Achieving Shared Care between Primary Care and Specialist Mental Health Services

Dr Clare Lewis and
Dr Elizabeth Tully
June 2024

Review of evidence-based practice in relation to adoption of consultation/liaison models in mental health service provision; implementation of a shared care approach between primary care and specialist mental health services

TABLE OF CONTENTS

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

ACKNOWLEDGEMENTS

This study was funded and supported by the National Mental Health Office, HSE Access and Integration.

The research was conducted by Xenon Health Solutions Ltd in 2023.

Authors:

Dr Clare Lewis,
Dr Elizabeth Tully,
Elizabeth Akintola.

The authors would like to acknowledge the guidance and support of the following key contributors throughout the development of this report.

- Poul Walsh Olesen, Senior Project Manager, National Mental Health Office, HSE Access and Integration.
- Dr Brian Osborne, Assistant Medical Director, Irish College of General Practitioners (ICGP).
- Ciara Ridge, Service Improvement Lead, National Mental Health Office, HSE Access and Integration.
- Shared Care Working Group.
- Mental Health in Primary Care Workstream.
- Focus Group Participants.
- Case Study Service Teams.

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

This report outlines the findings and observations of shared care in mental health to support a series of recommendations, focused on improving integration across primary care and specialist mental health services, and to assist in implementing Sharing the Vision (StV) a mental health policy for everyone (Department of Health, 2020). The report includes a literature review, key stakeholder engagement sessions, and a series of case studies conducted by Xenon Health Solutions on behalf of National Mental Health Office, HSE Access and Integration. It involved a review of practice in relation to adoption of consultation/liaison models in mental health and implementation of shared care approaches between primary care and specialist mental health services.

This work examines the challenges and enablers of delivering shared care in primary care and specialist mental health services, as well as identifying what key actions can support the delivery of this approach. In essence, shared care covers the spectrum of models of care, service arrangements, types of treatment options and interventions delivered by a range of healthcare professionals. This is based on the individual's needs at different time-points in their healthcare journey. The information from both the literature and stakeholder engagement sessions provides an evidence base for the development of key recommendations around the implementation of shared care approaches. By identifying best practice, enablers and barriers, research findings will help inform the most appropriate approach to implementation of shared care, in line with StV.

The project steps included:

- A comprehensive literature analysis conducted to understand the issue from an international context.
- Adoption of mixed methods approach, engaging with key stakeholders via focus groups and case studies to produce a rigorous evidence base, validate findings from the literature in the context of an Irish healthcare setting, and to examine the challenges and enablers.
- Identification of key themes and translation into a series of recommendations around best practice, delivery, and implementation.

The report outlines the key findings from the literature review, key stakeholder engagement sessions and case studies. This includes the positive effects of shared care in improving outcomes for individuals with greater recovery and remission rates, greater satisfaction with care, improved quality of life, and improved collaborative working across services as well as upskilling of clinicians. There is also evidence of longer-term impact with lower healthcare utilisation for people accessing shared care and improved prescribing practices.

A structured approach to shared care is recommended delivered through models of care. These include consultation/liaison and collaborative care approaches. Choosing either approach is based on local population needs and service infrastructure including access to specialist expertise.

Consultation/liaison supports shared care with specialist mental health teams working with primary care providers offering a structured approach. This includes case discussions, advice and guidance, education and training and option to offer brief interventions and a pathway to specialist mental health services. Collaborative care models support shared care through case management and offer longer term care for individuals with more complex care needs. This involves the multidisciplinary team including primary care providers, specialists in mental health and chronic disease management, and is overseen by a case manager to coordinate care and provide therapeutic interventions. Each of these models of care are adaptable and flexible and offer an opportunity to provide a stepped approach with pathways to consultation/liaison and collaborative care based on need. These approaches can be flexed around priority areas and tailored to populations such as children and young people and older persons. This is reflective of population needs and service requirements and access.

There are core fundamentals to deliver effective shared care and support engagement, service planning and coordination across services. These are applicable to both consultation/liaison and collaborative care approaches and include:

- An agreed structured approach to service delivery underpinned by a clear model of care. This includes shared care agreements, clinical guidelines, protocols and pathways of care.
- A clear communication plan for staff and people that will access these services to enhance engagement.
- An agreed clinical governance framework that includes clinical supervision to support the model of care and professionals.
- Champions and advocacy roles to engage clinicians and people accessing primary care and mental health services to support shared care as a new way of working.
- A link, liaison or case manager role working with primary care practices, primary care and mental health teams, and chronic disease management specialists to support engagement and a structured and sustainable approach.
- Development of a training and education programme for healthcare professionals involved in shared care.
- Ability to share information electronically across teams and services.
- Organisational buy-in from the senior management team with support and investment to sustain shared care approaches locally and nationally.
- Presence of clear outcome and impact measures to determine effectiveness and support investment and sustainability.

This report outlines key steps necessary to support the implementation of shared care across primary care and specialist mental health services, and presents an evidence base of international, national, and regional service delivery examples.

This is informed by outcomes and impact, as well as by key enablers, challenges, and barriers, to shared care along with possible methods to best address these. The aforementioned is significant for the HSE as it develops approaches to consultation/liaison and shared care through the implementation of StV.

LIST OF ABBREVIATIONS

AHP	Allied health professionals
CBT	Cognitive Behavioural Therapy
CLIPP	Consultation/Liaison in Primary-Care Psychiatry Program
CMP	Common Mental Health Problems
CMHTs	Community Mental Health Teams
COMPASS	Combined Psychosis and Substance Use Programme
CRS	Crisis Resolution Services
CRT	Crisis Resolution Team
ED	Emergency Department
EIP	Early Intervention in Psychosis
GP	Primary Care Physician/General Practitioner
HIG	HSE Implementation Group
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
ICT	Information and Communications Technology
IT	Information Technology
KPIs	Key Performance Indicators
LDL	Low-Density Lipoprotein
MDT	Multidisciplinary Team
MH	Mental Health
MHID	Mental Health of Intellectual Disability
MHP	Mental Health Problems
NCAP	International National Clinical Audit of Psychosis
NCPSHI	National Clinical Programme for Self-Harm and Suicide-related Ideation
NHS	National Health Service (UK)
NOSP	National Office of Suicide Prevention
OECD	Organisation for Economic Co-operation and Development
PHQ	Patient Health Questionnaire
PIPC	Psychiatry service in Primary Care
PWPs	Psychological Wellbeing Practitioners
QALY	Quality-Adjusted Life-Year
SBP	Systolic Blood Pressure
SCAN	Suicide Crisis Assessment Nurse
StV	Sharing the Vision
WHO	World Health Organisation

1.0 INTRODUCTION

1.0 INTRODUCTION

The publication of 'Sharing the Vision (StV) – A mental health policy for everyone 2020-2030' describes Ireland's whole system policy to enhance the provision of mental health support across a broad continuum, from the promotion of positive mental health to specialist mental health service delivery (DOH, 2020). In line with existing policy, StV acknowledges the importance of advancing a shared care approach between primary care and specialist mental health services in improving outcomes. It endeavours to further invest in this area by supporting the continued adoption of the consultation/liaison model of care within the health service, ensuring high quality and effective service provision that best meets the health needs of the people who use the services.

StV contains a number of recommendations to improve integration of care and collaboration between primary care and specialist mental health services. In doing so, the policy recognises the importance of adopting a 'shared care' approach to mental health in primary care. Launched in March 2022, the **'StV Implementation Plan 2022–2024'** outlines a programme of work to deliver StV recommendations, including what is to be achieved, required input, milestones, expected outputs and outcomes and the named implementation leads. To assist in delivering this complex change programme, the HSE's Implementation Group (HIG) for StV has established a number of thematic workstreams, including a Mental Health in Primary Care Workstream.

The mental health in primary care workstream has been tasked with overseeing the delivery of a cluster of recommendations, including recommendations 17, 18 and 19 (DOH and HSE, 2022).

- **Recommendation 17** *the mental health consultation/liaison model should continue to be adopted to ensure formal links between Community Mental Health Teams (CMHTs) and primary care with the presence of, or in-reach by, a mental health professional as part of the Primary Care Team or Network.*

- **Recommendation 18** *to develop an implementation plan for the remaining relevant recommendations in Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services (2012) to improve integration of care for individuals between primary care and mental health services in line with emerging models and plans for Community Health Networks and Teams.*

- **Recommendation 19** *the physical health needs of all users of specialist mental health services should be given particular attention by their General Practitioner (GP). A shared care approach is essential to achieve the best outcomes.*

To inform and assist in the delivery of these specific recommendations, the research described here will assist in directing activity and provide an evidence base for the Irish health service around the implementation and future development of consultation/liaison models, and shared care approaches to support consistent, efficient, effective communication and integrated care between primary care and mental health services, ensuring a better service experience and health outcomes for service users.

1.1 PROJECT AIM

This project aimed to investigate current enablers and barriers to the adoption of a shared care approach for mental health. It involved a review of practice in relation to adoption of consultation/liaison models in mental health and implementation of a shared care approach between primary care and specialist mental health services.

Specifically, the main objective of this work is to gather an evidence-base for the development of key recommendations around the delivery of a shared care approach for mental health.

The data gathered from this exercise will help to drive improvements and foster learning throughout the sector on the topic of shared care and the delivery approach. Better understanding of the key challenges and enablers will help to develop evidence-based frameworks to develop and implement international best practice services that are aligned to the StV recommendations.

The project focused on three key areas, (Figure 1).

1.2 PROJECT OBJECTIVES

To address these key areas, the following project objectives were identified:

- Scope of the evidence internationally via a narrative literature review.
- Case Studies to understand current operational frameworks for delivery of shared care approaches (n=3).
- Stakeholder engagement and insight gathering by conducting a series of focus groups with key health care professionals to understand the critical factors for adopting a shared care approach to mental health service delivery (n=23).

Figure 1 - Key Areas of Research

2.0 PROJECT METHODOLOGY

2.0 PROJECT METHODOLOGY

A mixed methods approach was employed to gather insights, combining qualitative and quantitative research methods to provide a more comprehensive and nuanced understanding of the project objectives. Information obtained via the stakeholder engagement process was linked back to the literature, to further understand and contextualise shared care and the implementation of consultation/liaison models in mental health.

This research is crucial to understand how shared care models between primary care and specialist mental health services can be developed and underpinned by evidence-based practice.

This approach and the associated outputs are described in Figure 2.

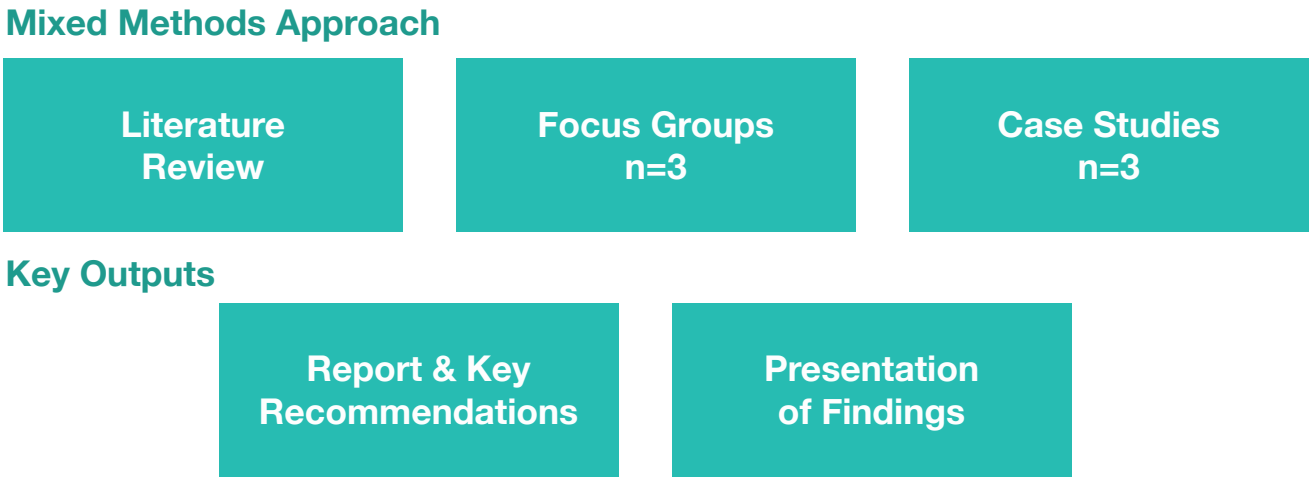

Figure 2 - Study Methodology

Phase 1 - Literature Review

The evidence was summarised from a comprehensive review of national and international peer-reviewed research and relevant grey literature addressing:

1. adoption of consultation/liaison models in mental health and

2. shared care protocols and guidance to support implementation of a shared care approach between primary care and specialist mental health services, including physical health care.

A central claim in several policy documents is that there are many factors that influence the efficiency and effectiveness and adoption of consultation/liaison models that are integrated with primary care (WHO, 2013, DOH, 2020, OECD, 2021). Moreover, these factors operate at multiple levels covering a system, organisational, service and individual level including areas such as functioning primary care and community networks, geographical coverage of teams, mental health and wellbeing of teams, service user access and engagement, care pathways, sharing of information, leveraging remote technology, standardised protocols and guidelines, shared competencies between healthcare professionals, training and education requirements and clinical governance (WHO, 2013 OECD, 2021). Understanding these key areas in the context of an Irish healthcare system to support the development of mental health consultation/liaison model and shared care approach between primary and secondary care is essential to ensure the best possible outcomes for service users. This includes enhancing capacity in primary care and operating under the principles of recovery, trauma informed, human rights, partnering and valuing and learning (Department of Health, 2020).

A literature review was conducted to understand these key areas through an evidence-base that fits pre-specified eligibility criteria as outlined in the objectives of this project:

- Adoption of consultation/liaison models in mental health.
- Implementation of a shared care approach between primary care and specialist mental health services.

This included an evidence review nationally and internationally, providing a deeper understanding of the key objectives of the literature review to identify key themes and barriers and enablers at an international level.

Definitions and descriptions of the requirements for adoption of consultation/liaison models in mental health and implementation of a shared care approach between primary care and specialist mental health services were explored. Alignment of these requirements to StV policy and the associated StV Implementation Plan 2022-2024, as well as work progress through the Mental Health in Primary Care Workstream, was undertaken alongside a situational analysis of current service level mapped against the literature findings to provide focus and direction.

Phase 2 – Stakeholder Engagement

Several methods were utilised to gather insights from nominated roles that represented a range of services and included both focus group sessions and case studies of existing services. This facilitated the process of collecting, analysing, and interpreting information to gain a deeper and more profound understanding of the topic of adopting a shared care approach between primary care and specialist mental health services.

Case Studies

Three national services examples were identified by the study working group to examine further and are presented as best-practice case examples. These involve existing coordination between primary care and specialist mental health services through:

1. consultation/liaison models in mental health and
2. guidance and protocols to support shared care and summarise learning.

Services utilising a collaborative approach among various healthcare providers to improve outcomes for people who use services and service efficiency, derived from successful implementations of shared care models in mental health are described. Implementing shared care in mental health requires a multifaceted approach that emphasises interdisciplinary collaboration, person-centred care, clinical governance frameworks, and the use of integrated digital technology, all of which are crucial for addressing evolving challenges and optimising shared care practices in mental health settings. The case studies were collated and summarised in table format against metrics and Key Performance Indicators (KPIs) derived from the literature.

Focus Groups

These stakeholder engagement sessions formed part of scoping to understand roles and delivery of services to enhance the literature review examining consultation/liaison models and shared care for mental health. The focus groups facilitated the capture of key themes and allowed cross reference of these with the literature and understanding of any enablers, barriers and challenges to the development of consultation/liaison and shared care models. The data collected was used to inform of recommended implications for policy implementation.

Focus groups were convened with twenty-three senior staff representing mental health services nationally across three online sessions of 60mins.

Participants were provided with detailed information about the nature of the project and their consent obtained in writing before each focus group session.

Participant responses were anonymised and remain confidential in the reporting process.

Key areas as identified from the literature were used as a discussion guide:

- Definitions and understanding of key terminology - what is consultation/liaison, collaborative care and shared care?
- How they could be implemented, target groups, stepped approaches and what would be required to roll out this service?
- KPIs, measuring outcome and impact.
- Challenges, barriers and enablers to consultation/liaison, collaborative care and shared care.

3.0 INTERNATIONAL EVIDENCE

3.0 INTERNATIONAL EVIDENCE

To support the planning and implementation of recommendations 17, 18 and 19 of StV [1] (Department of Health, 2020), this chapter presents the evidence on shared care, consultation/liaison and collaborative care models from an international perspective. The term shared care commonly underpins consultation/liaison and collaborative care models (Kelly et al., 2011, Smith et al., 2017). To understand the principles of shared care this chapter will initially present shared care as a concept of care demonstrated through service delivery approaches. Presenting shared care as a concept is important in understanding the fundamentals required to deliver on shared care within consultation/liaison and collaborative care models (Kelly et al., 2011, Smith et al., 2017).

Shared care approaches are transforming how services are delivered in the community resulting in better outcomes for people experiencing mental health problems (Kelly et al., 2011, Smith et al., 2017). General definitions of shared care, consultation/liaison and collaborative care are discussed for each model along with service delivery approaches including populations accessing these services. The evidence on staffing approaches underpinning each concept is presented to assist in informing the key requirements for implementation. Additionally, key enablers, any barriers and challenges with steps to overcome these are presented to assist with service planning.

A summary of the evidence on outcomes of shared care are presented in addition to measuring general outcomes and impact to demonstrate effectiveness. The experiences of people accessing shared care approaches and staff operating within these are also presented.

3.1 SEARCH STRATEGY

The search strategy adopted a broad-based approach focusing on primary care and community care including key words such as mental health OR psychiatry AND general practice, primary care, community AND shared care and consultation/liaison and collaborative care and case management. Databases searched included PubMed, EbscoHost, PsychInfo, Organisation for Economic Co-operation and Development (OECD), World Health Organisation (WHO) Europe and Global.

A total of 129 citations were generated with subsequent duplicates removed resulting in 50 publications informing the evidence review

(Figure 3). Dates of publications ranged from 2004-2022 with seminal papers included from 1989 and 1999. Publications included peer reviewed literature, original research, case studies and systematic reviews, as well as grey literature discussing the international perspective on shared care, consultation/liaison and collaborative care.

[1] **Recommendation 17** the mental health consultation/liaison model should continue to be adopted to ensure formal links between CMHTs and primary care with the presence of, or in-reach by, a mental health professional as part of the Primary Care Team or Network.

Recommendation 18 to develop an implementation plan for the remaining relevant recommendations in Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services to improve integration of care for individuals between primary care and mental health services in line with emerging models and plans for Community Health Networks and Teams.

Recommendation 19 the physical health needs of all users of specialist mental health services should be given particular attention by their GP. A shared care approach is essential to achieve the best outcomes.

LITERATURE SEARCH

Figure 3 - Literature Search.

- **Liaison and Shared Care - 131 citations total from PubMed, Ebsco Host, PsychInfo, 1 Citation Cochrane**
- **Duplicates excluded, screening of title/abstract to include mental health and/or chronic disease community and/or primary care.**
- **Total number Shared Care 13**
- **Total number Consultation/Liaison 17**

- **Collaborative Care and Mental Health and/or Chronic Disease -15 citations total from PubMed, Ebsco Host, PsychInfo,1 Citation Cochrane**
- **Duplicates excluded, screening of title/abstract to include mental health and/or chronic disease, community and/or primary care**
- **Total number 18**

- **Literature review internationsl perspective on Consultation/Liaison and Collaborative Care for Anxiety and Depression 1**
- **Literature review international perspective sustainable integration of mental health services in primary care 1**

3.2 SHARED CARE

There is a growing need for shared care with an ageing population and an increase in the number of people living with chronic illness that require multiple treatment options (Goto et al., 2021). Shared care approaches can assist in bridging the gap between the most effective treatment interventions and the person's values, wishes and choice (Smith et al., 2017, Goto et al., 2021). Shared care broadly covers the spectrum of service arrangements, treatment options and interventions delivered by a range of healthcare professionals at different points in time based on the person's individual needs (Byng et al., 2004, Byng et al., 2008, Kelly et al., 2011, Foster et al., 2022). Some of the most effective approaches to shared care are guideline-initiated care, treatment algorithms and formal stepped care approaches, with standardised assessment processes and agreements on sharing information and providing feedback (Simon et al., 2006, Fuller J et al., 2009, Kelly et al., 2011). This is often enabled by a shared care communication system (Simon et al., 2006, Fuller J et al., 2009, Kelly et al., 2011).

In general, shared care is defined as:

"A set of principles and fundamentals to enhance coordination of care and support a structured approach to integration involving multiple providers and services working cross collaboratively to contribute to areas of the person's overall care plan. The aim is to address unmet needs, reduce unnecessary interventions and assist in re-designing services to include, timely access, expert advice and input, service user engagement and the development of information systems. This involves a level of agreement about shared care activities and levels of responsibility for each provider with appropriate communication processes developed to support integration".

(Byng et al., 2008, Fuller J et al., 2009, Kelly et al., 2011, Kroenke and Unutzer, 2017, Foster et al., 2022).

The key terms underpinning this definition include coordination, structured approach, cross collaboration, timely access, expert advice and input and service user engagement. (Kelly et al., 2011, Smith et al., 2017, Foster et al., 2022), (Figure 4).

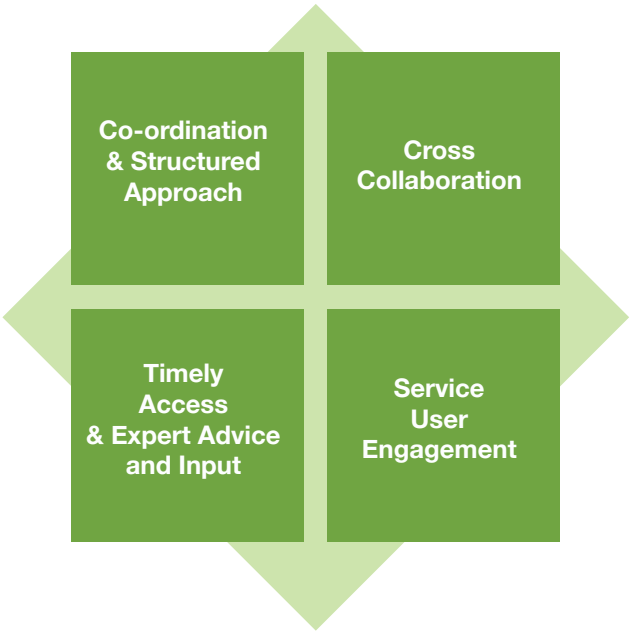

Figure 4 - Key Terms in Shared Care Definition

From a policy perspective shared care is seen as a key driver to improving both the physical and mental health and wellbeing of people accessing GP and mental health services (Department of Health, 2020). To deliver shared care requires structured service delivery models with clear shared care strategies and common goals (Foster et al., 2022). This is supported by robust clinical governance frameworks with clarity on roles and responsibilities and standardised processes of care that are flexible to local care needs (Kelly et al., 2011, Smith et al., 2017, Foster et al., 2022).

Internationally, there are various shared care service delivery models with primary care as the first point of contact (Byng et al., 2004, Simon et al., 2006, Byng et al., 2008, Fuller J et al., 2009, Kelly et al., 2011, Smith et al., 2017). Choosing a service delivery model such as consultation/ liaison or collaborative care is guided by the population needs, service infrastructure, financial model, workforce requirements and access to specialist knowledge and expertise (Kelly et al., 2011, Smith et al., 2017).

3.2.1 Service Delivery Approaches to Shared Care

In this section, examples of service delivery approaches focused on testing shared care will be presented. This is based on research that has specifically referenced shared care in the title and within the abstract, with examples from the United Kingdom (UK) and France. This will also include target populations and types of interventions. Providing these examples of shared care service approaches will assist in understanding the principles of shared care and how this is underpinned in consultation/liaison and collaborative care models. This will assist in informing implementation planning to deliver on recommendations 17-18[1] of StV, a mental health policy for everyone (Department of Health, 2020).

3.2.1.1 Service Delivery Model - UK

Study Background

In the UK, researchers tested a 12-month pilot to determine if a shared care approach in a primary care setting improved communication and processes of care between teams and healthcare outcomes for people through a health link programme (Byng et al., 2004). The health link programme was targeted towards the management of people with long-term mental health problems. A total of 24 GP practices with a mix of urban and inner-city practices participated in the study. Practices were randomised to either usual care (existing services provided by specialist mental health teams) or the mental health link intervention (three link workers assigned to support 12 GP practices to develop care processes such as shared care agreements). A total of 335 individuals with a diagnosis of chronic psychosis, or bipolar affective disorder were included in the study. To understand person experience researchers measured satisfaction with services (Figure 5), their perception of unmet need (adapting Camberwell Assessment of Need)[2], severity of mental illness score, and a global assessment of functioning (Byng et al., 2004).

