

Shared care for people with mental illness: a GP's perspective[†]

Helen Lester

Abstract Shared care in mental health is now a policy imperative in England and Wales, yet its meaning, form and function are still open to debate. In this article, I discuss the benefits of and barriers to a shared care approach, explain how policy is currently driving practice in this area, discuss recent shared care initiatives and highlight some of the tensions inherent in the approach, particularly from the viewpoint of patients. I also give some of the key factors that need to be in place within a 'whole systems' approach to ensure that shared care moves from the rhetoric of the statute book to everyday practice.

The meaning of shared care has changed over time in response to government policy imperatives and the geographical location of care. It also probably means different things depending on which side of the primary/secondary care interface you work, and indeed on whether you are a service provider or user. Hickman *et al* (1994) describe generic shared care as the joint participation of general practitioners (GPs) and hospital consultants in the planned delivery of care for patients with a chronic condition, informed by enhanced information exchange over and above routine discharge and referral letters. In this article, I use the term to describe a team approach to care, with both primary and secondary care practitioners contributing to elements of a patient's overall care package, communicating effectively and working together to make that patient's pathway through the system as smooth as possible.

In the early 1990s, it was estimated that, at any one time, between 20 and 30 people per 1000 of the UK population were being referred to out-patients or to a community mental health team (CMHT) for further care and were therefore in receipt of shared care (Goldberg & Huxley, 1992). There is little to suggest that the numbers are much different today.

What are the benefits of a shared care approach?

Shared care enables a 'best of both worlds' scenario, with the opportunity to provide good-quality holistic

care. Shared care should lead to pooling of expertise and enhanced creativity in problem-solving. It should also lessen the possibility that vulnerable patients are 'left in limbo', 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).

The particular strengths of primary and secondary care are outlined in Box 1. Shared care can enable the most appropriate parts of the health and social care system to be used as the patient journeys through that system, with strengths utilised and weaknesses offset.

Box 1 The particular strengths of primary and secondary care

Primary care offers:

- a low-stigma and accessible setting
- a robust information technology (IT) infrastructure: over 95% of practices are computerised and a significant minority are completely 'paperless'
- a holistic approach to problems
- informational, longitudinal and interpersonal continuity of care
- the opportunity to see individual patients in the context of their past, their social networks and the wider community

Secondary care offers:

- multidisciplinary working in triage and in access to mental health expertise
- strong links with social care

[†]For an invited commentary on this article see pp. 139–141, this issue.

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Shared care also offers opportunities for addressing long-standing issues regarding the morbidity and mortality of people with serious mental illness. Brugha *et al* (1989), for example, reported that, of 145 people with serious mental illness at a psychiatric day care facility, 41% were found to have medical problems requiring care and 44% had unmet needs. The UK's Office for National Statistics' survey on psychiatric morbidity among adults living in private households (Singleton *et al*, 2001) found that 62% of people with psychosis reported a physical condition, compared with 42% of those without psychosis. Adults with serious mental illness are significantly more likely than the rest of the adult population to die from infectious diseases and endocrine, circulatory, respiratory, digestive and genito-urinary system disorders. The standardised mortality rate for all causes of death for people with schizophrenia is 156 for men and 141 for women (Harris & Barraclough, 1998). People with schizophrenia are more likely than the general population to smoke and have a poor diet,* but there is evidence that such cardiovascular risk factors are less likely to be recorded in primary care records or to be acted on for these patients than for the general population (Kendrick, 1996). Burns & Cohen (1998) also found that, although the annual general practice consultation rate was significantly higher than normal for people with serious mental illness (13–14 consultations a year compared with about 3 a year for the general population), the amount of data recorded for a variety of health promotion areas was significantly less than normal. Clear roles and responsibilities around mental and physical healthcare within a shared care approach, allied to recent policy imperatives in this area (see below), might lead to better quality physical care and eventually to a reduction in morbidity and mortality rates.

