

Primary Mental Health Care Reform in a Global context

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Plan of lecture

Lecture in three parts:

- Differences between our two countries
- Possible ways of relating the 2 services
- The Virtual Group

Changing times

Across the world, great changes are occurring in the role and functions of primary care.

In the developed world, governments are anxious to limit hospital based care as much as they can, because it is much more expensive

In the developing world , governments know they can never afford to provide hospital based mental illness services to their entire populations, and rely on medical officers to widen the range of disorders they recognise and treat

Changing times - 2

In the developed world, collaboration is least where the two services are both fee-for-service, and independent of one another; it is greater when they are both publicly funded services; greatest when they are salaried services

Changing times - 3

In the developing world, specialist services tend to be concentrated on larger cities - it is therefore essential that medical officers have skills to enable them to deal with major, common illnesses

Differences between our countries

PRIMARY CARE TRUSTS serve 250,000 people in the UK, and consist of between 40 and 60 GPs: they are given most of the total money for health needed by that population

They get an annual budget, for ALL health needs of the population registered with them - including specialist care and hospital care

Differences between our countries

Out of this, they must pay

- Their own salaries, and those of all their staff
- The costs of maintaining their premises
- The costs of ALL drugs they prescribe
- The costs of ALL treatments in hospital
- The costs of ALL mental illness services

(the last two are the "gatekeeper" functions of primary care)

British doctors work in *GROUPS* between 6 & 8 doctors

And employ many paramedical staff:

- receptionists
- practice nurses
- District nurses
- Health visitors
- Counsellors
- Practice manager

- Each member of the population is registered with a particular GP or Group of GPs
- There is no "fee for service": a doctor's salary is dependent on the number of people he or she looks after
- Thus, there are many specialist clinics in primary care - Well Baby Clinics, Antenatal clinics, Clinics for diabetes, asthma, and hypertension.

These differences between UK and Australia have meant that GPs in the UK are even more motivated to become as independent as possible.

Thus, they wish to learn mental health skills.....

Psychiatrists, in their turn, depend on GPs for the cash to run their service; they are therefore motivated to be as helpful as possible....

Mental disorders are divided into

"common mental disorders"

anxious-depression, somatised form of distress, alcohol dependence; and

"severe mental disorders"

schizophrenia, bipolar illness, drug dependence and dementia

Common mental disorders

are treated by primary care staff in primary care; they are only referred to CMHTs if they fail to respond to treatment

Severe mental disorders

Treatment is shared between primary care and the CMHTs, using "shared care plans" and dedicated mental health workers who visit primary care

"Stepped Care"

Who needs treatment?

Who should give it?

When should patients be referred?

Who is responsible for care?

What do they do?

Why do they do it?

Acute Wards	Risk to Life	Medication, ECT nursing care
CMHT, OPD, crisis team, Day Hospital	Treatment resistance frequent recurrences	Medication, complex Psychological i.v's
PCMHW, GP, Counsellor, social worker, psychologist	Moderate or Severe Depression	Medication, Brief psych. interventions, support groups
GP, Practice nurse, Practice counsellor	Mild Depression	Active Review: Self Help, Computerised CBT, Exercise
	Recognition	

Possible relationships between the two services

- Virtually independent services: only contact between the two by referrals
- Active liaison with visits by psychiatrists to primary care
- Active liaison with all members of CMHC visiting primary care

Visits by psychiatrists

- "Shifted out-patient" model: sees own old patients belonging to practice
- Consultant model, sees patients referred by GP
- Consultant model, meets entire primary care staff, discusses problems
- Consultation liaison model: joint interviews between patient, GP & psychiatrist

Shifted out-patient model

PRO:

- fewer patients default
- good opportunity to see CPNs, and review their work

CON:

- little direct contact with GP, most contact via letters!

Consultant model, sees patients referred by GP

PRO:

- ✓ Widens range of patients seen by psychiatrist
- ✓ appreciated by GPs
- ✓ possible to combine it with reviewing old patients

CON:

- × Additional work beyond normal range
- × Time consuming

Consultation model, meets all PC staff in practice - but not the patient

PRO:

- ✓ Sees several GPs at once
- ✓ Entire PC staff benefit
- ✓ Discusses current problem patients

CON:

- ✗ Not much really - but it is little practiced!