[2] Nine items examining met and unmet needs for care such as medication, emotional support, financial advice Phelan M, Slade M, Thornicroft G, *et al*. The Camberwell assessment of need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *Br J Psychiatry* 1995; 167: 589-595.

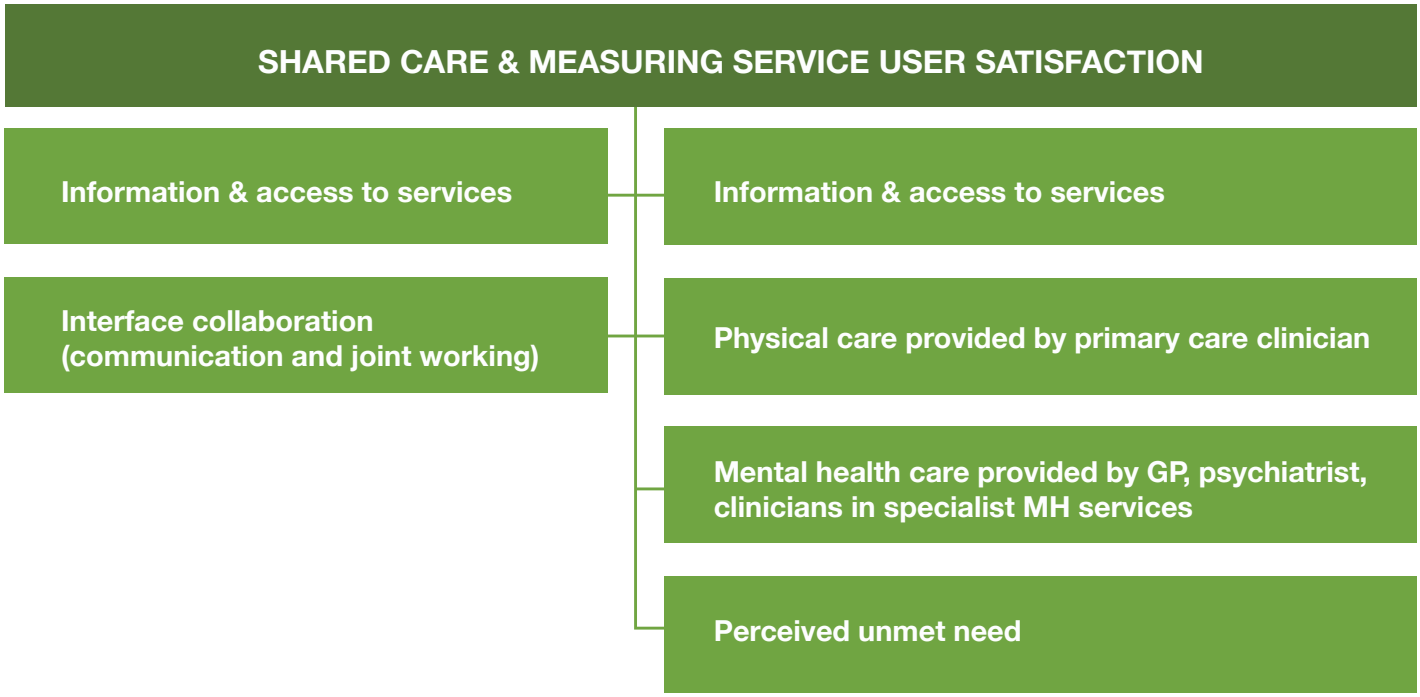

Figure 5 - Key areas measured for service user satisfaction of shared care

GP satisfaction with service delivery as part of the mental health link programme and GP level of interest in mental health were measured. At a team and care processes level, the presence of key service developments was captured for long-term mental health illness. This included link worker activities and the coordination and facilitation of team meetings with community mental health teams, setup of a register and patient database, and the setup of a recall and review system for patients for physical and mental health assessment.

Service Delivery Approach

The service delivery approach for shared care was underpinned by three stages covering assessment, development of a shared care agreement and system development.(Figure 6).

Link workers trained in facilitation processes worked with GP practices and joint working groups (including professionals and managers from each practice, and the associated community mental health teams) and assisted in the assessment process, development of a shared care agreement, set up of care processes including scheduling of review and recall, and annual joint clinical discussions to address unmet need.

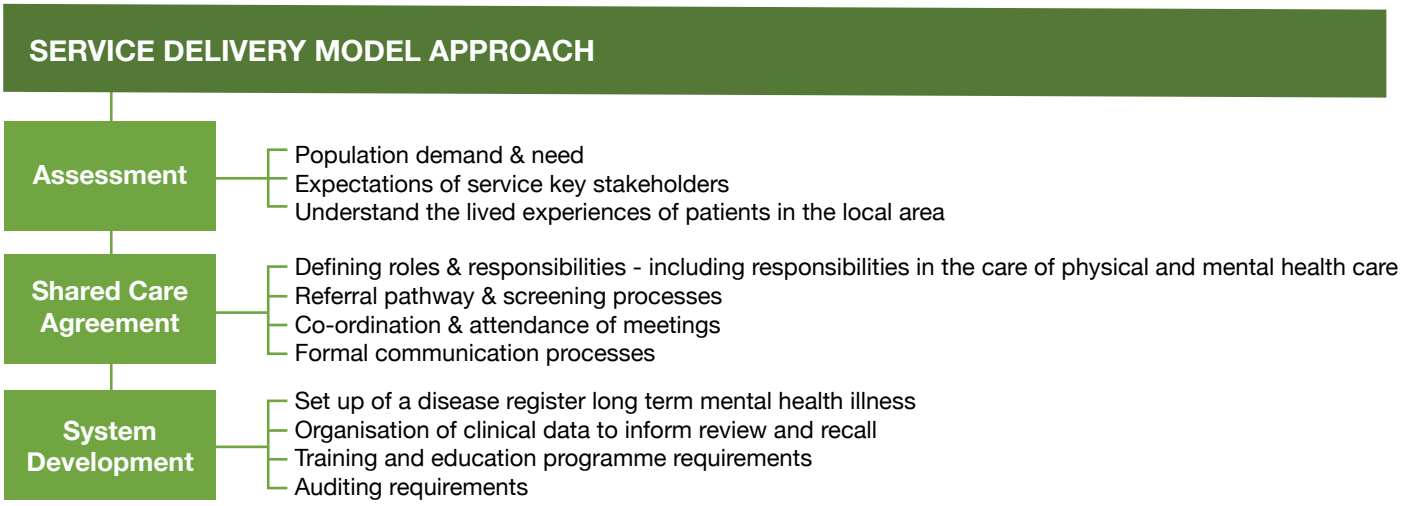

Figure 6 - Service Delivery Model Approach adapted from (Byng et al., 2004)

The first phase of the project was to undertake an initial assessment. This included:

Phase 1
Understanding populations with mental health symptoms accessing GP practices involved to establish demand and need.

- Exploration of the expectations of GPs and joint working groups to inform shared goals.
- The views from local advocacy focus groups on their lived experiences of service access and delivery (Byng et al., 2004).

Phase 2
The output of the assessment phase was the development of a shared care agreement. This defined several key areas covering:

- The roles and responsibilities of the link worker, GPs, and community mental health teams.
- Responsibilities in the care of groups of people including physical health and mental health.
- The referral pathway and screening process.
- Coordination and attendance at meetings including shared clinical review meetings.
- Formal communication processes such as the referral templates, information sharing and input of professionals.

Phase 3
The final phase focused on system development with four key stages for implementation including (Figure 7):

- Setting up a disease register for long-term mental health problems.
- Organisation of clinical data to inform review and recall processes.
- Training needs analysis to direct an educational programme for healthcare professionals involved in the shared care programme.
- Auditing requirements to measure service improvement and quality of care delivered.

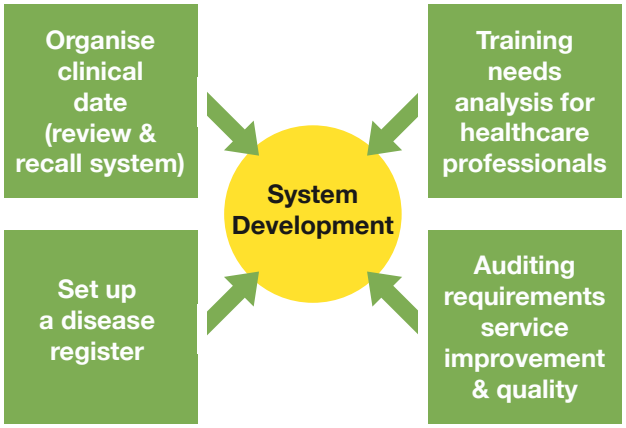

Figure 7 - System Development Shared Care

Link workers had responsibility to assist in the assessment phase and collate information to develop a shared care agreement. Additionally, they arranged for an annual joint review of charts with GPs practices and community Mental Health (MH) teams to address any unmet need and follow up to assess physical and mental care requirements. Link workers also co-ordinated and organised follow up arrangements based on mental and physical healthcare needs ranging from 3 month to 12 month follow up.

Study Outcomes

There was evidence of improvements in review and recall systems under the health link programme (Byng et al., 2004). This was in addition to improvement in GP satisfaction with specialist mental health services. There was also evidence of improved partnerships with community mental health services. Relapse rates were lower in people using the service managed through the health link programme, and there was evidence of improvements in mental health scores. There was no difference in perceptions of health, unmet need or service satisfaction between people using the service receiving usual care or under the health link programme. However, the low percentage of people using the services completing questionnaires affected the ability to accurately compare any differences between groups. Researchers concluded that the health link programme supported a proactive review for people with the greatest need, with the potential to achieve significant physical and mental health gains over the longer term (Byng et al., 2004).

The impact of the health link programme was further tested, examining the key functions of a shared care approach in mental health care (Byng et al., 2008). This retrospective qualitative study included 46 GPs and practice managers involved in the health link programme completing a total of 31 interviews. Outcomes from the study highlighted the importance of the role of the link worker to enhance facilitation and ensure structured follow up of people under the programme. The role was also central in fostering positive relationships with greater cross collaborative working between GPs and community mental health teams reported. Successful integration of the role as an active member of the primary care team was dependent on the flexibility and expertise of the link worker. This included the quality of advice and supporting the appropriate selection of people for case discussions (Byng et al., 2008).

3.2.1.2 Service Delivery Approach - France

Study Background

A study from France examined if the development of shared care interventions had an impact on health care perceptions, and mental health status of people with common mental health problems (MHP) (Younès et al., 2008). A total of 360 people were randomised to either shared care interventions delivered by a community mental health team and 349 were randomised to a control group (GP follow-up). Help seeking behaviours or attitudes were measured at baseline and at 18-months as well as remission rates (no current major depressive disorder, generalised anxiety disorder or psychological distress) and daily life functioning score (SF-36)[3], and satisfaction with care. People using the services involved in the study were also interviewed to determine if there were changes in attitudes.

Service Delivery Approach

The service delivery model included GPs with a pathway to a psychiatric nurse as the link person. The shared care intervention group were referred by GPs to the psychiatric nurse, referrals from GPs to this service were estimated as 500 per year. Populations were commonly referred to the service for the management of depression and/or anxiety. The nurse contacted the person using the services and linked with the GP to establish their expectations in terms of management. Three options were considered as part of the shared care approach. This was based on the individual's needs and reviewed by either the nurse, psychiatrist, or psychologist. The options included a consultation and review

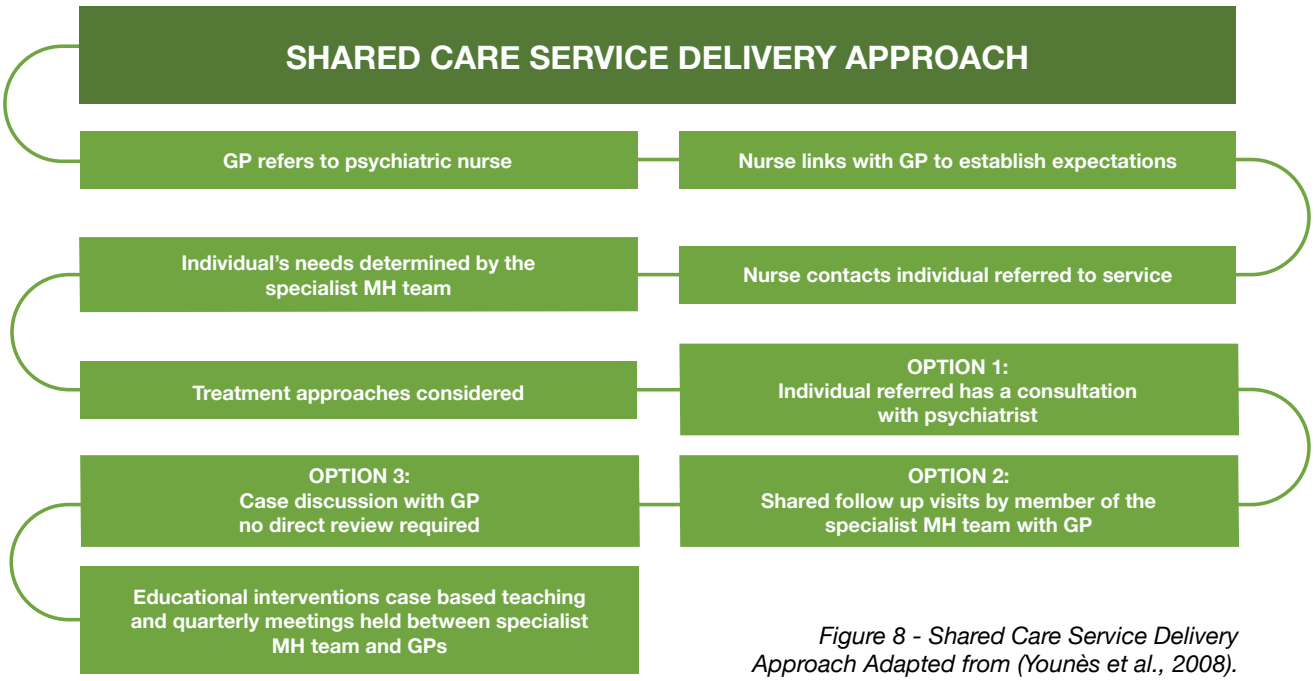

Figure 8 - Shared Care Service Delivery Approach Adapted from (Younès et al., 2008).

[3] SF-36 Assesses eight areas including: 1) limitations in physical activities due to health problems; 2) limitations in social activities and physical or emotional problems; 3) limitations in their usual role activities due to physical health problems; 4) bodily pain; 5) general mental health (psychological distress and wellbeing); 6) Reduction in usual role activities linked to emotional problems; 7) vitality (energy and fatigue); and 8) general health perceptions WARE, J. E., JR. and SHERBOURNE, C. D. 1992. The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. Med Care, 30, 473-83.

by a psychiatrist (estimated as approximately 300 per year), shared care follow up visits with the GP with a view to hand back care (estimated as approximately 200 per year), or case discussion without reviewing the person referred (estimated as approximately 50 per year) (Figure 8). Educational interventions, case-based teaching, and quarterly meetings were held between consultation staff and GPs.

Service Delivery Approach Outcomes

The study reported that people in the shared care intervention group reported a more positive attitude towards healthcare professionals in comparison to the control group (Younès et al., 2008). There were no statistical differences observed in rates of remission or daily life functioning rates between groups. Researchers reported several limitations that may have affected these results. This included the sample size with 400 participants required to each group to statistically show an improvement in remission rates. Whereas the study included 360 participants randomised to the control group and 349 randomised to the intervention group. Also, the long duration in measuring outcomes at 18-months resulted in a significant time lapse in the detection remission rates. There were reports of gaps in data to establish if the person received shared care or was predominantly managed by the GP (Younès et al., 2008). These are important points for policy and service planners to consider when designing the evaluation of any service delivery model as part of shared care to determine outcomes and impact.

3.2.2 Staffing Models in Shared Care

Staffing models to deliver shared care are reflective of the type of service delivery model approach for example, consultant/liaison or collaborative care approach (Foy et al., 2010, Kelly et al., 2011, Smith et al., 2017). Variations in staffing approaches are dependent on the level of coordination and types of interventions required ranging from single consultations delivered through consultation/liaison, to complex case management provided through collaborative care (Katon et al., 1999, Katon et al., 2004, Copello et al., 2013, Gillies et al., 2015). A link worker or case manager are commonly present within both consultation/ liaison and collaborative care models and are pivotal to the set up and development of shared care approaches (Byng et al., 2008, Younès et al., 2008, Kelly et al., 2011, Smith et al., 2017). These roles are normally held by nurses and are based in primary care and integrated with GP practices and community mental health teams (Byng et al., 2004, Younès et al., 2008, Kelly et al., 2011, Archer et al., 2012, Smith et al., 2017). Clinical supervision of these roles is required and commonly delivered by a psychiatrist (Meadows et al., 2007, Chang et al., 2013, Kroenke and Unutzer, 2017). The core team delivering shared care in the community are most commonly GPs, psychiatrists, nurses, psychologists, social workers with additions of occupational therapists, speech and language therapists, family therapists and childcare (Byng et al., 2004, Kroenke and Unutzer, 2017) (Figure 9).

Figure 9 - Staffing Model Shared Care.

3.2.3 Key Enablers of Shared Care

The key enablers and steps to shared care will be presented in this section. These are overarching drivers and requirements to deliver on shared care. Further key enablers and steps will be presented within consultation/liaison and collaborative care models.

There are several key enablers supporting the delivery of shared care and influencing effectiveness and outcome. These cover roles, shared care agreements, clinical guidelines/ protocols and Information and Communications Technology (ICT) systems. (Figure 10).

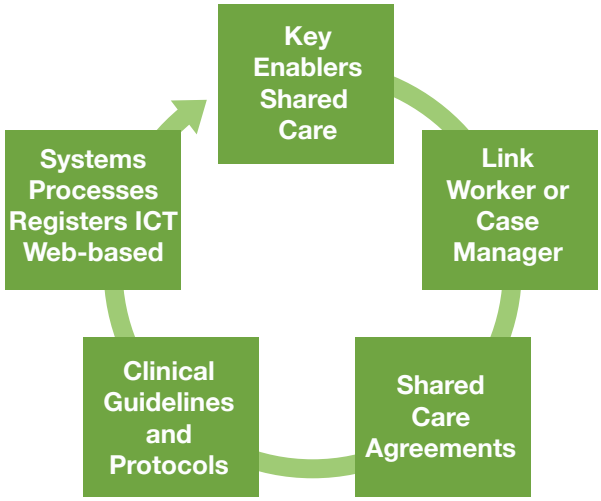

Figure 10 - Key Enablers Shared Care.

Link worker and/or case manager

A key enabler of shared care reported within the evidence is a link worker or case manager (Byng et al., 2004, Byng et al., 2008, Kelly et al., 2011, Smith et al., 2017, Camacho et al., 2018). These roles are pivotal as a central point of contact between primary care and community mental health services, whilst also providing care co-ordination and targeted interventions to support people using the services. This includes review and recall appointments based on need (Byng et al., 2004, Byng et al., 2008, Kelly et al., 2011, Smith et al., 2017, Camacho et al., 2018).

The link worker role has been attributed to facilitating higher remission rates for people living with mental health problems (Byng et al., 2004, Byng et al., 2008). There is also evidence of greater collaboration, trust and more positive relationships with primary care teams and community mental health teams when link workers or case managers are present (Byng et al., 2004, Byng et al., 2008, Archer et al., 2012, Ee et al., 2020). These roles are normally embedded in primary care and work closely with community mental health teams (Byng et al., 2004, Byng et al., 2008, Kelly et al., 2011, Smith et al., 2017).

Shared care agreements

To support engagement and sustainability several studies highlight the need for shared care agreements underpinning governance arrangements between primary care and specialist mental health services determined by the model of care (Byng et al., 2008, Smith et al., 2017). This includes a clear clinical governance framework reflecting upon the types of interventions to be provided, clear processes for clinical supervision of staff, and appropriate evaluation of the model of care in terms of outcomes for people using the services (Kirchner et al., 2004, Blasinsky et al., 2006, Kelly et al., 2011). Shared care agreements including service arrangements were key enablers to developing strong links, leadership, and a commitment to engage (Blasinsky et al., 2006, Byng et al., 2008, Smith et al., 2017).

Shared care agreements are also important to service planning, design, and implementation (Byng et al., 2004, Kates et al., 2019). These are seen as fundamental in defining target populations, care processes and systems required (Byng et al., 2004, Blasinsky et al., 2006, Smith et al., 2007, Kelly et al., 2011). They also provide a foundation to define shared care goals and provide clarity on roles and responsibilities of healthcare professionals involved, whilst also informing the clinical governance frameworks that shared care will operate within (Byng et al., 2004, Byng et al., 2008, Kates et al., 2019). They also serve a purpose in determining the level of collaboration and agreement on scheduled case discussions (Byng et al., 2004, Foy et al., 2010, Kelly et al., 2011, Smith et al., 2017). Additionally, they provide the basis upon which care coordination and scheduling clinical reviews are agreed based on local population needs (Byng et al., 2004, Foy et al., 2010, Kelly et al., 2011, Smith et al., 2017). Care pathways and formal communication pathways also form part of the shared care agreements (Blasinsky et al., 2006, Simon et al., 2006, Smith et al., 2007, Foster et al., 2022).

Clinical guidelines and protocols

Defined clinical guidelines and protocols are recommended to enable a systematic and standardised approach to shared care (Smith et al., 2007, Kelly et al., 2011, Smith et al., 2017). This includes pharmacological and non-pharmacological approaches to standardise care whilst also providing guidance on referral pathways to other services (Kates et al., 2019). The most effective approaches to shared care are underpinned by clear guidelines and protocols for clinical monitoring and treatment options based on clinical need (Kelly et al., 2011).

Systems perspective

From a systems perspective the evidence highlights the importance of a register to profile population need at a GP practice level, and assist in collating information to inform review and recall processes (Byng et al., 2004, Byng et al., 2008). Access to an ICT system and web-based platforms are also seen as fundamental to capture and share clinical information across teams whilst also providing alternative ways using approaches such as telemedicine[4] for patients/service users to interact and communicate with healthcare professionals (Foy et al., 2010, Kelly et al., 2011, Smith et al., 2017).

[4] Telemedicine is conceptualised as health care provision through information technologies and telecommunication systems. Smithson R, Roche E, Wicker C. Virtual models of chronic disease management: lessons from the experiences of virtual care during the COVID-19 response. Aust Health Rev. 2021;45(3):311-6.

3.2.4 Key Steps to Shared Care

In addition to key enablers, there are several key steps recommended for shared care to be successful. This includes defining the level of collaboration required as part of the model of care (Byng et al., 2004, Blasinsky et al., 2006, Kelly et al., 2011, Smith et al., 2017, Foster et al., 2022). This assists the informing of shared care agreements and clinical governance requirements including clinical supervision (Byng et al., 2004, Blasinsky et al., 2006, Kelly et al., 2011, Smith et al., 2017, Foster et al., 2022). Other key steps for successful shared care, refer to the design of care pathways inclusive of monitoring of physical and mental health symptoms, addressing staff education and training requirements, and the ability to share information electronically across services and teams (Byng et al., 2004, Blasinsky et al., 2006, Kelly et al., 2011, Smith et al., 2017, Foster et al., 2022) (Figure 11).

These key enablers and steps to deliver shared care are linked to better clinical outcomes for people who using the services and improvement in the quality of care (Byng et al., 2004, Blasinsky et al., 2006, Kelly et al., 2011, Smith et al., 2017, Foster et al., 2022). As well as understanding the key enablers and steps in the delivery of shared care, it is important to recognise the barriers and challenges as part of implementation planning.