Barriers to shared care

There are barriers to shared care on either side of the primary/secondary care interface. From a primary care perspective, even though mental health issues are the second most common reason for consultations (McCormick *et al*, 1995), many GPs are reluctant to pursue forms of shared care. There is confusion over roles and responsibilities: the majority of GPs see their role in the care of people with serious mental illness as limited to physical illness and prescribing; only a minority believe that they should be involved in the monitoring and treatment of mental illness, and even fewer that they

*For a discussion of the lifestyle and physical health of people with schizophrenia see pp. 125–132, this issue. Ed.

should be involved in care programme approach (CPA) review meetings (Bindman *et al*, 1997). There is also some evidence of negative stereotyping of patients with serious mental illness, causing GPs to perceive them as 'difficult' and as creating extra work; inner-city GPs are particularly negative towards such patients (Brown *et al*, 1999).

This relative lack of enthusiasm and involvement may also reflect a paucity of formal training in mental health. A recent survey found that only one-third of GPs had received any mental health training in the previous 5 years, while 10% expressed concerns about their training or skills needs in mental health (Mental After Care Association, 1999). A national survey of practice nurse involvement in mental health interventions found that, although 51% were administering depot injections at least once a month, 33% were involved in ensuring compliance with anti-psychotic medication and 30% with monitoring side-effects of medication, few of these nurses had specific training in mental health issues and up to 70% reported receiving no mental health training in the previous 5 years (Gray *et al*, 1999).

From a secondary care perspective, there is again a lack of certainty over roles and responsibilities, but other barriers are less those of training and stigma; rather, there is a lack of understanding of the culture of primary care, a tendency to stereotype other workers and to hold defensive attitudes (Nolan *et al*, 1998).

Poor communication on both sides of the interface is also an important barrier. The difficulties created by over-reliance on communicating by telephone or letter have been long recognised. There appear to be particular issues created by poor communication between psychiatrists and GPs about non-attendance by follow-up patients, who are often more unwell and harder to engage than new patients (Killaspy *et al*, 1999). These issues were highlighted in a report by the Clinical Standards Advisory Group (1999) on the treatment of people with depression in primary care. The Group found that joint working and interagency communication were generally poor, with little evidence of any shared care arrangements within the primary healthcare team. The majority of GPs reported that they did not know the mental health consultant well enough to telephone them for advice, and very few CMHTs had a clear strategy for communication with primary care. Preston *et al* (1999) found that many patients felt that they had been 'left in limbo', often because of poor communication and coordination across the interface. As one of the people interviewed in Preston's study commented:

'Separate clinics don't talk to each other or ring each other. I find the whole thing incredible, the length of time it takes: it's just been horrendous, waiting weeks

to see a consultant to be told "I don't know why you've been referred to me" ... It can make you feel very insignificant' (1999: p. 19).

Previous shared care initiatives

There are currently at least five models of working between primary and secondary care (Box 2), each of which attempts to improve communication across the interface and demonstrates greater or lesser degrees of shared care (Lester *et al*, 2004a).

Each of these models has strengths and weaknesses, but some include additional elements that encourage a more holistic shared care approach, for example by establishing serious mental illness registers and initiating regular structured reviews.

It is quite feasible rapidly and comprehensively to identify people with serious mental illness in a primary care setting (Kendrick *et al*, 1994): up to 90% of such patients can be identified from drug and diagnostic criteria searches and health professionals' knowledge. Current evidence, however, suggests that, although regular structured assessments can improve the overall process of care (for example, by enabling more timely re-evaluation of psychotropic drug treatment and increasing referrals to community psychiatric nurses and psychiatrists), few GPs could conduct them during routine surgeries, because of time constraints (Kendrick *et al*, 1995). Separate clinic sessions with payment to practices

Box 2 Five models of mental healthcare at the primary/secondary interface

CMHTs

These teams provide crisis intervention and increased liaison with primary care

Shifted out-patient clinics

Psychiatrists hold out-patient clinics in primary care health centres

Attached mental health workers

Trained mental health staff, usually community psychiatric nurses, work with people with mental health problems in a primary care setting

Consultation-liaison

The consultation-liaison model gives primary care teams access to the advice and skills of specialist mental health services

Integrated working

Models based on integrated working create seamless patient pathways through the health system, going one step beyond collaboration, to coordination, and often co-location, of care

for providing structured care assessments appear more feasible (Burns & Cohen, 1998), but the most successful method to date has been through the introduction of a nurse-led specialist clinic (Burns *et al*, 1998).

