

Ways of working with primary care

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Agenda

- Who will I treat?
- How will I intervene in the system?
- What would make it difficult?

Types of Patient

- Depression, anxiety
- Long Term Conditions
- Medically Unexplained Symptoms
- Age group?
- Others?

Activities



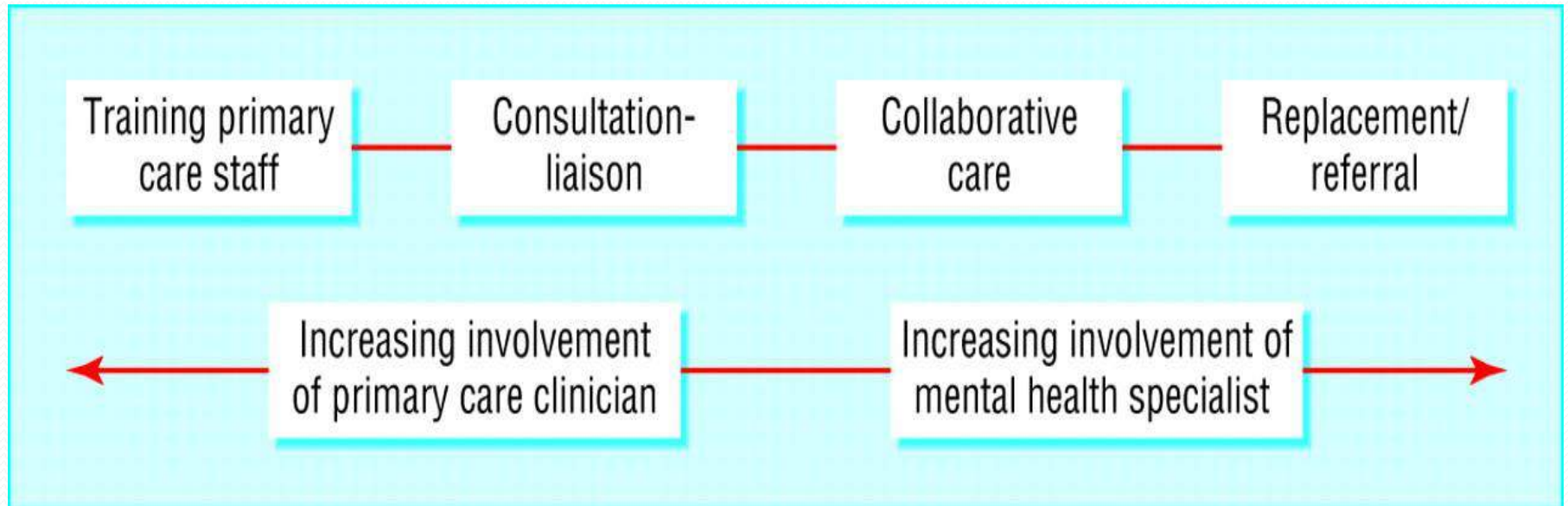
Activities

- Therapeutic interventions: what kind??
- Supervision

With primary care- *communication*

- Referral meetings?
- Case discussion?
- Skills sharing?
- Own skills development

Models of mental health care in primary care.



Peter Bower, and Simon Gilbody BMJ 2005;330:839-842

Direct collaboration- how much will you collaborate with primary care?

- **‘Link working’** with member of mental health team
- **Co-location** with face-to-face contact (not simply ‘shifted clinic’)
- **Consultation-Liaison**
- **Care management/’Collaborative Care’**