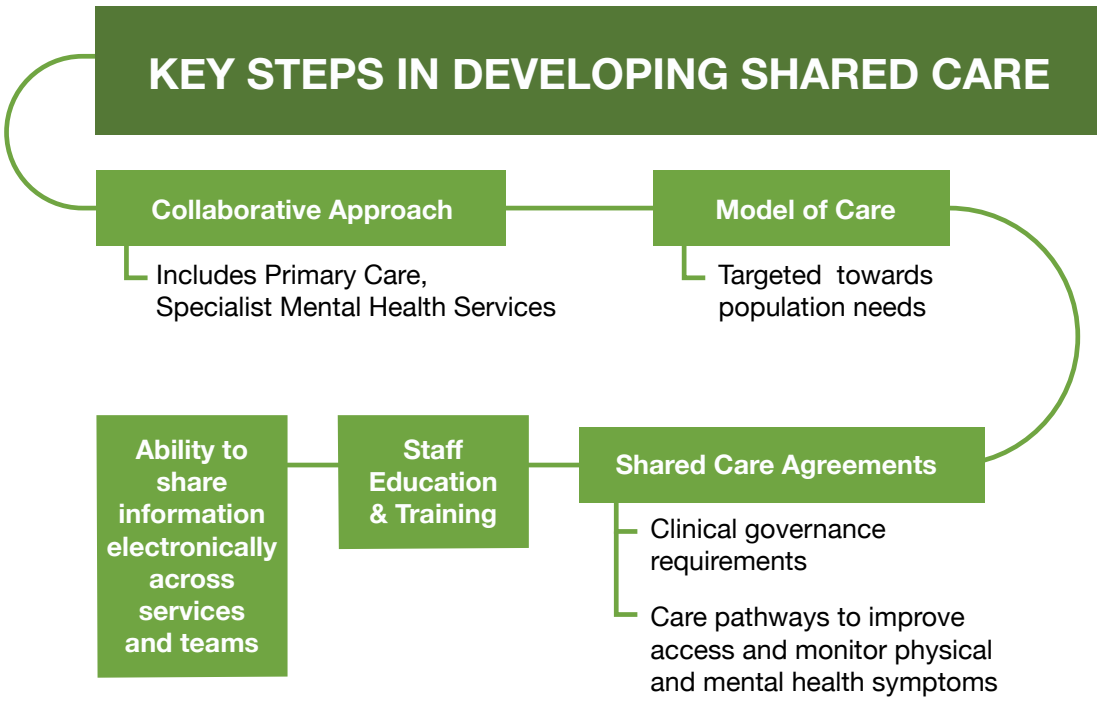

Figure 11 - Key Steps to Shared Care.

3.2.5 Barriers and Challenges to Shared Care

There are several barriers and challenges reported in the development and implementation of shared care. These are presented in table (1).

Core Areas reported as Barriers and Challenges to Shared Care	Examples of Barriers and Challenges
Communication and Information Technology (IT) systems	Developing IT systems to capture and share information cross-collaboratively with primary care and specialist mental health services was reported as both a barrier and challenge (Byng et al., 2004, Byng et al., 2008). Poor communication across primary and secondary care and an over-reliance on communicating via telephone or letter (Lester, 2005). Lack of access to an electronic health record creating communication barriers as primary care and specialist and community mental health services unable to connect to the same system (Foster et al., 2022). Access to real time information about people using the services including current access to services, care plan, and/or list of care providers were seen as barriers and challenges to shared care (Byng et al., 2008, Foy et al., 2010, Foster et al., 2022).
Recall and Review Processes	Time required to review charts at primary practice level and set up systems to proactively review both physical and mental health symptoms (Byng et al., 2004, Byng et al., 2008). Planning requirements and organisation of clinical data for review and recall programmes of care (Byng et al., 2008).
Leadership	The absence of local leadership at senior management team level affected sustainability and commitment to support shared care (Blasinsky et al., 2006, Byng et al., 2008, Kelly et al., 2011)
Resources	The additional financial requirements to sustain shared care approaches for example, additional administrative requirements and personnel (Blasinsky et al., 2006, Byng et al., 2008).
Care Pathways	Inconsistency in care transitions including coordination and continuity of health care between different settings (Foster et al., 2022).
Relationships	Disparate relationships and poor coordination were also reported as barriers and challenges to shared care (Foy et al., 2010, Foster et al., 2022).
Roles and Responsibilities	Confusion over roles and responsibilities in the delivery of shared care reported as both a barrier and a challenge (Lester, 2005, Foster et al., 2022).

Table 1 - Barriers and Challenges to Shared Care

3.2.6 Addressing Barriers and Challenges to Shared Care

Developing strong relationships through cross collaboration at the planning stage and promoting the model of care including key stakeholders (patients/service users and healthcare professionals) across services improves buy-in and co-ordination at an organisational level, and is recommended to address potential barriers and challenges (Foy et al., 2010, Kelly et al., 2011). This includes clarity on roles and responsibilities in the delivery of shared care (Lester, 2005, Foster et al., 2022). When introducing shared care, leadership and governance with local level leadership support and local champions is also reported as essential to overcome any barriers, particularly cultural norms, and work practices (Kelly et al., 2011).

Additionally, setting realistic timelines to identify demand and need at a GP practice level and inform the design and development of shared care agreements and set up care processes and systems of care is recommended (Blasinsky et al., 2006, Byng et al., 2008). On average developing and implementing shared care can vary from 6-12 months to resource and set up care processes and systems (Byng et al.,

2004, Meadows et al., 2007, Frost et al., 2012, Copello et al., 2013). This is also incumbent on availability of an electronic means to facilitate integration operating across services, with the capability to share information regarding people who use the services current service access, treatment options and interventions (Foster et al., 2022). Investing in resources and supporting access to services is also central to buy-in at GP practice level and specialist mental health services addressing potential challenges and barriers to engagement (Byng et al., 2008, Foy et al., 2010, Kelly et al., 2011). This includes provision of link worker and/or case manager working closely with primary care (Byng et al., 2008, Smith et al., 2007, Smith et al., 2017).

Realistic evaluation in understanding shared care in the context of clinical outcomes and collaborative partnerships with people accessing shared care services and healthcare professionals is also recommended in addressing barriers and challenges (Byng et al., 2008, Kelly et al., 2011). Core areas of evaluation to address barriers and challenges include, impact on addressing unmet need, effect on general physical and mental health symptoms, quality of care processes, satisfaction with services (service user and staff experiences) and service development progress for example, effectiveness of shared care agreements, set up of registers, recall and review processes and electronic methods to share information (Byng et al., 2004, Byng et al., 2008, Foster et al., 2022).

3.2.7 Outcomes and Impact of Shared Care

General outcomes and impact are presented in this section to highlight the benefits of shared care overall. Further evidence is presented under consultation/liaison and collaborative care models.

The evidence demonstrates that shared care improves mental and physical health outcomes with higher rates of recovery and remission and greater medication management particularly in the care of depression (Byng et al., 2004, Fuller J et al., 2009, Kelly et al., 2011, Smith et al., 2017).

There is consistent evidence that shared care improves prescribing and drug treatment (Kelly et al., 2011, Smith et al., 2017). This is further enhanced with improved clinical and social outcomes such as better self-management and self-management skills, higher levels of social functioning, greater satisfaction with services, and higher levels of service user engagement (Younès et al., 2008, Fuller J et al., 2009, Kelly et al., 2011, Smith et al., 2017). Other benefits include improved relationships and engagement between primary care and community mental health teams and improved referral pathways to specialist care (Byng et al., 2004, Byng et al., 2008). The most effective approaches showed strong linkages with services with agreed processes for clinical monitoring supported by treatment protocols (Kelly et al., 2011, Smith et al., 2017).

In terms of the economic impact of shared care, there is evidence of lower relapse rates in longer term mental health problems and supporting people in the community (Byng et al., 2004, Smith et al., 2017).

Additionally, in the treatment of depression there were a higher number of depression free days with a mean increase of depression free days of 114 days and lower outpatient costs of 594 dollars per person (Smith et al., 2017).

The following sections will present consultation/liaison and collaborative care approaches that underpin the principles of shared care.

3.3 CONSULTATION/LIAISON

There is increasing evidence demonstrating the advantages of consultation/liaison at primary care level in the care of people with mental health symptoms with early intervention, and reducing the need for specialist psychiatric services (Feltz-Cornelis et al., 2006, Meadows et al., 2007, Frost et al., 2012, Fleury et al., 2021, Tzartzas et al., 2022). Shared care underpins consultation/liaison supporting integration with cross collaborative working benefiting from the unique knowledge and skills to contribute to the overall care of people who use the services, and their families supporting informed choices and engagement (Creed and Marks, 1989, Kisely and Campbell, 2007, Grover and Kate, 2013). This is enabled by a systematic approach to assessment and monitoring supported by the development of care pathways providing guidance on treatment options, as well as level of specialist input from mental health services as required (Oslin et al., 2006, Tzartzas et al., 2022). In general, consultation/liaison offers support and guidance defined as:

"*The provision of knowledge and skills concerning mental health care to primary care clinicians. It involves mental health specialists entering an ongoing educational and supportive relationship with primary care clinicians providing opportunities for case discussion. This includes the provision of specialist guidance to enhance the care of individuals presenting with mental health symptoms. Interventions can include prescribing or providing skills in psychological therapy. Referral to specialist care is needed in a small proportion of cases*". *(Creed and Marks, 1989, Kisely and Campbell, 2007, Meadows et al., 2007, Frost et al., 2012, Fleury et al., 2021, Russell et al., 2021, Tzartzas et al., 2022).*

In this section, consultation/liaison will be presented in the context of service delivery approaches, staffing models, key enablers, barriers and challenges and outcomes and impact.

3.3.1 Service Delivery Approach to Consultation/Liaison

To understand different concepts of consultation/liaison service delivery approaches three service delivery models are presented from Australia, UK and Malaysia. These were chosen to provide different perspectives on consultation/liaison including the various steps such as level of collaboration required, principles of care, types of interventions and varying populations accessing these services.

3.3.1.1 Service Delivery Model Approach - Australia

Researchers in Australia adopted a case study and service evaluation approach to assess the effect of a consultation/liaison in primary care psychiatry program (CLIPP) including 62 people with a range of psychiatric illnesses (predominantly schizophrenia) and 10 GPs (Meadows et al., 2007).

The CLIPP model (Figure 12) adopted a stepped approach to care with the first step focused on consultation/liaison and second step focusing on collaborative care.

There were several key principles underpinning the model. This covered **support and guidance** facilitated by case discussions, management plans and education and training (Meadows et al., 2007).

Assessment and monitoring supported by structured assessments measuring clinical stability, mental health, functional levels and life skills profile and the role of the CLIPP nurse and case manager (Meadows et al., 2007). A review and recall process provided a structured approach to monitoring supported by an electronic system.

Early intervention was guided by protocols, and supported by care pathways enabled by a CLIPP nurse and case manager (Meadows et al., 2007).

Support & Guidance	Assessment & Monitoring	Early Intervention
Case Discussions Clinical Management Plans Education & Training	Structured Assessment Measuring Clinical Stability Mental Health Functional Levels Life Skills Profile Review & Recall Processes enabled by an electronic system	Protocols Care Pathways Case Manager Electronic systems to record events/adverse outcomes to shared care with psychiatrist and GP

Figure 12 - Principles within the CLIPP Model adapted from Meadows et al., 2007.

Step 1 CLIPP Model

Step 1 delivered a consultation/liaison and education and training approach provided by a psychiatrist supporting between 3-10 GPs as a group. This was a support and guidance approach through case discussions held every two weeks as a half-day session with an average of 2-3 case discussions for each session. This was normally as a single consultation for each person with a plan provided and an option to review again with the psychiatrist if required (Meadows et al., 2007).

The consultation/liaison sessions also provided an opportunity for education and training and to identify if further specialist mental health input was required (Meadows et al., 2007).

Step 2 CLIPP Model Collaborative Care

The second step involved transitioning people from community mental health services back into primary level care. A CLIPP nurse working within community mental health services identified people suitable for transfer and engaged with a case manager and the community mental health team to determine suitability and care needs. As a collaborative care approach, a case manager worked with GPs and specialist mental health services. People suitable for this pathway were normally clinically stable with evidence of social care needs and required higher levels of care coordination with a risk of relapse without a period of support and defined monitoring.

Any direct visits and telephone consultations were normally provided by the case manager (normally a nurse) and the programme lasted between 6-12 months (Meadows et al., 2007). An escalation pathway to community mental health services was developed for early intervention if there were any clinical or social issues emerging (Meadows et al., 2007).

Transitioning from **step 1** to **step 2** of the CLIPP model (Figure 12) was determined at primary care level at a case conference in the primary care clinic. The transfer of care was supported by a detailed management plan developed by the community mental health team including the CLIPP nurse. The transition of care was guided by care pathways from GPs to specialist mental health services and vice versa (Meadows et al., 2007).

To enable both steps required shared CLIPP documentation and a recall and review reminder system. Additionally, a structured approach to record clinical response and record any adverse outcomes to guide escalation of care was essential. Availability of administrative staff to support electronic systems and set up reminders and recall processes was key. The electronic system was fundamental to assist with re-call and recording any adverse outcomes/events that could be shared with psychiatrist and GP for early intervention (Meadows et al., 2007).

Study Outcomes of the CLIPP Service Delivery Model

The CLIPP model (Figure 13) included a consultation/liaison and collaborative care approach between primary care and community specialist mental health services. This benefited people as pathways of care were flexible to match their care needs providing a stepped approach (Meadows et al., 2007). This improved collaboration across services and sharing of clinical workload. There was also evidence of improved GP confidence in management of mental health symptoms and encouraging trust and positive relationships with mental health services. From a clinical perspective there was evidence of improvements in clinical status, higher general functioning, and reduction in healthcare utilisation (Meadows et al., 2007). The CLIPP model adopted a stepped approach

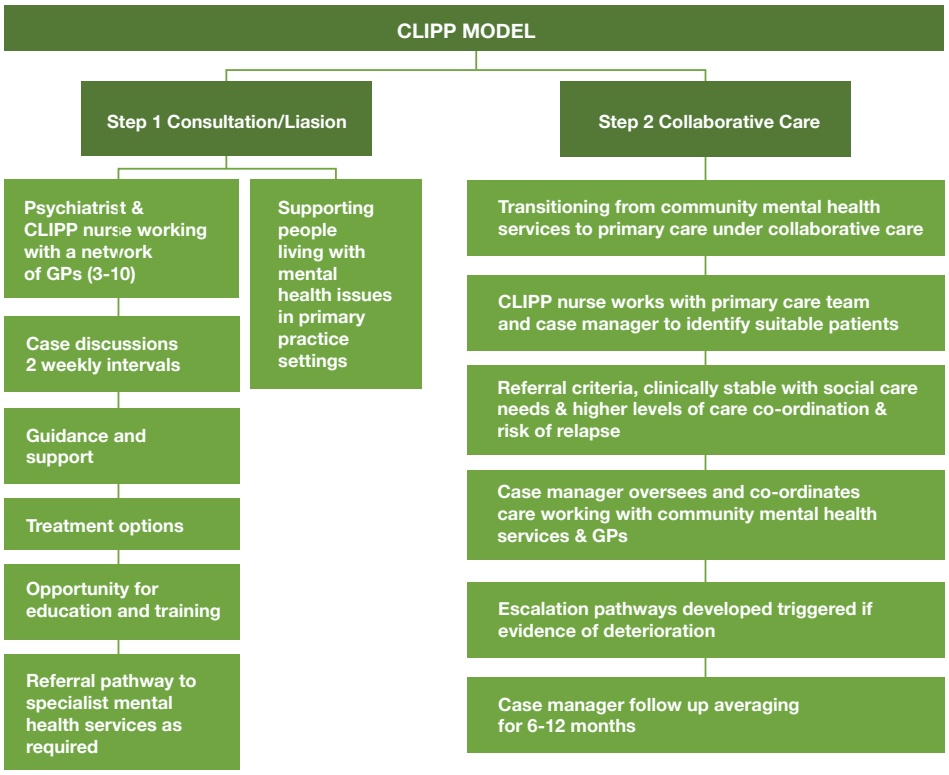

Figure 13 - CLIPP Service Delivery Model Adapted from Meadows et al., 2007.

to include consultation/liaison and collaborative care working with GPs, the primary care team and community specialist mental health services. Outcomes measured were based on the CLIPP model overall and step 1 and step 2 were not compared. Having access to both pathways as part of the same model was seen to benefit patients as flexibility matched the care needs offering a stepped approach (Meadows et al., 2007). This also improved collaboration across services and sharing of clinical workload. There was also evidence of improved GP confidence in management of mental health symptoms and building of trust and relationships with mental health services. From a clinical perspective there was evidence of improvements in peoples' clinical status, higher general functioning, and a reduction in healthcare utilisation (Meadows et al., 2007).

Sustained continuity of shared care within the CLIPP model required supervision by specialist mental health services working with GPs. This was in addition to the development of protocols, electronic means to capture, monitor and share information across services and sustaining the two pathways within the model supported by a CLIPP nurse and case manager (Meadows et al., 2007).

3.3.1.2 Service Delivery Approach Consultation/Liaison - UK

In comparison to the CLIPP model, a different approach was tested in the UK (Copello et al., 2013). This was initially developed for **Combined Psychosis and Substance Use Programme** (COMPASS) for people with concurrent mental health and substance use issues with a focus on the people who use services (Copello et al., 2013).

However, due to changes in demographics and demand to treat other mental health diagnoses, the programme expanded to include a range of mental health problems (depression, personality disorders and bipolar disorders). A total of 173 people using the services were included in the study with the majority referred from mental health services and a small number from addiction services. Outcomes measured included engagement in treatment, recognition of the importance and readiness and confidence to change, substance-related beliefs and severity of dependence, and changes in behaviour (Copello et al., 2013).

The COMPASS consultation/liaison service was accessible to services based within a Mental Health National Health Service (NHS) foundation trust with the exception of outreach,

early intervention, and homeless community mental health teams as they provide intensive programmes of care (Copello et al., 2013). The service was provided by a COMPASS practitioner as part of specialist mental health services.

Consultation/liaison service offered within COMPASS was time-limited starting with a structured specialist assessment to inform and direct motivational work as a joint approach working closely with the referrer, normally a care-coordinator (Figure 14). The joint approach assisted in facilitating treatment plans, offering guidance and support to the referrer to continue with the treatment plan following the brief intervention offered within the consultation/ liaison service (Copello et al., 2013).

This service offered six sessions (two assessment, two motivational, and two follow-up sessions) conducted over a 12-week period. Initial sessions guided the development of treatment recommendations, followed by two motivational enhancement sessions and finally two follow up sessions. Motivational sessions focused on understanding their beliefs and reason for substance misuse, strategies to engage with treatment plans and manage mental health symptoms, as well as their associated substance misuse. Follow up sessions were based on the individual's personal needs however, in general focused on recovery, sustaining positive behavioural change, and building a social network of support.

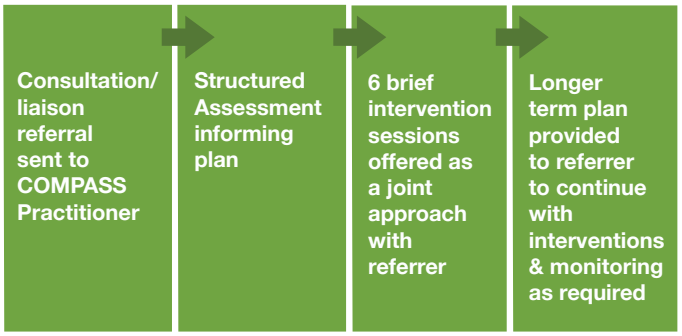

Figure 14 - Service Delivery Model Approach COMPASS Consultation/Liaison.

Study Outcomes

The COMPASS service delivery model adopted a short-term brief interventional approach to consultation/liaison providing six sessions followed by a management plan that the referrer followed. This alternative approach to consultation/liaison showed positive outcomes with evidence of improved confidence, a positive change in perspectives on substance use, increased engagement with treatment, reduced alcohol, and cannabis use. The enhancement of existing services through specialist assessment, advice, and consultation supported by the delivery of a brief intervention was attributed to the success of the model (Copello et al., 2013).

From a primary care perspective although the COMPASS model was tested with mental health services there is potential to extend this to GP and primary care services. The key enabler is the availability of a practitioner in specialist mental health and a care-coordinator to work with the consultation/liaison service with additional opportunities to link with a collaborative care model as a stepped approach to care (Meadows et al., 2007). For example, supporting people with concurrent addiction and mental health diagnoses to transition back into primary care from community mental health services, and reduce the risk of relapse and support remission (Meadows et al., 2007). This is in addition to a pathway from GPs offering an alternative treatment option within consultation/liaison approach to avail of brief interventions as detailed in the COMPASS programme (Copello et al., 2013).

3.3.1.3 Service Delivery Approach to Consultation/Liaison - Malaysia

In Malaysia an exploratory study examined clinicians' perspectives on common mental health problems (CMP) prior to and after the implementation of a consultation/liaison psychiatry service in primary care (PIPC) (Russell et al., 2021). The study included 17 clinicians including health and social care professionals working in the two primary care centres accessing PIPC.

The consultation/liaison service operated within the two primary care centres and was led by three psychiatrists providing one-half day session (8.30am to 12.30pm) once weekly (Figure 15). There were two options offered as part of service, these included an indirect consultation referred to as an in-person discussion, or a clinical assessment referred to as a direct consultation requiring an in-person discussion and clinical

assessment of the person with recommendations (Russell et al., 2021) .

Communication pathway with primary care clinicians was established providing a consultation report to the referring clinician within the following week of referral. Accessing consultation/liaison sessions were not limited to referring clinicians and were open to all primary care clinicians providing an opportunity to develop knowledge and skills (Russell et al., 2021).

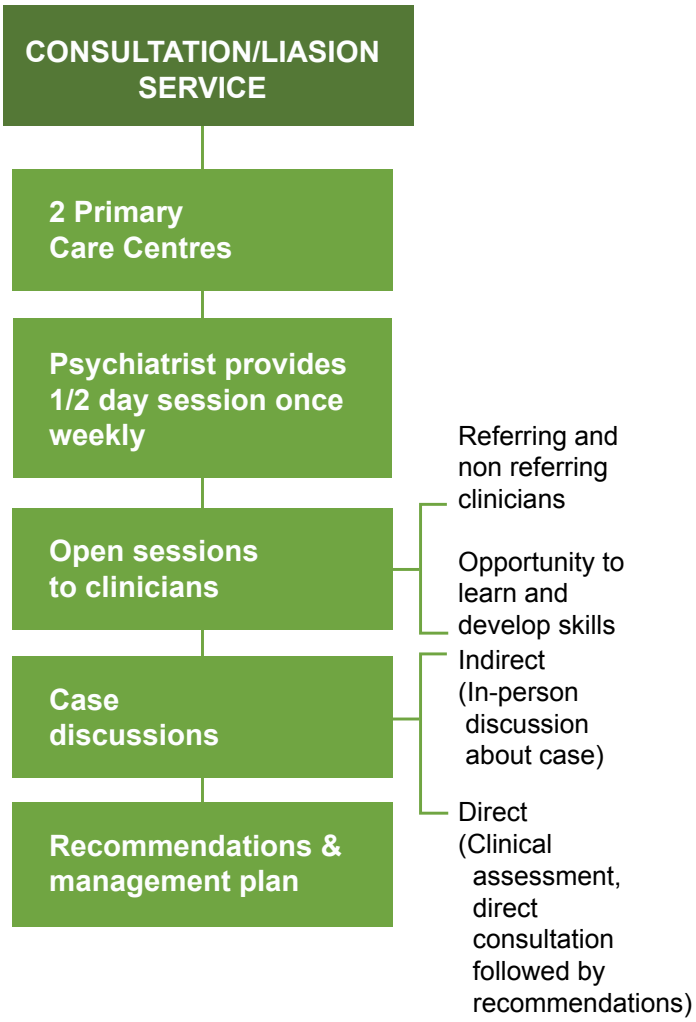

Figure 15 - PIPC Consultation/Liaison Service Delivery Approach (Russell et al., 2021).

A primary care physician was nominated to link with clinicians in the primary care centre to establish the number of referrals for discussion and liaise with the consultation/liaison team. Referrals were sent in advance of case discussions and face to face discussions with the referrer were in advance of any direct clinical assessment of patients.

Study Outcomes PIPC Consultation/Liaison

Prior to the introduction of the PIPC consultation/liaison service, there was evidence of a lack of knowledge underpinning screening processes for CMP in terms of symptoms, level of severity or functional impairment that would inform a diagnosis (Russell et al., 2021). This included lower levels of awareness and increased risk of depression and anxiety in chronic disease such as diabetes and heart disease. This improved following the introduction of the PIPC service with evidence of increased confidence and increased knowledge and skills with greater understanding of CMP. Clinicians recognised the benefits and value of access to the PIPC service with increased awareness of CMPs as medical diagnoses, sensitivity in approaching assessment of symptoms and any associated perceived stigma, and greater understanding of treatment options. This was enhanced by a formal structural approach to the service. This included a link person within the primary care centre, designated psychiatrists, a clear referral process, scheduled sessions for case discussions and support and guidance for treatment options, and an option for specialist mental health review of people accessing the service as required. Additionally, people using the services and their families reported satisfaction with their interaction with the PIPC service including quality of feedback received and management plan (Russell et al., 2021).

