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REVIEW ARTICLE

Improving collaboration between primary care and mental health services

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ABSTRACT

Objective: Previous guidelines and planning documents have identified the key role primary care providers play in delivering mental health care, including the recommendation from the WHO that meeting the mental health needs of the population in many low and middle income countries will only be achieved through greater integration of mental health services within general medical settings. This position paper aims to build upon this work and present a global framework for enhancing mental health care delivered within primary care.

Methods: This paper synthesizes previous guidelines, empirical data from the literature and experiences of the authors in varied clinical settings to identify core principles and the key elements of successful collaboration, and organizes these into practical guidelines that can be adapted to any setting.

Results: The paper proposes a three-step approach. The first is mental health services that any primary care provider can deliver with or without the presence of a mental health professional. Second is practical ways that effective collaboration can enhance this care. The third looks at wider system changes required to support these new roles and how better collaboration can lead to new responses to respond to challenges facing all mental health systems.

Conclusions: This simple framework can be applied in any jurisdiction or country to enhance the detection, treatment, and prevention of mental health problems, reinforcing the role of the primary care provider in delivering care and showing how collaborative care can lead to better outcomes for people with mental health and addiction problems.

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Introduction

In most countries, primary care is the first point of contact for many individuals with mental health or substance use addiction problems. It is the place where the majority of mental health problems are treated and where physical and emotional care can be integrated within a less stigmatising environment (WHO, Wonca 2008; Kates et al. 2011). Primary care should be seen as an integral part of the mental health system of any high-, middle- or low-income country (WHO 2008).

The prevalence of mental health and addiction problems in primary care is high. While many of these are successfully treated by a primary care provider (PCP), a significant percentage of these problems are not identified and, for those requiring specialised care, accessing mental health services may be a challenge (WHO 2008; WHO, Wonca 2008).

Although many first-contact providers are adept at handling the mental health problems of their patients, others are neither well trained nor well-supported to recognise these problems and initiate treatment. Consequently, these problems may remain untreated until they cross a threshold that leads to more urgent psychiatric care. But the scarcity of mental health specialists of all kinds means that these resources need to be used as efficiently and effectively as possible, placing a greater emphasis on increasing the skills and comfort of first-line providers and providing them with additional support (WHO 2008; WHO, Wonca 2008).

Management at the front line also happens within a broader regional and national context. While the organisation of a country's healthcare system will differ

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according to the availability of resources, geography, funding and healthcare priorities, many jurisdictions have recognised the importance of collaboration between specialised mental health and primary care services to enable primary care to deliver effective mental health care (WHO 2008; WHO, Wonca 2008). Indeed, the World Health Organisation (WHO) has recommended that integrating mental health services within primary care may be the optimal way of responding to the increasing demand for mental health care, in low- and middle-income countries (LMICs), particularly for depression, anxiety and substance use problems, but also for more severe conditions (WHO 2008).

Why a position paper?

Over the last 20 years, position papers, discussion documents and research findings have identified the central role of primary care and general medical services in delivering mental health care, the need for better collaboration between mental health and PCPs, and strategies that have been developed at national, regional and clinical service level to make this happen (Patel 2002; Kilbourne et al. 2004; WHO 2008; WHO, Wonca 2008; WHO 2010; Dua et al. 2011; Kates et al. 2011; AIMS Center, University of Washington 2012; Eapen et al. 2012; Government of British Columbia, Ministry of Health 2012; Ling et al. 2012; Woltmann et al. 2012; HSE National Vision for Change Working Group 2013; Jeffries et al. 2013; Patel et al. 2013; Unützer et al. 2013; Whitebird et al. 2014; Crowley et al. 2015; Dickinson 2015; Institute for Clinical and Economic Review 2015; Raney 2015; WHO 2015; APA, APM 2016; Durbin et al. 2016; Network 4 2016). The concept of the Patient's Medical Home in North America is noteworthy (The College of Family Physicians of Canada 2011), as is the work of the WHO both in their document entitled 'Integrating mental health into primary care: A global perspective' (WHO, Wonca 2008), and in the development of the mental health Gap Action Program (mhGAP) (WHO 2008). This position paper builds on this work and translates the most current evidence into a framework that will be of value to clinicians working in any community in any country.

Our approach

It is challenging to produce a position paper that is relevant to the needs of high-, middle- and low-income countries. We have addressed this by identifying the common principles and key elements of successful collaboration, and options that can be considered and adapted to most if not all settings, rather than something that is prescriptive or attempts to transpose models from one context to another. This is made a little easier because of the many similarities in the system issues faced when delivering care in different jurisdictions, despite differences in culture, resource availability, geography, service organisation and mental health policy. Social determinants such as poverty, housing, employment and social support, affect the presentation and outcomes of mental health problems in every country, even though they may manifest themselves in very different ways depending upon cultural, environmental and economic factors.

An electronic medical record may have little relevance to LMICs, and using volunteers in Village Health Teams may not at first glance appear to be applicable in more developed countries. However, if we look more closely at the underlying principles we will recognise the importance of keeping organised and accessible notes for every health care system, while (trained) volunteers have a role to play in delivering services to complement those offered by health professionals in any health care system.

Although the recommendations in this paper are evidence informed, it is not a review paper but attempts to synthesise and build upon concepts and recommendations from previous research, programme descriptions and position papers or guidelines.

The paper has adopted a three-step approach. The first is to identify mental health services that can be delivered by PCPs (primary mental health care), with or without the presence of psychiatrists or other mental health professionals (MHPs). The second is to outline the ways in which effective collaboration can enhance and expand this care. While the integration of mental health services within primary care settings is the major focus of this paper, we also summarise options for collaboration when mental health and PCPs are working in different locations.

The third step is to look at supports and changes in service delivery and the wider system changes required to support these new roles and activities, and how better collaboration can create new opportunities to respond to challenges all mental health systems are facing.

Definitions

There is often variation in the terms used to describe collaborative activities. The same phrase may be used in different places to refer to very different activities, while different terms might apply to the same activity. We therefore begin the paper with definitions of the

terms we have used, choosing those which are already in common usage, and for which there are accepted definitions.