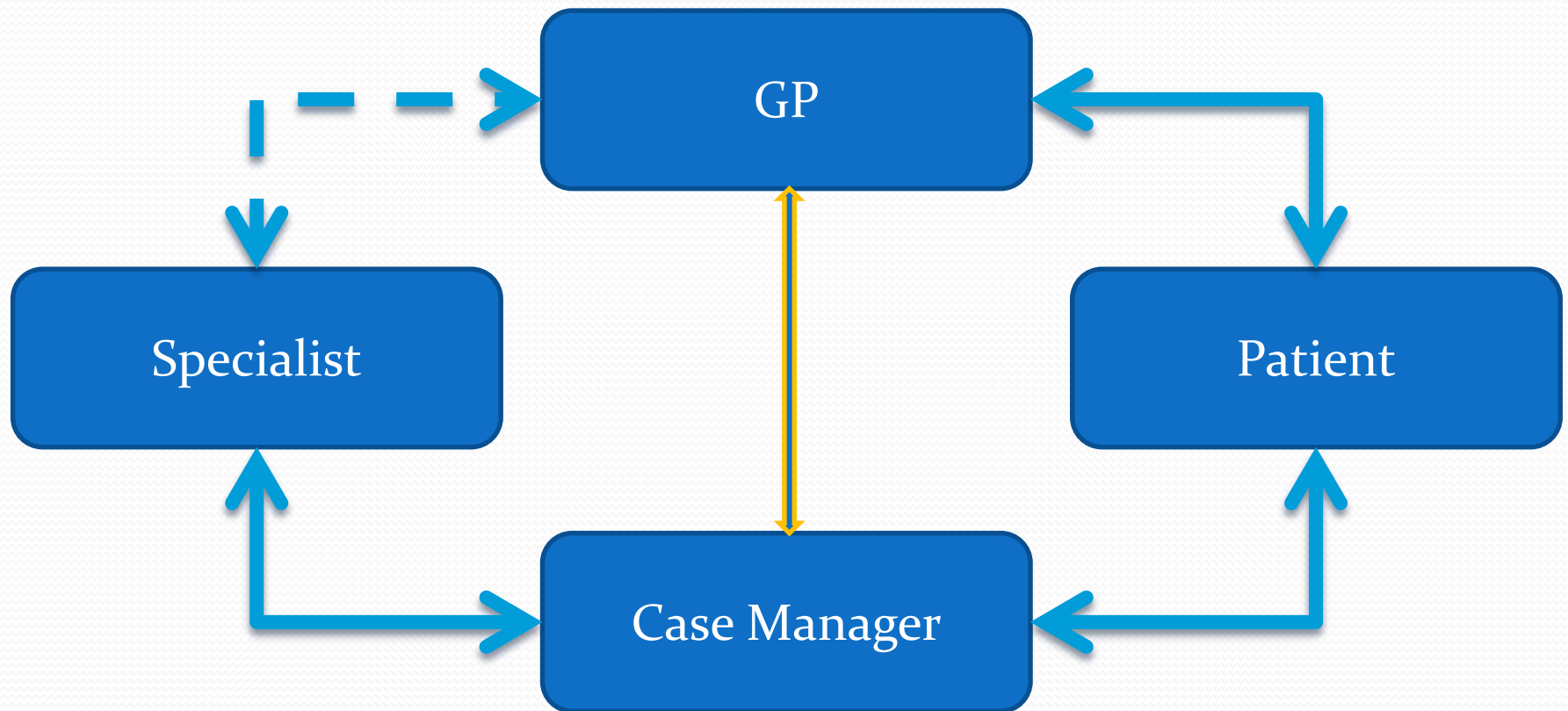
Consultation-Liaison

- Regular face to face contact between mental health professional and primary health care team (PHCT)
- Referral only after a discussion at a face to face meeting
- Some cases are managed by the PHCT only
- When referral does take place there is feedback to, and management by, the PHCT