There were several barriers and challenges reported affecting engagement with PIPC service. This included time constraints to attend sessions whilst also managing busy primary care practice schedules. There was also a low referral rate for people with medical long-term conditions. This was linked to time pressures in monitoring physical symptoms associated with medical conditions affecting review and early intervention of mental health symptoms. In addressing barriers and challenges participants highlighted the importance of resourcing the service appropriately to increase engagement and sustainability. There were mixed views on delivery of case discussion sessions, with various clinicians reporting that sessions should be avoided during busy clinical times, and others felt that it would be more effective to deliver as an ongoing medical education activity and separate from the working day (Russell et al., 2021).

Presenting service delivery approaches from Australia, UK and Malaysia assists in understanding alternative approaches to service delivery that underpin shared care through consultation/liaison and stepped approaches to care.

3.3.2 Staffing Models for Consultation/Liaison

Staffing models to deliver consultation/liaison vary depending on the level of intervention provided (Meadows et al., 2007, Copello et al., 2013). The most common staffing approach to consultation/liaison is the provision of a designated psychiatrist to work with a network of GP practices (Feltz-Cornelis et al., 2006, Meadows et al., 2007, Frost et al., 2012, Copello et al., 2013, Russell et al., 2021, Tzartzas et al., 2022).

A link person or co-ordinator role is often present providing support and coordination and can offer brief interventions as part of the consultation/ liaison role (Oslin et al., 2006, Kisely and Campbell, 2007, Meadows et al., 2007, Copello et al., 2013).

In this context, a consultation/liaison, co-ordinator or link role provides support to psychiatrists as part of the model of care and works with GP practices and specialist mental health services (Meadows et al., 2007, Copello et al., 2013). This role can be occupied by a nurse with specialist mental health knowledge and experience (Meadows et al., 2007). A case manager role can also operate within consultation/liaison approaches as part of a stepped approach to care when longer term monitoring and coordination of care is required (Meadows et al., 2007). (Figure 16).

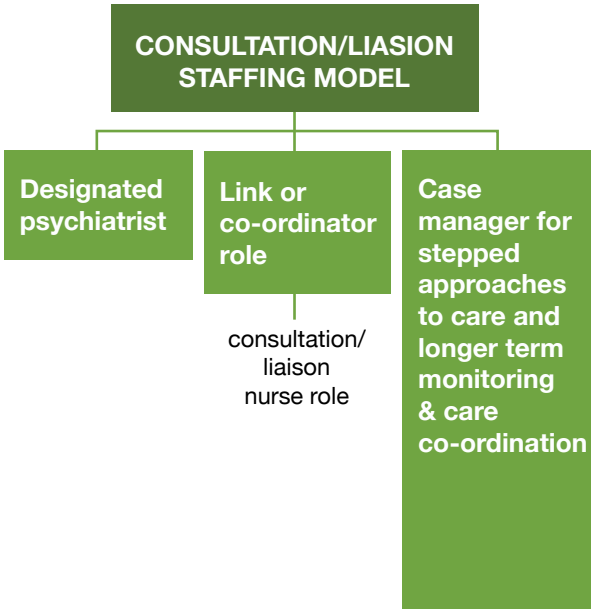

Figure 16 - Staffing Model Consultation/Liaison.

These roles are supported by a structured approach that includes guidelines, protocols and care pathways, agreed screening and assessment processes, scheduled sessions for case discussions and education and training (Figure 17) (Bodlund et al., 1999, Oslin et al., 2006, Meadows et al., 2007, Frost et al., 2012, Copello et al., 2013, Grover and Kate, 2013, Fleury et al., 2021, Russell et al., 2021). Flexible care pathways are also seen as a key enabler to consultation/liaison with the option to offer brief interventions as required with evidence of improved engagement of the person using the service and better clinical outcomes (Meadows et al., 2007, Copello et al., 2013). Having access to an electronic platform to share information was central to integration and operating the model across teams and services (Meadows et al., 2007, Frost et al., 2012).

3.3.3 Key Enablers for Consultation/Liaison

The success of consultation/liaison models is based on several key enablers (Figure 17). This includes a designated psychiatrist, consultation/ liaison nurse and/or a link role working across primary practice and with specialist mental health services (Meadows et al., 2007, Frost et al., 2012, Chang et al., 2013, Fleury et al., 2021, Russell et al., 2021).

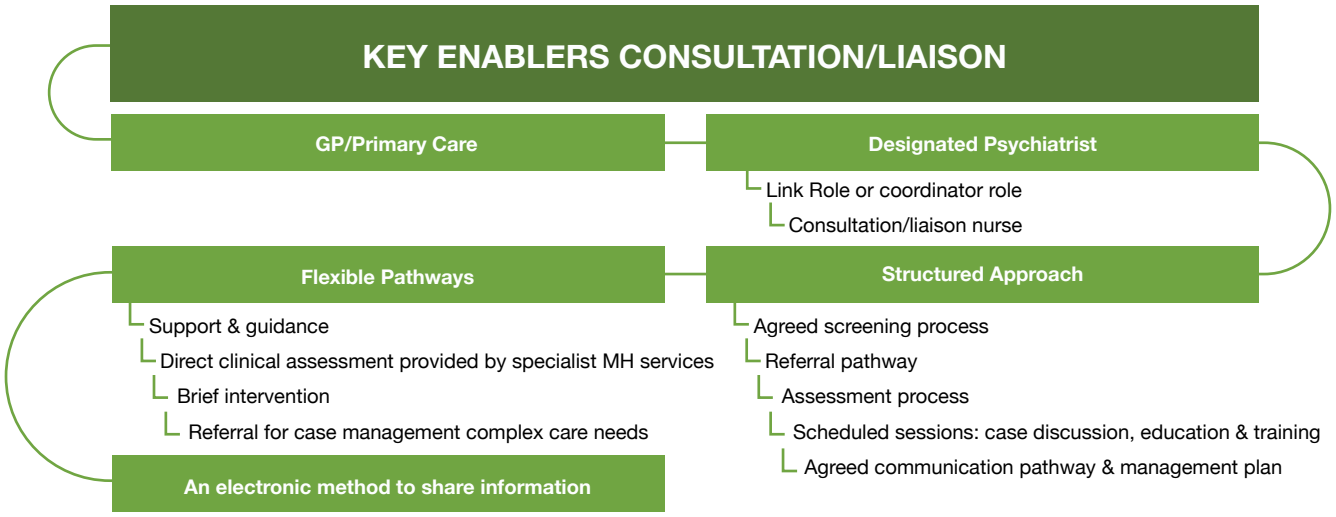

Figure 17 - Key Enablers Consultation/Liaison.

3.3.4 Barriers and Challenges - Consultation/Liaison

There are several barriers and challenges reported in the development and implementation of consultation/liaison approaches to care. These are presented in Table (2) and include time and resource constraints, different ways of working, clinical governance and organisational and systems support.

Core Areas reported as Barriers and Challenges to Shared Care	Examples of Barriers and Challenges
Time and resource constraints	Time constraints for primary care clinicians to engage in consultation/liaison as covering other clinics and sessions (Russell et al., 2021). Limited time to assess and detect mental health symptoms in general practice (Laufer et al., 2023). Increase in administrative duties and demand for direct face-face consultations and greater capacity to refer more people (Oslin et al., 2006). Lack of team stability and resources to cover large networks and distances to travel (Fleury et al., 2021).
Recall and Review Processes	Different ways of working between primary care and specialist mental health services are reported as barriers and challenges. This includes different consultation processes and population presentation such as multimorbidity, physical and psychological symptoms (Kisely and Campbell, 2007) A pattern of a hospital approach to care affecting primary care clinicians' ability to engage in consultation/liaison (Russell et al., 2021).
Leadership	Clarity on clinical governance and direct accountability and defining joint clinical governance frameworks (Kisely and Campbell, 2007).
Resources	Provision of adequate training and education (Kisely and Campbell, 2007). Defining roles and scope of practice for primary care clinicians and specialist mental health services (Kisely and Campbell, 2007). Lack of performance indicators (Russell et al., 2021). Inadequate processes and systems of work and processes for collective and self-appraisal (Fleury et al., 2021, Russell et al., 2021). Lack of flexibility in the delivery of a model of care (Fleury et al., 2021). Lack of space in primary care settings to deliver consultation/liaison services (Fleury et al., 2021).

Table 2 - Core Areas Reported as Barriers and Challenges to Consultation/Liaison.

3.3.5 Addressing Barriers and Challenges to Consultation/Liaison

There are several key areas that can address potential barriers and challenges to consultation/liaison approaches (Figure 18). This includes the introduction of psychiatrists into primary care to improve specialist access and facilitate case discussions (Laufer et al., 2023). The addition of link roles such as nurse liaison roles to support primary care and work closely with specialist mental health services are recommended (Meadows et al., 2007, Fleury et al., 2021).

Understanding different ways of working and designing service delivery approaches that are collaborative facilitates successful design and implementation of consultation/liaison (Kisely and Campbell, 2007).

Nominating champions at primary care practice level to work with networks of GPs is viewed as a key driver to facilitate the development of consultation/liaison (Russell et al., 2021).

This is in addition to support from collaborating specialist mental health services to offer guidance and input into the design of services (Fleury et al., 2021). Support from organisations and requirements to integrate and monitor training and education programmes, sharing of clinical information and reducing complexity in the development of pathways of care across networks assist in addressing barriers and challenges (Fleury et al., 2021, Russell et al., 2021).

The development of a decision support mechanism embedded in protocols and guidelines can also assist primary care to triage people for consultation/liaison service (Oslin et al., 2006). Potential time and resource constraints are addressed through appropriate screening and identification of mental health symptoms (Oslin et al., 2006).

Additionally, adopting a hybrid approach to consultation/liaison using in-person and virtual consultation/liaison approaches can assist in overcoming challenges in direct face-face consultations and covering large networks, distances and limited availability of clinical space (Oslin et al., 2006, Fleury et al., 2021).

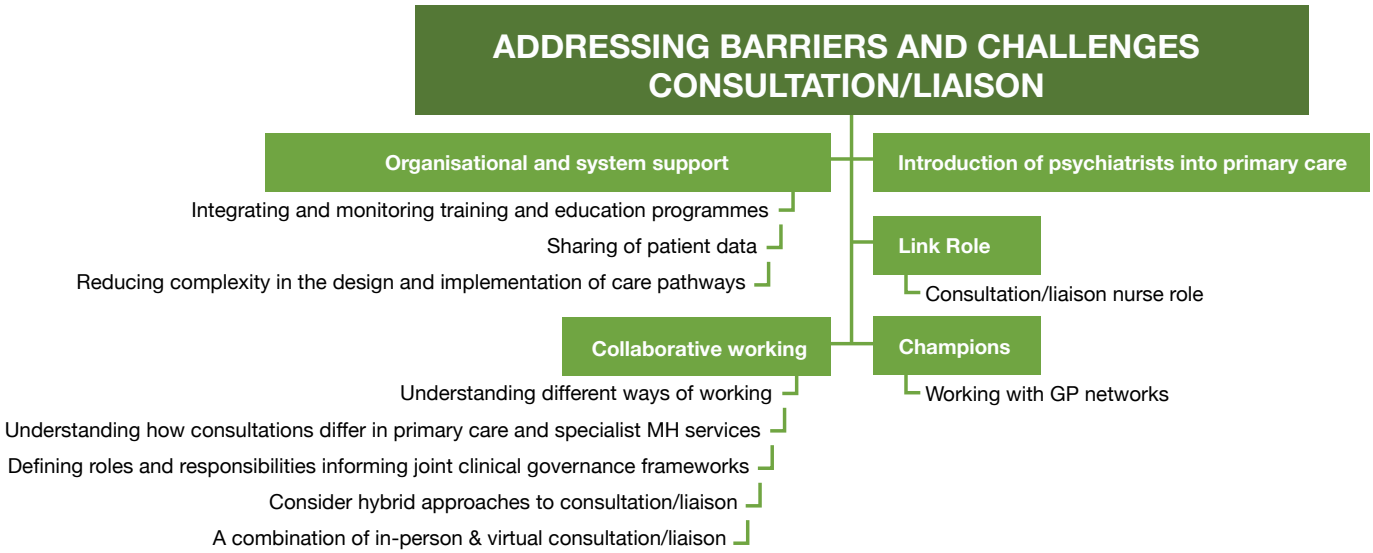

Figure 18 - Addressing Barriers and Challenges Consultation/Liaison.

3.3.6 Outcomes and Impact of the Consultation/Liaison

In this section, general outcomes and impact of consultation/liaison are presented to understand the overall benefits.

Seminal research examined the benefits of consultation/liaison service over a 5-year period showing that the care of people with mental health symptoms improved in conjunction with the skills of GPs in the detection and treatment of mental health symptoms (Creed and Marks, 1989). People were often treated without requiring a specialist referral for input reducing demand (Creed and Marks, 1989). There is also evidence of improvements in doctor/person relationships as service users observed progression in treatment plans with positive responses (Oslin et al., 2006, Kisely and Campbell, 2007, Tzartzas et al., 2022).

The benefits of consultation/liaison in improving mental health symptoms and conditions are observed in the first 3 months of treatment (Copello et al., 2013, Gillies et al., 2015). This effect is also extended to substance misuse with lower levels of alcohol and cannabis in people with concurrent mental health symptoms following access to consultation/liaison services (Copello et al., 2013). Higher levels of recovery and remission rates were also observed in the treatment of depression (Oslin et al., 2006, Grover and Kate, 2013, Gillies et al., 2015). This was enabled by improved prescribing practices by primary care providers (Feltz-Cornelis et al., 2006, Grover and Kate, 2013, Tzartzas et al., 2022). Healthcare utilisation was also observed with fewer return visits for people managed through consultation/liaison services and evidence of higher levels of treatment adherence observed up to 12-months following intervention (Feltz-Cornelis et al., 2006, Copello et al., 2013, Gillies et al., 2015).

Greater satisfaction and experience in services was reported by clinicians and people using the services following access to consultation/liaison services with reduced wait times for specialist review (Gillies et al., 2015, Russell et al., 2021). Improvements in confidence and knowledge and skills of primary care clinicians in diagnosing and treating mental health symptoms were evident (Feltz-Cornelis et al., 2006, Fleury et al., 2021, Russell et al., 2021, Tzartzas et al., 2022). This is in addition to greater collaboration and less stigmatising attitudes associated with attending specialist MH services as care was provided at practice level (Copello et al., 2013, Russell et al., 2021).

3.4 COLLABORATIVE CARE

Collaborative care supports shared care approaches through joint working and is viewed as an integral step to enhance quality of care, and integrate with multiple services in delivering mental health care in primary care settings (WHO., 2008). This includes improving management of mental health problems and concurrent chronic illnesses such as diabetes and heart failure (WHO., 2008). Collaborative care models were originally developed for chronic disease management and have since developed to treat people with mental health issues due to increasing evidence of the mental and physical health benefits (Katon et al., 1999, Katon et al., 2004, Archer et al., 2012). This includes improved recovery and remission rates, improved health and wellbeing and reports of improved satisfaction with care by people accessing services (WHO., 2008, Archer et al., 2012).

Collaborative care models have the flexibility to operate in conjunction with consultation/liaison approaches as a stepped approach to care for people with complex care needs including higher social care needs (Meadows et al., 2007). In comparison to consultation/liaison approaches, that often include a GP and psychiatrist, collaborative care is commonly multi-professional and can also involve screening, medication management, self-management techniques and interventions such as talking therapies (Archer et al., 2012). Care is normally organised and co-ordinated by a case manager following a structured management plan working with primary care and specialist mental health services (Archer et al., 2012, Reist et al., 2022). Case managers are normally clinicians (most commonly a nurse) that manage and monitor people with a range of mental health problems in primary practice settings (Kroenke and Unutzer, 2017, Ali et al., 2020) Common elements of care provided can include managing and updating a disease registry, providing education and self-management techniques, tracking and monitoring response to treatment, and working with the multidisciplinary team (MDT) (Kroenke

and Unutzer, 2017). The case manager facilitates regular caseload reviews with the MDT, there is joint decision making and joint standardised approaches to assessment, planning and evaluation of care (WHO., 2008, Archer et al., 2012, Kroenke and Unutzer, 2017, Reist et al., 2022)

In general, collaborative care is defined as:

> *"An approach that uses a process of collaboration between primary care providers (normally a GP) and specialist mental health teams to re-design systems and pathways of care supported by an integrated electronic platform to share information.*
> *It is underpinned by a multidisciplinary team (MDT) approach with MDT guidelines, joint decision making, standardised assessment and treatment approaches with regular monitoring and evaluation of care. This is normally a pathway of care offered for people requiring longer term interventions and monitoring and support for mental health symptoms, chronic disease management and social care. The presence of a case manager oversees and coordinates care whilst providing support and interventions working in partnership with the person and MDT."*
>
> (Bower and Gilbody, 2005, Meadows et al., 2007, Katon et al., 2010, Archer et al., 2012, Camacho et al., 2018, Kates et al., 2019, Reist et al., 2022).

In this section, collaborative care will be presented in the context of service delivery approaches, staffing models, key enablers, barriers and challenges and outcomes and impact.

3.4.1 Service Delivery Approaches to Collaborative Care

To understand the different concepts of service delivery, three service delivery models are presented from America, UK and India. These were selected as they provide different perspectives on collaborative care approaches including the principles underpinning service delivery, the approach to collaboration, varying populations accessing services and types of interventions provided.

3.4.1.1 Service Delivery Approach to Collaborative Care - America

Researchers in America examined the effect of a collaborative care model over a 12-month period for 214 individuals from 14 primary care clinics with poorly controlled diabetes and/or coronary heart disease with concurrent depression (Katon et al., 2010). Clinical indicators for recruitment included a glycated haemoglobin HbA1c[5] 8.5% or higher, a low-density lipoprotein (LDL) of >3.4 mmol/per litre (cholesterol levels), and a blood pressure above 140/90 mm Hg and had evidence of depression (measured using the Patient Health Questionnaire PHQ-2, scores of 3 or more indicating depression, Kroenke et al., 2003). People were randomised to either usual care under the primary care physician (GP) providing care for depression and/or diabetes and coronary heart disease, or collaborative care provided by a nurse working with individuals and the primary care physician. The collaborative care approach was supported by guidelines and targeted goals to control risk factors associated with these chronic diseases. Outcomes measured included changes in glycated haemoglobin (HbA1c), low density lipoprotein (LDL), systolic blood pressure and depression levels at 12 months (Katon et al., 2010).

The service delivery approach consisted of three part-time collaborative care nurses with experience in diabetes education that worked in collaboration with primary care physicians (GP) (Figure 19). A 2-day training course was provided to nurses as part of the intervention covering chronic disease management and treatment of depression. This was designed and delivered by a range of healthcare professionals from specialist mental health, primary care practice, endocrinology, and nephrology.

The interventions provided to people in the collaborative care arm of the study received support for self-care, pharmacotherapy, and behavioural strategies in the treatment of depression. This was in addition to the treatment of hyperglycaemia, hyperlipidaemia, and hypertension.

Collaborative care nurses worked in partnership with the primary care physicians and individuals to set clinical and self-care goals delivered through structured visits held every 2-3 weeks in the primary care clinic. Clinical supervision was provided to nurses weekly through a

[5] A HbA1c measures your average blood sugar levels over the past 3 months.

collaborative care approach supported by a psychiatrist, GP, and psychologist. This provided an opportunity to review progress and recommend changes if required. Progress was monitored and measured by the collaborative care nurses and guided by treatment protocols to advise on adjustments if clinical goals were not met.

A motivational and coaching approach was adopted by nurses to support people to meet their self-care goals and support engagement in treatment. Once clinical and self-care goals were
met, the nurse worked in partnership with the individual to develop a long-term plan including behavioural goals, identification of symptoms of worsening depression and chronic disease, stress management and medication management. Ongoing monitoring was provided 4-weekly via telephone consultations supplemented by the completion of the PHQ-9 questionnaire to measure the level of depression (Kroenke et al., 2003). Telephone consultations were guided by protocols and informed escalation of care with direct review (Katon et al., 2010).

Study Outcomes for the Collaborative Care Approach - America

At 12-months, there were significant improvements in HbA1c, LDL, systolic blood pressure and levels of depression in people accessing collaborative care in comparison to usual care. This included a higher proportion of people achieving 50% or higher reduction in their depression scores. Satisfaction with care was also higher in the collaborative care group and there was evidence of greater improvement in quality of life. There were no significant differences between the collaborative care group and usual care in the number of people adhering to recommendations for diet and exercise (Katon et al., 2010).

Researchers concluded that a collaborative care approach was associated with improved clinical and quality of life outcomes (Katon et al., 2010). This was supported by a joint primary care disease-control approach to treat depression and poorly controlled concurrent diabetes and/or cardiovascular disease. The success of the approach was linked to the level of structured support provided to the primary care team in the treatment of individuals with complex care needs. Weekly supervision and case reviews were viewed as important to this process as offered timely intervention and support to achieve

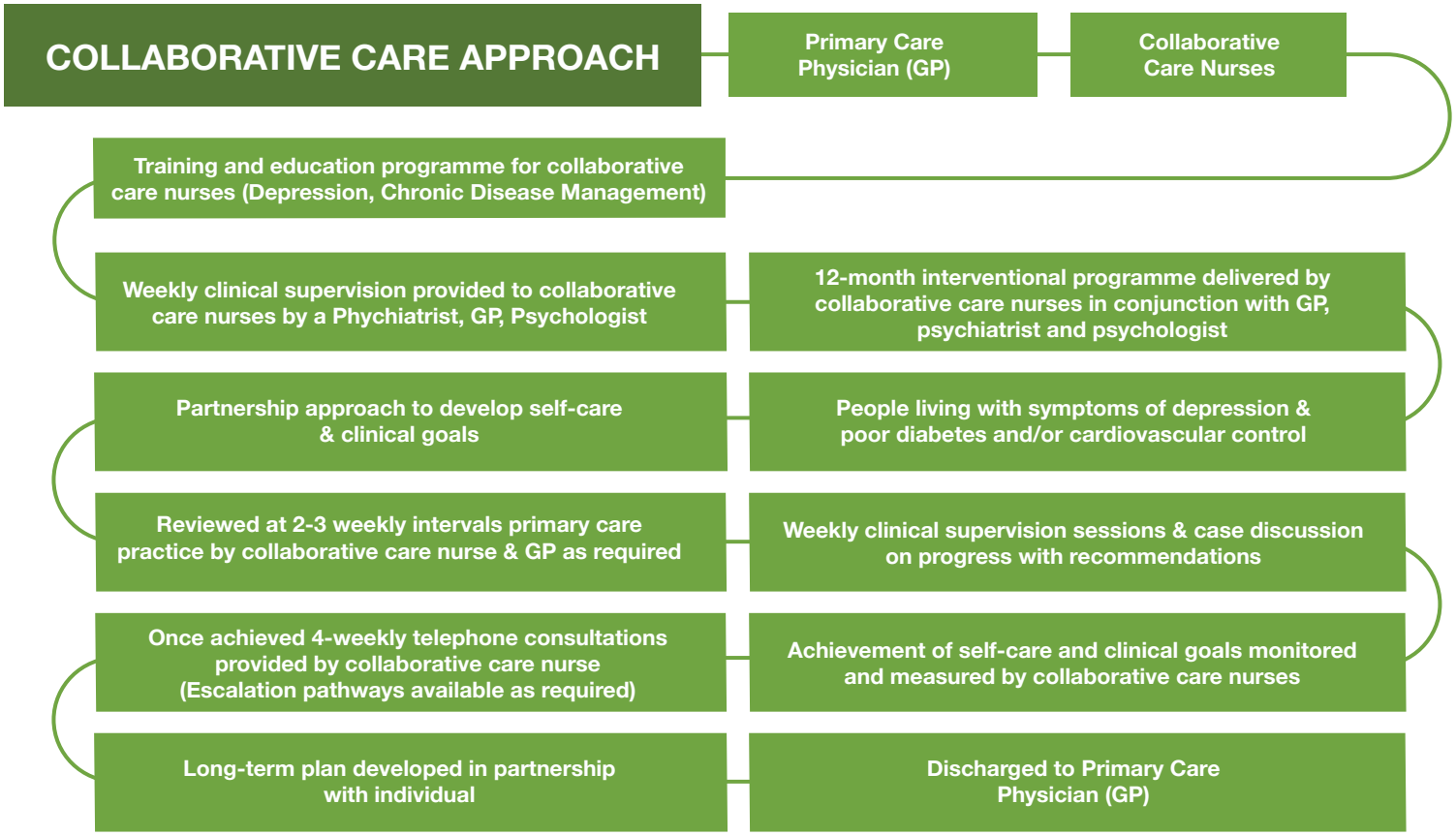

Figure 19 - Collaborative care service approach adapted from Katon et al., 2010.

clinical goals and measure progress. The role of the collaborative care nurses was central to the service delivery approach in supporting both primary care and individuals to meet their clinical and self-care goals. This also included self-monitoring and encouraging goal setting that included social engagement (Katon et al., 2010).