Current policy imperatives

The National Service Framework for Mental Health

Shared care has been increasingly politically mandated since the election of the Labour government in 1997, reflecting, in part, the partnership approach within its wider modernisation agenda. It has also been facilitated by the increasingly central role played by primary care in the development and delivery of mental health services. Primary care, for example, now has specific responsibility for delivering standards two and three of the National Service Framework (NSF) for Mental Health (Department of Health, 1999) and is also integrally involved in the delivery of the other five standards. The NHS Plan (Department of Health, 2000) further underpinned the NSF with over £300 million of investment to help implementation. It also included specific pledges to create 1000 new graduate mental health workers to work in primary care and encourage a shared care approach. There are also negotiations at a national level to formally extend the role of GPs with a special clinical interest, so that those specialising in mental health could play a key role in managing people with depression and other serious mental illnesses within appropriate arrangements for sharing of care with secondary services.

The new general medical services contract

The introduction of a new general medical services contract, effective from April 2004 (British Medical Association & NHS Confederation, 2003) created a further policy impetus for shared care. The new contract, which directly affects the 36 000 GPs in the UK and their patients, is a practice-based agreement between the primary care organisation and the practice, as opposed to a contract with each GP. There are many more centrally driven targets, which (theoretically) will encourage a better quality core service, and points (meaning money) are awarded for the delivery of specific services. The contract, along with the effect of greater control held by primary care trusts over contracted services, may therefore ensure greater consistency in standards and services across the UK.

In terms of mental health, the new general medical services contract is explicit that primary care is responsible for the provision of physical healthcare

Box 3 Summary of the mental health quality indicators in the new general medical services contract (British Medical Association, 2004)

A GP practice should be able to:

- 1 produce a register of people with severe long-term mental health problems who require and have agreed to regular follow-up
- 2 show that 90% of patients with severe long-term mental health problems have had a review recorded within the previous 15 months; it should include review of the accuracy of prescribed medication, physical health and coordination arrangements with secondary care
- 3 show that the records of 90% of patients on lithium therapy show that lithium levels have been checked within the previous 6 months
- 4 show that the records of 90% of patients on lithium therapy show that serum creatinine and thyroid-stimulating hormone have been checked within the previous 15 months
- 5 show that the records of 70% of patients on lithium therapy show that lithium levels have been within the therapeutic range within the previous 6 months

1. The minimum threshold for each indicator is 25%; maximum points are awarded if the practice achieves the percentages shown here.

for people with serious mental illness and it emphasises the need for effective communication with CMHTs. The contract awards up to 41 points (about 8% of the total points available) if a practice can provide evidence of good-quality care on five mental health indicators (Box 3). This builds on the work of the Primary Care Schizophrenia Consensus Group, which published similar management guidelines (Burns & Kendrick, 1997).

The contract also awards points to practices that regularly review critical incidents, including suicides and compulsory admissions under the Mental Health Act 1983, and show evidence of caring for carers.

A range of secondary care policy initiatives is also encouraging shared care. The recent implementation guidance on CMHTs, for example, defines their role as providing psychological advice and treatment, coordinating care for people with serious mental illness and communicating effectively with primary care (Department of Health, 2002). Guidance on implementing the National Institute for Clinical Excellence's clinical guideline on schizophrenia in clinical practice includes a series

of recommendations such as the compilation of primary care practice registers for people with schizophrenia, the recording of advance directives placed in both primary and secondary care, and the development of guidelines for referrals from primary to secondary care (National Collaborating Centre for Mental Health, 2003).

