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CONFERENCE ABSTRACT

Integrating services and education in primary care

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When developing integrated services in primary care mental health and wellbeing you also need to skill the workforce to deliver it. This workshop uses a practical case for the audience to work through to illustrate a whole systems model and pathway and the appropriate development and training plus the research from literature reviews that backs this up.

Integrated care services need to be intrinsically linked to local needs assessment, national/international policy and drivers. We will compare and contrast a researched and successful integrated primary care mental health and physical wellbeing model against other integrated care models identified through the literature, examining the outputs and outcomes of a horizontal and vertical integrated model of primary care mental health and wellbeing and conclude with key findings and recommendations for future organisational and workforce development.

Our work researched and developed a whole system pathway going across the whole life cycle and across all conditions, bringing in Primary Care and the Community. Poor outcomes from treatment of mental illness are frequently attributed to the failure of GPs to follow guidelines, but according to a literature search, GPs do recognise and support their patients when they are in mental distress, but they work in a chaotic environment that has not been defined and where guidelines are difficult, if not impossible, to follow. Borders between mental distress due to adverse life events and true mental illness are hard to distinguish.

For an integrated model and developed workforce to be successful it has to align itself with the reality in primary care and is. It is therefore much more likely to succeed if developed according to educational theory, through small group work, sharing, discussing successes and failures and learning from patients lived experiences, to improve and refine skills and attitudes. We will use a real case to demonstrate this with the audience. Leadership and peer education involving acute and secondary care plus patients participating as technical experts will improve relationships and help integration.

Mental health in primary care is poorly understood and scarcely researched. Its practice is substantially different from the practice of the specialism of psychiatry, being targeted mainly at the 93% of patients with mental illness who remain in primary care and are not looked after by specialists in secondary care nor are case managed within primary care. Despite this, training for the workforce in all aspects of mental health is performed mainly by psychiatrists, because they are seen as the experts, but they are experts in a systems based

approach that uses a classification system (DSM or ICD) which fails to recognise that primary care mental health is a very inexact science, and possibly more of an art, relying on the strength of the relationship between doctor, nurse and patient, an understanding of their social background and the ability to listen, support and empathise. Traditional style didactic education and pathways, using a guidelines approach, therefore fails to support patients and health professionals in primary care. The lack of a common language between primary, acute, social and secondary care does not help and leads to a strained interface with poor communication

The developed integrated model and case based training challenged this and was replicated across a number of UK sites with investment made in the development of low intensity interventions consisting of psycho educational courses, wellbeing and self care approaches alongside talking therapies, navigation and social support. These interventions were offered both at a whole population (horizontal) and targeted level (vertical). A stepped approach to primary care mental health is offered, which uses different levels of care to ensure the consistent flow of service users between the steps, resulting in no waiting lists. Steps are graduated from low to high intensity and are non-exclusive and recovery is built into each step. People can be referred back to primary care at any point and step back if needed. People are offered a range of evidence-based approved interventions, to give a choice of services, with different interventions offered at each level. Wellbeing and recovery is built in to all levels. Using a two prong approach of education and an integrated model showed both reliable outcomes and clinical change and that we were hitting the diverse needs of the target group outlined by the needs analysis. Added benefits were reductions in lengths of stay and a reduction in hospital admissions.

Keywords: integration; primary care; mental health; education; whole systems