve a standardised collaborative working service delivery approach between mental health and primary care. This requires a clear focus on shared care and a commitment to its development at national, regional and local levels. Working effectively together, primary and specialist services can ensure that patients can access the most appropriate, effective and timely service that they need.

A. Delivering Shared Care

i.   National policies and protocols that support shared care need to be developed and implemented between Primary Care and Community Mental Health teams.

ii. Further development of clinical governance structures and strong leadership is required to drive shared care.

iii. A consistent and standardisation of service delivery approach across the 4 HSE regions in terms of the collaborative working approach to primary care and mental health is required.

iv. Ensuring the boundaries for mental health and primary care services are co-terminus is an important measure that would help to achieve this goal.

v.   Primary Care and Mental Health Services should be co-located where possible.

vi. All patients should have access to a comprehensive range of interventions in Primary Care for disorders that do not require Specialist Mental Health Services.

vii. The Service User and their family/carer as appropriate should be involved at every stage of the delivery of the shared care model.

viii. Service Users need to be involved in the development and review of their plan of care and must sign off on all plans relating to their care and treatment.

B. Communication and Information Sharing

i.   A senior member of the Specialist Mental Health Team, ideally the Team Co-ordinator, should be given the key role of organising and liaising with GPs and Primary Care Teams in relation to referral and discharge processes.

ii. Regular meetings between Primary Care Teams's, GPs and Mental Health Services is an essential component of the shared care approach and should be actively developed and supported by senior management at both Primary Care and Mental Health service level where absent or not developed.

iii. National referral and discharge forms such as that developed by the Primary Care Working Group (2006) should be implemented.

iv. There is a need to develop effective communication systems between

Primary Care and Specialist Mental Health Services. It should include the development of effective working relationships between both services, including exchange of information and regular meetings of senior staff to review and monitor communication practices. (Goodwin et al 2011).

v. Standardised electronic referral and discharge processes should be developed and implemented.

vi. Procedures and practices that support a consistent and safe approach to referral management need to be prioritised.

vii. All mental health service users, including those in long stay wards, should be registered with a GP.

viii. All service users should have an identified care co-ordinator (keyworker), be this staff member from Primary Care or specialist mental health services.

ix. Patients who are identified as requiring the intervention of the Specialist Mental Health Team should be facilitated to access these services in as seamless a manner as possible with clear processes for discharge back to primary care to facilitate the patient's journey.

x. Information to support the shared care model for professionals and patients should be widely available.

C. Harnessing Existing Resources, Supporting Training

i. Inter-professional education of practitioners in brief interventions skills for primary care staff with an overview of knowledge and skills required to address the mental healthcare of the patients should be facilitated.

ii. Under graduate training programmes for health professionals such as Nurses, Social Workers and GPs should place a greater emphasis on how to support

and assist patients with mental health difficulties.

iii. All staff including GP's and Practice staff are particularly well placed to have a key role in mental health service delivery in primary care. The role of the Practice Nurse in mental health promotion should be further explored and developed.

iv. Consideration should be given to the training needs of the primary care practitioners in relation to the work of the specialist mental health services e.g. Team Based approaches to Mental Health in Primary Care and National Guidance documents (Advancing Community Mental Health Services in Ireland, Guidance Papers, May 2012).

v. Greater awareness and co-ordination between Mental Health Services, Primary Care and Community Mental Health resources and supports.

vi. Community Mental Health Teams have a key role in supporting clinicians who work in primary care to meet the needs of patients presenting with mental health problems. Community Mental Health Team's are in a key position to provide a range of specific therapeutic skills; their role should not be seen as confined only to those with the most severe mental disorders.

vii. Strengthen the interface between Primary Care and Specialist Mental Health services regarding physical health care needs of patients.

viii. It is recommended that a greater emphasis is placed on encouraging patients to self care and in so doing ensure greater access to choice in the care they receive and the services they access.

ix. Primary Care Team's and Community Mental Health Teams should develop resource lists of local, regional and national state & voluntary organisations,

self help groups and recommended reading materials as a support to teams, service users and their families.

D. Increased Access to Counselling and Psychological Therapies

i. Regardless of financial status universal access to psychological and counselling therapies should be available to ensure all patients, can access an appropriate service for their Mental Health difficulties in a timely and accessible manner.

ii. The Stepped Care Model of Service delivery should be evaluated and further developed as appropriate. The use of bibliotherapy should be extended in practice and training provided to primary care professionals in order to enable them to utilise this intervention more effectively.

E. Addiction Services – Care and Treatment

i. The effect and impact of alcohol and drug misuse on a person's mental health needs to be highlighted. The preventive role of the Primary Care Team in this area needs to be supported by training and resources from Specialist Services.

ii. Clarity needs to be provided on the organisation, delivery and alignment of substance misuse services to Primary Care and a national standardised model of service agreed and implemented.

iii. Strong links should be established with local addiction services as well as links with local addiction support groups such as AA & Narcotics Anonymous etc.

F. Evaluation of the Shared Care Approach in Action

i. Clear, measurable goals and performance indicators should be agreed and implemented to measure shared care including patient outcomes, activity and cost effectiveness.

ii. Evaluation of patient experiences of their care pathway in mental health should form a core component of how services are evaluated.

iii. Develop joint protocols in both Primary Care and Specialist Mental Health services in relation to the development of the Mental Health Clinical Care Programmes. (Currently 3 programmes are being developed in the areas of Self Harm & Suicide, Early Intervention in Psychosis and Eating Disorders).

A comprehensive implementation plan needs to be developed to support this guidance document.

THE POLICY CONTEXT
BACKGROUND

The National Health Strategy, *Quality and Fairness – A Health System for You* (DoHC, 2001(a)) sets out a new direction for the health and personal social services, with primary care seen as the cornerstone for the delivery of services through a multidisciplinary approach to service provision. This strategy formed the basis for subsequent Primary Care and Mental Health policies.

Primary health care is about providing 'essential health care' which is universally accessible, to individuals and families in the community, as close as possible to where people live and work. It refers to care which is based on the needs of the population. It is decentralized and requires the active participation of the community and family (WHO, 1978). Primary care is "where people are" and plays a fundamental role in caring for people with mental health problems.