3.4.1.2 Service Delivery Approach to Collaborative Care - UK

In the UK, researchers examined the long-term clinical and cost-effectiveness of collaborative care versus usual care for people with mental–physical multimorbidity (Camacho et al., 2018), (Figure 20). This cluster randomised trial compared collaborative care (case manager working with GP practices and talking therapy services) with usual care (GP management) for depression and co-existing diabetes and/or coronary heart disease. The nine-item Patient Health Questionnaire; PHQ-9 assisting in screening for depressive symptoms (Kroenke et al., 2001). In total, 19 practices were randomised to collaborative care and 20 to usual care. Following screening at practice level, 387 people with depression and heart disease and/or diabetes were invited to participate resulting in 191 people allocated to collaborative care and 196 to usual care.

Outcomes measured included levels of self-reported depression using the Symptom Checklist-90 scale (SCLD13; range: 0–4) 24-months after randomisation (Bernstein et al., 2009). Health status was measured using EuroQol 5D-5L (EQ-5D-5L) (EuroQol Research Foundation, 2019). Health care utilisation was collected at 4 months (covering the period between baseline and 4 months) and 24 months (covering the period between 4 and 24 months). This was informed by self-reporting of the total number of visits to healthcare professionals (including GP, practice nurse), in-patient, outpatient and day patient activity, and attendance to the emergency department. Estimations of direct costs were also measured and included training and education for case managers and cost-effectiveness was measured using cost per Quality Adjusted Life-Year (QALY[6]) (Camacho et al., 2018).

Psychologists who operate in the role of case managers in this model of care are referred to as psychological wellbeing practitioners (PWPs). These roles were developed as part of the Talking Therapies Team based in the community. The PWP provided targeted psychological interventions for people with anxiety and depression living with concomitant chronic disease identified at GP practice level. Interventions were provided over a period of 3-months and included eight face to face sessions of brief psychological therapy (Camacho et al., 2018). Initial sessions identified correlations between long-term conditions and mood and/or anxiety. This assisted in determining the main issues and informed goals and direction of subsequent sessions such as cognitive restructuring and/or lifestyle changes. Additional meetings were scheduled with the individual, practice nurse and PWP at session two and eight of the programme to discuss goals, management plan, responses, and relevant physical and mental health monitoring. The final session (session eight) focused on relapse prevention strategies. The PWPs (case managers) liaised with practice nurses and GPs to discuss medication and update on progress.

Figure 20 - Collaborative Care Service Approach adapted from (Camacho et al., 2018).

[6] A QALY measures the value of health outcomes by calculating the treatment effect over the duration of the treatment. Essentially, a year of life lived in perfect health is worth 1 QALY and that a year of life lived in a state of less than this perfect health is worth less than 1 QALY. PRIETO, L. and SACRISTÁN, J. A. 2003. Problems and solutions in calculating quality-adjusted life years (QALYs). *Health Qual Life Outcomes*, 1, 80.

Study Outcomes of the Collaborative Care Approach - UK

Following comparisons with usual care, people accessing collaborative care had a 40% reduction in depression scores at 12 months, and this was maintained at 24 months. There was evidence of higher healthcare utilisation in the collaborative care arm of the study using approximately £1800 more of healthcare resources over 24 months than those receiving usual care. This was potentially due to improved reporting of symptoms, navigation of health services and more engagement with health-directed behaviours. However, this is potentially offset by a higher number of QALYs gained in those receiving collaborative care in comparison to usual care over a 24-month period. This was estimated as £13,069 for every additional QALY gained from collaborative care compared with usual care. Researchers concluded that collaborative care was effective in people living with symptoms of depression and concomitant long-term conditions. This was linked to the effect of improvements in mood on physical health (Camacho et al., 2018).

3.4.1.3 Service Delivery Approach to Collaborative Care - India

In India researchers examined the effect of a collaborative care model for people with symptoms of depression and uncontrolled diabetes to assess if there were sustained health effects following intervention after 12 months of completion (Ali et al., 2020). This randomised controlled trial included 404 people from different socio-economic backgrounds from four urban clinics allocated to either collaborative care (n=196, team approach to care overseen by a care coordinator, a psychiatrist and diabetologist) or usual care (n=208, followed up by a GP). People were screened using the Patient Health Questionnaire-9 score (Kroenke et al., 2001) and included with a score of at least 10 (range, 0-27); a HbA1c of at least 8%, systolic blood pressure (SBP) of at least 140 mm Hg, or low-density lipoprotein (LDL) cholesterol of at least 130 mg/dL (Ali et al., 2020).

Each site had a care coordinator and two consulting specialists in psychiatry and diabetology (Figure 21). This was enhanced by facilitators (normally social workers) assisting individuals with self-management of diabetes and depression. The collaborative care intervention was delivered over 12-months and overseen by a care coordinator working with the GP, psychiatrist and diabetologist. Interventions focused on self-care goals strategies and overcoming barriers and challenges as well as monitoring clinical response following treatment initiation. Care coordinators received training by the study team in behavioural activation[7] and skills to support self-management, coupled with disease modification through lifestyle changes and pharmacological treatments. The role of the coordinator included active monitoring, establishing regular (every 2-4 weeks) telephone or in-person contact. The PHQ-9 was administered during reviews to assess and monitor depressive symptoms and provide counselling and support to achieve individual goals. Blood glucose levels and/or blood pressure levels were reviewed, and responses discussed at team meetings. The service was supported by an electronic platform to record, measure and track progress sharing information with the team to inform caseload review discussions held every 2-4 weeks.

There were several steps developed and implemented to support clinicians with collaborative care. Each of the four sites received a 3-day in-person training on the collaborative care model and clinical workflows, structured approaches to caseload review, and the use of a decision support electronic health record system. The decision support tool followed evidence based behavioural and pharmacological approaches in the management of depression, glucose, blood pressure, and lipid management. This was incorporated into the electronic health record developed as part of clinical workflows. The tool was designed to integrate patient demographics and characteristics, depressive symptom scores, and laboratory data collected at review visits. This provided clinical prompts to clinicians following algorithms that were based on treatment guidelines to inform recommendations including individualised outreach reviews, treatment modification and/or behavioural activation (Ali et al., 2020).

[7] Behavioural activation focuses on how someone's environment shapes their actions and, therefore, their mental health. MAZZUCCHELLI, T. G., KANE, R. T. and REES, C. S. 2010. Behavioural activation interventions for wellbeing: A meta-analysis. *J Posit Psychol*, 5, 105-121.

Study Outcomes of the Collaborative Care Approach - India

Following a period of 12 months of intervention, people in the collaborative care group had a 50% improvement in depression scores in comparison to usual care. This was accompanied by a minimum of a 0.5-percentage point reduction in HbA1c, and minimum reduction of 5-mm Hg in SBP, or a reduction in LDL cholesterol by 10-mg/dL. Demographics such as age, gender, education, income, duration of symptoms, public versus private clinics had no significant impact on outcomes in the collaborative care group. Researchers concluded that a collaborative care approach for people living with depression and diabetes achieved clinical improvements overall (Ali et al., 2020).

The positive effect of collaborative care was observed up to 24 months and was most notable in depression scores, however there was evidence of a narrowing in group differences indicated in scores and level of diabetes control. This suggested that sustainable management of comorbid diabetes and depression in low resourced, and often fragmented healthcare settings requires ongoing monitoring and review (Ali et al., 2020). This would align with review and recall processes to guide annual reviews of people at higher risk of deterioration (Byng et al., 2004, Byng et al., 2008).

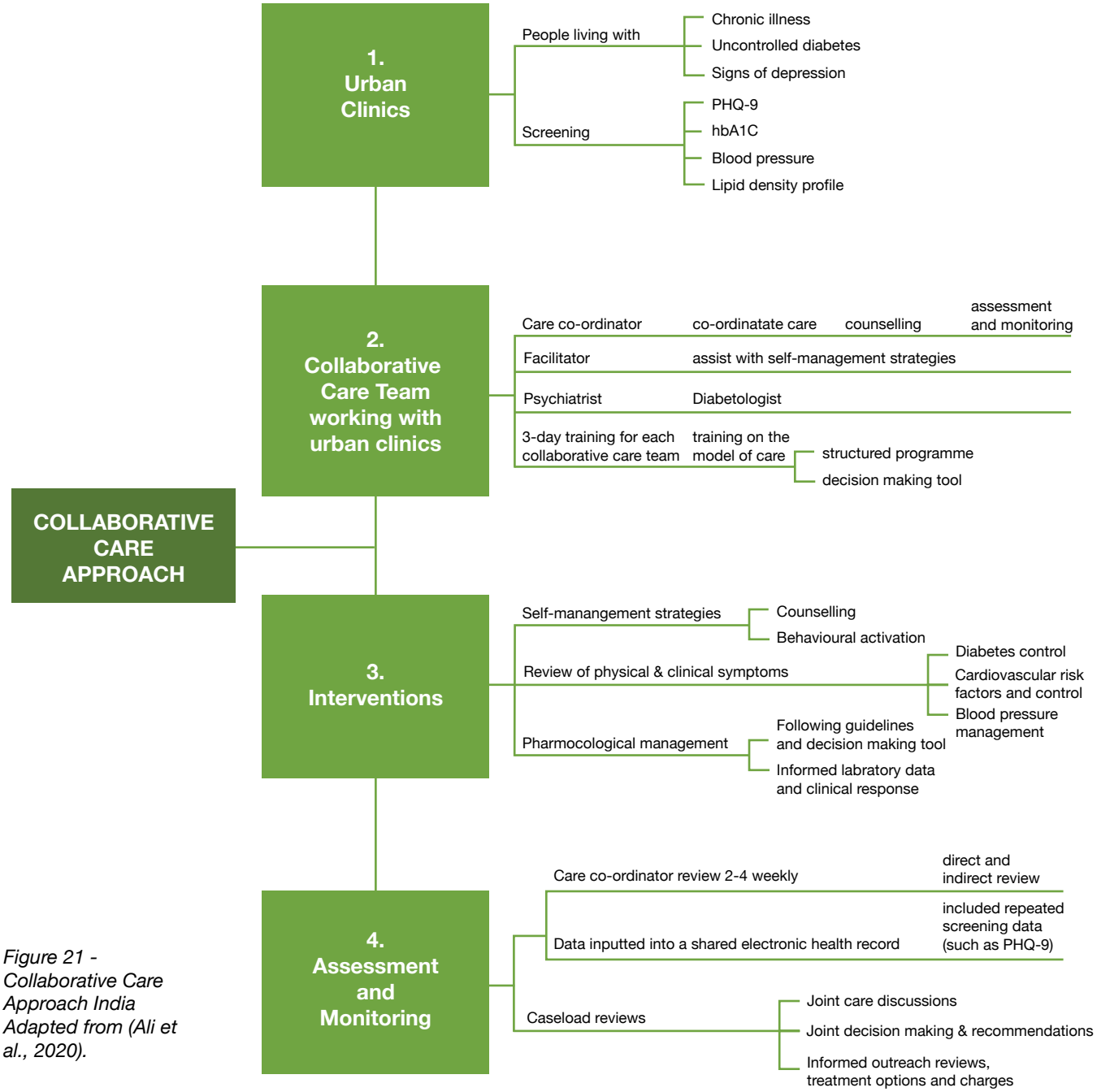

Figure 21 - Collaborative Care Approach India Adapted from (Ali et al., 2020).

3.4.2 Staffing Models for Collaborative Care

Staffing models to deliver on collaborative care normally include a multi-professional approach (Katon et al., 2010, Camacho et al., 2018, Ali et al., 2020, Reist et al., 2022) (Figure 22). The pathway of care most commonly begins at primary care level and involves the GP and practice nurse (Foy et al., 2010, Camacho et al., 2018, Kates et al., 2019, Ali et al., 2020). Collaborative care team roles differ depending on the population accessing the service (Katon et al., 2010, Camacho et al., 2018, Ali et al., 2020). The role of a case manager, coordinator/facilitator is consistently referenced as a key role to deliver the service and is normally occupied by a nurse (Meadows et al., 2007, Katon et al., 2010, Chang et al., 2013, Camacho et al., 2018, Ali et al., 2020). However, these roles are flexible and can be occupied by psychologists or allied healthcare professionals such as social workers depending on the model of care (Camacho et al., 2018, Ali et al., 2020). Support from a psychiatrist and specialists in chronic disease are normally part of the core team and also provide clinical supervision to the case manager (for example diabetes, heart failure) (Katon et al., 2010, Chang et al., 2013, Ali et al., 2020).

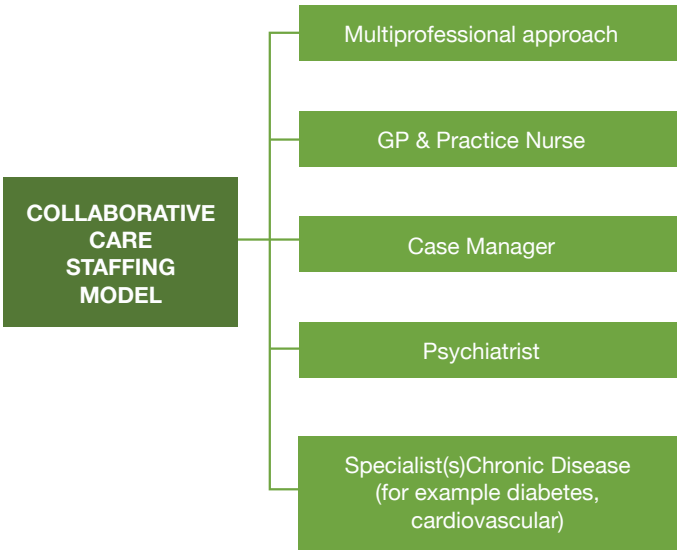

Figure 22 – Collaborative Care Staffing Model.

3.4.3 Key Enablers for Collaborative Care

There are several key enablers that are viewed as fundamental to deliver on collaborative care (Figure 23). These include the role of the case manager/coordinator role that are integrated with primary care providing psychological treatment interventions, assessment and monitoring, education and training, coordination of care and referral to other services (Blasinsky et al., 2006, Katon et al., 2010, Chang et al., 2013, Camacho et al., 2018, Ali et al., 2020, Reist et al., 2022). Development of protocols and guidelines to include pharmacological and non-pharmacological approaches standardise care and provide guidance on referral pathways to other services (Katon et al., 2010, Kates et al., 2019, Ali et al., 2020).

Additionally, agreements on joint decision-making approaches and standardised assessment tools and triage protocols support a systematic approach (Chang et al., 2013).

Specific training in the delivery of collaborative care within the community including primary care providers, case managers, and specialists in mental health and chronic disease to understand clinical workflows, joint working, case load reviews, decision making approaches and data collection is recommended (Chang et al., 2013, Ali et al., 2020).

Agreements on clinical supervision for case managers are required and are linked to better outcomes in the delivery of the model of care (Chang et al., 2013). This is normally provided weekly by GPs, psychiatrists, and specialists in chronic disease (Chang et al., 2013, Curth et al., 2019, Ali et al., 2020). Ability to record, track, monitor and share information electronically assisted in facilitating joint decision making and informing recommendations for changes in treatment plans and longer-term management (Kates et al., 2019, Ali et al., 2020).

Clear communication plans with staff, people using the services, and their families on new ways of working within collaborative care approaches is advised to encourage engagement (Kates et al., 2019).

Organisational endorsement, support and leadership is required for sustainability and can improve the outcomes of collaborative care (Foy et al., 2010, Chang et al., 2013, Kates et al., 2019).

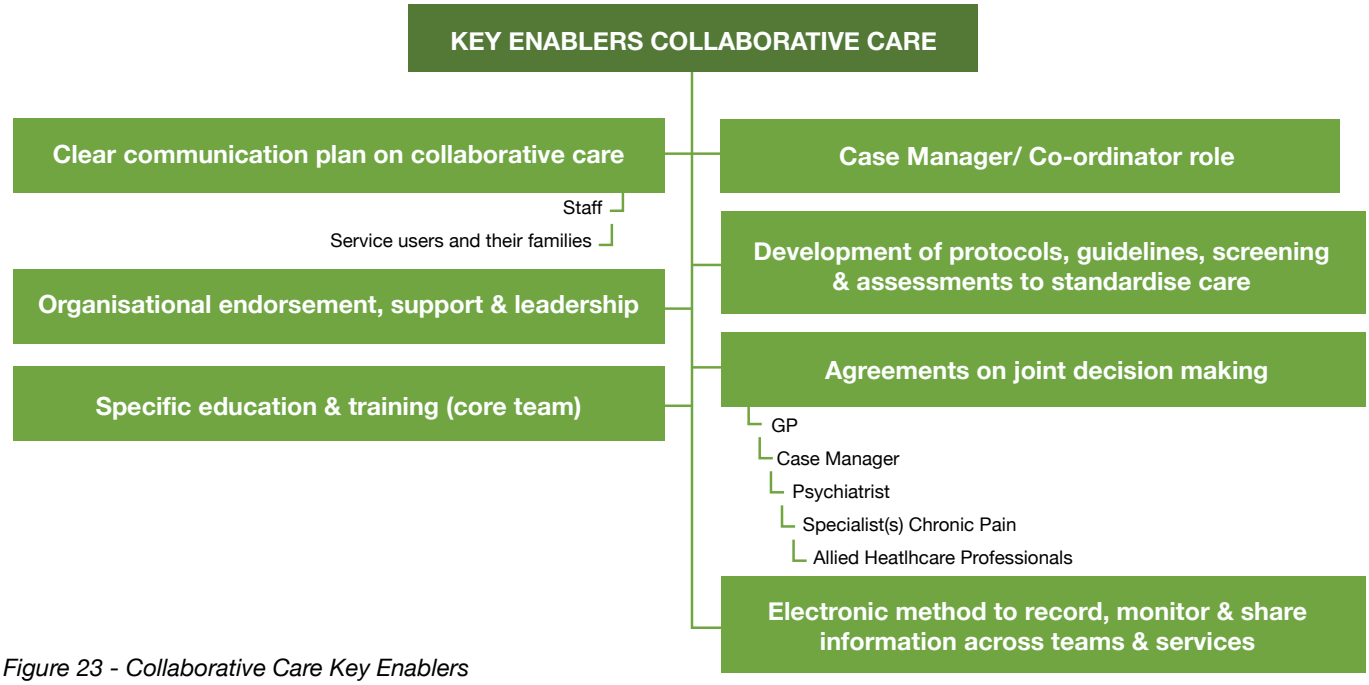

Figure 23 - Collaborative Care Key Enablers

3.4.4 Barriers and Challenges to Collaborative Care

There are common barriers and challenges reported in delivery of collaborative care. These are described in Table (3) and include poor communication between primary care and specialist mental health services, new ways of working, lack of understanding of roles and responsibilities, lack of leadership, funding and resources.

Key Challenges	Examples of Barriers and Challenges
Communication and relationships	Nearly half of GPs previously surveyed reported a less satisfactory relationship with mental health professionals and this was viewed as a barrier to collaborative care (Younes et al., 2005). Poor communication plans with no clear goals can impact on the delivery of collaborative care (Kates et al., 2019). Ability to support communication flow of real-time information between teams to improve shared and collaborative care (Kates et al., 2019). People's concerns about how their information is being used and effect on relationships and engagement with collaborative care (Reist et al., 2022).
New ways of working	Changing embedded systems of care to adapt to the model for example, behavioural interventions in primary care settings that are normally provided by specialist services (Blasinsky et al., 2006). People accessing mental health services and families' and their understanding and attitudes towards collaborative care as a new way of delivering care (Kates et al., 2019).
Understanding of roles and responsibilities	Lack of understanding and confusion of each other's roles and responsibilities in delivering collaborative care (Kates et al., 2019). Staff attitudes and beliefs, and varying approaches to delivering clinics in the community (Blasinsky et al., 2006).

Table 3 - Barriers and Challenges to Collaborative Care

Key Challenges	Examples of Barriers and Challenges
Leadership	Readiness and preparedness of the organisation and lack of clinical and organisational leadership and support (Kates et al., 2019, Chang et al., 2013). Lack of regional endorsement and ability to monitor progress and evaluate fidelity to the model of care impacting on sustainability (Chang et al., 2013, Kates et al., 2019). Inadequate training and clinical supervision for staff delivering collaborative care (Kates et al., 2019).
Funding and resource constraints	Financial insufficiency, sustained funding, lack of physical space to deliver collaborative care and availability of a psychiatrist to support (Chang et al., 2013). Availability of resources (inclusive of staff and systems to deliver), geographical coverage and time constraints for staff (Kates et al., 2019). Challenges to deliver collaborative care if population disperses over a wider geographical area and not clustered to align to practices, and challenges with workforce and balancing demand for services. This was a barrier if collaborative care was not viewed as a priority within the organisation (Blasinsky et al., 2006). Data collection and increasing administrative duties (Reist et al., 2022).

3.4.5 Addressing Barriers and Challenges of Collaborative Care

There are several areas suggested to address potential barriers and challenges to collaborative care approaches (Figure 24). These include the development of a model of care that is flexible and reflects the local population's needs including severity of symptoms (Meadows et al., 2007, Kates et al., 2019, Reist et al., 2022).

This is informed by populations accessing primary care that could benefit from collaborative care such as depression and chronic disease management (Foy et al., 2010, Kates et al., 2019). This is influenced by the availability of resources including access to expertise, staffing and geographical coverage (Foy et al., 2010, Kates et al., 2019). Defining the model of care and populations accessing the service will assist in informing shared care goals and agreements at the outset, with a clear communication plan to build strong relationships (Kates et al., 2019). Improving access to mental health expertise is viewed as a mode to develop partnerships and engagement with primary care providers (Kates et al., 2019). Adequate training and education for primary care providers can also improve engagement and increase knowledge, skills and confidence (Kates et al., 2019). The importance of having a clear communication pathway and quality of information shared has been linked to clinically significant benefits and can improve service users experience and engagement (Foy et al., 2010, Reist et al., 2022).

The availability of a case manager to coordinate and work with the core team including GPs and specialist mental health teams is integral to collaborative care (Katon et al., 2010, Ali et al., 2020, Kates et al., 2019). The role enhances interventions to improve self-management and better outcomes for service users (Katon et al., 2010, Ali et al., 2020, Kates et al., 2019). Additionally, clarity on roles and responsibilities and consideration of task sharing aspects of collaborative care determined at the outset can avoid barriers and challenges in the longer term (Blasinsky et al., 2006, Archer et al., 2012, Chang et al., 2013, Kates et al., 2019). This can also inform a structured and systematic approach to collaborative care and development of guidelines and protocols that direct care pathways and scheduled reviews offering both in-person and virtual consultations (Archer et al., 2012).

Several other readiness factors are viewed as influential in determining the success of collaborative care approaches. This includes information technology capable of sharing real-time information electronically across teams and services (Kates et al., 2019). The nomination of clinical champions is viewed as key to support a shift in attitudes and new ways of working towards a collaborative care approach (Chang et al., 2013, Kates et al., 2019).

This is in addition to advocacy roles to support people who use the services and their families and changing attitudes and behaviours toward mental health services that can be delivered at primary care level (Chang et al., 2013, Kates et al., 2019). In addition to champions and advocacy roles, organisational commitment to support collaborative care and improve access to services is linked to long-term success (Archer et al., 2012, Chang et al., 2013, Kates et al., 2019).

This requires support from national programmes to address unmet physical health care needs and leverage technology to improve service users' access and choice (Kates et al., 2019). Having clear evidence on the impact of collaborative care approaches that includes the experiences of people accessing these services can also assist in sustained change and support investment (Blasinsky et al., 2006, Chang et al., 2013, Reist et al., 2022).

