MR. THIJS BECKERS (Orcid ID : 0000-0003-1557-5387)

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Substituting specialist care for patients with severe mental illness with primary healthcare. Experiences in a mixed methods study.

Short title: primary healthcare for patients with SMI

Thijs Beckers, MSc (Advanced practice Nurse, Roermond, the Netherlands)[1,2,3], Bauke Koekkoek, PhD (Associate Professor, Nijmegen, the Netherlands)[1,4], Bea Tiemens, PhD (professor, Nijmegen, the Netherlands)[3,4,5], Lia Jaeqx - van Tienen, MANP (Advanced practice Nurse, Roermond, the Netherlands)[2] and Giel Hutschemaekers, PhD (full professor, Nijmegen, the Netherlands)[3,4,5]

1 Hogeschool Arnhem Nijmegen University of Applied Science, Research Group Social Psychiatry and Mental Health Nursing (Nijmegen, The Netherlands); **2** METggz, (Roermond, The Netherlands); **3** Radboud University, Clinical Psychology. Behavioural Science Institute (Nijmegen, The Netherlands); **4** Pro Persona, Research Institute (Wolfheze, The Netherlands); **5** Indigo, (Utrecht, The Netherlands)

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Corresponding author:

Thijs Beckers

Minister Beverstraat 3, 6042 BL Roermond, +31-6-41424943

thijsbeckers@me.com

Accessible summary

What is known on the subject

- Care planning and coordination are currently insufficiently based on scientific insights due to a lack of knowledge on this topic.
- Most patients with severe mental illness receive long-term treatment from specialized mental health services.
- This long-term, highly intensive treatment is not always the best option for two reasons. Firstly, because as long as a patient receives intensive treatment aimed at safety, it is hard for that patient to take full responsibility for their own life. Secondly, because care is not available unlimitedly, some patients are waiting to receive specialist mental healthcare while others who do not need it anymore still receive it.

What this paper adds to existing knowledge

- Most stable patients with severe mental illness can be treated outside of specialized mental health services.

- Some patients are too dependent on a specific mental healthcare professional to be referred to primary healthcare. In such instances, a referral will most likely lead to destabilization and the referral will therefore be unsuccessful.
- Patients preferred primary healthcare to specialized mental health services, mainly because of the absence of stigma associated with the latter.
- There should be more attention for personal recovery (especially the social support system) of patients with severe mental illness who are referred to primary healthcare services.

What are the implications for practice

- Most stable patients with severe mental illness can be treated in primary healthcare.
- Professionals in primary healthcare should keep personal recovery in mind when treating patients, focusing on problem solving skills and also making use of social support systems.

Abstract

Aim/question: Care planning and coordination are currently insufficiently based on scientific insights due to a lack of knowledge on this topic. In the UK and the Netherlands, most patients with severe mental illness receive long-term specialized mental healthcare, even when they are stable. This study aims to explore the outcome of these stable patients when they are referred to primary healthcare.

Methods: Patients (N=32) receiving specialized mental healthcare that were referred to primary healthcare were interviewed in focus groups, as were the involved professionals (N=6).

Results: 84% of the participants still received primary healthcare after 12 months. Despite the successful referral, the patient's personal recovery did not always profit. The participants of the focus groups agreed that some patients were too dependent on a specific mental healthcare professional to be referred to primary healthcare.

Discussion: Most stable patients with severe mental illness can be referred to primary healthcare. Personal recovery and dependency on a specific healthcare provider should be considered when referring a patient to primary healthcare.

Implications for practice: Professionals in community mental healthcare teams should consider a referral to primary mental healthcare in stable patients. Professionals in primary healthcare should keep the patient's personal recovery in mind.

Keywords: discharge, matched care, primary care, recovery, referral, severe mental illness

Relevance statement

Nurses are involved in the long-term care for people with severe mental illness. Patients who receive intensive treatment for too long can become overly dependent on care, which is called care dependency. In this paper we provide insights into the considerations of patients and care providers about providing primary health care to patients with severe mental illness instead of specialist mental healthcare, based on their experiences. Noteworthy conclusions are that some

patients are too care dependent on a specific professional to be referred to primary healthcare and that and that the focus on personal recovery is lacking in primary healthcare.

Introduction

Many people with severe mental illness (SMI) are treated by specialized mental health services. Most often treatment for people with SMI is provided among others by multidisciplinary community mental health teams (CMHT's), as is traditionally the case in the United Kingdom (Hannigan, 2011). In the Netherlands, such treatment is provided by outreaching teams, named Flexible Assertive Community Treatment (FACT)-teams (Remmers van Veldhuizen, 2007; Nughter et al, 2016), i.e. multidisciplinary teams of professionals like psychiatrists, specialized nurses, and psychologists. A social worker, a vocational specialist or a peer worker sometimes provide supplemental services.

