

CHAPTER 3

COMMUNITY AND PRIMARY CARE SERVICES

INTRODUCTION

3.1 A fundamental principle of this Review is that mental health and social care should be provided in the community unless there is good reason for not doing so. The following key themes provide a rationale and foundation for the development of community and primary mental health care:

- Most people with mental health problems who receive health and social care do so entirely in the community or in a primary care setting.
- Service users and their carers prefer community and primary care based interventions, which are accessible, responsive, and work in partnership, thus respecting the insight of service users and carers.
- Much psychological and emotional distress can be resolved by the imaginative use of generic services, the voluntary sector and by community development approaches which provide support to people at times of need.
- The principle of equity must underpin future community and primary care services.
- Not all mental health problems need to be, or should be, solved by statutory Health and Social Services organisations. There are many voluntary and community based alternatives.
- Commissioners of mental health services must carry out comprehensive needs assessments at population and community level in order to understand significant local variables and to identify gaps in service provision.
- No strategy for community and primary mental health care could be successful without systematic efforts being directed towards mental health improvement. This is being examined by a separate Expert Working Committee.
- Each individual with mental health problems should be given the opportunity to have their mental health needs understood and addressed promptly, taking into account biological, psychological and social dimensions.

- Investment in primary care activity produces better healthcare outcomes in respect of activity in both primary and secondary care.¹
- The future of community mental health provision should be in partnerships generated within both the statutory and voluntary sectors.

ILLNESS PREVENTION

3.2 Mental health service providers can assist other organisations such as employers, educational establishments and community groups to develop specific strategies in time to prevent mental ill-health. Such strategies should be directed towards people who show no overt signs of mental disorder, but who are in high risk groups such as young adult males in socially disadvantaged localities. Much can be done using dedicated support systems and services for vulnerable individuals who show evidence of psychological distress.²

Good Practice Example

Rural Support. *A local example of good practice is in the farming community, where use of a telephone helpline and a rural health action zone has been of benefit to many. (Contact: 0845 6067607)*

3.3 Early detection of signs of distress may lead to the speedy resolution of the problem. Where the problem is more persistent, then it is essential that people have access to services offering early assessment and early treatment. At these early stages psychological distress does not often fit easily into conventional classifications and should be addressed in a manner and setting which is acceptable and accessible to those suffering. These early interventions have much in common with the public health model described by Albee.³

Good Practice Examples

Creggan estate, Londonderry, partnership approach to Health promotion. *This project demonstrates that statutory/community partnerships, accompanied by proper planning and long term commitment, work effectively, even in areas of high social disadvantage. Professional boundaries can be reduced, and a more open and flexible approach to health and social needs adopted.⁴ (Contact:028 71373870)*

Croydon Social Prescribing Scheme. *Social prescribing schemes are increasingly recognized as effective in dealing with early signs of stress and psycho-social difficulties. In this Scheme, GPs have established a partnership with the voluntary and community sector, and employed a community worker based at a health centre. Practice staff refer patients to this worker, who has extensive knowledge of local community and voluntary services.*⁵ (Contact: www.mindincroydon.org.uk)

- 3.4 Early prevention and assessment strategies can minimize any stigma associated with traditional mental health models. It is clear that there will always be those who, in spite of the very best system of prevention, will develop more severe or enduring problems.
- 3.5 Employers have a duty to ensure the mental well-being of their employees. The use of employee assistance and counselling programmes is commended by the Review and should be made more widely available.

Recommendation

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| <p>1. Employers, educational establishments and community groups must promote and ensure the mental well-being of those for whom they have responsibility.</p> |
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Good Practice Example

Both the University of Ulster and Queen's University have recently invested in the appointment of full time staff dedicated to supporting the mental health wellbeing of staff. (Contact: QUB 028 90245133 and UU 028 90522067).