Primary care

The Alma Ata definition of primary care (International Conference on Primary Health Care 1978) recognises that effective treatment of any health problem involves addressing social determinants, as well as recognising and treating specific problems.

> [Primary Care] is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process. (International Conference on Primary Health Care 1978, p. 2)

Many high-income countries have well-organised networks of family physicians and other trained staff working in primary care settings. In many LMICs, however, the first point (or level) of contact may be a village health team, a general health worker, or a community health team who will be supported by general medical officers or physicians, sometimes, but not always, working in teams, and who often have no specific training in delivering mental health care. We also use the phrase 'first-line provider' to denote the first contact with the health care system.

Primary mental health care

We use the term 'primary mental health care' to refer to those mental health services that are delivered by PCPs, without requiring the presence of MHPs. These can all be enhanced by better collaboration with mental health services, especially by the presence of mental health providers within the primary care setting, and by using all resources as efficiently as possible.

Collaborative care

Collaborative care is used as an overarching term to describe the process whereby primary care and mental health providers share resources, expertise, knowledge and decision-making to ensure that primary care populations receive person-centred, effective and cost-effective care from the right provider in the most convenient location and in the most timely and well-coordinated manner.

Integrated care

Integrated care refers to the care a patient receives as a result of a team of primary care and mental health care providers working together with patients and families within the same setting, using a systematic and cost-effective approach to provide patient-centred care for a defined population. It involves the realignment of the distribution, delivery, management and organisation of services to develop a comprehensive continuum of services to improve access, quality, efficiency and user satisfaction.

Stepped care

In stepped care, the type and intensity of care is linked to the nature, severity and duration of a person's symptoms or distress. The first step may be low intensity, evidence-based treatments for less-severe problems or problems of moderate severity that have not previously been treated. People who do not respond adequately or whose needs exceed the capacity of the first intervention can 'step up' to a treatment of higher intensity. Treatment outcomes are monitored systematically and changes made if current treatments are not achieving significant improvement. 'Stepping up' can also involve a referral to a different provider or service.

Tiered care

This paper presents a tiered approach according to the current skills and capacity of the primary care setting. This paper identifies four tiers (the 'levels of care'), although not all the skills and resources will be present in every health care system, and the tasks taken on will vary according to need and resource availability (Table 1). These tiers are:

1. Locations where community workers or volunteers are trained to deliver basic mental health and community care, usually delivering low intensity interventions.
2. First point of contact settings, but where there is no physician present. The PCP may be a nurse or a clinical or health officer (someone trained to deliver health care but without a medical degree), but the amount of training in mental health will vary.
3. Locations where there is a general physician or medical officer (i.e. they possess a medical degree at a minimum) looking after general populations, often without regular access to a mental health

Table 1. Activities in primary mental health care*.

Activity (Competency)	Tier I community worker	Tier II health professional – no physician	Tier III health service includes a general physician	Tier IV primary care team includes a (Trained) family physician
Recognition, Assessment and Initiation of Care				
Screening and identification	✓	✓	✓	✓
Assessment		✓	✓	✓
Initiating treatment		✓	✓	✓
Managing emergency presentations		✓	✓	✓
Integrating physical and mental health care		✓	✓	✓
Specific psychological treatments (i.e. CBT, IPT, ACT and MBCBT)		(✓)	(✓)	✓
Use of medication		✓	✓	✓
Care Management and Relapse Prevention				
Care co-ordination and system navigation	✓	✓	✓	✓
Care management		✓	✓	✓
Case reviews	✓	✓	✓	✓
Goal-setting and promotion of social inclusion	✓	✓	✓	✓
Monitoring and relapse prevention	✓	✓	✓	✓
Family interventions	✓	✓	✓	✓
Referral	✓	✓	✓	✓
Education and Support for Self-Management				
Health education	✓	✓	✓	✓
Patient education and self-management support	✓	✓	✓	✓
Family support and education	✓	✓	✓	✓
Lifestyle changes	✓	✓	✓	✓
Protection of Human Rights				
Reducing stigma	✓	✓	✓	✓
Eliminating barriers to care	✓	✓	✓	✓
Community partnerships	✓	✓	✓	✓
Advocacy	✓	✓	✓	✓

*While working within local regulations regarding scope of practice.

worker or psychiatrist. Again, these staff may or may not have received any specialised mental health training, and may not see mental health care as part of their role.

4. Settings that include a physician with specific training in family medicine or general practice that includes at least some specialised mental health training, and who see mental health care as an integral part of their role.

Task sharing

This is an important element of care whereby specific parts of a treatment plan are delegated by specialists to less highly trained health care workers and, in some situations, even to family members, community workers or community agencies, who will continue to work in partnership with the specialist. This contrasts with 'Task-Shifting', where specific tasks are taken on by less highly trained health workers in the absence of a specialist (Patel et al. 2013).

The person receiving care

Different cultures and health care systems use different terms to define the person seeking help. While mental health services may refer to clients, consumers or people with lived experience, we have chosen to use the word patient, simply because this is the term most commonly used in primary care.

Care manager

There are a variety of possible activities for a MHP in primary care and terms, such as care manager, care co-ordinator, therapist, counsellor or even mental health clinician are often used interchangeably. In this document, if we are referring to a MHP taking on a specific role such as a psychotherapist we use that term. Where a MHP is taking on more than one role and coordinating or managing different aspects of the care of an individual—we use the term 'Care Manager'.

The three step approach

Step 1. The role of primary care in delivering mental health care

WHO's mhGAP identified particular evidence-based interventions that can be implemented within primary care with or without—although preferably with—the support of mental health specialists (WHO 2008; WHO, Wonca 2008). We have slightly broadened the range of these activities. We have also drawn upon the *mhGAP*

Intervention Guide version 2.0 (WHO 2016) and *the mhGAP Humanitarian Intervention* (WHO 2015) and refer the reader to these excellent documents for more detailed guidelines on managing specific conditions and situations.

This paper has grouped primary mental health care activities under the four headings proposed by mhGAP for Primary Mental Health Care (WHO 2008): (1) Assessment and Initiating Treatment, (2) Care Management and Relapse Prevention, (3) Health Education and Support for Self-management, and (4) Protection of Human Rights. The components for each of these are spelled out in more detail in Table 1, which provides more information on what services can be delivered by each Tier. While most can, to some extent, be provided at any tier, the scope or complexity of the intervention will vary according to the skills of the provider, and the range and sophistication will increase at each level.

