DEVELOPING A MENTAL HEALTH TRIAGE SERVICE IN PRIMARY CARE

This is a summary: the full paper can be accessed at nursingtimes.net

AUTHOR Simon Sawyer, MA, RMN, is senior mental health triage nurse, Gloucestershire PCT and Gloucestershire Partnership NHS Foundation Trust.


This article describes the development of a mental health triage service that was rolled out across Gloucestershire between June 2004 and January 2007. The service was provided directly to clients with common mental health problems. The article focuses on the first cluster of GP surgeries to be covered in Cheltenham. It outlines the success in improving access for service users to appropriate and timely assessment as well as reducing referrals from GPs to specialist mental health services.

The primary mental health team (PMHT) was formed in 2000. By 2003 there had been agreement from the three PCT local implementation groups (LIGs), to varying extents, to roll out a mental health triage service in primary care. In addition, in line with Department of Health guidance (DH, 2003), there was an agreement to fund graduate mental health workers (GMHWs), with one for each cluster of surgeries.

Funding for what was now the primary mental health service (PMHS) came from two main sources – the PCTs and the Gloucestershire Partnership Trust (GPT).

The triage service was set several targets including: increasing capacity to expert assessment; reducing inappropriate referrals to secondary care services; a good working interface between primary and secondary care; and sustainable partnerships with agencies and community resources.

Another vital principle for the PMHT was to work within a stepped care model, in line with NICE guidance (NICE, 2004a; 2004b). The aim was to offer and deliver the least intrusive or complex treatment/input that could help clients to tackle their problems.

SETTING UP THE MENTAL HEALTH TRIAGE NURSE SERVICE

Before the first clinical activity, there was a three-month period of preparation, from March to early June 2004. This included the first group of three triage nurses taking part in some of the training programme for the GMHWs. This was important in forging a bond between each nurse and their identified GMHW.

My GMHW and I carried out a thorough audit of the cluster area in which we were to work. We also made frequent visits to the five surgeries I was to cover, setting up slots on their computer systems, explaining the service to as many staff as possible, and training reception staff on the correct forms to give out and booking available rooms.

I developed my own assessment pack, which included all the possible forms, leaflets, resource lists, relaxation CDs and guided self-help material I might need in an average clinic. We designed concise screening forms as well as a basic onward referral form with space to add more detailed information.

A vital task was forming relationships with staff from the specialist services in the area, including the community mental health teams (CMHTs), the psychological therapies service and the crisis service.

It was decided that initially we would use the hospital anxiety and depression scale (HADS) screening tool (Snaith and Zigmond, 1984). Clients would be given this form to fill in as they arrived for their appointment. In 2005 the PMHS decided to use the clinical outcomes in routine evaluation (CORE) outcome measure, which is particularly useful for measuring effectiveness and outcomes of psychological therapy.

THE TRIAGE CLINICS IN OPERATION

By mid June 2004 my first four clinics were up and running – the fifth started in November 2004.

Each surgery covered a similarly sized population of between 9,000 and 11,000 patients. Because of these comparable sizes, I could offer one clinic in each surgery every week. Clinics would cover a morning or an afternoon and comprise four 45-minute slots, with preparation and winding-up time before and after. The aim was to spend 30–35 minutes with each client, using the remaining 10 minutes for documentation. GPs and other health workers would be able to book clients directly into the slots. All clinics took place at the GP surgery sites. Triage nurses were also available for consultation by any of the primary care staff.

After assessment, the following could be offered, using the stepped-care approach:

- No further input – problems resolved between referral and assessment;
- Giving information, leaflets and phone numbers for advice centres;
- Books on prescription scheme;
- Giving contact details for independent counselling organisations;
- Giving guided self-help material I might need in an average clinic. We designed concise screening forms as well as a basic onward referral form with space to add more detailed information.

A vital task was forming relationships with staff from the specialist services in the area, including the community mental health teams (CMHTs), the psychological therapies service and the crisis service.

It was decided that initially we would use the hospital anxiety and depression scale (HADS) screening tool (Snaith and Zigmond, 1984). Clients would be given this form to fill in as they arrived for their appointment. In 2005 the PMHS decided to use the clinical outcomes in routine evaluation (CORE) outcome measure, which is particularly useful for measuring effectiveness and outcomes of psychological therapy.

THE TRIAGE CLINICS IN OPERATION

By mid June 2004 my first four clinics were up and running – the fifth started in November 2004.

Each surgery covered a similarly sized population of between 9,000 and 11,000 patients. Because of these comparable sizes, I could offer one clinic in each surgery every week. Clinics would cover a morning or an afternoon and comprise four 45-minute slots, with preparation and winding-up time before and after. The aim was to spend 30–35 minutes with each client, using the remaining 10 minutes for documentation. GPs and other health workers would be able to book clients directly into the slots. All clinics took place at the GP surgery sites. Triage nurses were also available for consultation by any of the primary care staff.

After assessment, the following could be offered, using the stepped-care approach:

- No further input – problems resolved between referral and assessment;
- Giving information, leaflets and phone numbers for advice centres;
- Books on prescription scheme;
- Giving contact details for independent counselling organisations;
- Using the stepped-care model, which is in line with NICE guidance.

IMPLICATIONS FOR PRACTICE

- The working relationship between the PCTs and Gloucestershire Partnership Trust worked effectively and helped to produce the positive results achieved.
- The triage service reduced inappropriate referrals to community mental health teams and increased the number of clients seen in a timely manner.
- The two satisfaction surveys that were undertaken indicate that the new service was well received by both healthcare professionals and mental health clients.
- The service aims to provide clients with a stepped-care model, which is in line with NICE guidance.
At the end of the 1990s there was increasing pressure for specialist mental health services to address the needs of clients with severe and enduring illness, so those with mild to moderate conditions should be receiving help from primary care services and non-statutory agencies.