- 3.6 Voluntary agencies play an important role in providing services to people with mental health problems. However, they are often unable to rely on consistent and planned levels of funding from statutory bodies. There are clear opportunities to expand the role of voluntary agencies at primary care level. Voluntary agencies often have the flexibility to respond innovatively to the changing demands of mental health care.

Good Practice Example

City of Toronto Mental Health Services.⁶ *This is an example of explicit funding arrangements combining statutory and voluntary sectors. A mixed economy of care is practiced, with clear definitions of responsibility and accountability in allowing*

planned and timely delivery of targeted care. All mental health service providers, including the local hospital, have entered into formal legal agreements to create a highly accessible system for the consumer, based on the strengths of each of the partner organisation. (Contact: www.toronto.cmha.ca).

- 3.7 The Review believes that those responsible for assessing mental health needs at community and primary care level must have available a quality assured range of adequately funded, supervised and monitored voluntary services to whom they might refer.

Recommendation

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| <p>2. Commissioners of mental health services must seek to develop and expand the range of voluntary services in order to provide a planned and quality-assured profile of care available to service users at primary care level.</p> |
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USERS AND CARERS INVOLVEMENT

- 3.8 In spite of much recent progress involving services users and their carers in the planning and delivery of mental health services, there is much left to do.⁷ All services providing care for mental health problems should foster a culture where users and carers are actively involved in the planning and delivery of services as well as being fundamental to the monitoring, developing and refinement of services.⁸ Service users and their carers have much to offer to programmes of education and initiatives designed to reduce stigma and increase acceptability of mental health services. Carers may have their own mental health needs requiring support and specific interventions.⁹

Recommendation

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| <p>3. All community and primary care mental health service provided by and commissioned by statutory services must have service users, their carers and families involved in the development, delivery, monitoring and evaluation of services.</p> |
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ADVOCACY

3.9 At present the use of advocacy in community and primary care is not well-developed. The Review recognises that primary care professionals advocate for service users in secondary services and welcome both formal and informal advocacy within the primary care setting. Advocacy occurs at individual, family, group and service level. Particular problems associated with mental illness might require specific advocacy skills. Advocacy services described in Chapter 5 should be linked to services within primary care.

Recommendation

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| 4. Community and Primary care organisations must ensure that advocacy arrangements are developed within primary care settings. |
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PERSON-CENTRED PLANNING

3.10 People should be encouraged to take as much control as possible over their own care. A Person-centred Plan could be developed, led by the service user, supported by his or her carers and advocates, in partnership with professionals. This would enable care to be planned in the context of the individual's aspirations and life as a whole. It would also enable service users to make more effective use of direct payments.

Recommendation

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| 5. Community and Primary Care organisations should facilitate person-centred planning. |
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PRIMARY CARE TEAMS

Team Structure

3.11 At present primary care teams in Northern Ireland face many difficulties. They vary in composition and size, and in the skills available within them. A full range of professionals is often not clearly identified, deployed or networked as a team, and there are a number of different management arrangements within teams. These include independent contractors such as General Medical Practitioners, Community

Pharmacists, practice employed staff such as Nurses and Receptionists; Trust staff, such as District Nurses, Health Visitors, Community Midwives, Social Workers and aligned staff such as specialist mental health professionals or Allied Health Professionals.

- 3.12 Quality patient care is dependent on the effective functioning of primary care teams. It is vital that the teams should comprise a full complement of professionals and that the varying contractual arrangements and managerial structures should not impede effective team working. A strategy for the development of primary care in Northern Ireland must recognise the obstacles to effective team working. Each practitioner should have a clear knowledge of the roles and responsibilities and when onward referral is appropriate.