Collaborative care aims to enhance and expand any or all of these activities, either through the presence of MHPs of various disciplines within the primary care setting, or by providing additional support and advice to primary care when located elsewhere.

Step 2. Improving outcomes through better collaboration

Goals of collaborative programmes

While the overall goal of all programmes is to improve outcomes for individuals (and their families) when dealing with a mental health or addiction problem, collaborative care programmes usually aim to achieve one or more of the following:

- Improve access to quality mental health care
- Increase the skills and comfort of PCPs, and the capacity and capability of primary care to deliver effective mental health care
- Enhance the experience for the patient with a mental health problem who is seeking and receiving care and for their family
- Enhance the experience for people who are providing mental health care
- Use resources as efficiently and effectively as possible.

Principles not models

The key to successful implementation in any setting is not so much the transplanting of models that have worked in another community, but following principles to guide emerging collaborative partnerships and adapting these to the local context or setting. These principles should shape the ways in which providers and services work together to implement evidence-informed ideas that have worked elsewhere.

Guiding principles for collaborative care

In their 2008 document the WHO articulated 10 principles to shape collaborative partnerships (WHO, Wonca 2008). We have expanded this list and grouped them into those that apply (1) across the entire system; (2) at the regional or national level; and (3) at the organisation level; and (4) to the provision of care.

Across the entire system

- Advocacy is required to shift attitudes and behaviour, and combat stigma
- Healthcare policy and plans need to incorporate the role that primary care can play in delivering mental health care
- PCPs need adequate training and supervision to deliver effective mental health care
- Collaboration and integration is a process, not a single event
- Better collaboration is a means to an end—better outcomes for individuals with mental health and addiction problems –not an end in itself.

To guide the organisation of care at a local, regional or national level

- Collaboration with other governmental non-health sectors, non-governmental organisations, village and community health workers, and volunteers is required
- There should be a defined population for whom both primary care and mental health providers are responsible
- Financial and human resources and supports are needed
- MHPs need to be aware of the importance of collaborating with their primary care colleagues, and should be trained, encouraged and, where necessary, remunerated to do so
- Changes at the front line need to be supported by a national or regional policy framework that promotes collaborative care.

To guide collaborative partnerships

- Planning should be collaborative from the outset, with clear goals that are reviewed and, where necessary, adjusted regularly

- Mutual respect and support and a recognition of each other's strengths and limitations are the underpinnings of collaborative partnerships
- Personal contacts and direct communication between health care providers to improve the quality of care are the foundation of successful collaboration
- Collaborative care is enhanced by well-functioning inter-professional teams
- Approaches need to be adapted according to the availability of resources, local cultural and geographic factors, and the severity of the mental health problems being seen
- All partners need to be willing to make adjustments.

To guide the provision of care

- Primary care tasks must be realistic and relevant to the skills, interests and resources of the providers
- Patients must have access to the essential psychotropic medications that they require
- Care should be person and family centred and responsive to their changing needs
- Care needs to address contributing social determinants
- There needs to be effective co-ordination of care plans
- There should be a regular and unimpeded flow of information between providers.

Ways in which all mental health services can collaborate with primary care

Although the focus of this paper is on the integration of mental health services within primary care settings, there are many things that any mental health service can do to support primary care, although the range of options increases when there is greater proximity or personal contact. These include:

1. Steps that any mental health service provider(s) can take to improve communication and better co-ordinate care.
2. Initiatives aimed at increasing the skills and comfort of PCPs in managing mental health problems in their practice (building capacity).
3. The integration of PCPs within mental health programmes to address the many unmet physical health needs of psychiatric patients.
4. Using web-based and other innovative communication technologies to improve access to information and care for individuals living in more remote communities (Telehealth).

What mental health services can do to improve access, communication and co-ordination of care

Many of the ideas proposed here can be introduced by any mental health service and adapted to the local context and resource availability at little or no cost.

Improving access

To improve access, mental health services need to examine their intake criteria and processes, including 'did not show' policies, to see if these present barriers to referrals from primary care. Services can also look at new ways to use their resources, find ways to free up time to accommodate additional referrals, or focus on providing consultation and ongoing support for referrals from a PCP. There may also be patients who have stabilised, whose care could be transferred back to primary care with a maintenance plan and ongoing support, freeing up slots for those needing more specialised attention.

While face-to-face consultation with a patient remains a core activity for a mental health service, there are other ways in which advice about a patient can be provided such as telephone consultations, particularly when the PCP is looking for support or validation of a treatment plan rather than wanting care to be taken over. Email and text communication are increasingly popular options, especially if patient identification information is not exchanged. Questions can be asked and responded to quickly, although privacy guidelines need to be established.

Improving communication

The foundation of collaborative partnerships is effective communication between providers who know and respect each other and understand their respective strengths and weaknesses. A simple first step for a mental health service is to meet with local family physicians, and through face-to-face meetings or small focus groups learn how collaboration is working, how it could be improved and where there may be easy changes to introduce. Feedback from service users can be very useful in this regard, as their experiences can point out where improvements in collaboration may be required.

The development of protocols for contacting physicians when someone is admitted to a service, when starting discharge planning or changing medications and when making referrals to another service are

important for standardising care, and can complement the simplification of intake procedures and inclusion or exclusion criteria.

The rapid transmission of brief reports with relevant and practical information and a clear treatment plan is always helpful. The transfer of hospital discharge information to the patient's PCP within 48 h should be routine rather than the exception. Routinely contacting the family physician or the patient a week and a month after discharge allows a mental health service to find out whether connections have been made and if the plan is working. If it is not, the person can be seen again by the mental health team.

