Integrated primary mental health care: threat or opportunity in the new NHS?

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SUMMARY

In this paper, we argue that mental illness touches everyone's lives, and that mental health care is a core activity of primary care. The increasing move towards a primary care-led National Health Service has now created a climate where primary care can move beyond providing a gatekeeper function for secondary care specialist services. Primary care is also sufficiently mature as a discipline to commission, develop, and deliver integrated patient-focused mental health services grounded in the culture and built on the strengths of primary care. We discuss examples of integrated approaches to mental health care, and highlight the potential tensions created by new ways of working. We also suggest that any changes need to be accompanied by carefully negotiated adjustments to the way primary and secondary healthcare professionals conceptualise their roles and responsibilities, and must be underpinned by new ways of learning together.

Keywords: *delivery of health care, integrated; education; interprofessional relations; mental health services; primary care.*

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The cardinal requirement for mental health services in this country is not a large expansion and proliferation of psychiatric agencies but rather a strengthening of the family doctor in his/her therapeutic role.[1]

Introduction

MENTAL illness touches everyone's lives. It accounts for 28% of the years lived with a disability in most world regions, and for 10.5% of the 'total global burden of disease'.[2] Projections suggest that this could rise to 15% by 2020.[2] At a national level, antidepressants account for 7% of the United Kingdom (UK) primary care drug budget and the total cost to the economy of people with serious mental illness and common mental health problems is greater than for ischaemic heart disease, breast cancer, and diabetes combined.[3] On an individual level, in the UK only 13% of people with long-term mental health problems are employed (compared with 35% of disabled people, in general),[2] and they are over-represented in poorly paid and less secure jobs.[4] Mental illness has a measurable effect on families, who often act as unpaid carers. The prevalence of mental illness also impacts on the more difficult to quantify, but nonetheless important concept of the emotional wellbeing of a nation,[5] and it has been argued that it can impact on the social capital of society through the medium of social exclusion and poverty.[6]

Until very recently, a key role of primary mental health care in the UK has been one of gatekeeping for specialist secondary care mental health services. Service models have been dominated by secondary care mental health views of the world, and standards of care have been influenced by secondary care assumptions about the meaning of 'good quality' primary mental health care.

In this paper, which draws on *Cases for change*, a narrative review of over 650 documents published between January 1997 and December 2002 concerning adult mental health service delivery and policy in England,[7] we will argue that the time is now right to consider different ways of working in primary care mental health. We will discuss the evidence base on the current state of primary mental healthcare services and argue that mental health care is a core activity for primary care. We will suggest that primary care is now sufficiently mature as a discipline to commission, develop and deliver integrated patient-focused mental health services, grounded in the culture and built on the strengths of primary care. We will discuss examples of an integrated approach to mental health care, and highlight the potential tensions created by new ways of working. Finally, we will suggest that primary care's experience of developing innovative postgraduate education programmes will be important in setting up interprofessional training programmes that are key to encouraging an integrated approach to primary mental health care.

The prevalence of mental health problems in primary care

Mental health care is a central part of the work of primary care. The majority of people with serious mental illness and with common mental health problems are now registered with a general practitioner (GP) and 90% of patients with all mental health problems, including up to 30–50% of people with severe mental illness, are only seen in primary care.[8,9] Mental health issues are the second most common reason for consultations in primary care.[10] A mental health problem is the sole reason for attending in 20–25% of consultations,[11] and a feature of up to 40% of consultations. People with chronic or recurring physical health problems, traditionally seen as the core work of primary care, also often have higher rates of mental health problems than the general population. Myocardial infarction, for example, is followed by major depression in up to 20% of cases, and by depressive symptoms in many more,[12] further emphasising the central role of primary care in diagnosing and treating mental illness. There is also a significant group of patients with medically unexplained symptoms who consult frequently and who often have significant mental health problems. The 10 most common complaints in primary care consultations account for 40% of all consultations, and for patients with these complaints only 10–15% have a physical diagnosis after 12 months.[13]