Mental Health Services have moved from a model of institutionalised care to a community based model with the service delivered by Community Mental Health Teams who provide specialist Mental Health Services for patients whose needs cannot be met in Primary Care. These developments have been supported through the recommendations outlined in *A Vision for Change* (2006) and other guidance documents produced by the Mental Health Commission.

The SLAN Survey of Lifestyle, Attitudes and Nutrition (2007) showed that Irish adults have a reasonably high level of positive mental health. The survey demonstrated a strong association between positive mental health, gender, social and economic factors. Thus reflecting the need for mental health service delivery to be integrated and holistic in its approach.

Primary Care Policy

Primary Care A New Direction defines primary care as *"An approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services"* (Primary Care, A New Direction, 2001, page 15).

The Primary Care Strategy (DoHC 2001(b)) envisaged improved integration between primary care teams and specialist services including mental health. It recommended the introduction of referral protocols, direct access to diagnostic facilities, discharge plans, individual care plans, integrated care pathways and shared care arrangements in order to facilitate primary care teams to have a greater role in providing for the mental health needs of patients. When an individual experiences a mental health problem, contact with their General Practitioner (GP) is usually their first point of contact when seeking help. This contact can be the key to a timely and successful resolution of their mental health problem if the problem is identified and treated by the GP or where appropriate, the person is referred on to the specialist mental health services. There is a recognition that well integrated and best-fit primary care services result in better adherence to treatment regimes, leading in turn to better treatment outcomes (DoHC, 2006).

Mental Health Policy

The World Health Organisation in its 2008 publication entitled *Integrating Mental Health into Primary Care – a global perspective* described primary care for mental health as an *"essential component of a well functioning health system"*. To be fully effective and efficient, primary care must be complemented by additional types of services. *(WHO, 2008, PAGE 12)*. These include specialist mental health services to which primary care workers can turn for referrals, support and supervision. Linkages to voluntary and community based services are also necessary. Understanding and appreciating these relationships is crucial to understanding the role of integrated primary mental health care within the context of the overall health system.

A Vision for Change (DoHC 2006), outlines as one of its key recommendations the enhancement and formalisation of links between specialist mental health services and primary care. Some of the key recommendations in Chapter 7 include that:

➡ All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.

➡ All mental health service users, including those in long stay wards, should be registered with a GP.

➡ Appropriately trained staff should be available at primary care level to provide programmes to prevent mental health problems and promote well being.

Finally it is recommended that a shared care model be adopted to ensure formal links between Community Mental Health Teams and Primary Care Services with protocols and policies agreed locally by Primary Care Teams and Community Mental Health Teams to ensure effective working together.

Primary Care in the Management & Care of Mental Health Difficulties

GPs are often the first point of contact and in many cases the only health professionals to be involved in the management of a wide range of mental health problems. The typical mental health problems encountered by GPs are often centred on life events and social circumstances, such as bereavement or marital difficulties. Other members of the primary care team are central to the identification of mental health issues and will refer to the GP if required.

Any patient who contacts their primary care team with a common mental health problem will have their mental health needs identified and assessed and be offered effective treatments (where available), including referral to specialist mental health services for further assessment, treatment and care if required.
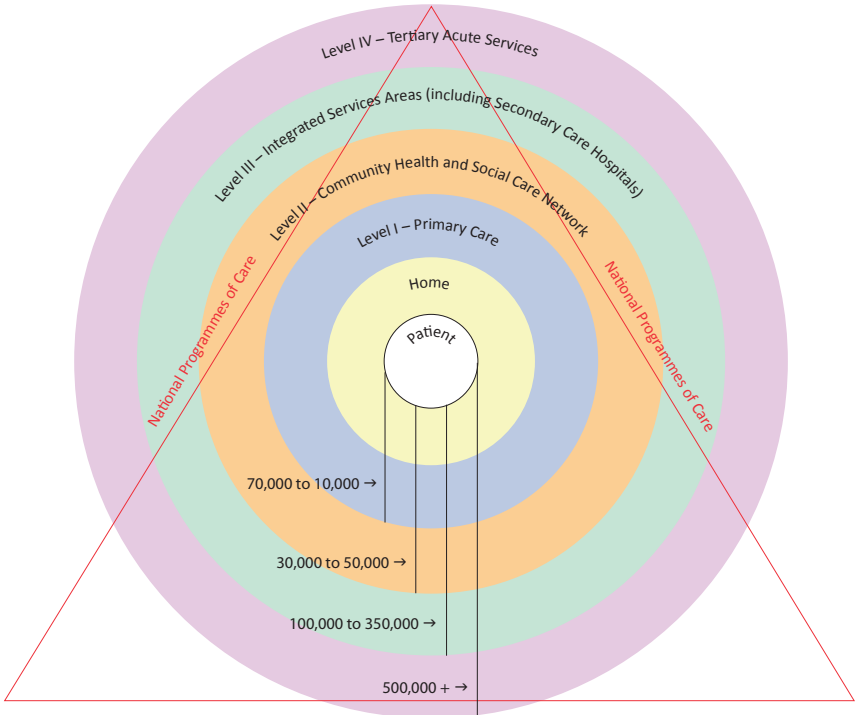
Currently, the treatment most usually offered to individuals with mental health difficulties in primary care is medication. GPs have however identified that a wider range of interventions are needed to meet the needs of patients. In particular the access to counsellors and psychologists who can provide a range of psychological therapies appropriate to the majority of mental health problems encountered in primary care, is required (ICGP 2011).

Psychological therapies including counselling are recognized as the treatment of choice for many mental health difficulties as well as an adjunct to medication for more serious forms of mental health difficulty. Research has consistently indicated that psychological therapies are effective and beneficial for a wide range of mental health issues (Carr 2007) and that there are significant gaps in provision and access to psychological therapies in Ireland with an over reliance on medication.