Improving co-ordination of care

Individuals with mental health problems are frequently disadvantaged by the fragmentation of services, and may face challenges in moving smoothly from one service or sector to another, or in advocating for their own needs. Clarity about who is responsible for each part of the care plan, and the roles and responsibilities of each service and provider are valuable in countering this, as is flexibility in intake or admission criteria. Central to well-co-ordinated care is the development of a simple individualised treatment plan that is brief, focussed and practical. The person should be given a copy of their plan and medications that they can bring with them to all appointments, thereby ensuring that everyone involved with their care knows what the plan is and what their respective responsibilities are and the patient knows who to contact when an issue arises.

Co-ordination can also be improved by the creation of a discharge planning checklist with simple steps that all providers in a service would routinely follow. A mental health provider can also arrange for the last appointment before discharge to take place in the office of the family physician, so that everyone involved knows the plan and who is responsible for what.

Building capacity—education, training and support for PCPs

Increasing the skills and comfort of family physicians and other PCPs in recognising and managing mental health problems in their own treatment setting can expand the number of people who are being seen and the range of mental health problems being managed in primary care.

Continuing education workshops and presentations can be effective but need to be relatively brief, case or problem-based, interactive and relevant to the realities and demands of primary care. They need to address topics chosen by family physicians and include family physicians as co-presenters, ideally with built in follow-up rather than being just a 'one-off'.

Alternatively, mental health specialists can visit the primary care setting for educational events which should follow the same principles outlined above. Options include case- or problem-based presentations on a specific topic, and discussing or reviewing cases the family physician is seeing. Any case seen in consultation also provides opportunities for educational input.

Educational content can be delivered in person, by videoconference or through web-based presentations, supported by learning guides or web-based resources. But educational programmes and guidelines alone are usually ineffective unless accompanied by system changes to facilitate their implementation and uptake. 'Just in time' case-based sessions are much more likely to be effective than 'just in case' prescheduled didactic presentations.

Telehealth

This allows services to be provided to communities where there is no available psychiatrist. While video consultation using telehealth networks is more common in remote or isolated communities, telephone advice is a viable alternative in places where internet access can be problematic. Educational sessions can also be delivered in this way. Telehealth or telephone consultation is more successful when a consistent relationship is developed between the consultant and consultee.

Integrating PCPs within mental health services

There is one other form of collaboration that is more common in middle- and high-income countries, which recognises that individuals with severe and persistent mental illnesses have an increased risk of developing chronic conditions such as diabetes, vascular disease and respiratory problems, or nutrition-related problems and infectious diseases, but often have trouble accessing timely primary care or end up using Emergency Rooms for this purpose. This can contribute to the chronicity of these conditions and increased mortality rates compared to the general population. All mental health workers should be aware of the need to monitor closely the physical health of patients with chronic psychiatric disorders.

One option is to integrate a visiting PCP within a mental health service, sometimes referred to as

'reversed shared care'. This can be a family physician or a nurse whose role is to assess the physical health problems of consumers using that service, initiate treatment, monitor progress and refer on to more specialised care if required.

Integrating mental health services in primary care

Increasingly, the focus of improving access and collaboration is to find ways to bring mental health providers into primary care settings. This applies in high income countries such as the United States, where the American Psychiatric Association is training 3,500 psychiatrists to work in collaborative partnerships (APA, APM 2016), as much as to LMICs where the WHO has identified that the key to improving access is to bring mental health services into primary care in first-line settings.

The framework presented in this paper draws upon the collaborative care model of Katon and colleagues (Unützer et al. 2013; APA, APM 2016) in Seattle, Washington, the most highly evaluated model for collaboration (albeit in high income countries), which has identified key principles and practices for effective collaborative care. These include a mental health worker in primary care, visits by a psychiatrist, a focus on person-centred and population-based care, evidence-based treatment and measurement-based treatment to target and team-based care. There is strong evidence for its applicability to mild to moderate depression, some anxiety disorders, depression in the elderly and bipolar disorder and children's mental health problems, but the evidence is weaker for severe mental illness or individuals with complex needs.

Models of integration

There are three broad ways to bring mental health providers into primary care settings, which incorporate, to varying degrees, the elements identified above. These are co-location, a visiting mental health provider or team and integrated care. All build on the approaches to improving access, communication, co-ordination and capacity-building outlined earlier, and which can all be expanded and enriched when providers are working in the same team or setting.

i. Co-location

This occurs when mental health and primary care services are located in the same setting, but do not routinely interact or collaborative on the care of shared patients. While access to services may be improved and patients may find this more convenient, care is not necessarily collaborative and it does not automatically facilitate knowledge exchange between practitioners or lead to significant differences in care planning or outcomes.

ii. The visiting mental health provider

This can take place in different ways:

One-off visits to primary care by a mental health provider working elsewhere for a clinical consultation or assessment, or for an educational event or to review cases.

A visiting mental health team, where one or more mental health specialists (usually from different disciplines) visit a primary care practice for one or more half days a week. While there they may (1) assess cases; (2) offer stabilisation and some ongoing short-term care; (3) discuss cases with members of the primary care team; (4) provide educational input; (5) assist with care co-ordination; and (6) facilitate referrals to other services.

The specialised hub and spoke model, this is a variation on the visiting team, whereby individual providers or teams with specialised mental health expertise based in a mental health service will visit a primary care setting on an 'as requested' basis. This is usually more applicable for populations who need access to specialised outreach teams such as seniors, individuals with developmental disorders and children, but has also proven effective for early intervention for psychosis and for addiction problems.

iii. Integrating mental health specialists within primary care

The degree of collaboration increases further when the mental health specialists are an integral part of the primary care team. Whether they are there on a full- or part-time basis, these models can support a broader range of activities such as prevention and early detection, care management, education and community partnerships. They incorporate and expand the activities described earlier for all mental health services and, while they may focus predominantly on health needs, they have the potential to become involved in activities that aim to address social determinants, reduce the impact of risk factors, and assist with earlier recognition and treatment. In some instances, staff of community agencies or social agencies may also be based within a primary care setting or even be part of the integrated team.

The elements of successful collaborative models

We have divided the core elements of effective collaborate activity under three headings: (1) participants, (2) the model of care, and (3) changes that need to made in a system of care to support collaborative care.

Key participants

The PCP who has an ongoing relationship with and knowledge of the patient and will continue to provide comprehensive and ongoing care for the patients in their practice or clinic. They need to be willing to commit time to meet with the mental health team or discuss cases being seen, and to share care according to respective skills and availability. There also needs to be a PCP who is the lead and champion for the collaborative care project within the practice, who will engage their colleagues and assist in solving problems as they arise.