The quality of primary mental health care

The quality of primary mental health care can be variable. Up to 60% of people with depression may go undetected, although GPs are more likely to recognise people with severe symptoms for whom the prognosis is worse, and effective treatment therefore more important.[14-16] Many practice nurses also find it difficult to detect depression, with up to 77% of cases missed.[17] In addition, evidence suggests that people with serious mental illness have higher morbidity and mortality rates than the general population, with standard mortality ratios for people with schizophrenia more than double the population norms. This is partly owing to suicide and accidents, but also to a doubled incidence of cardiovascular and respiratory disorders.[18] People with schizophrenia are also more likely than the general population to smoke and have a poor diet.[19] Such cardiovascular risk factors are, however, less likely to be recorded in primary care records or acted upon than in the general population.[20,21]

There are multiple reasons for variability in care. Primary care is a complex and difficult environment to work in. It is not a neat high-ground of well-defined symptoms, but a messy swamp of experiences and interpretations that rarely conform to ICD-10 case definitions.[22] Within this environment, there are significant time and workload pressures, with patients consulting at 10-minute intervals with coughs and colds, depression, and cancer. Fewer than 35% of GPs have undertaken any continuing education relevant to primary mental health[23] and 98% of practice nurses have had no specific mental health training.[24] It is therefore hardly surprising that many GPs are reluctant to open 'Pandora's box', worried about the skills, time, and resources then required to support them and the patient if mental health problems are disclosed.

Variable standards of diagnosis and care may also reflect different professional perspectives. Much of the research on primary mental health care has been developed and conducted from a secondary care perspective, so that GPs have perhaps been judged by assumptions and experiences from that paradigm. Primary care clinicians may in fact hold views on mental illness that are closer to those of the lay person than the medical model. Symptoms are seen in the context of social life stress and distress, rather than viewed through the filter of a medical model. Some GPs may therefore concentrate their efforts more on bearing witness and understanding the patient's experience and understanding of it, than on applying diagnostic categories and drug treatments.[25]

Detection and diagnosis can also be affected by the way in which patients present their problems. Many people are reluctant to talk about their mental health symptoms and are worried about the stigma of mental illness. Even if they technically reach 'caseness' on a screening questionnaire, from the patient's perspective a discussion of poor housing and the need for a sick note may be more pressing requirements than a discussion of symptoms. Tiredness and poor sleep may be normalised and minimised and therefore not mentioned to the primary care team.[26] There is also growing evidence that some patients perceive GPs as 'too busy' to spend time on mental illness.[27,28]

Policy imperatives

During the previous decade, and particularly since the advent of primary care trusts (PCTs), primary care has become increasingly central to the development and delivery of quality health services and is now a key focus of the government's National Health Service (NHS) agenda. This emphasis on primary care rather than hospital-led care is a global phenomenon.[29] Within the field of mental health, policy makers are now actively encouraging primary care to take a lead role in developing and delivering mental health services. Primary care has specific responsibility for delivering standards two and three of the *National service framework (NSF) for mental health*[30] and is also integrally involved in the delivery of the other five standards (Box 1).

The NHS plan,[31] which underpinned the *NSF* with over £300 million of investment to help implementation, included specific pledges to create 1000 new graduate mental health staff to work in primary care and provide a training programme for the new workers that may also be of value to existing members of the primary healthcare team. There are negotiations at a national level around formally extending the role of GPs with a special clinical interest,[32] with national guidance frameworks produced by the Modernisation Agency in nine clinical areas, one of which is mental health. Recognition of the importance of primary mental health care has also been reinforced by the creation of a primary care arm within the new National Institute of Mental Health (England) and the inclusion of mental health quality indicators in the proposed General Medical Services contract.[33] These primary mental healthcare policy imperatives have been underpinned by legislative and structural reorganisation within the NHS that give PCTs significant responsibility for commissioning, and in some cases providing, mental health services.[34]

Standard two
Any service user who contacts their primary healthcare team with a common mental health problem should:

- have their mental health needs identified and assessed,
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Standard three
Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care,
- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services.