Historically, people with SMI are often treated in CMHT's. Recently, however, initiatives have been developed to substitute care from specialized mental health care settings to teams working in primary care (Beckers et al, 2018; Kendrick et al., 2000; Reilly et al, 2012) with initiatives being developed in multiple countries, such as the United Kingdom and the Netherlands (Röhricht, 2017). In the Dutch situation new care arrangements have been constructed in which, stable patients with SMI are treated in primary healthcare are treated by their general practitioner (GP) in collaboration with a Community Mental Health Nurse (Hutschemaekers, 2014; Stringer, 2011).

There are two obvious differences between CMHT's and primary healthcare. First, patients receiving care from a CMHT or a FACT-team often receive specialized treatment from a multidisciplinary team of healthcare professionals, whereas primary healthcare is usually provided by one single professional. Second, professional expertise varies between CMHT's and professionals in primary healthcare. Nurses, GP's and psychiatrists in CMHT's differ in the focus of their clinical decision making, resulting in different opinions on adequate levels of care for patients (Stange et al, 2009). Whereas a CMHT focusses on treatment of the illness with the most effective interventions, professionals in primary healthcare usually have a broader focus, also aimed at more practical problems.

For most patients with severe mental illness, periods of intense mental health problems are alternated with periods of recovery and relatively little change in symptoms. In this paper, we define recovery as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles (Anthony, 1993). Although the importance of recovery is generally accepted, there is a strong debate on the question, whether recovery needs stability as well as on the question how and when to determine whether patients with SMI could be considered stable, but no consensus has been reached. In the Netherlands, patients are considered stable when both symptomatic and functional remission are achieved, for example when a patient has had no psychiatric admission in two years and some roles in life have been resumed (Delespaul, 2013).

There can be financial or recovery motives for the treatment of patients with SMI outside of a CMHT. The financial motive is that CMHT's and other specialized mental healthcare services are expensive and scarce, and thus should be reserved for those

patients who need it the most (Davies, 2006; Kendrick et al, 2000). From a recovery perspective, it is argued that when the intensity of mental healthcare is reduced, it becomes easier for patients with SMI to take responsibility for their own recovery and for their own lives. In other words: a side effect of intensive care can be loss of autonomy, dependence on care and further withdrawal from social networks (Bonavigo, 2016). Additionally, receiving mental healthcare at the GP's office instead of an office of a specialized mental healthcare professional can reduce self-stigma and stigma by others (Vogel et al, 2007; Watson et al, 2007; Evans-Lacko et al, 2012; Slade, 2014; Slade, 2015).

Research in community mental health care planning is scarce and there are clear gaps in the international research on treating patients with SMI in primary healthcare (Jones, 2018). Recently however, there is an increasing number of studies on the topic of treating patients with SMI in primary healthcare, including randomized controlled trails. An example is the EQUIP-study, in which mental health professionals learned to enhance patient involvement in care planning (Bower et al, 2015). The study concludes that mental health professionals can be taught to improve patient involvement in care planning and that patients and mental health professionals can improve patient involvement in care planning together (Fraser, 2017; Grundy, 2017).

Other examples include a recently published review describing the association between continuity of care and health outcomes (Weaver, 2017) and a qualitative study about mental health care planning among mental health nurses working in primary care in England, that concludes that clear referral criteria are needed (Mcleod, 2017). Studies like these add to the knowledge base on treating patients with SMI in primary healthcare. However, more studies are required that focus on the specific care a patient

needs at a specific point in his or her recovery, and how to coordinate this care to improve scientific based care planning for patients with SMI (Jones, 2018). This study adds to the topic of referring patients to primary healthcare that are traditionally treated in CMHT's, to help achieve this larger goal of care planning on scientific basis instead of on a mainly policy basis, as is common practice (Hannigan, 2018)."

Also noteworthy is the difference in view on whether patients with SMI can be treated outside of a CMHT. Many professionals who work in a CMHT believe that the care for patients with SMI is too complex for treatment in primary healthcare, while patients frequently disagree with this viewpoint and emphasize the importance of hope, optimism, and recovery, which they feel they get more in primary healthcare (Wang et al, 2002; Bower, 2002, Lester et al, 2005, Stuart et al, 2016).