Current Service Delivery Model

The model of primary care service provision through Primary Care Teams (PCTs) and Health and Social Care Networks (HSCNs), sets out to enable delivery of integrated and enhanced primary care services to patients including structured approaches to delivery of chronic disease management, enhanced multi-disciplinary working and integration between primary, secondary and tertiary services (see Figure 1. Service Delivery Model). Both Primary Care Teams and Health and Social Care Networks have important functions with regard to health promotion, population health and early intervention. The importance of flexibility at individual, team and network levels cannot be overstated in enabling integrated services to work efficiently and effectively.

Figure 1   HSE Service Delivery Model (HSE 2002)

Level IV – Tertiary Acute Services

Level III – Integrated Services Areas (including Secondary Care Hospitals)

Level II – Community Health and Social Care Network

Level I – Primary Care

Home

Patient

National Programmes of Care

National Programmes of Care

70,000 to 10,000 →

30,000 to 50,000 →

100,000 to 350,000 →

500,000 + →

How Should Primary Care and Mental Health Services Work Together?

Findings from a study on mental health in primary care (H. Lester, 2005) identified the need for increased collaboration between GPs and mental health service providers and how best this might be organised. The authors recommended that effective communication, continuity and coordination of care can be most effectively addressed by establishing a model of shared care, as outlined in *A Vision for Change*, between the primary care team and mental health service providers. The network of mental health services proposed in *A Vision for Change*, (DOHC 2006) offers one point of access for GPs to refer individuals to mental health services or who are looking for advice and guidance on the management of a specific individual. The proposed model also identifies the importance of a single point of access for a crisis response when needed.

In addition *A Vision for Change,* (DoHC 2006:66) also recommended that primary care and mental

health services should be co-located where possible. Evidence from practitioners indicates that where this has occurred that it improves communication between teams, reduces stigma for patients in relation to mental health and helps in the early identification and treatment of people experiencing mental health problems.

For patients Primary Care Teams provide them with a local, identifiable and accountable entry point to the health service. When they access the service they should be confident that their journey will be seamless and delay free. Primary Care Teams are the ideal vehicle to provide enhanced services due to the easy access for service users in their local community and the multi-disciplinary clinical staff available. PCTs can also provide a one-stop-shop approach to service delivery. Effective integration of care is easier to achieve where PCT professionals assume key significance in the healthcare system. This approach is built on effective collaboration, a sense of common purpose, mutual respect, clear communication and which is preferably delivered by professionals who are co-located.
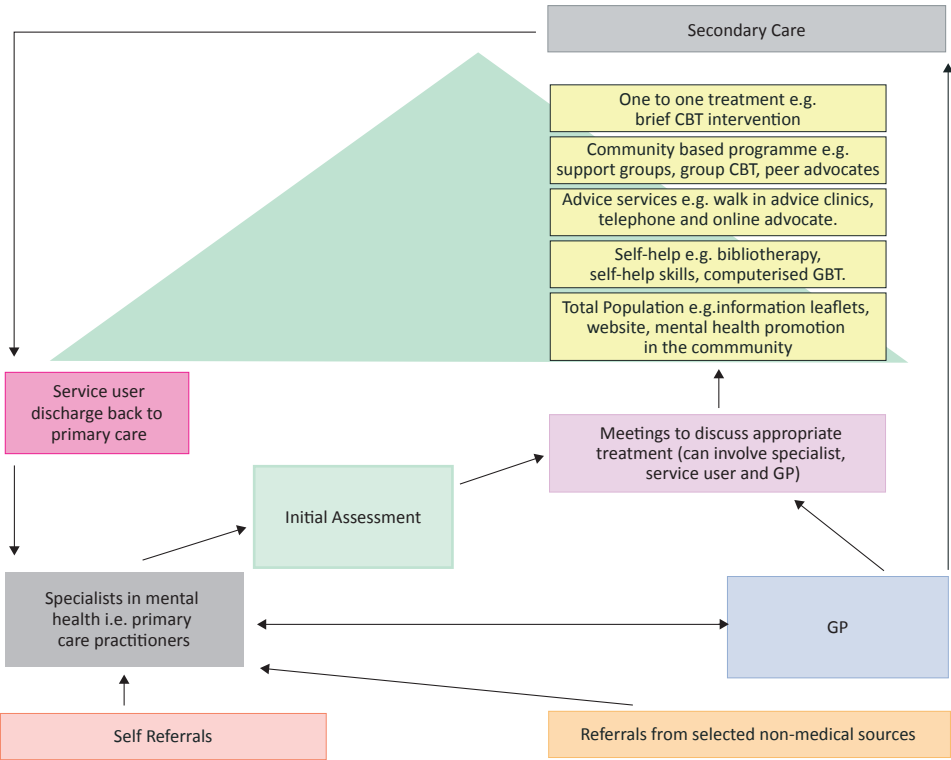
THE SHARED CARE MODEL
INTRODUCTION

Chapter 7 of *A Vision for Change* (2006) outlines the Shared Care model see Figure 2 below.

The model of Shared Care as outlined has the benefits of not denuding services by removing staff from either service but allows for effective inter-agency working. This is referred to as the Consultant Liaison model, the aim of which is to develop close links between services, so as to reduce referrals of milder mental health problems, whilst selectively encouraging referrals of serious mental illness to secondary mental health services. Key to the effective implementation of the Shared Care/Consultant

Liaison model is that both services play their part. In relation to mental health services, a senior member of the team, ideally the Team Co-ordinator takes on the role of liaising with GPs and primary care team professionals, to offer advice and manage referrals to the Community Mental Health Team (CMHT). In tandem Primary Care Teams need to have suitably trained professionals with the skills to work with patients presenting with mild mental health problems and the understanding of when referral to secondary mental health services should be considered.

Figure 2   The Shared Care Model (2006)

Adapted from *A Vision for Change* (DoHC 2006: 65)

Secondary Care

One to one treatment e.g. brief CBT intervention

Community based programme e.g. support groups, group CBT, peer advocates

Advice services e.g. walk in advice clinics, telephone and online advocate.

Self-help e.g. bibliotherapy, self-help skills, computerised GBT.