Recommendations

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| <p>6. Membership of the primary care team should be clearly defined and each team should have the full complement of professionals. Organisational barriers should not impede effective multi-disciplinary working.</p> <p>7. There should be targeted investment in the development of primary care teams to promote better recognition of common mental health problems and clear working arrangements for managing such problems.</p> |
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WORKING ARRANGEMENTS

- 3.13 The new General Medical Services Contract offers opportunities to improve mental health care at primary care level. Work will be required to determine how mental health services can be arranged within the framework of core, additional, extended and enhanced services.
- 3.14 Local Health and Social Care Groups play a key role in the developmental of primary care mental health services. Where they become commissioners of services, it will be necessary to ensure that conflicts of interest do not occur within organisations responsible for both commissioning and provision of similar services.

- 3.15 The new contractual arrangements for groups such as Community Pharmacists offer opportunities to reflect the substantial contribution to be made by people throughout the primary care setting.
- 3.16 Efficient working at primary care level can be dependent on efficiency of working at secondary care level. Mental health care working in Northern Ireland shows that seamless delivery by single management structures provides better services than when several Trusts are involved in delivering care. It is in service users best interest that management boundaries are broken down where possible.

Recommendations

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| <p>8. Statutory mental health services must have seamless management arrangements between secondary and primary settings in order to maximise the efficiency and effectiveness of service delivery.</p> <p>9. New working arrangements in primary care should seek to maximise treatment of mental health problems in primary care.</p> |
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ASSESSMENT

- 3.17 The fundamental role for primary care is to ensure that individual needs are met in a timely, appropriate and accessible manner. In many cases this can be achieved by members of the primary care team such as Social Workers, offering social care and intervention, Health Visitors and Community Midwives giving advice about the emotional effects of pregnancy and childbirth, Practice Nurses giving lifestyle advice, Community Pharmacists managing concordance and the General Practitioner prescribing for significant depressive illnesses.
- 3.18 In all occasions it will be necessary for assessment of more complex needs to be available at primary care level and appropriate referral to other agencies arranged where necessary. A minority of practices presently have directly attached mental health workers. Such arrangements have advantages for patients and for the primary care team. It is important however that such workers retain the ethos of team working with colleagues from a mental health background and that adequate professional supervision, clinical guidance and personal support are offered, as well

as opportunities for continuing professional development. It is equally important that mental health workers feel part of the primary care team in order to integrate care within primary care services. Identified primary care mental health professionals should offer support, advice and guidance within the primary care team. The assessment process should be auditable and should contribute to the continuing education of all involved. Lessons may be learnt from the experience of innovative projects such as in Limavady and Mid Ulster.

Good Practice Examples

Limavady Pilot Project. *The pilot review of referral pathways and the use of a senior skill professional based in primary care has led to reductions in log jamming of referrals, improvement of morale and development of timely, accessible assessment services. Audits of satisfaction have shown enthusiasm for continuing the service from service users, primary care staff and secondary care staff. (Contact: 028 7772123).*

The Mid Ulster Primary Care Mental Health Project. *This began in June 2002. The aim of the project is to provide a primary care based mental health service offering brief therapies to patients of 45 General Practitioners within 16 surgeries. Early evaluations showed high levels of acceptability to service users and practitioners with a significant demand for extension of the service. (Contact:028 86747250).*

Recommendations

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| 10. | All primary care teams must have access to a named mental health professional in order to provide timely, appropriate and accessible assessment, and management of people with mental health problems. |
| 11. | Mental health services must be planned, integrated and accessible in order to provide timely, accessible and appropriate assessment and treatment in a manner valued by service users, their carers and by practitioners. |

IDENTIFICATION AND ACCESSIBILITY

- 3.19 Most people with mental illness should be and are treated in the primary care setting. There is a problem of under-recognition of mental health problems by General

Practitioners and other members of the primary care team. Present evidence suggests that educational initiatives, whose effectiveness has been measured, have a limited effect, which might only be of short duration. There are many contributory causes to under-recognition of illness including time constraints, characteristics of the practitioner, setting of the consultation and characteristics of the patient.

