

# Managing severe mental illness in primary care

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# Culture of connectedness is crucial

- Building and maintaining relationships that trickle down beyond corporate level – space and incentives for regular meetings between GPs and psychiatrists
- Doing away with fortress mentality
- Conversations can happen and relationships are built if each of the organisation (CCG, Mental Health Trust) have less complex organisational structures and services offer continuity of care.
- The above makes it more likely that ownership exists for the patients both at primary care and specialist mental health end.

# Scope,

- A proportion of people with SMI (approx. 20-25%%) currently under Spec. MH Services can be managed within primary care (Fear et al (2009) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777602/>)
- The commissioning considerations could define the clinical characteristics of this patient group who could be safely managed within primary care with monitoring considerations.
- People who have been stable (for over 24 months) and adherent to their treatment /care plan.
- In my experience, GPs have justifiable apprehension to manage patients disengagement and any risks that ensue
- The mechanism of CPA can be broadened to transfer Responsible Clinician responsibility to the GP, whilst existing links with the CMHT Care Coordinator are loosely maintained (6 monthly joint reviews with the GP), which need to be stepped up in the case of patient disengaging.

# Support for the primary care - 1

- Most of the GPs will be willing to manage stable people with SMI, if they are able to promptly access and engage with lead clinician (often a psychiatrist) in the MH Trust ( i.e. communication & relationships exist).
- In some GP practices, one of the GP can assume specialism (GPwSI) in mental health and lead on working closely with the catchment area psychiatrist and CMHT
- Creating opportunities and environment of shared learning (e.g. refresher on assessment, diagnosis and managing psychosis and red flag signs).

# Support for the primary care - 2

- Example of empowering Primary care and collaborative working
- In my patch in Walsall, we have started a successful pilot in one GP practice (July 2016)
- Integrated CPA reviews are hosted in GP Surgery for all patients with SMI (currently under MH) involving GP, Psychiatrist, CMHT Care Coordinator and Pharmacist.
- Each patient review takes 45 minutes (15 minutes with the pharmacist to undertake physical health review using Lester Tool) and subsequent 30 minutes for CPA, where mental health, physical health and psychosocial needs are discussed and addressed. Some of the stable patients can then be stepped down to the primary care.

# Physical health of SMI

- The commissioning guidance could be reviewed & expanded to include the role of care coordinator to be effective bridge between GP and secondary care MH in monitoring physical health examination and investigations at the 12 monthly CPA reviews as per NICE schizophrenia guidance. There are likely to be cost implications but additional cost is likely to offset the health gains made due to timely interventions.
- Case for shared IT systems (between GPs and MHT)
  - Prompt access to patient notes
  - Physical health issues and investigations
  - Risk assessments

**THANKS**