Total Population e.g.information leaflets, website, mental health promotion in the commmunity

Service user discharge back to primary care

Meetings to discuss appropriate treatment (can involve specialist, service user and GP)

Initial Assessment

Specialists in mental health i.e. primary care practitioners

GP

Self Referrals

Referrals from selected non-medical sources

Benefits of the Shared Care Model

The Shared Care model has the potential to achieve effective integration between primary care and secondary mental health services in terms of referral protocols, assessment and diagnosis, and discharge care planning. It does however require good clinical governance with senior managers, consultants and heads of discipline from both services, providing leadership in achieving effective communication and sufficient flexibility within each service so as to meet the needs of patients.

The Shared Care model could lead to a pooling of expertise and enhanced creativity in problem-solving. In addition it should lessen the possibility that vulnerable patients are 'left in limbo' (Preston et al 1999), with patients and carers feeling that they are failing to make progress through the mental health system. Shared care may also be more cost-effective (Thornicroft & Tansella, 1999).

In order for this model to work clear policies and protocols need to be developed at a local and national level.
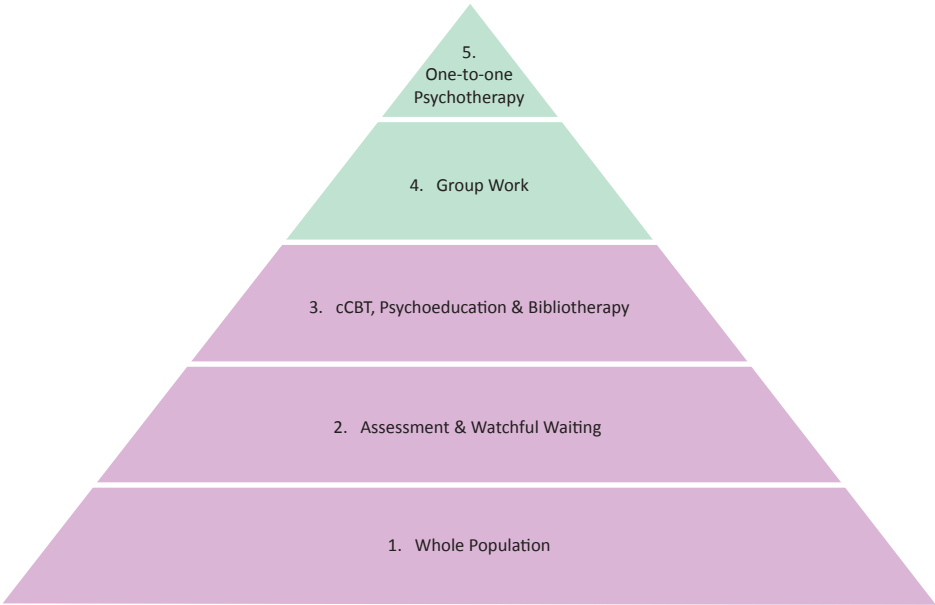
Innovative Shared Care Approaches – Current Practice

Shared care is happening in practice as evidenced by the initiatives outlined below. These initiatives are a small sample of what is happening around the country, however in order to facilitate greater accessibility and wider application of these services there needs to be a much greater level of support for the Shared Care Approach in practice.

Roscommon Primary Care and Adult Mental Health Service: A Stepped Care Approach

The Stepped Care Approach adapted and developed by Roscommon Primary Care and Adult Mental Health Service (Bourke & Byrne, 2012; Kierans & Byrne, 2010;, Twomey & Byrne, 2012), aims to increase the range of effective and appropriate therapy options available, whereby low-intensity, low-cost psychological treatments are provided prior to delivering higher-intensity, high-cost care. Currently five professionals in the primary care team are supported and supervised by a senior psychologist within the mental health service. This allows them to work with service users with mild to moderate mental health problems and to make appropriate referrals to secondary mental health services when required.

Figure 3   Roscommon Stepped Care Model

5. One-to-one Psychotherapy

4. Group Work

3. cCBT, Psychoeducation & Bibliotherapy

2. Assessment & Watchful Waiting

1. Whole Population

HSE North East Primary Care Counselling Service

The HSE National Counselling Service (NCS) in the North East, developed a generic counselling service in primary care, called the North East Primary Care Counselling Service (PCCS) (Ward 2010), which offers time limited counselling to adults presenting in primary care with non-complex psychological difficulties. Since it was established in the North East region in 2006 it has provided counselling to more than 5,000 adults. The service is currently operational across 59 GP practices and 4 primary care teams in the North East serving counties Meath, Louth, Cavan and Monaghan. The majority of the counselling is offered on site at participating GP practices. The service aims to offer rapid access to counselling in order to facilitate early intervention with psychological difficulties. This model of service has been positively evaluated. The HSE National Service Plan (2012) provides for the roll out of the North East Primary Care Counselling model nationally, managed by the National Counselling Service, as a way of meeting the requirement to improve access to counselling in Primary Care as has been set out in the *Programme for Government* (2011).

The Power of Words – Bibliotherapy as a Resource in Primary Care

Bibliotherapy offers the benefits of psychological therapy to people who are experiencing mild to moderate psychological difficulties involving the use of effective self help books.

The effectiveness of Bibliotherapy has been well established in clinical research, with the best books producing results comparable to those of drug therapy or psychotherapy. Bibliotherapy has been recommended by the UK's National Institute for Clinical Excellence (NICE, 2004), as the appropriate first active treatment strategy in a stepped care programme for treating depression, anxiety and other mental health problems. Self help books can be highly effective for some clients when used as the main source of help, or in addition to prescribed medication or counselling. The first book prescription scheme in Ireland was launched in March 2007 by the North Inner City Partnership in Primary Care (Dublin), in collaboration with Dublin City Public Libraries, led by, Elaine Martin, HSE Senior Psychologist. The aim of the scheme was to give GPs, mental health professionals and their patients, choice in the treatment approach to some mild and moderate mental health difficulties through access to high-quality self-help books. In 2009, following on from the success of this initiative, the Library Council of Ireland, the HSE and the Irish College of General Practitioners introduced the 'Power of Words' scheme to support and aid people with emotional and psychological difficulties to gain insight into and treat the problems that are upsetting or disturbing them. Books included on the scheme address many of the common psychological problems that people experience including depression, eating disorders, obsessive compulsive problems, social phobia, relationship and sexual problems, panic, anger, and stress.