Consultation-liaison model, sees patients jointly with GP

PRO:

- ✓ Widens range of patients seen by psychiatrist
- ✓ improves mental health skills of GPs
- ✓ care of patient remains with GP

CON:

- × Others do not benefit
- × The most time consuming

Regular visits by many members of CMH team

PRO:

- ✓ Extends range of mental health services available to GP
- ✓ Good liaison between the 2 services

CON:

- × Severe logistic problems: only large group practices receive the service

Goldberg & Gournay, 1996

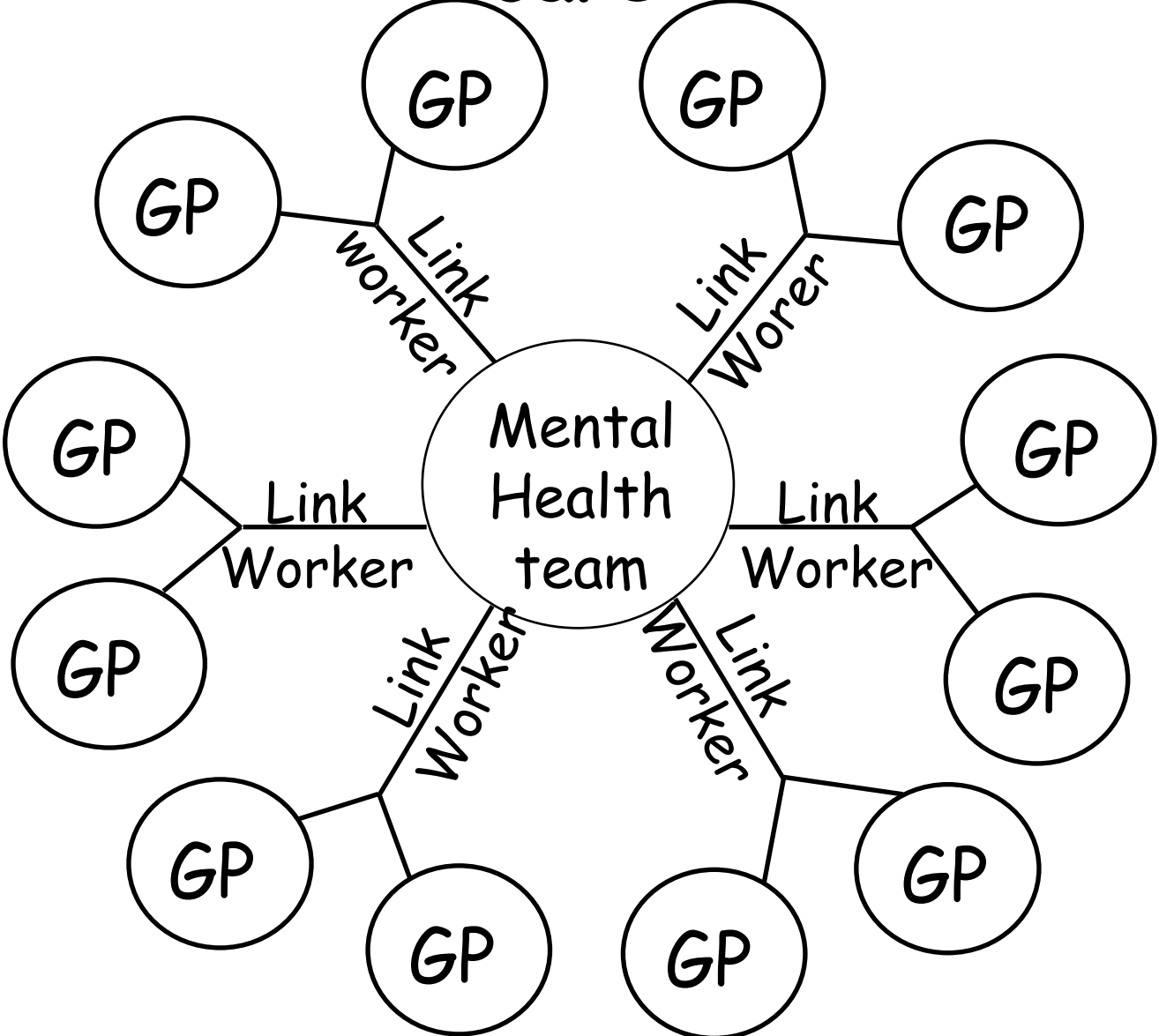
The usual arrangements are not that good. Chronic patients are looked after by community nurses, and reviewed from time to time by psychiatrists.