The patient needs to be an informed and active partner within the collaboration, possessing all relevant information about their problem and its management, and being involved in all key care decisions.

A mental health care manager who may take on a variety of roles according to patient need is in many ways the central provider within an integrated team. Whether they are permanently based in the practice, or there periodically (e.g. once a month), they are a visible presence, meeting and communicating regularly with all primary care staff, with clear guidelines as to their role.

Their activities can include therapist, care co-ordinator, case manager, educator and system navigator. They can deliver psychological treatments, monitor medication and provide family support and bring knowledge of community and mental health resources and best practices into primary care.

While all of these activities are likely to be beyond the scope of a single provider, practices or clinics will decide which of these roles are most relevant in meeting the needs of their patients, or can divide the tasks between different individuals.

Many tasks are not discipline specific, and a variety of health professionals can take on these roles in primary care, although nurses and social workers are the most commonly encountered disciplines.

A visiting psychiatrist or mental health specialist whose activities can include providing consultations (either in person or electronically) and selected follow-up care, discussing cases with the primary care team or mental health care manager and offering management advice, providing education and evidence-based guidelines and participating in regular case reviews. Psychiatric consultants can address concerns around diagnosis, treatment and medication, make recommendations about adjusting treatment if a patient is not improving and help with problem solving or negotiating the system. They can also provide short-term care or follow-up, although they need to be careful that this does not prevent them from seeing new cases.

The expertise of the psychiatrist can be extended by discussing cases or situations where the patient may not need to be seen, holding meetings to review cases and supporting PCPs (in person or by phone). These increase the number of cases receiving specialised input or advice, while enhancing the skills, comfort and confidence of the primary care team in managing mental health problems, especially if teaching can be based upon clinical cases.

The care manager and psychiatrist often work more in the style of a PCP than they would in a traditional mental health care setting, providing brief focussed interventions when a problem arises while being readily available, without any complicated referral process, to see someone again at any time if their clinical situation changes or a primary care colleague requests additional assistance or support. They do not always need to be 'the expert'. In a shared relationship mental health and PCPs bring complementary knowledge, expertise and experience, learn from one another and allocate responsibilities according to the clinical needs, their respective skills and resource availability.

Other members of the primary team, the MHPs can also work closely with other primary care staff if they are part of the primary care practice, such as the practice nurse, a dietician or a pharmacist, who all have a role to play in the management of individuals with mental health problems.

Aims for effective collaborative care

We have synthesised the components of care in the collaborative care model (Unützer et al. 2013; APA, APM 2016) in the 2008 WHO document (WHO, Wonca 2008) and Whitebird et al.'s (2014) identification of what is needed for successful collaboration to identify nine components of collaborative care that need to be in place to achieve the best possible outcomes. Care should be:

Patient and family centred: keeping the patient and their family at the centre of care and building services around their needs help to engage patients as partners in their own care, and they should also be involved in designing and improving services. This can also provide a common focus that can bridge divisions between colleagues from different specialties.

Evidence informed: there is a growing body of evidence that supports the benefits of collaborative care

and how it can be adapted to different settings. This does not preclude innovation, but building on what we know works can save time and effort for both patient and provider and lead to better outcomes.

Focussed on populations as well as individuals to enable earlier intervention, and active monitoring and recall after an episode of care (pro-active care). This allows a clinic or practice to assess its performance by tracking population data to monitor the overall well-being of all their patients, rather than just those who are being seen.

Linked with community partners and resources to better address social determinants of health care problems and can assist individuals navigate the system to reach the services they require.

Treating to target ensures that the progress of individuals is monitored regularly, and adjusted if a person is not responding sufficiently. This can also involve regular reviews of everyone in a practice with an identified problem or who are undergoing a specific treatment such as taking an antidepressant.

Team-based with all team members working to their full scope of practice, sharing responsibilities according to their respective skills.

Stepped: linking the intervention to the severity of the problem and the skills of the provider.

Co-ordinated: in addition to the points raised earlier to improve co-ordination, physical proximity can significantly increase collaboration and expand the opportunities for personal contacts.

Enhancing communication: in addition to the points raised earlier, notes and reports should be succinct without repeating information the family physician may already have. The note should include a summary (formulation) explaining the problem, with a treatment plan with contingencies in case it does not work.

Activities of MHPs in primary care to improve outcomes of primary care patients with mental health problems

To support and expand the work of primary care in managing mental health problems (primary mental health care) without automatically taking over responsibility for care, roles of the mental health providers can include:

Assessment and Initiation of Treatment

- Conducting consultations and assessments of complex patients
- Making a diagnosis
- Linking patients with necessary resources and assisting with system navigation and negotiating intake processes
- Advising about the choice of/indicators for specific medications
- Introducing evidence-based guidelines for care.

Care Management and Monitoring

1. Clinical Care
   - Providing ongoing care for selected individuals
   - Delivering psychological therapies, especially Cognitive Behavioural Therapy (CBT), Inter-Personal Therapy (IPT), and Acceptance and Commitment Therapy. Shorter (five sessions) forms of both CBT and IPT have been developed and adapted for primary care, reflecting again how primary mental health care involves more than just transposing 'traditional' mental health care in primary care settings
   - Care co-ordination and case management
   - Developing and implementing a care plan with the roles and responsibilities of all involved being clearly spelled out
   - Providing telephone back-up to PCPs when not in the practice
   - Systematic and pro-active follow-up of patients after treatment is initiated or completed (relapse prevention)
   - Leading groups which can be psychoeducational, provide support or focus on skill development
   - Organising shared medical appointments.
2. Case Reviews
   - Participating in regular meetings to review cases, discuss emerging problems and exchange information on referrals or assessments and progress towards treatment targets. These can also identify individuals who might benefit from a direct (re)assessment
   - Helping to identify new approaches for challenging patient groups
   - Introducing tools to measure progress or outcomes.
3. Education
   - Introducing clinical guidelines or pathways based upon current literature
   - Delivering educational sessions for PCPs based on cases they are seeing.