Effective Working Together in West Tallaght: Primary Care Teams and the Tallaght Adult Mental Health Service

The primary care and mental health services in West Tallaght have well established relationships and referral pathways between GPs and Consultant Psychiatrists, however professionals were cognisant that this was not the case for other members of the newly established primary care teams. Very often information about services available and how to access them was limited. Following discussions between relevant service managers, a number of steps were taken to address this gap including:

➡ Organisation of information sessions between mental health professionals and primary care team members

➡ Improved communication through attendance at Primary Care Team network meetings by Mental Health Professionals

➡ Provision of community health fairs in each primary care team area as a means of improving the public's knowledge of available services. All relevant statutory and voluntary services were invited to attend, and members of both primary care and mental health teams provided advice and information at the events

➡ Establishment of relationships between primary care and mental health team members and exchange of contact details. Professional team members make contact as required to discuss concerns regarding patients, address the needs, organise care plans and to seek advice.

Team Based Approaches to Mental Health in Primary Care: Training for Primary Care Health Professionals

The Team based approaches to Mental Health in Primary Care module delivered from Dublin City University (DCU) was established in 2010 by the HSE, Irish College of General Practitioners and DCU to provide primary health care professionals with the knowledge and skills required to respond appropriately to patients with mental health related issues, whom they might meet in their day to day work in the primary care setting. The course aims to facilitate primary care professionals to develop the confidence to meet the health and welfare needs of patients with mental health difficulties with an appreciation of when and how to make appropriate referrals to secondary mental health services.

Challenges to Implementing the Shared Care Model

Whilst it is clear that the range of benefits offered by the Shared Care Model are immense there continue to be challenges to implementing this model in practice. Some of the main obstacles are outlined below.

➡ There is evidence that the majority of GPs see their role in the care of people with serious mental illness as limited to addressing

their physical illness and prescribing. Just a minority of GPs believe that they should be involved in the monitoring and treatment of mental illness (Bindman et al, 1997).

➡ From a specialist mental health care perspective, there is lack of understanding regarding the organisation of primary care services and in particular of the potential skills and knowledge that team members may possess to help in supporting patients with mental illness.

➡ A recent HIQA report (2011) outlined that one of the biggest risks to patient safety occurs when the patient passes across the "boundaries" of care for example between primary and secondary care. (p7). The Report of the Commission on Patient Safety and Quality Assurance attributed failures in patient safety of this kind to *failures in communication, lack of protocols for care handover, differing systems of care provision between provider and lack of clarity about where responsibility and accountability of care lies in such situations* (p96).

➡ There is a need to provide active support [such as facilitation] to both Primary Care and Community Mental Health Teams to facilitate effective working together.

➡ There is a need to ensure that sufficient numbers of professionals within primary care teams have the required skills and knowledge to work effectively with patients with mental health related difficulties of a mild to moderate nature that do not require referral to secondary mental health services. The Team Based Approaches to Mental Health in Primary Care module is one important way this can be achieved. It is important that professionals are facilitated to attend this course and have access to appropriately trained supervisors in their future work with patients with mental health related problems.

MENTAL HEALTH & PRIMARY CARE
GROUP SURVEY – RESULTS

As part of the work of the Primary Care and Mental Health working group, a questionnaire was developed the aim of which was to ascertain the perceived level of collaboration that currently exists between primary care & mental health (See Appendix III for questionnaires). In October 2010 questionnaires were circulated through the National Primary Care Office and Regional Specialists in Primary Care. In mental health the questionnaire was distributed by the Regional Specialists. *There was a very low (18%) response rate from Primary Care teams (78 completed questionnaires were returned from a total of 316 Primary Care teams) making it difficult to draw any firm conclusions.* This low response rate may be reflective that PCTs were only in the early stages of development. The response rate from mental health services was 60% (74 completed questionnaires were returned

out of a total of 123 Community Mental Health Teams) see figures 4 and 5. This process highlighted the extent of inconsistency and lack of standardisation of approach to service delivery across the four HSE regions in terms of the collaborative working approach to primary care and mental health. The key findings showed that 58% of Primary Care Teams who responded did not have formal referral protocols in place. Only 1in 4 PCTs had a formalised link with specialist mental health services, whilst 30% reported an informal level of collaboration.

The working group did receive many useful policy documents dealing with referral and discharge practices which have been developed in some areas. These documents have very helpfully contributed to the recommendations in this report.