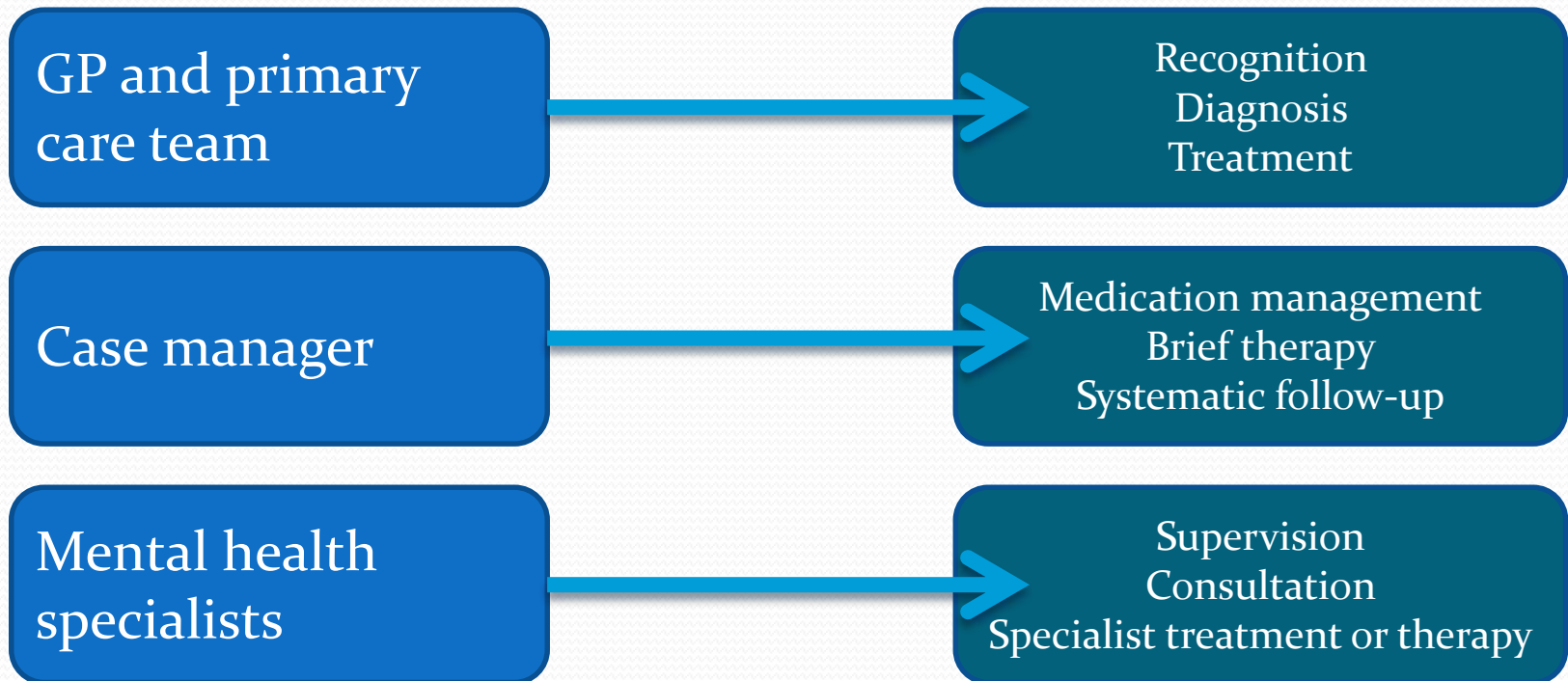
Collaborative care

- **Multi-professional approach to patient care** provided by a case manager working with the GP under regular supervision from specialist mental health clinician(s)
- **A structured management plan** of medication support and brief psychological therapy
- **Scheduled patient follow-ups**
- **Enhanced inter-professional communication** patient-specific written feedback to GPs via electronic records and personal contact
 - *for UK example see CADET study: Richards et al. BMJ 2012*

Collaborative care relationships



Collaborative care interventions



Improving access

Collaborate to develop local care pathways that:

- support integrated delivery across primary and secondary care
- have clear and explicit entry criteria
- focus on **entry** and not exclusion criteria
- have multiple means and points of access, including self-referral
- have a designated lead to oversee care
- promote access for people from socially excluded groups

Developing local care pathways:1

Design local care pathways that promote a stepped-care model of **integrated** delivery to:

- provide least intrusive, most effective interventions first
- have explicit criteria for different levels of intervention
- not base movement between levels on a single criteria
- monitor progress and outcomes
- minimise the need for transition between services
- establish clear access and entry points
- have designated staff responsible for coordination of care

Developing local care pathways: 2

Develop protocols for communicating information:

- for patients/service users about their care
- with other professionals (GP, psychiatrists)
- between services within the pathway
- to services outside the pathway e.g. Social care/education

Robust systems should be in place to ensure routine reporting of outcomes



Difficulties?

- Where is 'clinic'?
- Records?
- Supervision and support?
- Medical Responsibility?
- Building trust and relationships
- Suitability of referrals- 'appropriateness'



What are your experiences of/concerns about working with primary care?

- Expectations
- Problems
- Developments
- Solutions...

Working together effectively

- People (especially MH staff) need to be clear what their roles are and be trained to do them and properly supervised to carry them out..
- Flexibility and tolerance are key attributes
- Senior managerial support essential
- Opportunities to meet/co-location
- Joint problem-solving, agreeing of protocols and referral guidelines- need to work together
- Ensure that outcomes are properly evaluated, discussed and acted upon.

Questions?

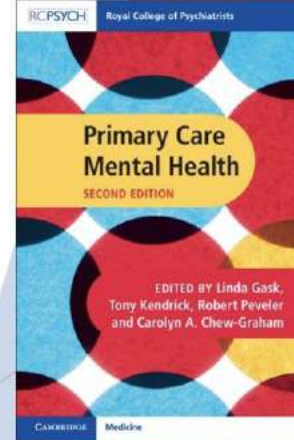
Thank you!

Thank you!

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