New initiatives

A number of initiatives, some in development long before the introduction of the new general medical services contract, and other recent policy imperatives offer opportunities for implementing meaningful shared care. Three of these – the further development of care protocols, patient-held records and 'link-working' agreements – are discussed below.

Care protocols

The NSF for Mental Health encourages primary and secondary care organisations to work together and agree protocols for the assessment and management of common mental health problems such as depression, postnatal depression, eating disorders, schizophrenia, anxiety, and drug and alcohol dependence. Protocols have been usefully defined as

'negotiated agreements amongst providers and agencies about how care for certain conditions, series of conditions or populations might be delivered. They are guidelines adapted to fit local circumstances' (Tomson, 2001: p. 507).

Although there have been some notable examples of successful development (Bruce, 2003), the fact that the initial target of introducing the first five basic protocols by April 2001 was met by only a minority of organisations reflects the difficulty of implementation. The research evidence suggests that protocols are more likely to be effective if they are locally developed and owned, but are therefore less likely to be evidence based because of local limitations. This has implications for their ability to help standardise and benchmark quality of care. If protocols are to be fit for purpose, both primary and secondary care need to be involved in their development. This will ensure realistic expectations of what each can provide and that training needs for successful implementation are identified.

Bindman *et al* (1997) suggest that the sending of information from CPA reviews to the GP, albeit post hoc, offers opportunities for increasing shared care and could form the basis of an explicit shared care protocol that includes not only primary and secondary care, but also the patient and carer.

Patient-held records

Patient-held records, where individuals with a medical condition hold all or some information relating to the course and care of their illness, are common in the management of chronic physical illnesses such as diabetes.

Two randomised trials of patient-held records for people with long-term mental illness (Warner *et al*, 2000; Lester *et al*, 2003a) suggest that they are valued by patients and improve communication across the interface between primary care and specialist services (a valuable outcome in its own right), but do not affect longer-term outcomes such as symptoms and satisfaction with care. This may be because of professionals' reluctance to use them, with GPs and psychiatrists fearful of increased workloads and that patients might question the content of their own records. Patients may also perceive a patient-held record as potentially stigmatising or a threat to confidentiality (Lester *et al*, 2003a).

There is evidence that patient-held joint crisis plans governing the use of compulsory treatment (Henderson *et al*, 2004) can reduce compulsory admission and treatment of patients with serious mental illness, and these could, in the future, become a valuable part of a shared care approach.

Link-working

Mental health services in south-east London have set up a programme to encourage general practices and associated CMHTs to work together to develop a configuration of shared care for people with long-term mental illness. Initiatives include the placement of 'aligned caseload' link workers; guidance on setting up registers, databases and systems of recall; the development of shared care agreements; 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 experiences of integrated care in the USA (Byng *et al*, 2004).

Patients' views of shared care

The 'patient choice' agenda, fuelled by the wider availability of information, more treatment options, a slowly growing private sector and consumerism, has become an increasingly strong political imperative. Recently, it has generated not only heated debate, but also a new 'Patient Tsar' (employed by the Department of Health to advise the government how patient experience can be improved) and a

Command Paper *Building on the Best* (Department of Health, 2003), which sets out a series of measures to extend patient choice across primary, secondary and community care. The whole notion of choice, however, is at best a relative concept for people who are subject to compulsory detention, have no obvious exit from the system or experience social exclusion, which itself limits choice. Nevertheless, shared care has the potential to give patients a greater voice and choice in their healthcare.

To date, relatively little has been published about patients' views on shared care. Bindman *et al* (1997) found generally high scores for patients' satisfaction with primary care services, but mixed views on greater GP involvement in their care. This may, however, represent limited experience of, rather than resistance to, shared care. Another study (Lester *et al*, 2003b) found that patients valued the longitudinal and interpersonal continuity of care, relative ease of access and the option of a home visit offered by primary care, often contrasting these with the difficulty of seeing a constant stream of new faces in secondary care and of having to tell and retell painful life stories for the benefit of the staff rather than of themselves. Most thought shared care to be an ideal state, offering secondary care expertise and primary care continuity.