Figure 4   Response Rate from CMHTs

Number of Community Mental Health Teams V's Completed Questionnaires Received
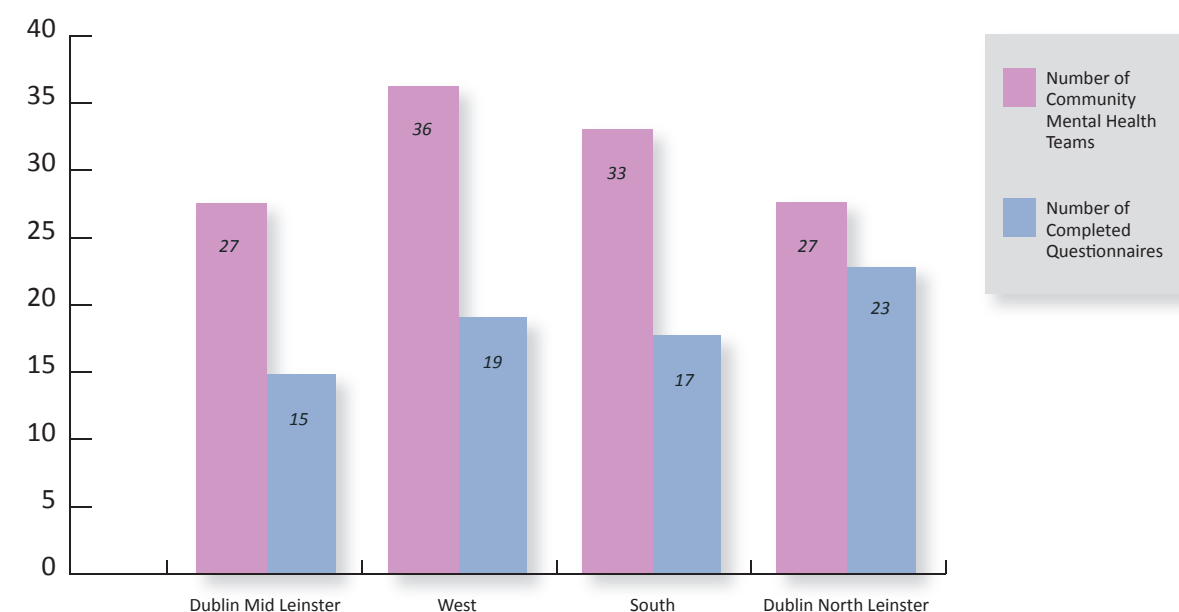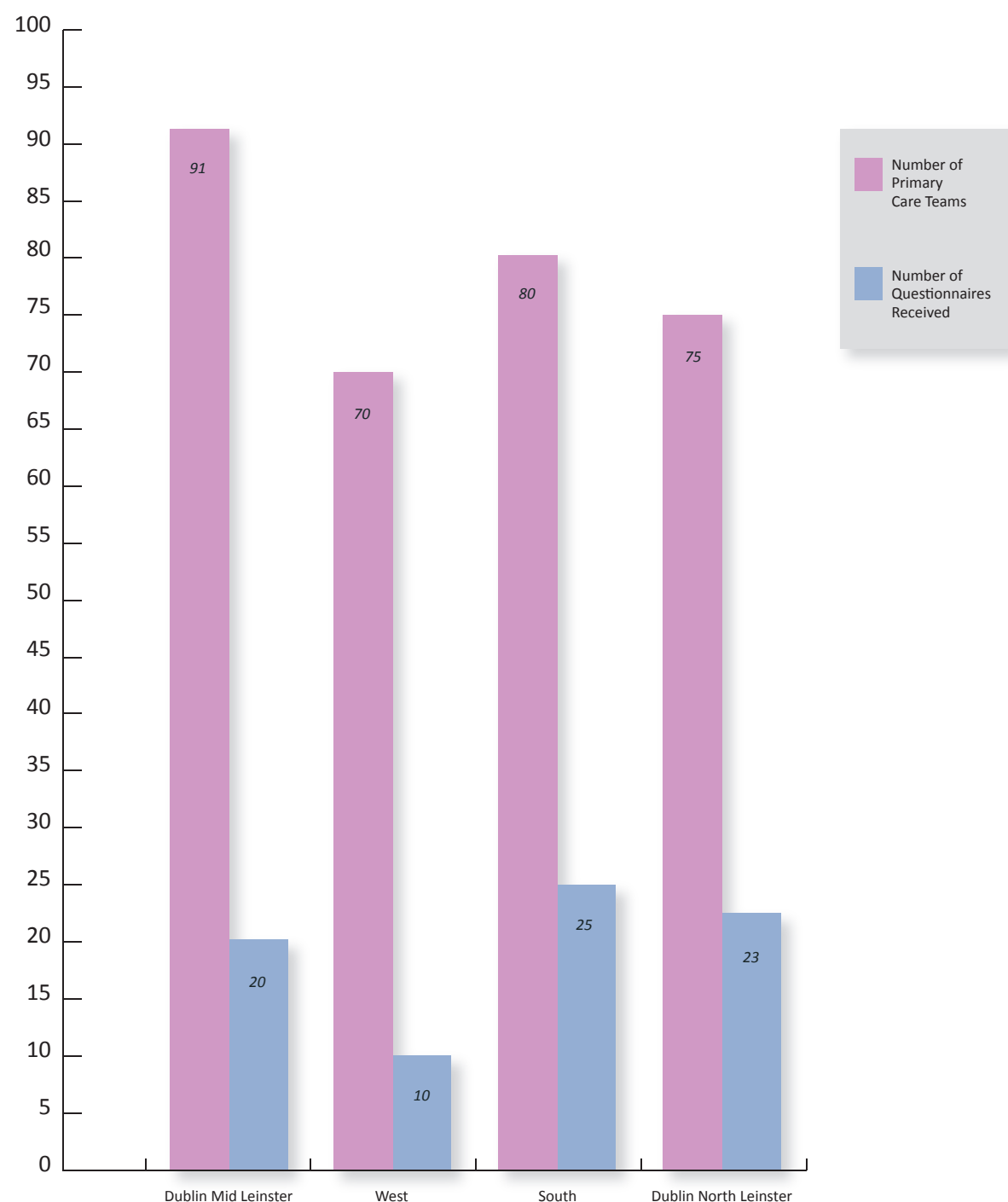
Figure 5   Response rate from PCTs

Number of Primary Care Teams V's Completed Questionnaires Received

| | Number of Primary Care Teams |
| | Number of Questionnaires Received |

ADDRESSING THE CHALLENGES OF COLLABORATIVE WORKING: REQUIREMENTS FOR A SHARED CARE MODEL IN PRACTICE

Management & Organisation of the Shared Care Model

The shared care model as has been outlined in section 4 provides a framework for the delivery of mental health services in primary care and secondary mental health. The governance structures currently being developed within the Health Services will be required to support this model of service delivery. Structural and organisational changes that can facilitate greater co-operation between primary care and mental health services should be identified and implemented. Ensuring co-terminus boundaries between mental health and primary care services for example is a simple measure that would help to improve co-operation. In addition regular meetings between GPs in the mental health catchment areas and the mental health teams are an essential part of maintaining an effective relationship between the two services. Recent examples of new primary care centres (such as Letterkenny, Inchicore) where community mental health bases have dovetailed on to these developments offer very positive models for service delivery. Cognisance should be given to the involvement of service users in their own care and treatment.

Primary Care and the Role of the Team Coordinator within Community Mental Health Teams

The HSE Vision for Change Implementation

Group has devised national guidance outlining the role of team co-ordinator on the Community Mental Health Team (Guidance Document Advancing Community Mental Health Teams). This role (See Appendix IV) is essential as it helps to achieve effective integration between primary care and mental health. The guidance document outlines how the post of team co-ordinator will be established. While there are a number of services who have team co-ordinators in place, there are differences in their role and responsibilities. These differences have now been addressed through the provision of national guidance.