Education and Support for Self-Management

- Providing information about
  - mental health problems and their management (1:1, in groups or in community fora)
  - available resources
  - relapse prevention

Protecting Human Rights

- Helping to decrease stigma
  - towards people with mental health and addiction problems among primary care staff
  - among family and community members
  - patient self-stigma
- Participating in advocacy efforts in the wider community
- Eliminating discrimination in access to physical health care.

Skills and tools to assist with the delivery of mental health care in primary care

Skills for PCPs that can be taught/enhanced by the mental health team

The mental health team is in a position to introduce additional tools and clinical skills that can be readily employed by any PCP, and can both train providers to use these tools and support them in their implementation. These include psychological therapies, screening and assessment tools, helping patients develop new skills, and supporting self-management. One of the most useful skills that psychiatrists can impart is the effective use of medication.

i. Use psychotropic medication effectively

Although the formularies in many countries may have a limited range of anti-depressants, mood stabilisers, antipsychotics and anxiolytics, first-line physicians and nurses should be familiar with basic principles when prescribing these medications. For each group they should be familiar with:

- Starting, target and maximum dosages
- The rate for increasing a medication
- Commonly occurring, or rare but serious side effects
- Possible interactions with other psychotropic and non-psychotropic medications
- How to discontinue a medication
- Supporting adherence
- Shared decision-making with a patient about medication
- Switching to another medication
- Use of these medications for specific problems: these include:
  - pregnant women
  - weomen who are breast-feeding
  - older adults
  - co-morbid medical conditions
  - children and adolescents

ii. Identifying individuals with mental health problems in primary care

- Improve communication skills that make it easier to discuss mental health problems
  These include listening skills to be able to pick up non-verbal cues, being able to follow the patient's agenda, clear explanations, regular checks to ensure the patient understands what is being explained or proposed, and a willingness to gently explore sensitive areas
- Use simple screening instruments
  There is strong evidence that measurement and using available data can improve outcomes (Fortney et al. 2016). There are many instruments or scales that can be used, especially to detect and monitor progress of anxiety and depression. Two of the commonest and easiest to apply are the PHQ9 for the detection of depression and the GAD7 for detecting generalised anxiety.
  The first two questions in the PHQ-9 and the GAD-7, also referred to as the PHQ-2 and the GAD-2, can also be incorporated easily into any interview, including routinely with individuals with a chronic medical condition. A positive response would then lead to a fuller assessment of the problem. Perceived need for care in primary mental health can also be useful to assess, for instance with the General-practice Users Perceived-need Inventory (GUPI) (McNab and Meadows 2005).
- Identify, screen and monitor individuals at greater risk of having a mental health problem
  - Anyone with an enduring communicable or non-communicable medical condition or disability
    There is a high co-morbidity of depression and anxiety with almost every chronic medical condition. This can result from co-existing conditions, exacerbations of pre-existing (but possibly undetected) problems, the direct results of the physical illness or its treatment, challenges in adjusting to the presence and consequences of a chronic condition or the response of a person's family or environment. Incorporating the two question screens for depression and anxiety can help determine whether this is the case.
  - Anyone who is pregnant or who has children under the age of 5
    The prevalence of depression and anxiety in the perinatal period is often high. If

untreated these conditions can have significant implications for the long-term well-being of both mother and child.

iii. Evidence-based brief interventions

1. Supportive therapy and active listening
   This is often the commonest therapeutic approach in primary care. It requires the PCP to be able to listen to the patient and reflect back on what he or she has heard, while helping them explore different options, supporting (or supportively challenging) their choices and ensuring that their goals are realistic and attainable. Effective communication skills include knowing when not to say anything and learning to recognise and manage one's own emotions to prevent these from interfering with the process of the interview.
2. Motivational interviewing
   This enables a provider to help a patient deal with their ambivalence towards change, reinforcing the positive reasons for making a change while gently questioning some of the resistance or reasons not to change, without becoming proscriptive or directive. The interventions are brief, with the patient being left to consider what he or she has heard, to help them move to the point where they are ready to make a change in their behaviour. This can be applied to behavioural changes in any specific condition or general lifestyle changes, such as reducing alcohol consumption or losing weight.
3. Behavioural Activation
   This is integral to all care and can be encouraged at any visit. The goals are to occupy time productively in rewarding activities, build a sense of self-confidence and efficacy, and provide a step-wise path to getting back to previous activities. This can include:
   - Physical activity in increasing amounts. For mild-to-moderate episodes of depression physical activity may be more helpful than medication, and can be 'prescribed' at any visit
   - Gradual increases in social or recreational activities of the person's choosing
   - Gradual increases in tasks to complete around the home or within the community
   - Building or reconnecting with a social network that can lead in turn to opportunities for greater social interactions.
4. Distress Tolerance
   These are skills that patients can learn to help them cope with situations that are stressful, such as simple relaxation techniques, mindfulness skills, cognitive approaches to rethinking situations and their outcomes and using available support.
5. Problem Solving
   These involve simple steps that a PCP can teach or reinforce to assist a patient who is struggling with a problem to define and analyse the different components, and develop and test possible solutions for each component, using small but attainable steps.

iv. Support for self-management

This is an integral part of the work in primary care. Most of the time a person (with the support of their family or support network) is managing their own problems without face-to-face contact with a health care provider, and they need to be provided with all necessary resources and support to do whatever they can to better manage their own care.