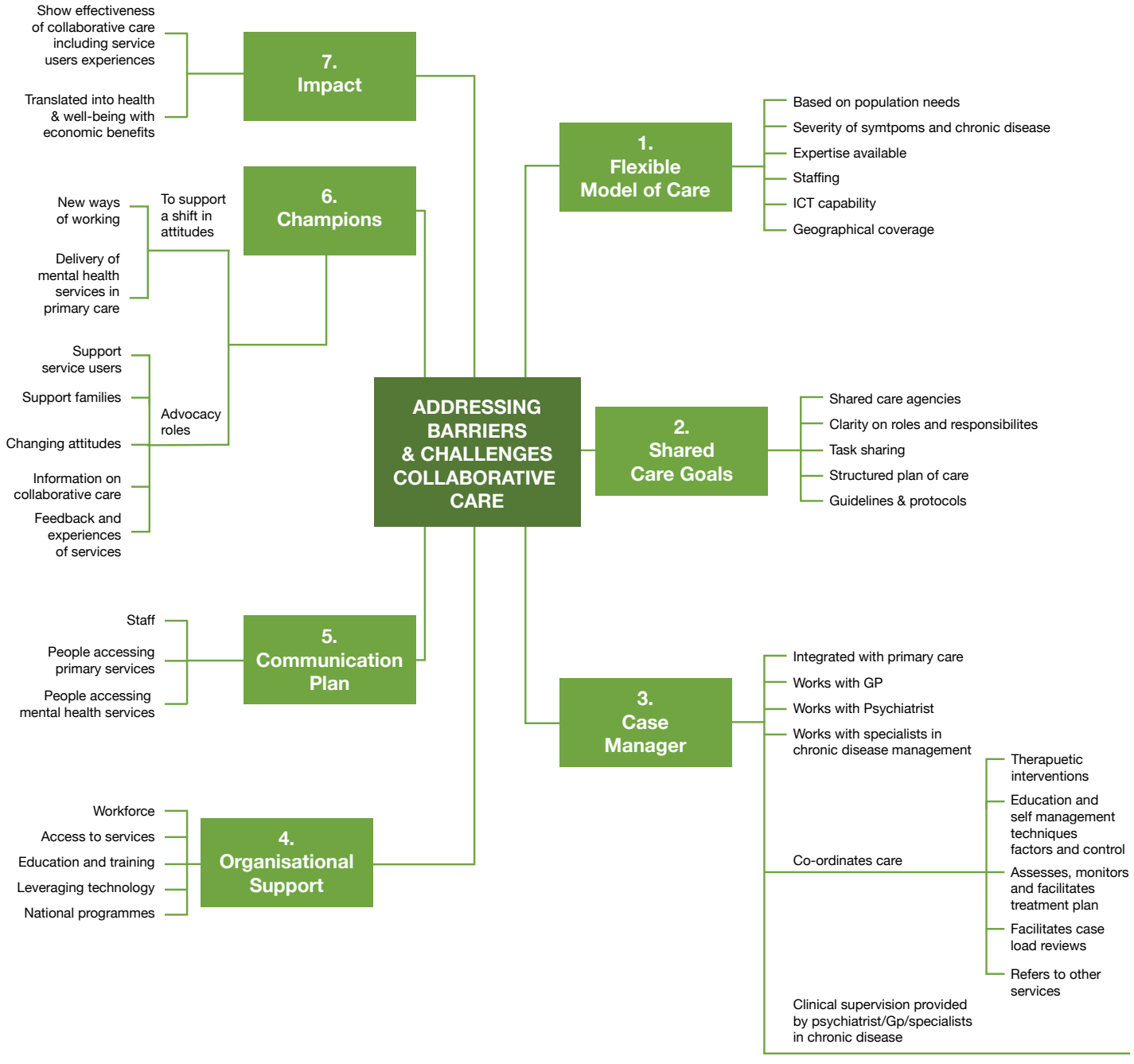

Figure 24 - Addressing Barriers and Challenges Collaborative Care

3.4.6 Outcomes and Impact of Collaborative care

In this section, general outcomes and impact of collaborative care are presented to understand the overall benefits. There is strong evidence that collaborative care has a positive effect on people living with anxiety and depression with reports of up to a 50% improvement in depression scores following intervention (Camacho et al., 2018, Ali et al., 2020). When compared to usual care (GP level care), collaborative care significantly improved symptoms of depression and poorly controlled chronic illness such as diabetes and cardiovascular disease (Katon et al., 2010, Camacho et al., 2018, Ali et al., 2020). This extends to improvements in daily functioning and greater overall quality of life (Blasinsky et al., 2006, Kates et al., 2019, Ali et al., 2020). Greater engagement with people using the services in their treatment plans and higher levels of satisfaction in care are also reported (Archer et al., 2012, Camacho et al., 2018). The role of the case manager is significant in the delivery of collaborative care, with evidence of supporting individuals to achieve recovery with long term health benefits such as lower remission rates and positive behavioural changes in the management of depression (Rubenstein et al., 2010, Chang et al., 2013). Case managers also referred lower rates of people to specialist mental health services supporting people with mental health symptoms at primary care level (Rubenstein et al., 2010).

The positive outcomes of collaborative care are linked to programme duration with evidence showing that programmes delivered over 6-12 months have lasting effects of up to 24 months (Archer et al., 2012, Camacho et al., 2018, Ali et al., 2020). Programmes that delivered collaborative care approaches for more than 24 months, have shown no significant difference when compared to usual care in terms of quality of life (Archer et al., 2012). When compared to usual care (provided by a primary care provider) collaborative care resulted in early remission rates after 16 weeks of intervention when compared to 52 weeks of usual care (Reist et al., 2022).

There is evidence of a positive economic impact associated with collaborative care with reports of a 2 to 3 times reduction in medical spending observed up to 3 years for people accessing a collaborative care programme with mental health symptoms (Reist et al., 2022). Higher QALY gains are also observed in comparison to usual care based on the effect of collaborative care over the duration of the treatment (Camacho et al., 2018). Healthcare utilisation is also lower in people receiving collaborative care over the longer term linked to better controlled chronic disease, improvements in mental health symptoms, reduction in alcohol and fewer adverse signs of alcohol use and less cannabis use and positive behavioural changes (Rubenstein et al., 2010, Camacho et al., 2018, Reist et al., 2022).

3.5 MEASURING OUTCOME AND IMPACT MEASURES OF SHARED CARE

Outcome and impact measures presented in this section are commonly used to measure effectiveness of shared care approaches, including consultation/liaison and collaborative care approaches. These cover physical and mental health symptoms and service effectiveness. These measures are presented under person related outcome measures, person's experience, staff experience, system development, healthcare utilisation and impact of shared care approaches.

Measuring person related outcome measures:

Although unique to the population accessing shared care services there are commonalities in measurements that are normally measured at the point of assessment, during the intervention and following discharge (Meadows et al., 2007, Copello et al., 2013, Camacho et al., 2018, Ali et al., 2020).

These can include:

- **Screening and measuring the severity of depression/anxiety** using screening tools such as the Patient Health Questionnaire PHQ-9 and (Kroenke et al., 2001), Patient Health Questionnaire PHQ-2, scores of 3 or more indicating depression) (Kroenke et al., 2003) and Symptom Checklist-90 scale to assess psychological problems (SCLD13) (Bernstein et al., 2009).
- **Changes in quality of life** employing the EuroQol 5D-5L (EQ-5D-5L) (EuroQol Research Foundation, 2019).

- **Changes in functional level** using 6-Item Short Form Survey Instrument (SF-36) (Ware and Sherbourne, 1992).
- **Changes in help seeking behaviours or attitudes** (no current major depressive disorder, generalised anxiety disorder or psychological distress) (Younès et al., 2008).
- **Screening and changes in the Clinicians' Rating Scale** for Alcohol and Substance related disorders (Darke, 1998).
- **The level of substance use is measured** using the Abuse Treatment Scale to assess understanding and engagement in interventions (Mueser et al., 1995, Copello et al., 2013).
- **Clinical parameters associated with physical symptoms** and chronic illness. For example, HbA1C levels, LDL levels and blood pressure measured at baseline, during the programme of care and after completion (this ranges from 12-24 months) (Katon et al., 2010, Camacho et al., 2018, Ali et al., 2020).
- **Recovery and remission rates** can be measured using symptom and functional screening tools as described above, in addition to the individual's quality of life and regaining self-control (Oliveira-Maia et al., 2016).
- **Number of relapse rates** during the intervention and following discharge (Byng et al., 2004, Blasinsky et al., 2006).

Measuring the Person's Experience:

This is normally collected using questionnaires with a focus on satisfaction and engagement with services and can include:

- **Information received, access and choice to services** (Byng et al., 2004, Younès et al., 2008).
- **Satisfaction with physical and mental health care** (Byng et al., 2004, Younès et al., 2008, Foster et al., 2022).
- **Attitudes towards health care professionals** (Younès et al., 2008).
- **Level of engagement in plan of care and treatment options** (Oslin et al., 2006).
- **Perceived unmet need** (Byng et al., 2004, Byng et al., 2008).
- **Any barriers and challenges to engagement** with the programme (Foster et al., 2022).

Measuring Staff Experience:

This is generally captured using questionnaires and through interviews covering areas such as:

- **The benefits and any barriers and challenges** to delivering shared care approaches (Kroenke and Unutzer, 2017, Russell et al., 2021).
- **Satisfaction of people using the services and relationships** with healthcare professionals including timely access to advice, support and specialist input and upskilling in the identification and management of mental health symptoms (Byng et al., 2008, Gillies et al., 2015, Russell et al., 2021).

Measuring System Development:

This often measures the progress of systems to support shared care and can include:

- **Case manager/coordinator role** in place (Byng et al., 2008, Katon et al., 2010).
- **Set-up of a register** and organisation of demographic and clinical information to inform the level of population need (Byng et al., 2004, Byng et al., 2008, Reist et al., 2022).
- **Development of shared care agreements** (Byng et al., 2004, Byng et al., 2008).
- **Training needs analysis** for staff involved in shared care approaches (Byng et al., 2004, Byng et al., 2008).
- **Set up of recall and review** processes (Byng et al., 2004, Byng et al., 2008).
- **Access to an electronic platform** to share information (Oslin et al., 2006, Foy et al., 2010, Meadows et al., 2007).

Measuring Health Care Utilisation:

This is often measured during and after period of intervention normally ranging from 3, 6, 12 and 24 months and can include:

- **In-person and virtual visits** to different healthcare professionals and the total number of contacts (Oslin et al., 2006, Camacho et al., 2018, Ali et al., 2020, Fleury et al., 2021).
- **Emergency department attendance** in-patient, day case outpatient activity (Camacho et al., 2018, Ali et al., 2020). This is often tracked and monitored using an integrated electronic method to capture information and self-reporting (Camacho et al., 2018).

Measuring Impact of Shared Care Approaches:

This is normally measured using indicators such as:

- **Depression free days and outpatient costs** during the intervention and following discharge (Byng et al., 2004, Blasinsky et al., 2006, Smith et al., 2017).
- **The number of relapse rates** during the intervention and following discharge (Byng et al., 2004, Blasinsky et al., 2006, Smith et al., 2017).
- **Number of people managed in primary care** that have not required referral to specialist mental health services (Rubenstein et al., 2010).
- **Recovery and remission rates translated into cost savings** comparing the total cost of care to treat relapses (Kelly et al., 2011, Kroenke and Unutzer, 2017).
- **Wait times** for referral for shared care services (Reist et al., 2022).
- **Quality-adjusted life-year (QALY)**, measuring the value of health outcomes combined with the effects of shared care health interventions on mortality and morbidity (Camacho et al., 2018).

3.6 PEOPLES EXPERIENCES OF ACCESSING SHARED CARE

In general, people accessing shared care services have positive experiences and develop purposeful relationships with their healthcare providers building trust (Meadows et al., 2007, Russell et al., 2021, Reist et al., 2022). This includes more positive attitudes towards health care professionals and greater satisfaction with services (Younès et al., 2008, Reist et al., 2022). There are also reports of a reduction in stigma that is associated with attending mental health services as available in primary care and therefore, people are more likely to attend appointments and engage in treatment (Reist et al., 2022, Tzartzas et al., 2022).

The ability to demonstrate progression in terms of interventions and access to services as well as improved outcomes for people using the services increased credibility, trust and engagement of people using the services accessing shared care (Byng et al., 2008). Having common goals set with healthcare professionals that was realistic and achievable increased the person's engagement, satisfaction with care and longer-term effectiveness of the interventions once discharged (Copello et al., 2013, Camacho et al., 2018, Ali et al., 2020, Foster et al., 2022).

In addressing any potential barriers and challenges a clear communication plan that involves people accessing primary care and mental health services is recommended. This includes information on new ways of working and how clinical details will be used as part of shared care (Kates et al., 2019, Reist et al., 2022). Having a clear communication plan involving people accessing primary care and mental health services has been linked to improved relationships and engagement (Kates et al., 2019, Reist et al., 2022).

3.7 CLINICIAN EXPERIENCES WORKING IN SHARED CARE APPROACHES

Most of the literature that includes feedback from staff operating in shared care approaches is positive. This includes evidence of upskilling in the identification and treatment of mental health symptoms and increased confidence to provide interventions (Byng et al., 2004, Fuller J et al., 2009, Kelly et al., 2011, Smith et al., 2017). Primary care providers also report better

medication and prescribing practices (Kelly et al., 2011, Smith et al., 2017). There is also evidence of improved relationships between healthcare professionals and with people accessing shared care services (Byng et al., 2008, Kelly et al., 2011, Russell et al., 2021). Greater integration and inter-professional collaboration with mental health services are also reported with improved relationships between clinicians (Oslin et al., 2006, Kisely and Campbell, 2007, Tzartzas et al., 2022). This is influenced by improvement in access to specialist advice, reduction in wait times for specialist intervention and streamlining of care pathways (Oslin et al., 2006, Kisely and Campbell, 2007, Tzartzas et al., 2022).

A direct benefit of shared care and access to specialist advice and guidance are reduced pressure on GPs to make formal referrals to specialist mental health services and, reduces any potential anxiety experienced by the by the people using the services that is associated with attending a specialist mental health clinic (Russell et al., 2003). Access to specialist advice and guidance also provide an opportunity for GPs to ask specific questions to enhance the care of the individual (Russell et al., 2003). Positive experiences reported by clinicians are influenced by the level of planning and preparation including the development of shared care goals, a shared care agreement, availability of link, liaison, or case manager roles, and operationalising models of care that reflect primary care and specialist services ways of working and clinical workflows (Byng et al., 2004, Byng et al., 2008, Fleury et al., 2021, Reist et al., 2022). This is in addition to an appropriate level of clinical supervision and the development of skills to work within a model of shared care efficiently and effectively (Wright and Russell, 2007).

Other areas that positively influenced clinician experiences was the availability of an electronic method to share information across teams and services as well as an option of in-person and virtual consultations (Oslin et al., 2006, Kisely and Campbell, 2007, Chang et al., 2013). Moreover, clinicians reported that shared care is not an alternative practice and successful shared care enhances current clinical practices within primary care and mental health services (Foster et al., 2022).

3.8 SUMMARY OF THE EVIDENCE

This chapter has presented an evidence review on shared care approaches including consultation/liaison and collaborative care.

Shared care is conceptualised as principles of care to enhance coordination and support a structured approach to integration working cross collaboratively. The principles of shared care can include shared care goals, shared care agreements, clinical governance arrangements, and care pathways to improve access and monitor physical and mental health symptoms.

The core fundamentals to deliver on shared care are applicable to both consultation/liaison and collaborative care approaches and include:

- A clear communication plan for staff and people accessing services.
- A structured approach to service delivery for example delivered through consultation/ liaison or collaborative care approaches.
- Clinical governance frameworks and clinical supervision.
- Champions and advocacy roles to engage clinicians and people accessing primary care and mental health services to drive shared care as a new way of working.
- A link, liaison or case manager role working with primary practices and mental health teams, services, and chronic disease management specialists.
- Training and education for staff.
- An electronic method to share information across teams and services.
- Organisational support and investment to sustain shared care approaches.
- Clear outcome and impact measures to determine effectiveness and support investment and sustainability.

There is significant evidence demonstrating the benefits of shared care delivered through consultation/liaison and collaborative care approaches. These approaches underpin shared care with evidence of improved health benefits. This includes greater recovery and remission

rates, improved quality of life and better engagement in the planning and delivery of care for people living with mental health symptoms and problems and concurrent chronic illness.

Both consultation/liaison and collaborative care approaches have shown significant positive outcomes for both people accessing these services and staff operating within them. These can be offered as stepped approaches to care depending on the local populations' needs.

Consultation/liaison normally offers short-term advice, guidance, and brief intervention to support primary care providers (normally GPs) in the identification and treatment of people with mental health symptoms. This is normally supported by a psychiatrist and a link person/ liaison role based in mental health services working directly with primary care providers. In addition to clinical advice, guidance, and short-term intervention the approach offers an opportunity to upskill increasing knowledge and experience with improved prescribing practices, non-pharmacological interventions, and greater knowledge of treatment options.

The outcomes and impact of consultation/ liaison are translated into the numbers of people that are managed at primary care level without requiring long-term specialist mental health interventions, and lower relapse rates. This is coupled with improvements in mental health symptoms and evidence of improved self-management and engagement in treatment.

Collaborative care offers longer-term management with MDT input and is overseen by a case manager working in partnership with the MDT to coordinate care, support the implementation of a treatment plan, monitor, and assess response, and provide interventions to increase the person's engagement and confidence in developing personal goals and strategies to achieve these. This approach is normally delivered over a 12-month period and can be offered to people with mental health symptoms, mental health problems and concurrent chronic diseases that are poorly controlled. The positive health benefits of collaborative care in terms of mental and physical health are observed for up to 2 years following intervention. This has an economic impact as translated into lower levels of healthcare utilisation, and greater control and management of mental health and physical symptoms.

A collaborative care approach as a pathway of care can include egress from mental health services to support the person transitioning back into primary care, or from primary care services to reduce the need for longer term specialist mental health input and improve overall physical health.
The flexibility of both approaches offers alternative pathways of care for individuals dependent on physical and mental health needs.

The next chapter will present a series of case studies demonstrating shared care approaches currently provided by specialist mental health services in Ireland. This will assist in translating the evidence and focus group findings into practice and inform implementation planning to support StV and shared care approaches (Department of Health, 2020).

4.0 STAKEHOLDER ENGAGEMENT CASE STUDIES

4.0 STAKEHOLDER ENGAGEMENT - CASE STUDIES

Case studies allow for a service to be presented in real-world situations and provide a comprehensive examination of the current use of shared care approaches in delivering mental health services, allowing exploration of the nuances, details, and contextual factors that may not be captured during focus groups.

The chosen case studies are based on real-life services in Ireland, providing insights that are directly applicable to practical scenarios, translate evidence into practice and assist in informing implementation planning to delivery on shared care. To inform this process, a case study report template was developed and circulated to heads of service for completion. A critical analysis of each case study was undertaken using criteria and best practice analysis definitions garnered from the literature with a summary of each case study presented. The full case study template is available in the appendices.

Case Study 1

Suicide Crisis Assessment Nurse (SCAN) Donegal

The National Clinical Programme for Self-Harm and Suicide-related Ideation (NCPSHI) Model of Care (HSE 2022) states that General Practitioners (GPs) should be regarded as the first point of medical care for all persons with mental health problems, including those who engage in self-harm, with the exception of those requiring hospital based medical care arising from a self-harm episode.

The Suicide Crisis Assessment Nurse (SCAN) service was first established in South Dublin in 2007 as a pilot project, and subsequently in Wexford the following year. The success of these projects, as shown by detailed and comprehensive evaluation report by the HSE in 2012, and a subsequent review completed for the National Office of Suicide Prevention (NOSP) in 2019 (Griffin et al 2019b) has led to the SCAN service being rolled out nationally as part of the National Clinical Programme in February 2022.

The role of the SCAN service is to provide assessment and support to GP patients who have suicide related thoughts, who do not have an acute mental illness requiring immediate input from a secondary mental health team and are not at immediate risk of suicide. The SCAN service aims to provide a timely response to appropriate requests for assessment of patients in suicidal crisis from named GP practices.

The GP is often the first point of contact when someone is in crisis or struggling with a mental health difficulty, with GPs in a unique position to respond early to people in crisis or potential crisis, to promote health but also to prevent suicide. In a busy primary care centre, it can be challenging to respond to a crisis and support the individual's needs. GPs found that there was a gap between primary and secondary services in trying to access secondary services during a crisis.

GPs and the public understand that an emergency department (ED) is not the appropriate place to send someone when they are in psychological distress. Therefore, there was a need identified for a service that would respond to GP request for assessment of an individual who was in suicidal and/or self-harm crisis avoiding the need without to send them to ED, and to reduce waiting times for an appointment in outpatient mental health clinic.

The existing SCAN services were amalgamated under the National Clinical Programme with the launch of the revised model of care in Feb 2022. They are a good example of how shared care principles such as effective communication, structured service delivery, streamlined governance and specialist training can be utilised to deliver better care for those in crisis.

SCAN demonstrates a shared care approach between primary care GPs and secondary care SCAN Clinical Nurse Specialists and Community Mental Health Teams with evidence of improved relationships between primary care providers and mental health services. (See SCAN Evaluation[8] and SCAN Operational Guidance[9] Documents for more information).

[8] HSE, (2012) Research Evaluation of the Suicide Crisis Assessment Nurse (SCAN) **https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/research/scanevaluation.pdf**

[9] HSE, (2023) National Clinical Programme for Self-Harm and Suicide-related Ideation Operational Guidance Document **https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/scan/ncpshi-scan-operational-guidance.pdf**

SUICIDE CRISIS ASSESSMENT NURSE SERVICE DONEGAL

Location and Reach	• SCAN service pilot in 2007,expansion nationally as part of National Clinical Programme in 2022 • Case Study - Donegal catchment area & participating GPs
Unit of Service Delivery	• First point of contact is GP who can refer into SCAN service • Meetings and follow up in GP setting
Population and Caseload	• Adults 18+ within the catchment area • Presenting to their GP in a suicidal crisis which does not require specialised medical intervention
Staffing	• Administrative Staff • CNS x 2

Description of Service	Therapeutic Interventions	ICT
GP refers patient to SCAN and a primary bio-psychosocial assessment is carried out by a SCAN nurse within 72 hours referral in the GP surgery.	Motivational interviewing Decider skills intervention	TPRO dictation system
The SCAN nurse also liasies with family or trusted friends with consent of the patient to collect collateral information.	Brief person centered counselling	Projectors, email. Laptops and Smartphones.
The nurse develops and delivers a written safety plan for the patient - fed back to the GP via a follow up meeting.	Distress tolerance and CBT skills	Databases on GP Primary Care network and mental health services
Provision of short term interventions via safety plans alongside onward referral of the patient to secondary care or wider specialised services.	Referral to secondary care units	Patient history via IPIMS services
Barriers/Challenges	**Enablers**	**Impact**
Mis-referral of patients who do not meet SCAN criteria..	Flexible approach/Free Service	Successfully builds trusting professional relationships with GPs
GPs tend to be very busy and do not always have time to engage with the service.	Personal relationships with GPs/Communication	Bridges the gap between primary and secondary care which traditionally has long waiting periods between
Funding for staffing as demand and reach increase – role of SCAN in CAMHs service.	Operational guidance document developed and launched in May 2023	Relationships with non-statutory and voluntary organisations delivering mental health care are extremely important as are the relationships with CMHTs and the inpatient acute unit.

SCAN - SUICIDE CRISIS ASSESSMENT NURSE SERVICE

Case Study 2

Crisis Resolution Services (CRS)

The HSE Crisis Resolution Service (CRS) aims to provide mental health intensive support in an individual's home or communities as an alternative to hospital admission.

This approach is important for individuals who experience mental health difficulties. It offers timely and person-centred support, reducing hospital admission via a multidisciplinary team approach and is based within the community. It aims to provide more accessible and personalised support to individuals empowering them on their recovery journey and offering an alternative to hospital admission when appropriate. The pilot service is under evaluation to inform future development of the service and there are indications of low rates of admission to EDs and offering early supported discharge.

The case study is the Mental Health Crisis Resolution Service in CHO1 which was launched in December 2022. This is a collaborative service where the MDT will work with the person, and their family/loved ones as appropriate (and with consent etc.), in the community. The individual is seen in their own home, or at another suitable venue if they have unstable/unsuitable living conditions (e.g. local primary care centre). The service aims to reduce pressure on in-patient beds and offer an alternative pathway for people presenting in a mental health crisis. Additionally, the service aims to reduce the demands of community mental health teams in responding to urgent/next day referrals. The service is designed to offer specialist integrated support to people who are experiencing a mental health crisis that require brief person-centred intensive support in a timely way, as an alternative response to inpatient admission.

All potential referrals require an assessment by a clinician before being referred to the CRS and referrers include a liaison mental health team, GP, adult mental health unit, community mental health teams (including psych of old age and mental health of intellectual disability), authorised officers.
The team works intensively with individuals up to a maximum period of 6 weeks, and either refer to a community mental health team, or discharge to the GP with a care plan as appropriate.

The CRS is another good example of how shared care principles and approaches such as clear communication plan, structured service delivery, dedicated staff such as link, liaison, or case managers and organisational support and investment can help in delivery of safe and effective mental health services. It is hoped that the CRS will both decrease the demand on the ED whilst also providing people with a safe and effective resource to deal with mental health crises in the community, and facilitate treatment and management in their own homes.