Clinical Governance

The recent announcement by the Minister for Health of plans to dissolve the HSE and the creation of Seven Directorates offers a fresh opportunity to shape the governance structures and thus integration between Primary Care and Mental Health services. *A Vision for Change* (2006) outlines a governance structure for mental health services, whilst agreement has yet to be reached on the governance structures within primary care and in relation to service integration.

Referral Processes

Currently referrals to Specialist Mental Health Teams are through the GP and discharge of patients from mental health services is back

to the GP. There is a need to improve the communication pathway between the wider primary care team and CMHTs teams. This could be supported through the adoption of a National referral and discharge forms such as that developed by the Primary Care Working Group (2006). One development which could help to facilitate this issue would be through the establishment of a secure electronic referral pathway between both services such as that offered by Health Link which currently operates between GPs and some hospital services.

Referral Criteria

This section describes the differences in referral criteria between primary care, and the specialist care services for adult mental health, mental health services for older people and child and adolescent mental health. This is designed to be a practical guide for clinicians.

Counselling in Primary Care and Specialist Mental Health Teams: Referral Criteria to Primary Care Vs Adult Mental Health

The *Guidance Document on the Provision of Counselling in a Primary Care Setting*, (HSE 2006) highlighted the importance of detailed and accurate assessment at the time of referral to determine the care pathway. If assessment at the primary care level is accurate, multiple referrals to inappropriate services can be avoided. A structured assessment process is a key factor in identifying patients appropriate to counselling in a primary care setting.

Tables 1 and 2 below summarise what constitutes appropriate referrals to counselling in primary care as distinguished from that which is more appropriately seen in the specialist mental health services care pathway of care for adults, older persons, children and adolescents who present with mental health difficulties.

Table 1
Summary of Appropriate Referrals to Primary Care & Adult and Older Persons Specialist Mental Health Teams

Problems Appropriate for Counselling In Primary Care	Problems Appropriate for Mental Health Services
Mild to moderate problems	*Moderate to severe problems*
• Depression: reactive • Relationship difficulties • General anxiety and mild specific phobias • Loss • Coping with injury or illness • Life cycle developmental issues • Adjustment problems • Stress and trauma • Psychosexual difficulties • Alcohol and drug misuse	• Major mood disorder • Anxiety disorders • Personality disorders • Eating disorders • Schizophrenia and related disorders • Bi-polar disorder • Cognitive impairment or dementia • Obsessive compulsive disorder • Post traumatic stress disorder • Substance/alcohol dependency co-morbidity • Suicidal ideation/intent and/or deliberate self-harm

*These referrals are specific to Counselling services. Other services will also address the vast majority of mood and anxiety disorders in Primary Care.

Table 2
Summary of Appropriate Referrals to Child Psychology/Counselling in Primary Care and Specialist Child and Adolescent Mental Health Teams (CAMHS)

Problems Appropriate for Child Counselling In Primary Care	Problems Appropriate for Child and Adolescent Mental Health Services
Mild to moderate problems	*Moderate to severe problems*
• Depression and low self-esteem • General anxiety and mild/specific phobias • Behaviour problems • Bereavement and loss • Coping with injury or illness • Stress and trauma	• Significant mood disorder • Anxiety disorders, e.g., OCD • ADHD • Eating disorders • Psychotic disorders • Suicidal ideation/intent and/or deliberate self-harm

Discharge Processes

The exchange of health information between specialist mental health, primary care and general practitioners has traditionally been via hard copy. Given that 92% of general practice is now computerised a secure electronic pathway for discharge needs to be developed. This model has been successfully implemented as part of the Cancer Control programme and is currently being piloted between GPs in Dublin's South Inner City and in HSE South. It includes a secure mail referral system to a central point within the hospital with a read receipt sent to the GP. All GP's need to be set up with secure mail, once referral is received by the hospital they can email securely internally to relevant department. The development of the ICT infrastructure to support electronic referral and discharge processes requires prioritisation.

Training and Education Needs

Support to both Primary Care Teams and Community Mental Health Teams in how they work together as teams is vital to ensure effective working. Models of Team based performance management currently in place within the HSE support team working. The "Team Based approaches to mental health in primary care" module which has been in place in Dublin City University since 2010 offers a comprehensive training programme for primary care staff. It empowers primary health care staff with knowledge and skills to respond to the mental health care issues that they may encounter in a primary care setting. To date more than 100 Primary Care staff from the range of disciplines including GPs have completed the training which has been positively evaluated.

Conclusion

It is hoped that this document is useful in terms of advancing collaborative and shared working between Primary Care and Specialist Mental Health Services. The main objective is to ensure that the patient is supported at Primary Care level as far as possible and that a quality Mental Health Service is available at primary care level as well as from the Specialist Mental Health Services. Patients should be able to move seamlessly between the levels of services according to clinical need. Health Care Professionals in primary and specialist services should work in closer co-operation with each other. Greater commitment is required to advance collaborative working to ensure that a quality service is delivered to patients. This can be best achieved by restructuring services to facilitate the implementation of the shared care model as outlined in this guidance document.

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ICGP – http://www.icgp.ie/index.cfm?spPath=courses/mental_health/articles_publications/B5245FFA-19B9-E185-83963F1AD48F351A.html

GP Exercise Programme Link: http://exercise-referral.ie/

Mental Health Act E Learning Module: available at www.mhcirl.ie

Mental Health Hub link – http://www.hseland.ie/tohm/default.asp

National Service Users Executive – www.nsue.ie

Cancer Control Programme – www.cancercontrol.hse.ie

National Counselling Service – www.hse-ncs.ie

Vision for Change Newsletter

http://www.hse.ie/eng/services/Publications/services/Mentalhealth/avisionforchangenewsletter.html

APPENDICES

APPENDIX I

Mental Health in Primary Care Working Group

Membership

Catherine Brogan (Chair) –
National Planning Specialist, HSE

Louise Owens –
National Office for Mental Health, HSE

John Meehan –
Regional Mental Health Specialist, HSE West

Catherine Duffy –
General Manager NCCP, HSE West

Fiona Ward –
Director of Counselling, NCS, HSE DNE

Alan Doran –
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Pearse Finegan –
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Marie Prendergast –
TDO, HSE West.