Box 1. The National service framework for mental health*: standards two and three*.[30]

Creating a new kind of primary mental health care

The dominance of specialist mental health services has meant that, until recently, models of care broadly designed to support primary mental health care have been largely based on a specialist view of the world.[29,35] There are currently four main working models of mental health care at the interface of primary–secondary care, all modelled on secondary care services (Box 2). Although it could be argued that these models are part of a continuum that patients can access to meet varying needs at different points in their illness pathway, in practice the variation in availability of local resources means that primary care practitioners are often only able to access one, or at best two, of the models described in Box 2 at any one point.

Each of these models has particular strengths and weaknesses, and none fully recognises primary care's central role in delivering good-quality mental health care, or builds on primary care's unique strengths. Evidence suggests that the creation of community mental health teams often brings about a major increase in the rate of new patients referred,[35] but that the new patient population consists largely of people with common mental health problems who might otherwise have been managed by their GP. There are also problems with non-attendance at community mental health team appointments,[36] and the issue of 'inappropriate' referrals, where patients are seen on one occasion in secondary care and assessed as requiring a different type of response. Communication across the primary–secondary care interface can also be slow or incomplete, with missing information in referral letters and delayed clinic letters adversely affecting patient care.[37]

Limited evidence suggests that the shifted outpatient model attracts similar referrals and has similar significant non-attendance rates to traditional outpatient appointments in a hospital setting.[38] It also appears that both the community mental health team and shifted outpatient models lead to little improvement in GP mental health skills.[39]

The impact of attached mental health professionals on referral patterns is still unclear. A Cochrane review of the effect

1. Community mental health teams that provide increased liaison and crisis intervention.
2. Shifted outpatient clinics where psychiatrists operate clinics within health centres.
3. Attached mental health workers, usually community psychiatric nurses, designated to work with those with mental health problems in a primary care setting.
4. The consultation–liaison model where primary care teams are provided with advice and skills from specialist mental health services.

Box 2. Mainstream models of mental health care.

of on-site mental health workers in primary care found that the effect on consultation rates is inconsistent.[40] Referral to a mental health professional reduces the likelihood of a patient receiving a prescription for psychotropic drugs or being referred to specialist care, but the effects are inconsistent and restricted to patients directly under the care of the mental health professional. Roles and responsibilities are also unclear, with consequently less-efficient working patterns.[41] A Cochrane review also concluded that consultation–liaison interventions may cause short-term changes in psychotropic prescribing, but that these are also usually limited to patients under the direct care of the mental health worker.[40]

Developing a new approach to primary mental health care

An increasing case can now be made for developing an alternative approach to delivering primary mental health care, grounded in the strengths of primary care. Primary care has developed sophisticated methodologies for working with the uncertainty and complexity often associated with mental illness.[42] Decisions may be based more on intuition, experience, and knowledge of the patient's previous history than slavish adherence to algorithms. It occupies an important space at the interface of users, families, communities, and professional worlds and is able to address mental, physical, and social aspects of care. Primary care is also a low-stigma setting, able to offer rapid access for both routine and crisis care, a longitudinal approach to care where patients are never discharged, and perhaps above all, interpersonal continuity of care. A recent review of continuity of care identified a number of important elements, such as continuity of information, cross-boundary and team continuity — which includes effective communication between professionals — longitudinal continuity care with as few professionals as possible involved in care, and relational or personal continuity that emphasises the importance of having a named individual with whom the patient can establish and maintain a therapeutic relationship.[43] Although in an ideal world, continuity would be good both within and between primary and secondary care sectors, the evidence base suggests that primary care is perhaps better placed to fulfil each of these elements of continuity than secondary care specialist services.[43] Primary care also appears to be generally preferred as a setting by both mental health service users and carers,[44,45] with the few studies from this perspective again highlighting the importance of issues such as access

and continuity,[46] and of a continuing therapeutic relationship.[47]

In practical terms, an integrated approach to primary mental health care involves breaking down the interface boundaries with services that are traditionally provided by secondary care, led by staff employed by or working in a primary care setting and utilising many of the strengths of primary care. It also encourages a new way of thinking about mental health. Blount, an eminent exponent of this approach, suggests that an integrated approach unifies medical and mental health care in a primary healthcare setting and avoids the dichotomy of defining a patient's problem as either physical or mental.[48] In terms of structure, integrated care goes one step beyond collaboration and good communication across the primary–secondary care interface, to coordination and co-location of care. To be sustainable, an integrated approach also needs to be underpinned by opportunities for health professionals from different backgrounds to train and learn together.[49]

The evidence base is largely from the United States (US) and suggests that a more integrated approach to care has a number of benefits compared to usual practice (Box 3).