Aim

This study aims to explore the effects of the referral of patients with SMI from a CMHT to primary healthcare by collecting the experiences of these patients and the experiences of their healthcare professionals. A secondary aim of the study was to collect opinions on which patients might have better chances at success when being referred from a CMHT to primary healthcare. Additionally, basic data was collected about how many of the patients in the natural experiment received primary healthcare one year after the referral to primary healthcare. To pursue these aims, we conducted a study in three primary care-practices in the Netherlands.

Methods

This study was an observational cohort study of people with SMI whose specialized mental health care was replaced by primary healthcare on the initiative of the local specialist mental health service. Focus group interviews were conducted with the involved healthcare professionals (CMHN's, general practitioners and the consulting psychiatrist) and with a sample of the involved patients. Additionally, data was collected on the percentage of patients who were referred back to a CMHT while receiving primary healthcare. All details of the study methods and results are reported in accordance with the COREQ-checklist for the reporting of qualitative studies (Tong, 2007).

Setting, sample, and procedure

The study was conducted from a specialized mental health service with a catchment area of 150,000 residents and 250 GP's, three of which participated in the study. All patients who met the inclusion criteria were eligible to participate in the study and were approached to participate. SMI was defined as a mental disorder, for which specialized mental healthcare had been received for a minimal duration of two years and having a GAF-score of 50 or less (Parabiaghi et al, 2006).

To be included, the patients had to be (a) a patient of one of three participating GP's, (b) meet the criteria of SMI, (c) have had no psychiatric admission in the last two years, and (d) be compliant with prescribed medication, as judged by their psychiatrist. Patients that used psychotropic drugs that required (according to their GP) complex follow-ups, for example regular blood tests, were excluded. Patients who were judged to be eligible were invited to participate and asked to give written informed consent.

During their last appointment in specialized mental health services, all patients completed the Brief Psychiatric Rating Scale (BPRS) and the Camberwell Assessment of Needs.

Replaced care

The intervention started when patients were referred by healthcare professionals from a CMHT to primary healthcare. Regular sessions with a community mental health nurse (CMHN) in the practice of the GP's were the main part of the treatment (see table 1 for details on the difference between the care from a CMHT and from primary healthcare). Each session lasted 30 minutes, was individual and the sessions had a six-week interval. At each session, patients were invited to introduce their own topics for discussion. The CMHN promoted self-support and used techniques that are common in supportive psychosocial treatment, such as structuring problems and using positive appraisal. The CMHNs had specific knowledge about SMI and had previous experience working in a CMHT. When the CMHN or the patient requested it, a consultation with the GP was arranged. The GP's supervised the treatment of the patients, and had the opportunity to consult a psychiatrist if needed.

Measures

As the primary aim of the study was to explore the experiences of a referral from a CMHT to primary healthcare for patients with SMI, the main method of data collection was collecting focus group data. Secondary data was collected on the percentage of patients who were referred back to a CMHT due to a relapse while receiving primary healthcare.

Data collection

Procedure

Patients were followed up for twelve months after their referral to primary healthcare, and referrals back to a CMHT were monitored.

Focus group data

The data were collected in three focus-group interviews, which took place between 12 and 15 months after the patient's initial referral to primary healthcare. One of the focus groups consisted of the three participating GP's; the second one included the two participating CMHNs and the participating psychiatrist who could be consulted by GPs during the study; and the third one consisted of four randomly selected participating patients. The patients participating in the focus groups were selected from all participating patients by allocating each a random number and then contacting the patient with the lowest number to participate. If a patient declined (or would decline) to participate, the patient with the next lowest number was (or would be) contacted.

The focus-group interviews were organized at the offices of the mental healthcare service where all participants received treatment before starting this study. Digital audio recordings were made from all focus group interviews. All interviews were fully transcribed and the transcriptions were checked by a second researcher. Field notes on the organization and execution of the focus group interviews were made. Patients gave informed consent at the start of the focus group.

The focus-group interviews were conducted by Master-trained advanced practice nurses TB (MSc, PhD candidate, advanced practice nurse, male) & LJ (MSc, advanced practice nurse, female). Both worked in a CMHT at the time and were interested in decreasing the intensity of care in patients with SMI after experiencing difficulties with referring patients from the CMHT to primary healthcare. As outlined in the introduction, both assumed some patients with SMI may be referred to primary healthcare. The participating patients did not know the interviewers but were informed about the nature of the focus-group interviews and the background of the interviewers. Some of the participating professionals had worked with the interviewers as colleagues.