Frank Browne –
Principal Social Worker, Dublin West/South West, HSE DML

Siobhan Murphy –
TDO, HSE DML

Dr. Michael Byrne –
Principal Psychologist Manager, HSE West

Consultations

The National Vision for Change Working Group including –

Irish College of General Practitioners

National Service User Executive (NSUE)

Irish Advocacy Network (IAN)

Executive Clinical Director's

Occupational Therapy

Social Work

Psychology

Directors of Nursing

National Primary Care Group

Submissions received from:

Irish Advocacy Network

Dr. Brid Hollywood – ICGP

Dr. Margaret O Riordan – ICGP

National Primary Care Steering Group

Teresa Bulfin –
Senior Operations Officer, Mental Health Services Limerick, HSE West

Esther Crowe Mullins –
Occupational Therapist, HSE West.

Sheena Hanrahan –
Primary Care Specialist HSE South

Gerry Maley –
Principal Social Worker, Mental Health CKST, HSE South East

AnneMarie Lanigan –
ISA Manager, HSE South

Nuala Slattery –
GP Liaison Nurse, HSE South

Helena McGuire –
Regional Specialist, Primary Care, HSE West

A Vision for Change – Chapter 7 Recommendations

Vision for Change Recommendations	
7.1	All individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services.
7.2	Further research and information on the prevalence of mental health problems in primary care and the range of interventions provided in primary care is needed to effectively plan primary care services and the interface between primary care and specialist mental health services.
7.3	All mental health service users, including those in long-stay wards, should be registered with a GP.
7.4	Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing.
7.5	It is recommended that the consultation/liaison model should be adopted to ensure formal links between CMHTs and primary care.
7.6	Mental health professionals should be available in the primary care setting, either within community care, the primary care team or the primary care network.
7.7	Local multidisciplinary CMHTs should provide a single point of access for primary care for advice, routine and crisis referral to all mental health services (community and hospital based).
7.8	Protocols and policies should be agreed locally by primary care teams and community mental health teams – particularly around discharge planning. There should be continuous communication and feedback between primary care and the CMHT.
7.9	A wide range of incentive schemes should be introduced to ensure mental health treatment and care can be provided in primary care.
7.10	Physical infrastructure that meets modern quality standards should provide sufficient space to enable primary care and CMHTs to provide high quality care.
7.11	The education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy (i.e. community-based mental health services). Service users should be involved in the provision of education on mental health.

Mental Health in a Primary Care Setting Questionnaire

MENTAL HEALTH

1. Please tick √ which of the following best describes your service.

   Adult Mental Health Services ☐   Other (please give details)
   Child and Adolescent Mental Health Services ☐
   Psychiatry of Later Life ☐

2. Does each Community Mental Health Team (CMHT) have a dedicated liaison person to one or more Primary Care Team?   Please tick √   Yes ☐   No ☐

   2.(a) If you have answered yes above please confirm the profession/grade of the dedicated liaison person. Please tick √

   Addiction/Alcohol Counsellor ☐   Other (please give details)
   Psychologist ☐
   Social Worker ☐
   Mental Health Nurse ☐
   Counsellor ☐

3. Do you have a referral policy/protocol with Primary Care Teams?   Please tick √   Yes ☐   No ☐

   If you have answered yes please give an example below:

4. Do you accept direct referrals from members of the Primary Care Team other than the General Practitioner?   Yes ☐   No ☐

5. Do you hold your clinics in local health centres?   Yes ☐   No ☐

6. Does your service provide a single point of access for Primary Care Teams for advice, routine and crises referrals?   Please tick √   Yes ☐   No ☐

7. Does any member of your team attend Primary Care Team meetings? Please tick√   Yes ☐   No ☐

   This questionnaire was completed by:

Name:	Title:
Email:	Phone:
Address:	

   Date Stamp:

Mental Health in a Primary Care Setting Questionnaire

PRIMARY CARE TEAM

1. Do you have any Mental Health Practitioners
   1.(a) as a member of the Primary Care Team?   Please tick √   Yes ☐   No ☐
   or 1.(b) as a member of the Primary Care Network?   Please tick √   Yes ☐   No ☐

2. If you have answered yes to question 1 above please indicate how many WTE's this equates to?

   Primary Care Team ☐   Primary Care Network ☐

   2.(a) Please tick √ the relevant box indicating the grade of Mental Health Practitioners in the Primary Care Team/Primary Care Network?

Psychiatric Nurse ☐	Psychotherapist ☐	Other (Please give details)
Psychologist ☐	Counsellor (Accredited only) ☐	
Social Worker ☐	Addiction/Alcohol Counsellor ☐	

3. Please name the primary care teams in your Primary Care Network?

	Primary Care Team		Primary Care Team
1		14	
2		15	
3		16	
4		17	
5		18	
6		19	
7		20	
8		21	
9		22	
10		23	
11		24	
12		25	
13		26	

4. Do you have a formal referral protocol/policy to secondary Mental Health Services?   Please tick √   Yes ☐   No ☐

5. What links have you to secondary Mental Health Care?

   5.a Are these links formal or informal?   Please tick √   Informal ☐   Formal ☐

Date Stamp:	Name:	Title:
	Email:	Phone:
	Address:	

The Role of the Team Co-Ordinator

A Vision for Change (2006) states that the functions of the Team Coordinator position should include the following;

- The administration and triage of referrals in consultation with the consultants and the managing of waiting lists.

- The organisation of team meetings,

- Liaising with GPs and primary care profes sionals, local community agencies, self-help and other community resources.

It is further stated that *"All referrals to the CMHT should be through a single point of entry, clearly identified to primary care services. This function may be assigned to the team coordinator, who will bring each new referral to the regular scheduled CMHT for discussion."*

In relation to working with primary care services the guidance recommends that the team co-ordinator should:

- Act as the point of contact between primary care teams and mental health services.

- Be the contact person in relation to mental health representation at primary care network meetings.

- Be the key person within the community mental health service to coordinate the referral process between primary care and mental health services.