Crisis Resolution Services have commenced implementation in Ireland on a pilot basis within five selected HSE Community Mental Health Services across the country in CHO 1, CHO 3, CHO 4, CHO 5 and CHO 6, as a direct recommendation of StV. These services will become an integral part of each community mental health service in the future.

The crisis resolution team (CRT) is one component of this service, with the other being a Crisis Café. Crisis Cafés, branded nationally as Solace Café provide an out-of-hours friendly and supportive community crisis prevention and crisis response service in the evenings and at weekends in a café style/non-clinical safe environment. The Solace Café service supports individuals and their family members/carers to deal with an immediate crisis and to plan safely drawing on their strengths, resilience and coping mechanisms to manage their mental health and wellbeing. Plans are underway to establish a Solace Café in Sligo, Leitrim.

There is a national evaluation of the implementation of the Model of Care across the five learning sites underway (See HSE Crisis Resolution Services Model of Care Doc for more information).[10] The Crisis Resolution Team in CHO1 is one of the demonstration teams for this new CRT approach.

[10] HSE, (2023) Crisis Resolution Services Model of Care **https://www.hse.ie/eng/services/list/4/mental-health-services/crs-moc.pdf**

CRISIS RESOLUTION TEAM

Location and Reach	• Sligo, Leitrim and small parts of South Donegal and West Cavan • One of 5 national pilot learning sites
Unit of Service Delivery	• Patient Home or alternative safe space
Population and Caseload	• Patients who are suitable to receive treatment in the home, over the age of 18 within the catchment area. • Caseload 85 as of the 6th July 2023.
Staffing	• 1 WTE Consultant Psychiatrist • 1WTE HST/Senior BST grade Doctor • 1 CNM3 or equivalent team coordinator • 1 WTE Admin • 4 Senior Nursing • 1 Senior Social Worker • 3 Staff Nurse Grade

Crisis Resolution Team, CHO1

CRISIS RESOLUTION TEAM SLIGO/LEITRIM

Description of Service	Therapeutic Interventions	ICT
Patients are referred to the Crisis Resolution Team via a number of pathways; GPs, Liaison Mental Health Teams, Adult Mental Health units, Community Mental Health units and authorised officers.	Psych-education and support for the patient and family	Data Capturing via Excel, Drive and Word
Collaborative care service where MDT works with consenting patients and their families or loved ones.	CBT and DBT skills	MS Teams- Enables video enabled care
CRT meets with the patient in their home or another suitable location if the home is not a viable option.	Accessing other services e.g. social services, benefits, housing, DIVAS, etc.	Email, laptops and smart phone
A case specific assessment is performed.	Mental State Reviews	Healthmail
CRT works with the patient for 6 weeks after which the patient can be discharged back to GP care, transferred to the care of a community mental health team or admitted to an adult mental health unit.	Medication management and monitoring	

CRISIS RESOLUTION TEAM SLIGO/LEITRIM (CONTD)

Barriers/Challenges	Enablers	Impact
Population density is low as service is often in a rural area - staff often have to travel long distances.	GPs can refer via phone call – practical and easy to refer.	Up to the end of June 2023 104 assessments were carried out.
Necessary to have a sufficient area for meeting with the patient.	Good relationship with GPS, easy access to mental health team for referral advice.	Supported the early discharge of 18 patients.
Short term solutions, may involve further referral after the 6 week time period.	Integration with GP practice and aligned with other services and community supports.	Number of patients referred from ED to the CMHT reduced by 61 from year previous.

Crisis Resolution Team, CHO1

Case Study 3

Early Intervention in Psychosis (EIP) National Clinical Programme

Early Intervention in Psychosis (EIP) is an evidenced-based approach that can transform the experience and outcomes of people facing psychosis. EIP services aim to change a message of despair to a message of realistic hope and optimism. In the absence of an EIP service, access to treatment is often in crisis and limited to medication. International and national data suggests that EIP services can improve outcomes, reduce relapses and hospitalisations, reduce suicide rates and increase retention in education and work.

The Early Intervention in Psychosis Clinical Programme published its Model of Care[11] in May 2019 describing a 3-year programme, which addresses three key areas:

- Reducing delays in accessing specialist care: Increase community education and awareness - GPs, schools. Ensure access to expert assessment within 72 hours.

- Increasing access to the full range of evidence-based interventions: medication, cognitive behavioural therapy for psychosis, behavioural family therapy, individual placement support (employment and education support) and physical health monitoring and support.

- Ensure assertive, person centred, recovery-oriented care. Each person with psychosis is assigned to an EIP key worker who collaborates with them, their family or supporters, the EIP team, the GP and other professionals to coordinate care and support recovery.

The overall vision of the Model of Care is that EIP services be established throughout the HSE mental health system in the Republic of Ireland so that everyone between the ages of 14-65 presenting with first episode psychosis to adult or child and adolescent mental health services will have access to EIP services for up to three years. EIP services will accept referrals for up to 2 years after their first episode onset.

The EIP service aims to reduce delays in accessing specialist care, increasing community education and awareness and ensuring access to expert assessment within 72 hours. It also promotes and increases access to the full range of evidence-based interventions: Medication, Cognitive Behavioural Therapy for psychosis, Behavioural Family Therapy, Individual Placement Support (Employment and Education support) and Physical Health Monitoring and Support. The service is focused on ensuring assertive, person centred, and recovery-oriented care. Each person with psychosis is assigned to an EIP Key Worker who collaborates with them, their family or supporters, the EIP team, the GP and other professionals to coordinate care and support recovery. The average caseload of an EIP Key Worker is 15 people who experience psychosis.

The Early Intervention in Psychosis National Clinical Programme takes part in the International National Clinical Audit of Psychosis (NCAP). All EIP teams in England (110 teams), Wales (7 Teams) and four of the five teams in Ireland participated in the NCAP audit in 2023. For the third year in a row the national audit findings demonstrate that the EIP teams are delivering high quality care to those people with psychosis with improvements noted in a number of domains. Of particular note are the improvements documented in the area of physical health screening and intervention with an improvement of 32% noted in 2023's audit compared to 2022's audit findings for these standards.

Currently there are five EIP teams in Ireland. The following case study describes the Early Intervention in Psychosis RISE service, Cork South Lee team and how they are utilising shared care principles to deliver this important service. Impact of the service shows improvement in the monitoring of early psychosis, reduction in GP workload in cases of early psychosis and development of purposeful relationships with primary care providers.

[11] HSE, (2019) National Clinical Programme for Early Intervention in Psychosis Model of Care
https://www.hse.ie/eng/about/who/cspd/ncps/mental-health/psychosis/resources/hse-early-intervention-in-psychosis-model-of-care-june-20191.pdf

EARLY INTERVENTION IN PSYCHOSIS - RISE SERVICE, CORK SOUTH LEE

Location and Reach	• Currently 5 national EIP Teams • Case study describes Cork EIP
Unit of Service Delivery	• Early Intervention in Psychosis (EIP) Units, Nationally.
Population and Caseload	• Open to any patient nationally between the age of 14 to 65 presenting with psychosis for the first time.
Staffing	• Clinical Lead • Clerical Officer • CHO Health Educator • Psychological Interventions Lead • Individual Placement Support Worker • Family Interventions Lead • Social Worker • Physical Health Lead • EIP Keyworkers • Occupational Therapist • GP

EARLY INTERVENTION IN PSYCHOSIS NATIONAL CLINICAL PROGRAMME

Description of Service	Therapeutic Interventions	ICT
Early Intervention in Psychosis (EIP) involves physical health screenings and intervention for those with psychosis.	Assessment of physical health and lifestyle. Review medication and risk of side effects. Advice on diet, smoking, alcohol, exercise and other lifestyle factors.	IT infrastructure is lacking – improved systems would improve ability to deliver service.
In Cork, South Lee: A weekly metabolic clinic is run in different locations across the city and county. Service users attend this clinic at initial contact, 6, 12, 24 and at 36 months.	Link to other support services e.g. QUIT to support smoking cessation, addiction services. The RISE team includes a community addiction worker on the team.	Email, laptops and smart phone
Clinic involves full physical health assessment. Recently introduced Point of Contact Testing (POCT) devices to monitor fasting lipids and HBA1C. These devices are mobile and can be brought to people's homes and the assessments completed there.	Review medication and adjust in line with side effects and metabolic profile. POCT ensures that assessment and intervention can be delivered in the same appointment.	Healthmail
Results of the clinic are sent to the service user and GP with any abnormalities flagged for investigation.	Prescribing metformin to reduce risk of weight gain associated with higher risk agents e.g. clozapine/Olanzapine.	
Abnormalities are also considered by the EIP worker and psychiatrist, resulting in potential changes in care plan.		

Early Intervention in Psychosis - RISE Service, Cork South Lee

4.1 SUMMARY OF CASE STUDIES

In summary, the three case studies have demonstrated shared care approaches that are making a difference in providing care for people experiencing mental health symptoms. All aim to bridge the gap between primary care and specialist mental health care to enhance shared care through early intervention, care pathways and standardised approaches to care involving the MDT. This includes interventions that address both physical and mental health needs and offering alternative options that avoid the need for attendance to acute hospital services.

Similar to the evidence, the main challenges are availability of ICT solutions and ability to monitor and track data electronically, level of active communication required across services and travel times in rural areas.

In adopting shared care approaches these case studies demonstrate a reduction in ED attendances, offering early supported discharge, reducing GP workload in addressing crisis situations and developing purposeful relationships between primary care and specialist mental health services.

The next chapter will present stakeholder engagement focus group findings with key themes on shared care in the context of specialist mental health services in Ireland. This will assist in translating the evidence presented in this chapter into lived experiences and inform implementation planning to support StV and shared care approaches (Department of Health, 2020).

5.0 STAKEHOLDER ENGAGEMENT

FOCUS GROUPS

5.0 STAKEHOLDER ENGAGEMENT - FOCUS GROUPS

A series of three focus groups were facilitated with key opinion leaders working in mental health services across the country. Each focus group included an average of 8 participants (total n=23) and consisted of consultant psychiatrists, mental health/psychiatric nursing staff, GPs, allied healthcare professionals, mental health programme management and other key stakeholders.

A breakdown of focus group participants is shown in Table 4.

Stakeholder Group	Representative	N = 23
Primary Care	GP Practice Nurse	3 2
Suicide Crisis Assessment Nurse Service	SCAN Nurse	2
Community Mental Health Services	Consultant Psychiatrist Mental Health Nurse Allied health professionals (AHP) Crisis Resolution Service Team Coordinator	4 2 1 1 1
Community Healthcare Organisation	Regional Service Lead Operations	1
Community Healthcare Networks	Network Manager Community Hub Representative	1 1
Acute settings	Liaison Psychiatry	2
Service user/ family member	Person who uses the services	1
Other	Early Intervention Psychosis Psychiatrist	1

Table 4 - Focus Group Participants

The themes presented here are based on aggregated data from these focus groups. Analysis of the focus group transcripts identified themes highlighting the challenges and enablers in delivering a shared care approach to mental health service provision.

The key findings from the focus groups are presented in Table 5. A detailed breakdown of each theme alongside additional supporting quotes are presented.

The key themes identified in relation to adopting a shared care approach were:

- Theme 1: Collaboration
- Theme 2: Fundamentals to Deliver
- Theme 3: Clinical Governance
- Theme 4: Standardised Care Pathways
- Theme 5: Education and Training
- Theme 6: Communication and Relationships

Themes	Key Points
Collaboration	• Promote joint effort among healthcare providers for holistic person centred care. • Interdisciplinary teams, regular collaborative meetings. • Encourage team-based models, regular communication channels. • Mitigate challenges related to role clarity, hierarchy, and effective teamwork.
Fundamentals to Deliver	• Implement technology to streamline communication and information sharing. • Appoint leadership champions to engage and inspire clinicians and primary care providers, fostering a culture of commitment to shared care practices. • Develop a flexible policy framework that supports shared care models, allowing for adaptation based on evolving needs, emerging best practices, and local contexts. • Concerns regarding the availability of resources, time constraints, and the overall culture for delivery must be understood.
Clinical Governance	• Establish governing structures to ensure quality, safety, and accountability. • Implementation of frameworks ensuring standards and compliance and adherence to quality standards and ethical practices. • Develop and implement policies, procedures, and quality assurance measures.
Standardised Care Pathways	• Develop consistent approaches and protocols for mental health treatment and referral. • Creation of pathways for common mental health conditions. • Define processes for care delivery. • Balance standardisation with flexibility to support staff and responsiveness to care delivery.
Education and Training	• Provide ongoing education and training for staff. • Empower staff with necessary knowledge and skills. • Continuous assessment of staff competencies and knowledge is crucial.
Communication and Relationships	• Establish trust and collaboration among healthcare providers and with people who use the services and their family members / supporters.. • Develop effective communication strategies and utilise shared platforms and tools. • Concerns may arise regarding information sharing protocols, the use of electronic health records, and the need for secure and streamlined communication. • Challenges or barriers encountered in the implementation of shared care, such as resistance to change, coordination issues, or concerns about confidentiality.

Table 5 - Key Findings from Focus Groups

Theme 1: Collaboration

This theme generated from feedback by key stakeholders recognised that effective mental health care requires a team-based approach that goes beyond the traditional roles of psychiatrists or mental health specialists. Shared care can involve collaboration among various healthcare providers, such as primary care physicians, psychiatrists, psychologists, social workers, and other mental health professionals and the person using the services. The team works together to create a comprehensive and integrated care plan tailored to the individual's needs.

Working together was seen as important in providing the most effective care for people accessing mental health and primary care services. This encouraged people to pool their expertise offering alternative options and considering different types of services in primary and community care. This also provided a great opportunity to increase awareness of each other's roles and responsibilities. This allowed for different professionals within the team to upskill, increasing knowledge and awareness and reduce any anxiety or fear experienced by primary care providers in assessing and treating people with mental health symptoms.

Developing positive relationships was seen as a key driver for shared care and being flexible and supportive to de-escalate situations.

"So, there is something about taking the fear factor out of that collaborative working, whether that's joint clinics or liaison roles, someone who knew the GP, knew the GP practice, knew all of the patients that are coming in and out they will also know the people and they can say, this one actually needs a bit of extra help, or I can support this. I can support the GP practice with this, that and the other. And then you do need that access to the other therapies as well. Things like Cognitive Behavioural Therapy (CBT) and addictions, and all those other stuff,

Because sometimes when you're in this job long enough, you know the tricks of the trade and what's going to make things easier to access and how to go about it, it's that relationship, the trust that has been built between the SCAN practitioners and the GPs. It's getting in there at their level and understanding how they work."

Shared care was seen as enhancing a person-centred approach, where the individual's preferences, values, and goals are taken into consideration when developing the care plan. Involving the person in decision-making was seen as important to enhance treatment adherence and outcomes. This required professionals to have the ability to share relevant information regarding diagnosis, treatment plans, progress, and any changes in the person's condition and address. Collaboration was also seen as supporting GPs in managing complex care and also addressing safety for people using the services.

"The vast majority of GPs will have tried every avenue and are referring the people that are really complex, that they aren't getting anywhere, that are just not improving. So it's having that communication back and forth and trying to figure out a bit better how to support GPs and provide the right care to the person,

We would meet with them and go through our patient lists, those who would be relevant for updates and sharing of information, sharing of diagnosis, sharing of issues and also dealing with referrals, we believed, that that particular model led to huge benefits in terms of safety, careful management, safety and sharing of information, and collegiality with GPs."

A formal local and regional lead to champion and advocate for shared care was seen as a key requirement to ensure sustained collaborative working and the development of formal communication pathways.

"So, I think it does need to have a GP lead or some form of local or regional GP lead that is able to assist the GPs. And I mean help, I don't mean dictate, I mean help and understand their perspectives and so on,

And another thing is getting buy-in from the patients. I mean, they're the ones who are going to be navigating multiple services so that they know and want to access. And it can be tough, even basic things. Sometimes it can be difficult to convince the patient to even get registered with a GP,

And clinical champions and advocates are vital, it really is about people championing things and running with it."

To support collaboration, key stakeholders reported several key areas that were required, and these are described in **Theme 2 Fundamentals to Deliver.**

Theme 2: Fundamentals to Deliver

This theme was informed by appropriate access to resources and support services as fundamentals to the delivery of shared care approaches to mental health. Ensuring access to community resources was seen as essential to deliver shared care. This may involve connecting individuals with peer support groups / services, recovery education, community mental health services, or other relevant resources closer to the person's home.

Setting up national and regional steering groups to assist and support the development of educational programmes for shared care was commonly referenced under fundamentals to deliver. This was seen as a crucial step to planning and design of educational programmes to support shared care.

"I think some sort of a national forum. I mean, from an education point of view, having a forum is fine, but I do think that there would need to be an awful lot of work done before that. In relation to what is reasonable to happen would have to be very much kind of already explored with the GPs and the services, the mental health services first before you start going near education, because who's going to come?"

The use of robust IT systems and the integration of technology, such as telehealth or secure messaging, can facilitate communication among team members and improve access to care for individuals in remote or underserved areas. Developing secure and effective systems for information sharing among different care providers is crucial and a key enabler to delivering an effective shared care service.

Additionally, regularly evaluating the outcomes of shared care interventions, including satisfaction of people using the services, clinical effectiveness, and adherence to treatment plans was identified as a key area of focus to help demonstrate the impact of shared care on mental health outcomes.

"IT systems to support each other are crucial. And I think that we're on a road to nowhere unless we have at least that, it's vital to make things easier for us and then make things easier for the clients that we are trying to serve."

The ability to use IT systems to set up recall and review processes was highlighted by stakeholders. Using technology to assist in determining when a person needs to be seen at primary practice level was also highlighted. This included having clarity about how a shared care model can be delivered when there are competing demands to see people in allocated appointment slots and having flexible approaches.

"Having an IT system that's intuitive, more like using Healthmail for letters and having that instant thing rather than posting things and having them findable and searchable has been helpful, but the reconciliation, there isn't a system, an easy system to just log in and check centrally,

Flexibility too, the exact model that you're going to be using is going to depend on all the different services in an area. You're not going to have a one size fits all."

Considerations for same system records for community mental health and GP practices were commonly referenced or a shared care record that was accessible to teams and services in primary care, community, and mental health.

"I think it would be much easier had we had the same records as GPs. I mean, if it was very easy to access the information on the patient's care, what's going on and just sort of I'm not sure how that could work around private because GPs tend to be private and then HSE, that's another level of complexity. But even within the HSE that already would be helpful to know just in relation to previous care history and contacts and it would save a lot of time and therefore it will allow us to spend more time on communication, on meeting people rather than just collecting that information and getting those details."

Offering additional community resources for primary care providers was reported as a key enabler for engagement and potentially increased buy-in to a shared care model. For example, increasing availability of cognitive behavioural therapists or psychotherapy services to primary care.

"If there was some way that signing up to this would come along with a cognitive behavioural therapist available to a practice or something like that, or some form of psychotherapy."

Access to information technology systems were the most referenced as a fundamental requirement to deliver on shared care. This was in addition to clinical governance frameworks presented as **Theme 3: Clinical Governance.**

Theme 3: Clinical Governance

The theme of clinical governance was seen as central to delivering high-quality mental health services through collaborative and coordinated efforts among different healthcare providers. Clear clinical governance structures were reported as fundamental to ensure a systematic approach to quality assurance, risk management, and continuous improvement within the context of shared care models. This included establishing and adhering to evidence-based clinical guidelines and standards and ensuring that mental health care provided within the shared care models meet recognised benchmarks for quality and effectiveness. Appointing clinical leaders was seen as important to ensure there is oversight and responsibility for the quality and safety of mental health shared care services. Clinical leadership to facilitate communication, collaboration, and adherence to best practices among team members was referenced by key stakeholders. This was reported as an essential aspect of ensuring that collaborative efforts lead to the provision of safe, effective, and person-centred mental health services.

Developing clinical governance frameworks for accountability, transparency, and continuous improvement in the delivery of care across different healthcare providers and settings was reported as an important part of developing shared care agreements.

"Clinical governance needs serious consideration, we need to think about how it will work from an oversight perspective so even something as simple as whether shared care agreements are going to be coming in between various services, having even a very slight template that's put forward and available so that people know that this is a thing and how to do it."

Having clear clinical governance was also important in defining roles and responsibilities and who is responsible for different aspects of a person's care.

"And I suppose the difficulty I've found with caseworkers or key workers, is who is that? What is their role, what responsibilities do they have, who can take on that role? And also, if you have a caseworker, then who is planning meetings?"

Clinical governance was linked to standardising care pathways to provide a systematic and safe pathway of care for people presenting to primary care services and these are described in **Theme 4: Standardised Care Pathways.**

Theme 4: Standardised Care Pathways

The theme of standardised care pathways was seen as a key enabler to shared care and to support safe and coordinated care plans that address both mental and physical health needs. This includes strategies for managing comorbid conditions and promoting overall wellbeing.

Standardised care pathways were felt as playing a crucial role in any shared care model, ensuring that individuals with mental health concerns receive comprehensive and timely services and avoid inconsistencies. This was particularly important to support the development of relationships between professionals and teams and avoid re-active care, whilst also reducing professional anxiety and fear in supporting people presenting with mental health symptoms.

"So, you do need your pathways of care and all the rest of it, but I think there is something about relationships but that's very person-dependent. There's something about that relationship and that access to advice early in a way that can offset the kind of things escalating and escalating and people panicking."

Having access to standardised care pathways was reported as key to the development and implementation of structured plans that include the management of mental health and comorbid conditions promoting overall wellbeing. The starting point of care pathway was seen as the initiation of standardised assessment to identify mental health issues, physical health concerns, and any existing comorbidities. The assessment phase was linked to developing tailored care plans that are integrated with mental health and physical components of care. Care plans were seen as facilitators of shared care as they outline requirements and approaches to treatment. This included medication management, therapy, lifestyle interventions, and monitoring of both mental and physical health indicators, adopting a holistic approach to supporting the people using the services.

"The care plan can act as a facilitator of shared care as often involves some groups or services, but for the most part it can really help with signposting and advice to the GP and that again, can manage and has managed a huge number of moderate level people in the community that may not require referral to specialist mental health services."

Standardising care pathways were reported as required to standardise care and avoid inconsistencies in different approaches to care whilst also developing shared care agreements and interdisciplinary collaboration.

"We need to develop a shared care agreement, and that's where the agreement lays out the model of what the shared care is going to be, who does what, when and things like that. And I think that's a great enabler. I mean, in Ireland, every time I set it up it's all been about schmoozing and talking to people and getting buy-in with each person individually. But if you have a clear structured agreement in place, it can really help."

Many stakeholders felt that developing care pathways reduced inconsistencies and supported services to adopt a standardised and cohesive approach to care with evidence-based practices to guide interventions, thus ensuring that the care provided is grounded in the latest research and best practices, contributing to better outcomes for individuals with mental health concerns.

"In our area alone, I think it's 68 GP practices in our catchment area, and within that, then there's almost 200 GPs. So that's potentially 200 different approaches to referring and collaborating and working and expectations of secondary mental health services. And then not every secondary mental health service works in the same way or accepts the same type of referrals. And other national clinical programs are creating or trying to create some standardised models of care."

Care pathways were also reported as a way to consider alternative approaches to care and pool expertise to design services that will provide low and high complexity care in the community.

"So, people with complex care to a degree, the local team are struggling to find a bespoke answer or a bespoke plan with themselves, what can they access, as well as a seniority and expert review of the case. So, we have those real challenges in terms of mechanisms to try to make sure that the pathway is clear."

The development and implementation of robust care pathways involves education and training and this is discussed in **Theme 5: Education and Training.**

Theme 5: Education and Training

Education and training were seen as fundamental to deliver on shared care to upskill and increase knowledge and skills with early detection and an understanding of treatment options in caring for people experiencing mental health symptoms. This was also seen as an integral step to understanding each other's roles. Much of the feedback referred to the engagement and buy-in from clinicians and resources to support a structured and sustainable programme. Most of the stakeholders reported that healthcare professionals involved in the delivery of shared care services require ongoing updates and training on evidence-based practice and standardised care pathways. This was to ensure that all team members have a clear understanding of any new models or pathways and the knowledge and skills to operate within them. Training and education were also seen as a way to value health care professionals and support better relationships and reduce inappropriate referrals.

"How you can systematically support communication and better relationships, where you value all the players properly and you recognise all the players properly, the answer is in education, education and training plays a huge role in that,

Inappropriate referrals are often a source of frustration, so I definitely agree with education around things like how and where to refer correctly because many of these services change all the time,

So, more education on that, knowing what a more accurate referral needs to look like and what information would be could help to shorten the process."