Examples of integrated primary mental health care

Although the evidence base for the value of an integrated approach is still relatively sparse from the UK perspective, an increasing number of localities are beginning to develop and evaluate a range of more integrated models of delivering primary care mental health services.

In Aberdeen, a community psychiatric nurse, dedicated to the care of people with serious mental illness, was employed by primary care, rather than simply being attached to the practice, to promote a slow transfer of people from institutionalised care to a community setting.[54] The team reports that: 'the boundaries between primary and secondary care teams were blurred because of the shift in operational base'. The service has been evaluated using the health of the nation outcome scale for severe mental illness.[55] Additional qualitative data generated from focus groups with carers in four hostels that housed patients in the study practice, and through semi-structured interviews with GPs in participating and comparison practices, found that improvements in communication, liaison, and drug management were reported in the intervention practice. However, the evaluation found little impact on patients' health outcome scores.

In Southeast London, the Mental Health Link programme has been set up to encourage general practices and associated community mental health teams to work together to develop a series of options for the configuration of shared care for people with long-term mental illness.[56] These include the placement of 'aligned caseload' link workers, guidance on setting up registers, databases and systems of recall, and an annual joint review of patients' notes to detect and address unmet mental and physical healthcare needs. Evaluation using a cluster randomised controlled trial found significant reductions in relapse rates and increased practitioner satisfaction in the intervention practices, echoing US experiences of integrated care.[57] The recent National Institute of Clinical Excellence (NICE) clinical guidelines on schizophrenia,[58] also encourage the organisation and development of practice case registers for people with schizophrenia, and discussion about guidelines for referral across the primary–secondary care interface.

From April 2004, the new role of primary mental health worker (PMHW) will also have significant potential to encourage a more integrated approach to delivering primary mental health care for people with common mental health problems, as well as serious mental illness.[59] PMHWs will be involved in providing evidence-based therapies, such as cognitive behavioural therapy, and in developing the infrastructure of primary mental health care, for example by developing mental health audits, registers, and protocols. They will also have an important liaison role with both the voluntary sector and secondary care mental health professionals. PMHWs will be supervised by secondary care mental health professionals, will be based in primary care, and will work to improve patient care pathways through the mental health system. The Camden and Islington PCT's pilot site is evaluating the effect of PMHWs on facilitating access to voluntary sector services for patients with common mental health problems.[60] The Heart of Birmingham PCT pilot site is evaluating the effectiveness of PMHWs on satisfaction with care (measured by the consultation satisfaction questionnaire) and mental health symptoms (measured with the CORE-OM [clinical outcomes in routine evaluation outcome measure] questionnaire) using a cluster randomised controlled trial.[60]

1. It reflects the way that the majority of patients present their distress in primary care. Their problems are not entirely physical or psychological, but often both presenting in undifferentiated form.[50]
2. It can improve adherence to medication and satisfaction with care. A US initiative, involving collaborative management by the primary care physician and psychiatrist, improved adherence to antidepressant regimens in patients with major and with minor depression. It also improved satisfaction with care and resulted in more favourable symptom resolution in patients with major depression.[51]
3. It is the best way of improving the skills of primary care providers in dealing with the psychosocial aspects of care, with training through teamwork and a significant transfer of expertise between team members.[52]
4. Primary care providers are happier with their work; this is demonstrated by enhanced job satisfaction in integrated settings.[53]
5. Integrated approaches appear to break even or be cost saving in the longer term.[49]

Box 3. The benefits of integrated primary mental health care.

Factors affecting success

The success of a more integrated approach to care will depend on a number of factors. New services are often championed by 'hero innovators' who are likely to move on and seek fresh challenges once a service is up and running.[61] To be truly sustainable, new approaches to working should not depend on single individuals.