Patients are assigned to nurses on two criteria:

- dangerous patients go to more experienced nurses
- the nurse with fewest patients gets next case

Thus, the case load of a particular nurse will be looked after by different GPs.

Relations between primary & secondary care



Role of the link worker

- culture carrier between the teams
- carries out care plan for each SMI patient
- trained in specific therapeutic skills

Goldberg & Gournay, 1996

Four groups of patients:

1. Severe disorders associated with high disability
2. Effective drug and non-drug treatments available
3. Only non-drug treatments available
4. No specific treatment available

Group 1: Severe mental disorders

unlikely to remit spontaneously,
associated with severe disability

- schizophrenia,
- organic disorders,
- bipolar disorder,
- life threatening eating disorders

Shared Care: Managed by CMH team and
primary care

Shared Care

The CMH team draw up a Care Plan for each patient with a severe disorder:

- what is prescribed, by whom
- alternative drug
- probable symptoms in relapse
- who to contact in an emergency
- how to obtain hospital admission

68% reported shared care plans in 2002

Royal College Survey

The pattern of service described by Goldberg & Gournay is being tried out by 14% of PCTs:

91% of those with "link workers" were satisfied, but only

54% of those with many CPNs were satisfied

Rajagopal & Goldberg, 2003

Group 2: Drug & non-drug treatments available

Well defined disorders, associated with disability, even when disorder remits they are likely to relapse

- anxious depression,
- pure depression,
- generalised anxiety,
- panic disorder,
- OCD

Managed within primary care;
backup when required

Group 3: Effective non-drug treatments

Rarely treated within 1ry care; but effective treatments available; can become chronic; associated with disability

- somatised presentations
- agoraphobia;
- mild eating disorders
- PTSD
- substance abuse
- chronic fatigue

**Managed within primary care;
backup when needed**

Royal College of Psychiatrists

Survey of future pattern of services: 2002

Representative samples of Mental Health
Trusts and Primary Care Groups

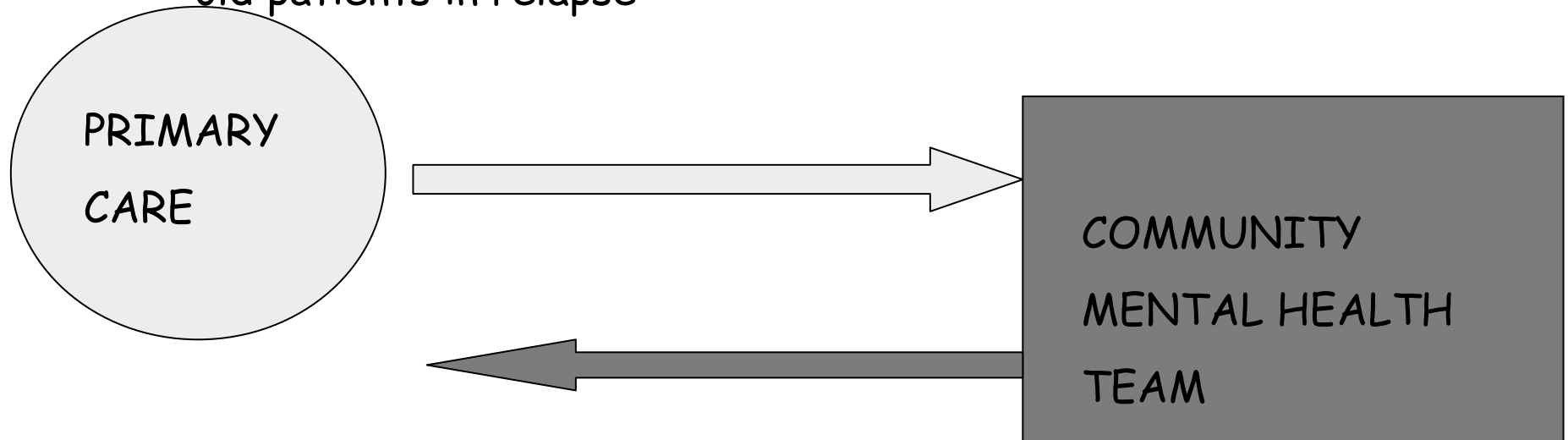
Who will provide routine care for patients
with schizophrenia and bipolar illness in the
future?