- 3.20 It is recognised that issues of stigma can prevent people accessing appropriate mental health care.¹⁰ It is important the primary care teams recognise the internal¹¹ and external causes of stigma¹² in order to devise working arrangements to facilitate access. Teams should formulate policies of good practice for health promotion, disease prevention, early diagnosis, illness management and referral within and outside the team. Difficulties regarding confidentiality and consent should be addressed specifically.
- 3.21 One of the key skills of a General Practitioner is to interpret the complex and different range of problems often presented by their patients, to come to an agreed understanding regarding the nature of these problems and then negotiate an appropriate course of action for each problem. General Practitioners have crucial roles to play in managing inter-relationship between physical and mental health problems and ensuring the delivery of holistic healthcare to people.
- 3.22 Similarly, one of the key skills for Social Workers, working within teams for families and children, people with disabilities, older people et cetera is to identify psychological and emotional stress and refer on appropriately.
- 3.23 The uptake of specialist community mental health services is likely to be better where such services are developed locally, are not perceived to be institutional and provide specific interventions as well as offering supportive aspects of care.
- 3.24 It is known that major psychiatric illnesses such as schizophrenia and affective disorders, carry a significantly increased burden of mortality and morbidity from physical causes. It is essential that primary care structures offer opportunity for assertive recognition and management of risk factors and early management of physical health problems in those with mental illness.

3.25 The needs of people with mental health problems to be accommodated away from their homes from time to time should be met. The use of a hospital-based place should not be the only option available. Where accommodation away from home is desirable, it should be in a setting that recognises the person's autonomy, provides gender sensitive care and is easily accessible to the service user and their carers. (Chapters 4 and 5).

Good Practice Example

South Stockholm Mental Health Service. *In this project, a strong community-based service uses a mix of generalist and specialist services to provide locally-based services which endeavour to “meet people with mental problems with respect on their home ground, in their own context”. The emphasis is on outpatient service, although there is recognition that twenty-four hour care may be necessary from time to time. Such care might be provided at home or in locally-based community facilities. Treatment in social psychiatry units is integrated between outpatient and inpatient services. There is integration of outpatient and inpatient services through all specialisms. (Contact:Jan Strand@SSPO.SLL.SE)*

Recommendation

12. Community mental health services must be sited within the community they serve and must be accessible, targeted and appropriate.
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OUT OF HOURS SERVICES - THE NEED FOR MENTAL HEALTH SERVICES NOT CONFINED TO OFFICE HOURS

3.26 Service users and carers value the opportunity to get advice about their problems and about treatment. Crisis assessment and intervention services (see Chapter 4) should be provided for those for whom hospital admission would be the only other alternative. Mental health providers should also however, offer locally-based dedicated telephone advice from qualified staff. Such services might also offer support, advice and arrange appointment for people with services that might be offered during the next or subsequent working days.

- 3.27 The new contract for General Practitioners allows practices to opt out from responsibility for twenty-four hour care and offers opportunities for Health Boards to rethink the nature of out-of-hours cover, allowing the development of integrated out-of-hours mental health cover and out-of-hours General Practice cover. Local protocols should be developed to describe access to mental health professionals out of hours. Such arrangements will have to take careful account of costs, clinical effectiveness and practitioners' working hours.
- 3.28 Service users and their carers value initiatives to offer extended hours facilities and services at times convenient for users, rather than those based on office hours that avoid holidays and weekends. Examples include statutory services provided by Trusts and Voluntary sector services.

Good Practice Example

The Carecall Counselling Service and the information/advice and support services provided by the Northern Ireland Association for Mental Health. (Contact: 028 90245821).

Recommendation

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| <p>13. The means of access to out-of-hours mental health services should be stratified according to clinical need and to comprise face-to-face contact, telephone advice and arrangements for organisation of services during subsequent working days.</p> |
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SCREENING TOOLS

- 3.29 While there is evidence that the use of screening tools in clinical practice might increase the detection of mental health problems, a substantial number of false positives are yielded by commonly used research tools. There is not evidence to advocate the widespread use of screening tools. The Review encourages their use to support trained practitioners in the assessment of targeted populations at risk or suffering severe mental health problems, such as those admitted to hospital following deliberate self-harm, or those thought to be at risk of developing perinatal psychiatric illness.