Underpinning strategies for shared care

As I have emphasised throughout this article, good communication is key to successful shared care. However, this in turn is influenced by a number of other factors, including the commitment to shared care on both sides of the interface and a mutual understanding and respect for different ways of working and approaches to care. These features can be encouraged by interprofessional education, which enables practitioners to learn about each setting's strengths and weaknesses and can encourage a culture of collaboration and mutual respect (Department of Health, 2001). New services are often championed by 'hero innovators', who are likely to move on and seek fresh challenges once a new scheme is up and running. To be truly sustainable, new approaches to shared care cannot depend on single individuals: they need to be embedded in the fabric of the service.

Conclusions

Shared care is now a political priority. It offers a way of working in partnership that can provide better quality, holistic patient care. It may also be

more cost-effective and enable tacit and active learning opportunities for health and social care staff. To be successful, it requires good systems of communication and coordination, so that patients are not left in limbo at the interface; a shared vision; clarity of roles and responsibilities; and a system of accountability.

The form and function of shared care, however, must be negotiated with patients. The development of serious mental illness registers as part of shared care, for example, even with the caveats contained within the new general medical services contract, raises potential problems of stigmatisation, indefinite registration and the risk that an intentionally benign development could become a form of subtle control rather than care (Lester *et al*, 2004b). Arrangements must therefore be informed by service users' wants and needs if they are to have a meaningful impact on their lives.

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MCQs

1 The proven benefits of a shared care approach include:

- a the opportunity to use the strengths of different healthcare settings
- b fewer in-patient admissions
- c a pooling of expertise
- d reduced consultation rates in primary care
- e a smoother patient pathway.

2 The physical health of people with schizophrenia is poorer than that of the general population because:

- a people with schizophrenia are more likely to smoke
- b people with schizophrenia rarely see a GP
- c antipsychotic medication can have significant long-term side-effects
- d GPs are less likely to engage in health promotion or prevention with people with schizophrenia than with the general population
- e most GPs are unaware of their responsibilities in this area of healthcare.

3 Barriers to shared care include:

- a good communication across the primary/secondary care interface
- b adequate training in mental health in primary care
- c confusion over roles and responsibilities
- d negative attitudes towards people with serious mental illness
- e lack of understanding of primary/secondary care cultures.

4 The mental health indicators in the new general medical services contract state that:

- a the GP practice should have a register of people with serious mental illness regardless of their wish to be included on it
- b the practice must review people on the register annually
- c the review should include arrangements for coordination with secondary care
- d for the majority of patients on lithium, the practice should have a record that serum creatinine and thyroid-stimulating hormone have been checked within the previous 15 months
- e the practice nurse is responsible for administering all depot medication.

5 Successful implementation of protocols requires:

- a top-down implementation
- b restricted local input into development
- c appropriate training in how to use protocols
- d a commitment to development and implementation across the interface
- e patient involvement in their development.

MCQ answers

1	2	3	4	5
a T	a T	a F	a F	a F
b F	b F	b F	b F	b F
c T	c T	c T	c T	c T
d F	d T	d T	d T	d T
e T	e T	e T	e F	e T

Shared care, individual expertise

INVITED COMMENTARY ON... SHARED CARE FOR PEOPLE WITH MENTAL ILLNESS

Tom Burns

'Shared care in mental health is now a policy imperative in England and Wales, yet its meaning ... [is] ... still open to debate'. Dr Lester's opening line says it all (Lester, 2005, this issue). We're all in favour of it, but none of us is exactly sure what it is. Ambiguity is considered a failing in academic publications and, under pressure from editors, we

usually excise the unnecessary and unclear. Politicians, however, often deliberately insert ambiguity, as it allows scope for interpretation. By a simple shift in emphasis, either shared care's achievement can be claimed as a manifesto success or slow progress towards it can be cited to justify further targets.