95% of both groups surveyed said:
primary care

Rajagopal & Goldberg, 2002

The UK Model

New problems that fail to respond to treatment,
old patients in relapse



CMHC staff visit chronic patients, liaise with GP; stable patients in remission sent back to primary care

SHARED CARE PLANS HERE

The Virtual Group

contact mainly by e-mail

28 members -

in Australia, Austria, Bulgaria,
Denmark, Holland, India, Italy,
Pakistan, Rumania, Russia, Singapore,
Switzerland, United Kingdom, United
States

What is the relationship between primary care and MH services in these countries?

20 members, in 13 of these countries, completed a questionnaire

- the present relationship between the two services
- who they would refer, who they would treat?
- Present opportunities for training primary care staff in mental health skills
- training methods used

How common is shared care?

USUAL: Nowhere!

FREQUENT: United Kingdom, Russia

SOMETIMES: Australia, Italy, Holland,
[some] Denmark, [some]
United States, Spain

NEVER: Austria, [some] Denmark,
Pakistan, India, Singapore,
[some] United States

If GP asks, will MH staff visit patient at home?

PSYCHIATRISTS WILL: United Kingdom, Italy, Austria, Holland, Denmark, Pakistan, Romania, Russia, Spain

A PSYCHIATRIC NURSE WILL: United Kingdom, [some] Australia [some], Holland, Romania, Russia, Singapore, [some] USA

NO, NOBODY WILL: [some] USA, [some] Australia [some], India

Do members of the CMH team do clinics in primary care ?

PSYCHIATRISTS DO: United Kingdom, USA, Austria, Denmark, Pakistan, Spain

PSYCHIATRIC NURSES: United Kingdom, Holland, United States

PSYCHOLOGISTS: United Kingdom, Holland, Australia, United States, Pakistan

NO-ONE DOES: Denmark, Austria, Spain, Italy, Romania, India, Singapore, Russia

Treat in primary care, or refer to mental health services?

- 1) Acute depressive episode
- 2) Phobic illnesses
- 3) Treatment resistant depression
- 4) Well controlled bipolar illness
- 5) Well controlled chronic schizophrenia
- 6) Acute psychotic illness
- 7) Drug dependence

GENERAL AGREEMENT

7 common MH conditions

DRUG DEPENDENCE:

Refer to mental illness services (ALL)

ACUTE PSYCHOTIC ILLNESS:

Refer to mental illness services (ALL)

TREATMENT RESISTANT DEPRESSION:

Refer to mental illness services (except Pakistan)

EPIISODE OF ACUTE DEPRESSION:

Treat in primary care (All except Russia, Romania)

LITTLE AGREEMENT

7 common MH conditions

TREAT IN PRIMARY CARE:

PHOBIAS: United Kingdom, Italy, Denmark, Australia, Spain

CONTROLLED BIPOLAR: United Kingdom, Pakistan, Australia, United States, Denmark

CONTROLLED SCHIZOPHRENIC: United Kingdom, Australia [some], United States [some], Denmark [some], Pakistan, Austria, Spain