- 3.30 Many practitioners value checklists for common disorders, such as those contained in the World Health Organisation Guide to Mental Health in Primary Care.¹³

Recommendation

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| 14. Formal screening tools should be used to support trained practitioners in a global assessment of at risk populations. |
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PSYCHOSOCIAL CARE, COUNSELLING AND SPECIFIC PSYCHOLOGICAL THERAPIES IN COMMUNITY AND PRIMARY CARE

- 3.31 There is patchy and inadequate provision of psychological therapies in community and primary care. There is clear evidence that psychological therapies should be routinely considered as an option when considering mental health problems, with particularly strong evidence for patients suffering from addictions, depression, psychosis, anxiety disorder, eating disorders and post traumatic stress symptoms. Specific psychological therapies do not preclude the simultaneous use of medication or social interventions, and which may have an additive effect, for treatment for some presentations.¹⁴
- 3.32 The core role of the primary care mental health worker should be to participate in brokerage assessment. It is recommended that a tiered approach to assessment and treatment is considered (see Chapter 6.4).
- 3.33 The evidence for counselling is variable in quality and outcome. The best evidence for efficacy is for structured specific interventions rather than generic counselling¹⁵. Counselling is not recommended as the main intervention for severe and complex mental health problems or personality disorders. Much support and counselling can be provided by voluntary agencies providing that guaranteed standards are assured.

Good Practice Examples

Lenadoon Counselling Service, West Belfast. *This service is under the guidance of a management panel of local community representatives, a Clinical Psychologist, a Consultant Psychiatrist and a General Medical Practitioner. A number of trained counsellors provide focused counselling interventions to a population that has*

experienced a substantial burden of civil disturbance and socio-economic deprivation. This service is highly valued by the local community, by local statutory providers and by General Medical Practitioners. (Contact:028 90585544).

The Primary Care Counselling Service, Armagh. *This counselling service, established in 2000, provides for people with: mild to moderate depression with a first time diagnosis, delayed or unresolved post-natal depression, acute bereavement, Post Traumatic Stress Disorder, anxiety disorders, panic disorders, health anxiety, low self-esteem, stress, interpersonal difficulties. The Service has been a very effective and successful initiative, not only in clinical efficacy, but in reduced referral figures to the Community Mental Health Teams and in admission rates. It has also prevented a number of mental health problems developing into more serious disorders. The successful outcomes led to a request to expand the service to the Dungannon area, and in conjunction with the local Health and Social Care Group the service is being extended to this area. (Contact: 028 37522037).*

- 3.34 Much can be achieved by people availing of self help. This may be through access to written or electronic media, guided self help or by participating in self help groups.

SKILLS AND COMPETENCIES

- 3.35 All professional staff in the mental health field have a role in providing psychological interventions. This may include psychosocial interventions which are an integral component of routine mental health care and/or specific psychological interventions. The qualifications, training and skills of each practitioner will differ. More complex problems require greater skills.¹⁴ It is essential that anyone delivering psychological treatments has received the minimum level of training that would enable them to carry out therapies safely and effectively. It is also essential that adequate clinical supervision is provided for the work to ensure that it is done safely and effectively. Continuing development of a therapist's skills and supervision is also important if therapy is to be delivered to an acceptable standard.¹⁵

3.36 Key considerations with regard to psychological therapies are:

- education, training and workforce development for all primary care staff to develop cultures of excellence;
- the use of partnerships between statutory and voluntary sectors, particularly to allow creative use of community resources for those with less severe mental health problems;
- the provision of health promotion and illness prevention programmes targeted at those in at risk groups;
- the need for the service to develop with regard to evidence-based guidelines to practice in order to allow joint decisions between practitioner and service user about care packages; and
- a focus of adequate resources in primary care.