Any change in working practices also requires a commitment from primary care health professionals and PCTs.

There is, however, already evidence to suggest that the *NSF for mental health* is being marginalised in some PCT agendas, unable to compete on an equal footing with other clinical priorities.[62] However, developing a more integrated approach could be perceived as an opportunity to extend the role of the practice nurse, perhaps through encouraging a case-management approach in depression. It may also provide a suitable framework for implementing and developing the roles of GPs with a special clinical interest in mental health.[63] The General Medical Services contract[33] includes specific guidance on reviewing coordination arrangements with secondary care, for people with severe long-term mental health problems, and outlines for enhanced specialised services for people with depression, providing opportunities for developing a more integrated approach to care.

New ways of working also crucially rely on specialist secondary mental health workers being comfortable and valued within a primary care working environment.[64] The shift towards a primary care-led NHS, has led to some tensions and power struggles between PCTs and mental health trusts in terms of commissioning and providing mental health services.[65] Any changes, particularly those that impact on professional roles and boundaries, could therefore be perceived as threatening the power base of an individual or team. The role of secondary care mental health providers is, however, crucial. For example, Katon *et al*'s US collaborative care programmes in depression found that improvements in care were not sustained when the consultant specialist withdrew from the treatment team,[51,66] demonstrating the importance of ongoing input from secondary care mental health specialists in developing and delivering services. Secondary care skills and a knowledge base in key areas such as triage, risk assessment, and delivery of specific psychological therapies also need to be acknowledged and valued when new approaches to care are debated.

Education and learning strategies in primary mental health care

Integrated services will not happen overnight and may not happen at all unless they are underpinned by the development and delivery of appropriate learner-centred interprofessional education, and learning strategies that enable current and future generations of NHS and social care staff to understand the value of working together.

Previous attempts to educate the primary care workforce about mental health have met with mixed success. The Hampshire depression project,[67] for example, found that education delivered to practice teams, although well received, did not lead to significant improvements in recognition of or recovery from depression. A randomised controlled trial on the effectiveness of teaching GPs skills in brief cognitive behavioural therapy to treat patients with depression, found that the training had no discernible impact on user outcomes.[68] Such traditional pedagogic methods of training are, however, being challenged as a means of changing GPs' behaviour in mental health care. A more flexible learner-centred approach to education that draws on primary care's long tradition of developing and delivering learner-centred education is being increasingly advocated.[69,70] This requires trust and a belief in the ability of GPs to teach each other. There is, however, evidence that many GPs still prefer 'expert' educators who impart knowledge in a pedagogic manner. If education in mental health care, and in other areas, is to truly become learner centred, then GPs need to address this paradox.[71]

Interprofessional education is also key, since it is one of the ways in which practitioners learn about each setting's strengths and weaknesses, and can encourage a culture of collaboration and mutual respect.[72,73] Interprofessional learning has been a feature of primary care, albeit in a small way, for decades. In certain centres, particularly around the Tavistock Clinic in North London, psychiatrists, psychotherapists, and GPs have worked together for years to understand the problems of their patients with mental health issues along the lines developed by Balint.[74] As yet, there have been relatively few such interprofessional educational opportunities in mental health for primary care and secondary specialist care staff.[75,76] Notable exceptions are the 'duo training courses', based on the principles of teaching the teachers. An evaluation of one such interprofessional primary mental healthcare training course in the West Midlands found a positive impact on the development and delivery of integrated mental health care across the interface, and may provide a model for future interprofessional training initiatives.[77] Truly interprofessional learning should also involve service users as participants and teachers, thus helping to ensure that future service models are informed by users' wants and needs rather than being professionally dominated.

Conclusions

In this paper we have argued that mental health is a core activity of primary care. The increasing move towards a primary care-led NHS has now created a climate where it is possible to develop a more integrated approach to working, grounded in the culture of primary care. New ways of working must be seen as a remedy to perceived problems, rather than simply good ideas to be pursued for their own sake. Services need to be commissioned and evaluated in a sustained manner, accompanied by carefully negotiated adjustments to the way primary and secondary care health professionals conceptualise their roles and responsibilities, and underpinned by new ways of learning together.

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