1. Education, support and skill building
   This can entail exploring barriers to a patient's ability to manage parts of their treatment, including overly complicated treatment plans or medication regimens. It may also involve providing easy to use resources such as simple, clearly written and eye-catching information leaflets, posters or handouts; links to downloadable materials; providing patients with notes, reports and results related to their care; identifying ways a person can monitor their own progress and recognise the signs that suggest a possible recurrence; supporting treatment adherence; developing a plan they can follow, based upon their own goals; and teaching relaxation techniques and other simple ways of handling stress. These approaches are consistent with Recovery Oriented Practice.
   These can be taught individually, in groups, through shared medical appointments and by links with peer supports. For patients with limitations (such as cognitive difficulties), family or others may need to be involved to assist with aspects of the self-management plan.
2. Access to other resources
   Web-based or community resources can offer practical advice or management guidelines for PCPs, or information that can be given to patients and their families to provide them with additional practical skills to assist them to better manage their own conditions These may be treatment programmes such as online CBT, workbooks to assist with self-management of depression or anxiety,

educational resources on common problems or information on community programmes. These can all be collated within a single accessible web location, integrated within an electronic health record or compiled in a paper library.

v. Assessing the needs of family members and other caregivers and providing support

Families and caregivers will often benefit from receiving information on the cause, course and management of a problem. This can also reduce any associated stigma that may interfere with their recovery. With permission from the patient they can be involved in information gathering and discharge planning, and be provided with relevant information about the problem and the plan. It is important to enquire how the family is managing and assess what assistance they might need as they support their relative or come to terms with the presence of the illness and its possible consequences.

Step 3. Changes in delivery systems to support collaborative care

Care processes and structures within a health care setting, whatever its size, need to be adapted to support collaborative care. Examples of this include:

- Treatment protocols, guidelines or pathways to guide care
- The use of case registries to support population-focussed care
- Pro-active outreach and recall (planned care)
- Clarity regarding roles and expectations, especially of the care managers
- Person to person handovers of responsibilities for care
- Support for collaboration by primary care leadership
- Incentives to promote collaborative practice, including in the way physicians are remunerated
- Shared record keeping and charting, with the patient having a copy of the plan and all relevant reports
- Opportunities to meet to discuss or review cases
- A PCP who will be the lead/ambassador for the project
- Support for task sharing.

Measuring the impact of collaborative programmes

The impact and benefit of collaborative care models can be measured by looking at health outcomes, patient and provider satisfaction and the use of other services. This can be done within a quality framework, such as the one developed by the Institute of Medicine (Korsen et al. 2013), with each quality domain supporting three to four

Table 2. Measuring the impact of collaborative projects.

Effective
• The extent to which practices follow evidence-informed guidelines in the treatment they deliver
• Patient outcomes such as improvements in symptoms, functioning, quality of life, family functioning, and work place or community tenure, participation or productivity
• The percentage of a population who show improvement or reach treatment targets
Timely
• The waiting time for service
• The number of people waiting to be seen
Efficient
• The extent and type of integration and co-ordination within a practice
• How well the integrated team is functioning
• Changes in utilisation of other services, i.e. emergency rooms or specialised services
• Length of stay in mental health services for patients in collaborative care arrangements
• The quantity of different services being delivered, waiting times, the different personnel involved in the care of an individual
Patient-centred
• The involvement of patients in developing their own plans and goals
• Whether a patient has a copy of their plan
• Patient experience of seeking and receiving care
• Provider experience of working in a collaborative partnership
Equitable
• The identification and elimination of barriers that may face particular groups or subpopulations within a practice
• Reduction in implicit bias amongst primary care provider
Safe
• Steps taken to ensure patient safety, such as medication reconciliation or the elimination of preventable adverse events
Population-focussed
• The extent to which the programme serves the entire (sub) population of a practice, rather than just those who have been identified as having a problem

outcome measures (Sunderji et al. 2016). Examples are summarised in Table 2.

Preparation of the workforce

Working in primary care demands some specific competencies and preparation for all participants. Some apply to all disciplines, while others may be discipline, role or task specific.

The competencies required to work in collaborative partnerships

1. Competencies for all providers when working in collaborative partnerships:
   - Respect for their primary care partner and the work they do
   - Flexibility
   - An openness to new ideas
   - A willingness to learn from each other
   - An understanding of team dynamics
   - The ability to recognise and understand cultural differences between primary care and specialised mental health care, including the way problems present
2. Specific skills for mental health providers working in primary care:
   - Strong general clinical skills without being rigidly wedded to a particular approach
   - Awareness that they are 'guests' in someone else's home and part of a team led by a PCP
   - Understand the context in which they are working and the demands of primary care
   - The ability to translate their language and concepts to make them relevant to the world of primary care and general medical settings
   - The ability to use resources and manage time efficiently

Preparing mental health staff to work in primary care settings

Before working in primary care, mental health providers need to be prepared for the demands and realities of primary health care. Ongoing support, especially during the transition is important. Orientation and training programmes for primary care staff should cover three areas:

1. Why we need to improve collaboration:
   - The role primary care plays—or could play—in mental health care systems
   - The prevalence and treatment of mental health problems in primary care
   - The prevalence of mental health problems in patients with enduring medical conditions or communicable disorders
   - Problems that can arise in the relationship between mental health and primary care services and providers
   - Principles to guide better collaboration
2. Examples of successful collaborative partnerships:
   - Evidence from the literature
   - The benefits of working collaboratively with PCPs
   - Core components of successful collaborative models
3. Working effectively in primary care:
   - Conducting an assessment in a non-traditional setting
   - Preparing and delivering a relevant and concise verbal or written report for a family physician following a clinical encounter
   - Opportunities for indirect (patient does not need to be seen) care
   - Providing telephone or email back-up to the family physician and the primary care team
   - Involving the patient as a partner in their own care

It can also be very helpful for a mental health provider who is about to start working in primary care to spend one or two half days 'shadowing' someone who is already performing that role.

Implementing a project

Any collaborative project needs to be a joint endeavour from the outset, rather than one party approaching the other with pre-determined ideas for a project. Shared ownership increases buy-in and encourages all parties to contribute their ideas and understanding to the eventual programme. There are three broad steps.

1. Partners need to get to know each other and discuss their respective needs, strengths, assets, resources and priorities; the problems as they see them and possible goals for a new project. Agreement on a shared common purpose needs to be the starting point for any new programme, with objectives that are shared and attainable, and their attainment and relevance reviewed on a regular basis. If a programme contains multiple components, these should be introduced one at a time, so the impact of each can be assessed or measured, before the next is put in place.
2. Roles of participants need to be clarified, expectations spelled out and criteria for measuring the

success of the project determined. Each organisation should identify a liaison, who will work with their counterpart around implementation.
3. A small steering committee can be established to oversee the project and monitor its progress and make adjustments based upon lessons learnt. The committee should meet at least quarterly.