Recommendations

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| 15. | People receiving care at primary care level must have access to a high standard of psychosocial care and to specific psychological therapies delivered by people working in managed clinical teams. |
| 16. | All practitioners offering psychological therapies must have assured levels of qualification, experience, supervision and monitoring. |

USE OF MEDICATION

3.37 There is clear evidence for the use of antidepressants in moderate or severe depression, for the use of antipsychotic drugs in psychosis, for prescribing mood stabilising agents in bi-polar affective disorder and for the short-term use of anxiolytic agents.

3.38 Perceived problems in the Province include long term use of benzodiazepines, polypharmacy, failure to offer appropriate treatment to those who need such treatment and use of treatment in those unlikely to benefit from treatment.

3.39 There are opportunities to develop closer working arrangements between prescribers and pharmacists. All people with mental illness, living in the community, who require medication will obtain this through a community pharmacy. The role of the community pharmacist is developing. The DHSSPS strategy¹⁶ for pharmacy in the

community envisages pharmacies as an open door to the health service providing up-to-date quality focused care. Opportunities exist to extend the existing Medication Management Service to psychiatric medications prescribed within the community.

- 3.40 Guidelines are available outlining the evidence-base for the use of drugs in the major mental health categories. It is known that guidelines seldom work unless practitioners have been involved in the production and ownership of such guidelines. The Review commends evidence-based guidelines such as those prepared by the British Association of Psychopharmacology¹⁶ and the National Institute of Clinical Excellence.¹⁷
- 3.41 Involvement of users and carers in the development of locally agreed practice guidelines is important. Pharmacists can provide a valuable role in developing treatment protocols. They can also facilitate educational initiatives with primary care staff as well as offering opportunities to patients to have their medication regimens monitored and tailored according to safety, tolerability and efficacy considerations.
- 3.42 Factors of particular note include:
- antidepressants are a first line treatment for major depression irrespective of environmental factors. Antidepressants are not indicated for initial presentation of acute mild depression. Education, support and problem-solving are indicated. People with minor depression are at risk of developing major depression.
 - it is essential that tolerability, safety and efficacy of the prescribed drugs are reviewed regularly.
 - particular care should be given in preparing patients for discontinuation of medication.
 - the choice of drug treatment should be made jointly by the individual and the clinician responsible for treatment based on an informed discussion of the relative benefits of drugs and their side-effect profile.
 - whatever treatments are offered it is essential to engage the service user in a collaborative, trusting and caring relationship at the earliest opportunity.¹⁸

Recommendation

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| <p>17. Those responsible for prescribing physical treatments in mental illness must be encouraged, within a multidisciplinary framework, to develop protocols for the prescribing, monitoring and review of treatment regimens according to evidence-based guidelines.</p> |
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RESEARCH, EDUCATION, DEVELOPMENT AND CLINICAL AND SOCIAL CARE GOVERNANCE

- 3.43 There is currently no clear structure in Northern Ireland for the recognition and dissemination of good practice in mental health care.
- 3.44 There is a clear need to stimulate innovation by directing funding towards research into service delivery and treatment choice in primary care settings.
- 3.45 The challenge of delivering continuous targeted education is great.¹⁹ There is a constant need for professionals to maintain high levels of knowledge and skills, while fostering developing and sharing examples of best practice.
- 3.46 The implementation mechanism following this Review must ensure that provider agencies are facilitated in delivering high quality, evidence based, accountable service models.
- 3.47 There is much that services in Northern Ireland can learn from other local services and by practitioners sharing information within their own services. There are also clear opportunities for fostering teaching and research links both locally and nationally.

Recommendations

18. The Department of Health, Social Services and Public Safety must ensure that there are mechanisms to identify examples of good practice and to encourage widespread implementation of these.
19. Local statutory mental health providers must be funded for, and take responsibility for, the continued professional development of primary and secondary care staff by ensuring targeted and audited learning. The Review commends the use of multi-disciplinary models of learning.