Upskilling on mental and physical health through education was also seen as a key enabler to shared care and reduce the likelihood of a person's care needs escalating,

"Better education in the community around the crossover of physical and mental health is key."

In addition to education and training communication and building strong relationships were reported as drivers for successful shared care and in supporting complex care. This is discussed in **Theme 6: Communication and Relationships.**

Theme 6: Communication and Relationships

Effective communication and information sharing were seen as fundamental to operationalise shared care approaches. This included a flexible approach to communication that is balanced with structured meetings and ability to share information electronically to ensure all team members are well-informed about the person using the services progress and treatment plan.

Building positive relationships through shared care was based on level of trust, openness, and the level of responsiveness when there is an issue.

"The psychiatrist has to lead out and keep the communication open. It's that communication piece, and that willingness, to kind of chat through how you can make this operational, and how you can make this work in the best interest of service users, so it's one; having a very good relationship with the community mental health team, and also having a very good relationship with the GP practices, and always being available to communicate, not being afraid of what you're going to be asked, because there really isn't anything to worry about, you know what I mean?"

Having strong communication pathways that are both structured and flexible was seen as key to providing care for people presenting with complex care needs. This enhanced the person's experience and supported primary care providers faced with sometimes very difficult and challenging situations.

"We've been open to GPs now since the beginning of March and the reception has been fabulous. They will often ring my colleagues, they'll ring for advice about where's the right place to send this person, what should we do with it? Look, I'm really stuck here, I need help, or there's an issue with XYZ, it's about communication and relationships,

Having communication pathways that have flexibility is hugely important in that you're not strict and stringent, not just to your protocols, but you have that flexibility to discuss other cases that maybe aren't relevant to you or that you'll not have any involvement in, but it can really help avoid unnecessary events, upskill colleagues, and support people in the community."

5.1 FOCUS GROUP SUMMARY OF FINDINGS

This chapter has presented the key themes based on feedback from key stakeholders and includes:

- Collaboration.
- Fundamentals to Deliver.
- Clinical Governance.
- Standardised Care Pathways.
- Education and Training.
- Communication and Relationships.

The themes uncovered are consistent with the evidence and highlight the importance of collaboration and team-based working underpinned by effective communication and understanding each other's roles and responsibilities.

Developing structured approaches to service delivery including standardised care pathways that are also balanced with flexibility to support primary care providers and build trust, positive relationships, and clear communication pathways to support engagement was emphasised by stakeholders.

Clinical leads or champions and liaison roles were recommended to deliver on shared care and support engagement. Stakeholders also emphasised the importance of clinical governance and supervision that is enhanced by structured education and training programmes that are properly resourced and are sustainable. Additionally, the availability of electronic methods to share information was seen as a fundamental requirement to deliver on shared care.

National and regional organisational support was recognised as a key enabler supporting the development and progress of areas such as education and training setting up forums to ensure consistency and sustained progress.

6.0 SUMMARY IMPLICATIONS FOR POLICY IMPLEMENTATION

6.0 SUMMARY IMPLICATIONS FOR POLICY IMPLEMENTATION

In summary, drawing on both the extensive literature review and the stakeholder engagement and insight gathering, the successful implementation of shared care approaches for the effective delivery of mental health services will require a multifaceted approach. This includes a clear communication plan, structured service delivery approach, clinical governance frameworks and standardised clinical supervision. Having champions and advocacy roles and link, liaison or case manager roles are important and have been linked to successful shared care. Developing a sustained training and education programme for staff to upskill and improve knowledge and skills to operate in shared care approaches is key to improve collaboration, develop new ways of working and facilitate integration of roles and services.

The ability to share information electronically is fundamental to support successful shared care including the ability to capture, monitor and track a person's response and inform alternative pathways of care. Organisational support and appropriate resourcing are vital to ensure sustainability and scalability that is informed by a clear outcome and impact measures demonstrating efficiency and effectiveness (Table 6).

Fundamentals	Description
Clear Communication Plan	Develop and implement a comprehensive communication plan to ensure effective information flow among staff and people who use the services.
Structured Service Delivery	Utilise consultation/liaison or collaborative care approaches to provide a structured and coordinated delivery of mental health services.
Clinical Governance and Supervision	Establish clinical governance frameworks and provide clinical supervision to ensure high-quality care and adherence to standards.
Champions and Advocacy Roles	Appoint champions and advocates to engage clinicians, primary care providers, and people who use the services, fostering a commitment to shared care.
Link, Liaison, or Case Manager Role	Implement a role responsible for connecting primary care practices, mental health teams, services, and chronic disease management specialists.
Training and Education for Staff	Provide ongoing training and education for staff to enhance their understanding of shared care principles and collaborative practices.
Electronic Information Sharing	Implement an electronic method to share information seamlessly across teams and services, facilitating real-time access to people who use the services data.
Organisational Support and Investment	Ensure organisational support and investment to sustain shared care approaches, recognising the value and importance of collaborative models.
Clear Outcome and Impact Measures	Establish clear outcome and impact measures to assess the effectiveness of shared care, supporting informed decision-making and sustainability.

Table 6 summarises the fundamentals identified to deliver an effective shared care service.

Shared care provides the framework to support the delivery of StV and recommendations 17, 18 and 19 in developing consultation/liaison models, informing the development of an achievable implementation plan to advance shared care approaches between primary care and specialist mental health services, and ensuring the physical health needs of all people who use specialist mental health services are addressed (DOH and HSE, 2022). This requires early-stage engagement with primary care providers and specialist mental health services involving individuals accessing services.

A clear communication plan is fundamental and will assist in informing the development of shared care agreements that will support and guide the principles of shared care and set the direction in terms of level of input and define roles and responsibilities. This requires enhancement by comprehensive and ongoing interdisciplinary training for healthcare providers, in understanding shared care, increasing knowledge and skills, and fostering a person-centred approach that actively involves individuals accessing mental health services.

Standardised communication tools and integrated electronic health records are important for seamless information sharing among care teams. The establishment of dedicated roles, such as link, liaison, or case manager roles, are integral to relationship building across services and to facilitate coordination between primary care practices and mental health teams, whilst also providing therapeutic interventions.

Continuous quality improvement processes, community engagement, and flexible policy frameworks are recommended to adapt to evolving needs. Adequate resource allocation, clinical governance and organisational support are paramount for sustained success, while clear outcome measures and regular feedback mechanisms ensure ongoing assessment of shared care effectiveness. Knowledge dissemination efforts should target all stakeholders, promoting a shared understanding of and commitment to collaborative care in mental health.

This report provides a strong evidence base for StV in its implementation of shared care approaches between primary care and specialist mental health services. It outlines relevant international best practice services, whilst highlighting key challenges and enablers in the area. In so doing, it allows improved understanding for StV in determining what is possible with developing shared care within the Irish context.

7.0 REFERENCES

7.0 REFERENCES

ALI, M. K., CHWASTIAK, L., POONGOTHAI, S., EMMERT-FEES, K. M. F., PATEL, S. A., ANJANA, R. M., SAGAR, R., SHANKAR, R., SRIDHAR, G. R., KOSURI, M., SOSALE, A. R., SOSALE, B., RAO, D., TANDON, N., NARAYAN, K. M. V. and MOHAN, V. 2020. Effect of a Collaborative care Model on Depressive Symptoms and Glycated Haemoglobin, Blood Pressure, and Serum Cholesterol Among Patients with Depression and Diabetes in India: The INDEPENDENT Randomized Clinical Trial. Jama, 324, 651-662.

ARCHER, J., BOWER, P., GILBODY, S., LOVELL, K., RICHARDS, D., GASK, L., DICKENS, C. and COVENTRY, P. 2012. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews.

BERNSTEIN, I. H., WENDT, B., NASR, S. J. and RUSH, A. J. 2009. Screening for major depression in private practice. J Psychiatr Pract, 15, 87-94.

BLASINSKY, M., GOLDMAN, H. H. and UNÜTZER, J. 2006. Project IMPACT: a report on barriers and facilitators to sustainability. Adm Policy Ment Health, 33, 718-29.

BODLUND, O., ANDERSSON, S. and MALLON, L. 1999. Effects of consulting psychiatrist in primary care: 1-year follow-up of diagnosing and treating anxiety and depression. Scandinavian Journal of Primary Health Care, 17, 153-157.

BOWER, P. and GILBODY, S. 2005. Managing common mental health disorders in primary care: conceptual models and evidence base. Bmj, 330, 839-42.

BYNG, R., JONES, R., LEESE, M., HAMILTON, B., MCCRONE, P. and CRAIG, T. 2004. Exploratory cluster randomised controlled trial of shared care development for long-term mental illness. Br J Gen Pract, 54, 259-66.

BYNG, R., NORMAN, I., REDFERN, S. and JONES, R. 2008. Exposing the key functions of a complex intervention for shared care in mental health: case study of a process evaluation. BMC Health Services Research, 8, 274.

CAMACHO, E. M., DAVIES, L. M., HANN, M., SMALL, N., BOWER, P., CHEW-GRAHAM, C., BAGUELY, C., GASK, L., DICKENS, C. M., LOVELL, K., WAHEED, W., GIBBONS, C. J. and COVENTRY, P. 2018. Long-term clinical and cost-effectiveness of collaborative care (versus usual care) for people with mental–physical multi-morbidity: cluster-randomised trial. The British Journal of Psychiatry, 213, 456-463.

CHANG, E. T., ROSE, D. E., YANO, E. M., WELLS, K. B., METZGER, M. E., POST, E. P., LEE, M. L. and RUBENSTEIN, L. V. 2013. Determinants of readiness for primary care-mental health integration (PC-MHI) in the VA Health Care System. J Gen Intern Med, 28, 353-62.

COPELLO, A., WALSH, K., GRAHAM, H., TOBIN, D., GRIFFITH, E., DAY, E. and BIRCHWOOD, M. 2013. A Consultation-Liaison Service on Integrated Treatment: A Program Description. Journal of Dual Diagnosis, 9, 149-157.

CREED, F. and MARKS, B. 1989. Liaison psychiatry in general practice: a comparison of the liaison-attachment scheme and shifted outpatient clinic models. J R Coll Gen Pract, 39, 514-7.

CURTH, N. K., BRINCK-CLAUSSEN, U., JØRGENSEN, K. B., ROSENDAL, S., HJORTHØJ, C., NORDENTOFT, M. and EPLOV, L. F. 2019. Collaborative care vs consultation/ liaison for depression and anxiety disorders in general practice: study protocol for two randomized controlled trials (the Danish Collabri Flex trials). Trials, 20, 607.

DARKE, S. 1998. Self-report among injecting drug users: a review. Drug Alcohol Depend, 51, 253-63; discussion 267-8.

DEPARTMENT OF HEALTH 2020. Sharing the Vision: a Mental Health Policy for Everyone. Dublin: Government of Ireland.

EE, C., LAKE, J., FIRTH, J., HARGRAVES, F., DE MANINCOR, M., MEADE, T., MARX, W. and SARRIS, J. 2020. An integrative collaborative care model for people with mental illness and physical comorbidities. International Journal of Mental Health Systems, 14, 83.

EUROQOL RESEARCH FOUNDATION 2019. EQ-5D-5L User Guide 3.0.

FELTZ-CORNELIS, C., OS, T., VAN MARWIJK, H. and LEENTJENS, A. F. 2006. Effect of psychiatric consultation models in primary care. A systematic review and meta-analysis of randomized clinical trials. J.Psychosom.Res., 68, 521-533.

FLEURY, M. J., GRENIER, G., GENTIL, L. and ROBERGE, P. 2021. Deployment of the consultation-liaison model in adult and child-adolescent psychiatry and its impact on improving mental health treatment. BMC Family Practice, 22, 82.

FOSTER, M., WEAVER, J., SHALABY, R., EBOREIME, E., POONG, K., GUSNOWSKI, A., SNATERSE, M., SUROOD, S., URICHUK, L. and AGYAPONG, V. I. O. 2022. Shared Care Practices in Community Addiction and Mental Health Services: A Qualitative Study on the Experiences and Perspectives of Stakeholders. Healthcare (Basel), 10.

FOY, R., HEMPEL, S., RUBENSTEIN, L., SUTTORP, M., SEELIG, M., SHANMAN, R. and SHEKELLE, P. G. 2010. Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. Ann Intern Med, 152, 247-58.

FROST, D. W., TOUBASSI, D. and DETSKY, A. S. 2012. Rethinking the consultation process: optimizing collaboration between primary care physicians and specialists. Can Fam Physician, 58, 825-8.

FULLER J, PERKINS D, PARKER S, HOLDSWORTH L and KELLY B, F. L., ET AL. 2009. Systematic Review on Service Linkages in Primary Mental Health Care: Informing Australian policy and practice Australian Primary Health Care Research
Institute. Canberra; 2009.

GILLIES, D., BUYKX, P., PARKER, A. G. and HETRICK, S. E. 2015. Consultation/liaison in primary care for people with mental disorders. Cochrane Database Syst Rev, 2015, Cd007193.

GOTO, Y., MIURA, H., SON, D., SCHOLL, I., KRISTON, L., HÄRTER, M., SATO, K., KUSABA, T. and ARAI, H. 2021. Association between physicians' and patients' perspectives of shared decision making in primary care settings in Japan: The impact of environmental factors. PLoS One, 16, e0246518.

GROVER, S. and KATE, N. 2013. Somatic symptoms in consultation-liaison psychiatry. Int Rev Psychiatry, 25, 52-64.

HSE. 2023. CRISIS RESOLUTION SERVICES MODEL OF CARE: **https://www.hse.ie/eng/services/list/4/mental-health-services/crs-moc.pdf.**

HSE. 2019. NATIONAL CLINICAL PROGRAMME FOR EARLY INTERVENTION IN PSYCHOSIS MODEL OF CARE: **https://www.hse.ie/eng/about/who/cspd/ncps/mental-health/psychosis/resources/hse-early-intervention-in-psychosis-model-of-care-june-20191.pdf.**

HSE. 2023. NATIONAL CLINICAL PROGRAMME FOR SELF-HARM AND SUICIDE-RELATED IDEATION OPERATIONAL GUIDANCE DOCUMENT: **https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/scan/ncpshi-scan-operational-guidance.pdf.**

HSE. 2012. RESEARCH EVALUATION OF THE SUICIDE CRISIS ASSESSMENT NURSE (SCAN): **https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/research/scanevaluation.pdf.**

KATES, N., ARROLL, B., CURRIE, E., HANLON, C., GASK, L., KLASEN, H., MEADOWS, G., RUKUNDO, G., SUNDERJI, N., RUUD, T. and WILLIAMS, M. 2019. Improving collaboration between primary care and mental health services. World J Biol Psychiatry, 20, 748-765.

KATON, W., VON KORFF, M., LIN, E., SIMON, G., WALKER, E., UNÜTZER, J., BUSH, T., RUSSO, J. and LUDMAN, E. 1999. Stepped Collaborative care for Primary Care Patients with Persistent Symptoms of Depression: A Randomized Trial. Archives of General Psychiatry, 56, 1109-1115.

KATON, W. J., LIN, E. H., VON KORFF, M., CIECHANOWSKI, P., LUDMAN, E. J., YOUNG, B., PETERSON, D., RUTTER, C. M., MCGREGOR, M. and MCCULLOCH, D. 2010. Collaborative care for patients with depression and chronic illnesses. N Engl J Med, 363, 2611-20.

KATON, W. J., VON KORFF, M., LIN, E. H. B., SIMON, G., LUDMAN, E., RUSSO, J., CIECHANOWSKI, P., WALKER, E. and BUSH, T. 2004. The Pathways Study: A Randomized Trial of Collaborative care in Patients with Diabetes and Depression. Archives of General Psychiatry, 61, 1042-1049.

KELLY, B. J., PERKINS, D. A., FULLER, J. D. and PARKER, S. M. 2011. Shared care in mental illness: A rapid review to inform implementation. International Journal of Mental Health Systems, 5, 31.

KIRCHNER, J. E., CODY, M., THRUSH, C. R., SULLIVAN, G. and RAPP, C. G. 2004. Identifying factors critical to implementation of integrated mental health services in rural VA community-based outpatient clinics. J Behav Health Serv Res, 31, 13-25.

KISELY, S. and CAMPBELL, L. A. 2007. Taking Consultation-Liaison Psychiatry into Primary Care. The International Journal of Psychiatry in Medicine, 37, 383-391.

KROENKE, K., SPITZER, R., and WILLIAMS, J. 2003. The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care
KROENKE, K., SPITZER, R. L. and WILLIAMS, J. B. 2001. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med, 16, 606-13.

KROENKE, K. and UNUTZER, J. 2017. Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care. J Gen Intern Med, 32, 404-410.

LAUFER, N., ZILBER, N., JECZMIEN, P., GILAD, R., GUR, S. and MUNITZ, H. 2023. Effect of implementation of mental health services within primary care on GP detection and treatment of mental disorders in Israel. Israel Journal of Health Policy Research, 12, 4.

LESTER, H. 2005. Shared care for people with mental illness: a GP's perspective. Advances in Psychiatric Treatment, 11, 133-139.

MAZZUCCHELLI, T. G., KANE, R. T. and REES, C. S. 2010. Behavioral activation interventions for wellbeing: A meta-analysis. J Posit Psychol, 5, 105-121.

MEADOWS, G., M.D., F.R.A.N.Z.C.P. ,, CAROL A. HARVEY , M. D., F.R.A.N.Z.C.P. ,, LYNETTE JOUBERT , M. A., D.LIT., PHIL. , DAVID BARTON , M. B. B. S., F.R.A.N.Z.C.P. , and GILLINDER BEDI , D. P. 2007. Best Practices: The Consultation-Liaison in Primary-Care Psychiatry Program: A Structured Approach to Long-Term Collaboration. Psychiatric Services, 58, 1036-1038.

MUESER, K., DRAKE, R., CLARK, R., MCHUGO, G., MERCER-MCFADDEN, C. and ACKERSON, T. 1995. Evaluating Substance Abuse in Persons with Severe Mental Illness.

OLIVEIRA-MAIA, A. J., MENDONÇA, C., PESSOA, M. J., CAMACHO, M. and GAGO, J. 2016. The Mental Health Recovery Measure Can Be Used to Assess Aspects of Both Customer-Based and Service-Based Recovery in the Context of Severe Mental Illness. Front Psychol, 7, 1679.

OSLIN, D. W., ROSS, J., SAYERS, S., MURPHY, J., KANE, V. and KATZ, I. R. 2006. Screening, assessment, and management of depression in VA primary care clinics. The Behavioral Health Laboratory. J Gen Intern Med, 21, 46-50.
PRIETO, L. and SACRISTÁN, J. A. 2003. Problems and solutions in calculating quality-adjusted life years (QALYs). Health Qual Life Outcomes, 1, 80.

REIST, C., PETIWALA, I., LATIMER, J., RAFFAELLI, S. B., CHIANG, M., EISENBERG, D. and CAMPBELL, S. 2022. Collaborative mental health care: A narrative review. Medicine (Baltimore), 101, e32554.

RUBENSTEIN, L. V., CHANEY, E. F., OBER, S., FELKER, B., SHERMAN, S. E., LANTO, A. and VIVELL, S. 2010. Using evidence-based quality improvement methods for translating depression collaborative care research into practice. Fam Syst Health, 28, 91-113.

RUSSELL, V., MCCAULEY, M., MACMAHON, J., CASEY, S., MCCULLAGH, H. and BEGLEY, J. 2003. Liaison psychiatry in rural general practice. Ir J Psychol Med, 20, 65-68.

RUSSELL, V., LOO, C., WALSH, A., BHARATHY, A., VASUDEVAN, U., LOOI, I. and SMITH, S. 2021. Clinician perceptions of common mental disorders before and after implementation of a consultation-liaison psychiatry service: a longitudinal qualitative study in government-operated primary care settings in Penang, Malaysia. BMJ Open 2021;11:e043923. doi: 10.1136/bmjopen-2020-043923.

SIMON, G. E., LUDMAN, E. J., BAUER, M. S., UNÜTZER, J. and OPERSKALSKI, B. 2006. Long-term effectiveness and cost of a systematic care program for bipolar disorder. Arch Gen Psychiatry, 63, 500-8.

SMITH, S. M., ALLWRIGHT, S. and O'DOWD, T. 2007. Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. Cochrane Database Syst Rev, Cd004910.

SMITH, S. M., COUSINS, G., CLYNE, B., ALLWRIGHT, S. and O'DOWD, T. 2017. Shared care across the interface between primary and specialty care in management of long-term conditions. Cochrane Database Syst Rev, 2, Cd004910.

TZARTZAS, K., OBERHAUSER, P.-N., MARION-VEYRON, R. and SAILLANT, S. 2022. Psychiatric consultation in general practitioners' daily practice: a qualitative study on the experience of consultation-liaison psychiatry interventions in primary care settings in French-speaking Switzerland. BMC Primary Care, 23, 316.

WARE, J. E., JR. and SHERBOURNE, C. D. 1992. The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. Med Care, 30, 473-83.

WHO. 2008. Integrating mental health into primary care: a global perspective. Geneva (Switzerland) and Singapore: World Health Organization and World Organization of Family Doctors.

WRIGHT, B. and RUSSELL, V. 2007. Integrating mental health and primary care services: a challenge for psychiatric training in Ireland. Ir J Psychol Med, 24, 71-74.

YOUNÈS, N., GASQUET, I., GAUDEBOUT, P., CHAILLET, M.-P., KOVESS, V., FALISSARD, B. and HARDY BAYLE, M.-C. 2005. General Practitioners' opinions on their practice in mental health and their collaboration with mental health professionals. BMC Family Practice, 6, 18.

YOUNÈS, N., HARDY-BAYLE, M. C., FALISSARD, B., KOVESS, V. and GASQUET, I. 2008. Impact of shared mental health care in the general population on subjects' perceptions of mental health care and on mental health status. Soc Psychiatry Psychiatr Epidemiol, 43, 113-20.

8.0 APPENDICES

8.0 APPENDICES

CASE STUDY REPORTING

BACKGROUND

The mental health in primary care workstream (HSE) is overseeing the delivery of a cluster of recommendations to support the implementation of Sharing the Vision: a mental health policy for everyone (DOH, 2020). The workstream is focusing on recommendations 17 to 19 of the implementation framework (DOH and HSE, 2022) in the establishment of formal links between Community Mental Health Teams (CMHTs) and primary care in the adoption of a consultation/liaison model and shared care approach to mental health care to include GP care, to achieve the best outcomes. To inform and assist in the delivery of these specific recommendations we are undertaking an international literature review. This is in addition to a series of key stakeholder focus group interviews and several case studies to inform the development of a consultation and liaison model approach that is underpinned by a shared care.

Thank you for agreeing to complete this case study. With permission of the service/organisation we will include this case study to inform best practice principles and as part of a best practice analysis as part of a final report.

Please provide a brief description under each heading to help us understand the service/model of care developed in your area. There are four sections.

Service Title	
Region	
Year implemented	

1.0 SERVICE OVERVIEW

A. Why was the model of care/service required?

B. Who is the population accessing the model of care/service?

C. Please briefly describe the model of care/service (include how service users access and where care is delivered)

D. Please briefly describe how does the model of care/service integrate with other services (pathways of care)

E. Please briefly describe how the model of care/service aligns to Policy and National Programmes?

2.0 SERVICE DELIVERY AND CLINICAL PRACTICE

A. Please briefly describe the types of assessment approaches?

B. Please briefly describe the most common interventions delivered?

C. Are there shared care approaches (For example, referral protocols, assessments working with service providers in primary and secondary care settings)

D. Are there standardised protocols for practice? If 'Yes', please briefly describe these under the following sub-headings:

i. What is the role of the protocols?

ii. How were these developed?

iii. How were these implemented? (include any workflows, training and education, change in practice)

iv. The basic principles they are operating within (for example to support recovery)?

v. How are they guiding the HCP and Team (including the core team) operating within the protocols?

vi. How are they supporting a proactive approach?

vii. How are they supporting integration?

viii. How are they monitored and updated?

ix. How they ensure the service users' needs are met

x. Please briefly describe clinical governance underpinning the model of care/service?

3.0 RESOURCE REQUIREMENTS AND SUPPORT

Please briefly describe the resources required to deliver the model of care/service

i. Workforce

ii. ICT

iii. Protocols

iv. Training and Education

v. Clinical supervision and clinical governance

vi. Infrastructure

vii. Access to other services

4.0 EVALUATION

Please briefly describe how you are evaluating the impact of the model of care/ service from a service user, staff, system, andorganisational perspective, and please include any outcomes captured to date.


Xenon
Health Solutions