Wider issues that may influence the design of a programme such as the skills of the workforce, training, space, workflow and data management need to be taken into account when developing a new programme. Other issues that may present challenges when developing collaborative partnerships include:

- **Culture** Variation in approaches and philosophies of care between mental health and primary care services, and in terms and language used can become impediments. This highlights the importance of mental health providers translating language and concepts to fit the culture of primary care.
- **Organisational factors** Leadership instability or change at the organisational or project level can disrupt smooth running partnerships, as can the departure of staff who are advocates for or leaders within collaborations. Confusion may arise from different documentation requirements, or understandings of medico-legal expectations and standards of confidentiality.
- **Finding time** PCPs and MHPs usually have busy schedules and time is often at a premium. For collaboration to work all providers need to appreciate its benefits and its potential to save time, and use their time together as efficiently as possible.
- **Funding and resources** Program funding and physician remuneration models need to be aligned with the goals of the collaborative project and support indirect as well as direct care. The separation of funding and governance arrangements for primary and secondary care providers can also limit opportunities for collaboration.
- **Stigma** Among primary healthcare providers, as well as family or community members, can affect the enthusiasm for a new project, while self-stigma (self-blame) can also reinforce feelings of low self-esteem or social isolation on the part of people using the services.

Wider system supports to enhance collaborative partnerships

If collaborative care in any practice or community is to have its optimal effect, it needs to be supported by changes at the national or regional level.

Ideally there should be a national policy and evaluation framework to guide collaboration between mental health and primary care, with mental health and primary care funders and planners working together and producing complementary or integrated plans. This should be supported by necessary resources, mechanisms for sharing and spreading programmes that have demonstrated their effectiveness, and a training strategy for staff preparing to work in collaborative models of care.

At a regional or local (community) level there needs to be opportunities for providers to get to know each other and build relationships and local networks, and learn from each other's experiences. Partnerships with community agencies and non-governmental organisations can assist in addressing social and economic determinants of mental health and helping patients reach the services they need.

Other partners have important roles to play. Academic departments and universities need to train future providers to work in collaborative models, while professional organisations and associations need to promote collaborative care amongst their members. Regional planning or coordinating bodies representing primary care or mental health providers can play significant roles in building partnerships and driving collaboration.

Future directions: the potential of better collaboration to address other system issues

Training future providers

In part, the long-term sustainability of collaborative care will depend upon graduates of all health care programmes learning the core skills and concepts of primary mental health care as an integral part of the training. This will help collaborative care become a part of their practice and make it more likely that they will seek out opportunities to work with colleagues from other specialties.

Reaching underserved populations

Collaborative care has demonstrated its potential to improve the care for high-risk populations who underutilise or have trouble accessing mental health services. This includes indigenous populations, the homeless, people with high-risk medical conditions, refugees and individuals from different cultural groups, who may feel more comfortable with their PCPs (who may also be more familiar with their culture). Integrated models and collaborative care also can play a significant role in improving access and continuity of

services in rural and remote areas. In all of these models, mental health providers need to be thinking about building local capacity and capability, rather than just positioning themselves as the experts.

Integrating physical and mental health care

The integration of mental health workers in primary care allows primary care teams to provide more comprehensive care for individuals with complex medical and mental health conditions, to appreciate the interactions between the different conditions and to reconcile the medications a patient may be taking.

Earlier detection and intervention

Every health care system aims to recognise individuals in distress or with emerging illnesses as early as possible. Collaborative partnerships can increase the skills and awareness of PCPs, provide them with simple screening tools, alert them to clues from the patient that there may be a problem and initiate treatment earlier. These can also focus on the needs of specific populations such as seniors with early cognitive impairment, or adolescents who are coming for a routine visit, but which can be turned into a 'well teen' visit or assessment.

Relapse prevention and surveillance

Collaborative models may lead to more consistent surveillance and monitoring of signs of early relapse, including for individuals who have been discharged from mental health services after successful treatment.

Increasing equity in access to health care

Providing services in primary care settings can make it easier to access care and more comfortable for many individuals who may not otherwise reach or wish to attend specialised mental health services. It can also support general medical providers who are working with at risk or marginalised populations, who may be suspicious or reluctant to see a mental health specialist.

Building system capacity and capability

Seeing primary care and mental health services as part of a single integrated mental health system whether through better collaboration or the integration of mental health services in primary care, will increase the number of people receiving mental health care in both sectors, and reduce the number of people who receive no mental health care over the course of a year.

Promoting early childhood development

Many opportunities arise in primary care to change the trajectory for children with multiple risk factors or who are coping with the consequence of adverse events, reducing the likelihood of problems developing later in life. A routine 18-month visit can identify children who are at risk, who can then be monitored closely and pro-actively to make sure they reach the services they need. The focus on the family in primary care also opens up opportunities to recognise and address problems in family functioning or improve the ability of families to buffer the challenges a child with a mental health need might encounter.

Perinatal mental health

There is increasing evidence about the importance of perinatal mental health and the impact that stress, depression, anxiety and substance use in pregnant women can have on a child's well-being. Primary care is uniquely positioned to be able to address these issues, and collaborative care can increase intervention rates, and help families cope.

Summary

Many countries have recognised that strengthening collaboration between mental health and primary care/first-line providers, including the integration of MHPs within primary care settings, can be an effective way to improve access to care, enhance the experience for people both seeking and providing care, and expand the capacity of primary care to deliver effective mental health care. And in LMICs this may be the only way to deliver care to millions of individuals who otherwise would have no access to mental health care.

Sharing care requires a three-stage approach that involves:

1. Defining the potential roles that PCPs can play in delivering mental health care.
2. Exploring and introducing ways for mental health providers to enhance and expand these roles, especially through the integration of mental health services and primary care services.
3. Identifying wider system supports required to optimise these new arrangements.

Everyone involved will need to make changes, adjustments and accommodations. But, if this can be

accomplished, collaborative care has the potential to improve the outcomes for individuals with mental health and addiction problems presenting in primary care, including those with co-morbid physical and emotional problems, to expand the role of primary care (consistent with the approach of mhGAP and the concept of the patient's medical home) and addressing broader issues facing health systems in every country and jurisdiction.

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