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Working together

Invited commentary on… The primary care management of anxiety and depression†

Linda Gask & Helen Lester

Abstract From the standpoint of primary care, mental health services in the UK now appear very fragmented. We have to address the problems of working across interfaces as they continue to multiply. There is now a considerable evidence base relating to what works at the interface between psychiatry and primary care. Psychiatrists should consider the challenge of adopting new ways of working in the management of anxiety and depression in partnership with primary care.

Of the total disability attributed to mental disorders, more than half is generated by anxiety and depression and less than 10% by schizophrenia (Whiteford, 2000). And yet, as Alan Cohen (2008, this issue) indicates, mental health services have gradually disengaged themselves from having the treatment of anxiety and depression as central to their remit. This process began well before the National Service Framework for Mental Health (Department of Health, 1999), with exhortations throughout the previous decade for specialist mental health services to focus on individuals with a diagnosis of severe mental illness (Patmore & Weaver, 1992; Department of Health, 1995, 1996). The impact of this policy can be clearly tracked over time in the changing caseload of mental health nurses (White & Brooker, 2001). Its effect on the work of psychiatrists is less easy to quantify, but is familiar to those involved in teaching juniors, who may progress through their training without gaining the expertise in the management of 'common' mental disorders that a general practitioner (GP) is now routinely expected to possess. At least we have stopped calling these problems 'minor', a term that belittles the complex mix of physical, social and psychological problems which are presented on a daily basis in primary care. Dr Cohen should not be afraid of teaching at least some grandmothers to suck eggs.

†See pp. 98–105, this issue. For a related editorial see pp. 84–85, this issue.

What options are suggested for addressing this change of focus? Several have been discussed. It is probably worth noting that, although the implementation of graduate workers has indeed been patchy, they are valued by patients, increase satisfaction with care and are cost neutral (England & Lester, 2007; Lester *et al*, 2007). Dr Cohen rightly heralds the inclusion of two depression indicators in the GP contract Quality and Outcomes Framework (QOF), but achievement scores for 2006/7 of 80% were the lowest of the 17 clinical areas in QOF, suggesting that a series of complex factors, including education, motivation and perhaps stigma, may be influencing GP behaviour. A recent survey of Norwegian GPs (Album & Westin, 2007) found that depression was ranked 33/38 in a 'disease prestige' list, just above schizophrenia and below AIDS, perhaps shedding a ray of light on the QOF findings?

Current policy makers seem keen to see a diversity of private, voluntary and public sector providers contributing to 'care closer to home' (Department of Health, 2006) and tendering to provide different parts of the stepped care model. This poses significant challenges regarding how all these different providers, which will also include statutory mental health services and traditional primary care, will be able to successfully work in partnership with each other and effectively coordinate and integrate their operations. Mental health services have led the way in the development of community-based teams, but what is needed now are teams that operate at the point between what can be managed with confidence

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by the GP and what requires referral and longer-term management by mental health services. These services roughly incorporate steps 2 and 3 in the stepped care model for depression (Cohen, 2008: Fig. 1). What is unclear is what medical input will be required by these services. There is certainly a role here for the GP with a special interest in mental health (the GPSI), but there continues to be uncertainty about the necessary training and accreditation of such professionals and how they will be supported.

Models of care

Bower & Gilbody (2005) describe four models that represent different ways of improving the quality of primary care mental health services (Box 1). Policy in the UK has focused on only two of the four. Top-down policy drivers have concentrated until recently on the training model, reflected in the Royal College of Psychiatrists' Defeat Depression Campaign (www.rcpsych.ac.uk/campaigns/defeatdepression.aspx), although the current national policy emphasis on Improving Access to Psychological Therapies (IAPT; www.mhchoice.csip.org.uk/psychological-therapies/psychological-therapies.html) is concerned with replacement/referral. Bottom-up quality improvement, driven by practitioners, has generally focused on increasing use of the replacement/referral model (for example, the rise of counselling and other psychological therapy services). Assuming equivalent effectiveness, models that put greater focus on increasing the abilities of primary care clinicians have the greatest potential impact on access and equity. This is because these models can most readily target the largest numbers of patients. In contrast, models that require considerable specialist involvement at the level of the individual patient (such as replacement/referral) can affect only the smaller proportion of patients who access specialist care.

Box 1 Models of mental healthcare in primary care

Training primary care staff
- GPs and other members of the primary care team, trained in:
  - recognition
  - pharmacological and psychological management

Consultation–liaison
- Focus on improving the skills of GPs
- Regular specialist contact to support and give feedback
- Referral only after discussion
- Management by primary care

Collaborative care
- Training
- Consultation
- Case management, involving:
  - direct patient contact
  - education, monitoring and psychological treatment

Replacement/referral
- The GP has overall clinical responsibility
- Referral passes the responsibility for mental healthcare to specialist in primary care
- Specialist treatment such as psychological therapy

(From Bower & Gilbody, 2005)

The evidence base

So what does research tell us? Well, educational interventions have been remarkably unsuccessful in improving outcomes for people with common mental health problems in primary care (Thompson *et al*, 2000; Gask *et al*, 2004). They are probably a necessary but not sufficient part of the equation.

Consultation–liaison is probably important as a model for improving working relationships across the interface between primary and specialist care but does not in itself improve outcome (Bower & Gask, 2002). Replacement/referral models vary in their impact depending on the model of therapy provided (Bower & Gilbody, 2005), but will always be relatively 'high-intensity, low-volume' interventions and therefore limited in what they can provide to improve access to mental healthcare. There is increasing evidence for collaborative care interventions (Gilbody *et al*, 2006; Richards *et al*, 2007) that incorporate the features of case management, brief psychological therapy and medication management, close liaison with primary care, active follow-up (not the patient's 'opting in' to care) and specialist medical and psychological supervision. Such models can provide the 'low-intensity, high-volume' service that is needed in primary care and there is a clear and important role for specialist medical input into this model. This could be provided by psychiatrists working alongside and in partnership with GPSIs.

Negotiating the interface

What is very apparent is that we have to address the problems of working across interfaces as they continue to multiply. From the standpoint of primary care, mental health services now appear very fragmented. Most do not have any form of dedicated

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service for severe affective disorders and there is real concern that GPs will be asked to take on the care of patients with ever more complex problems for whom they neither have the expertise nor the support. This is not in the best interests of service users, who are often forgotten in the process. Most GPs do not want to become psychiatrists. Someone has to negotiate the interface, provide advice, leadership and truly consult – an approach that is being promoted in New Ways of Working for Psychiatrists (Care Services Improvement Partnership *et al*, 2005). There is still a role for psychiatrists to work in the management of anxiety and depression in partnership with primary care.

Declaration of interest

L.G. has spoken on the topic of this commentary at meetings funded by pharmaceutical companies.

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