In many areas, there was a discernible gap between the withdrawal of specialist care input into the mild to moderate client group and the provision of appropriate cover in the primary care setting. GPs became increasingly frustrated with the growing numbers of referrals returned as inappropriate for the new community mental health teams.

Referral to the GMHW for guided self-help or Beating the Blues (Ultrasis, 2000–2007) – Beating the Blues is a computerised CBT programme recommended by NICE;

Referral to the psychological therapies service;

Referral to the CMHT or early intervention service;

Referral to the crisis team to be considered for admission or to receive intense support.

My philosophy with any client I assessed was not to let them leave the room empty-handed, as much as was possible.

The vast majority of clients were:

- Only seen once;
- Experiencing mild to moderate problems with anxiety or low mood.

During the period covered by the triage service, I made many referrals to other agencies and workers, which included:

- 56 direct referrals to CMHTs;
- 41 direct referrals to the psychological therapies service;
- 117 referrals to the GMHW.

Referrals to non-statutory counselling agencies increased noticeably and, for a while, their waiting-list times increased.

Over the two-and-a-half years, I ran 547 clinics. My colleagues in the other initial clusters in the county reported similar figures.

GPT statistics suggest a marked reduction across the county in inappropriate referrals to CMHTs. Between June and December 2003, six months before the scheme began, there were 369 referrals to these CMHTs. Between June and December 2004 (the first six months of the scheme) there were 219 – a reduction of nearly 41%. By halfway through 2006–2007, it was estimated by the PMHS that reductions of 50–80% had been made in referrals to CMHTs covered by our service. These figures are based on GPT statistics that are yet to be finalised.

My 1,590 total attended sessions greatly improved on the hoped-for 500 contacts per year – I averaged 615 per year.

The clinical effectiveness of the CBT-based treatment packages provided by the PMHS was measured using the CORE system. There are figures relating to the efficacy of these programmes in the various internal progress reports for the PMHS. In October 2004, a survey of health professionals revealed a strong awareness of the various PMHS services available – between 67% for the website and 97% for the triage service.

Other results from the staff survey include:

- The majority (27 out of 30; 90%) found the new service ‘helpful’ or ‘very helpful’;
- 28 out of 30 (93%) found it ‘useful’ or ‘very useful’;
- The vast majority (29 out of 30; 97%) found it ‘accessible’ or ‘very accessible’;
- Nearly two-thirds (19 out of 30; 63%) found it had reduced their workloads.

In a survey of service users in February 2005, 141 questionnaires were sent out and 55 were returned – a response rate of 39%. Survey results included the following:

- 87% found the service appropriate to their difficulties;
- Nearly all (96%) felt that things were explained in a way they could understand;
- The majority (89%) felt the triage nurse listened to what they had to say;
- 90% rated the care received as ‘good’ or ‘excellent’.

CONCLUSION

The triage nurses achieved all the main targets originally set, and often outperformed them. For me, the 31 months in this role have been the most enjoyable of my career. I also believe that, during my time with the PMHS, I did my most important, clinically effective and statistically significant work to date.

The difficult financial climate of the past two years led to a restructuring of community mental health care in Gloucestershire in January 2007. Although the PMHS was disbanded and subsumed into a new, larger team (which also had to take on some of the work previously done by CMHTs), very similar triage work is going on in GP practices county-wide, with every surgery covered.

This project was a mental health finalist in the NT Awards 2007.

For the full version of this paper, including background to an implementation of the project and full reference list, log on to nursingtimes.net, click NT Clinical and Archive and then Clinical Extra.

REFERENCES

Clinical Outcomes in Routine Evaluation (CORE) www.coreims.co.uk

Department of Health (2003) Fast-forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers – Best Practice Guidance. London: DH.

NICE (2004a, amended 2007) Anxiety: Management of Anxiety (Panic Disorder, with or without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care. London: NICE.


Fast-care services and non-statutory agencies. My colleagues in the other initial agencies increased noticeably and, for a while, their waiting-list times increased.

Other results from the staff survey include:

- The majority (27 out of 30; 90%) found the new service ‘helpful’ or ‘very helpful’;
- 28 out of 30 (93%) found it ‘useful’ or ‘very useful’;
- The vast majority (29 out of 30; 97%) found it ‘accessible’ or ‘very accessible’;
- Nearly two-thirds (19 out of 30; 63%) found it had reduced their workloads.

In a survey of service users in February 2005, 141 questionnaires were sent out and 55 were returned – a response rate of 39%. Survey results included the following:

- 87% found the service appropriate to their difficulties;
- Nearly all (96%) felt that things were explained in a way they could understand;
- The majority (89%) felt the triage nurse listened to what they had to say;
- 90% rated the care received as ‘good’ or ‘excellent’.

CONCLUSION

The triage nurses achieved all the main targets originally set, and often outperformed them. For me, the 31 months in this role have been the most enjoyable of my career. I also believe that, during my time with the PMHS, I did my most important, clinically effective and statistically significant work to date.

The difficult financial climate of the past two years led to a restructuring of community mental health care in Gloucestershire in January 2007. Although the PMHS was disbanded and subsumed into a new, larger team (which also had to take on some of the work previously done by CMHTs), very similar triage work is going on in GP practices county-wide, with every surgery covered.

This project was a mental health finalist in the NT Awards 2007.