Three questions were asked in the focus groups: What are the characteristics of patients with SMI that are appropriate for referral from a CMHT to primary healthcare? In what ways do these patients benefit from the referral to primary healthcare? What are the disadvantages of the referral to primary healthcare for the patient? Each question was discussed, and the researchers kept the discussion going until no new information emerged.

Data analysis

Outcome data

The data on the referrals back to a CMHT were collected and are reported in this paper.

Focus group data

Inductive content analysis (Elo et al, 2008) of the conventional type (Hsieh et al, 2005) was used to analyze the focus-group data. Analyses were conducted on a theme level by TB. Open coding was used to identify common themes that could be arranged into categories. Sub-themes were identified within the main themes. To ensure that the results were valid, author BK (PhD, advanced practice nurse, male) checked all steps in the analysis, and author LJ reviewed them. When the researchers disagreed about any step in the analyses, they discussed the result until they achieved concurrence.

Ethical considerations

This study was part of a planned reorganization of the healthcare services that were involved, thus a natural experiment occurred. Data used in this paper was routinely collected, however patients were asked to give written informed consent prior to their participation to use their outcome data for research purposes. This consent was also asked for the use of anonymous publication of their care experiences, as collected in the qualitative interviews, which were entirely voluntarily. Since the study itself did not make any changes to treatment provided, ethical review was not required under Dutch law (Central committee on research involving human subjects, 2018).

Results

Thirty-two patients were included in the study, which ran from late 2011 until early 2014. Of these patients, 63% was male, and the mean age of the participants was 47$\pm$10.8 years. See Table 2 for additional patient variables.

Success rate

Of the 32 patients who were initially referred to primary healthcare, 27 patients still received primary healthcare after one year. Four out of the five patients that did no longer receive primary healthcare, were referred back to the CMHT because the treatment in primary healthcare was not intensive enough for them, and either the patient or one of the professionals requested that the patients' treatment in primary healthcare be terminated. One other patient, in consultation with the involved professionals, decided to terminate treatment altogether.

Focus group results

All of the participating professionals were invited to, and participated in the focus group interviews. A random sample of four patients was drawn from the participating patients and was invited. One of the patients did not show up at the time of the focus-group interview. When contacted later by telephone, the patient did not provide an explanation for not showing up. All interviews lasted for 45-60 minutes. Three major themes and eight sub-themes were identified (see figure 1).

Theme 1: Patient characteristics

All participants agreed that patients' stability (as defined in the introduction) was essential when they were being referred to primary healthcare and that the goal of treatment in primary healthcare is to promote taking care of oneself. All participants also described a number of examples of instability, like suicidal or aggressive tendencies, having low motivation or being in the first years after an initial psychotic episode. All participants, including the patients, also mentioned that some psychotropic medications are too complex to prescribe in primary healthcare, due to the complex

follow-up, high risk for dangerous complications and insufficient knowledge on this topic by the GP's. Clozapine and lithium were named specifically in this context.

Examples of comments:

Patient #2: "I think you need to know about your illness and have received sufficient information about it."

CMHN #2: "They have to be motivated off course."

Psychiatrist #1: "Antipsychotics can be prescribed in primary healthcare, but clozapine or lithium cannot in our opinion".

CMHN #2: "I get that you cannot have those patients [with clozapine or lithium] in primary healthcare, but some of them are very stable. Their recovery is very good."

Additionally, all participants identified an insufficient support system (i.e., small or unsteady) as a risk for crisis and referral back to a CMHT. The GP's (and to lesser extent the patients) viewed patients' skills and their family's or friends' support as more important than professional support, whereas the CMHNs and the psychiatrist valued professional support more than the other kinds of support.

Examples of comments:

CMHN #1: "The significant other should know the patient and his illness well."

Psychiatrist #1: "I value it when professional support is involved, like home care or any other professional support. It takes away distress from the patient."

GP #3: "The social network should know the patient and his disorder."

GP#1: "Yes, the social environment can constantly give and repeat good advice. Like a father figure."

Theme 2: Benefits for the patients

The second theme was related to possible benefits for the patients. The most frequently mentioned benefit was that patients no longer had to deal with the stigma of specialized mental healthcare. The second most frequently mentioned benefit was that patients received treatment closer to home (i.e., less traveling, less time-consuming).

Examples of comments:

CMHN #1: "… and the feeling he no longer needs to enter the specialized mental health services building but can just sit in his GP's waiting room."

GP #1: "Maybe patients do not like going to specialized mental health services and be given a psychiatric diagnosis. They have been dealing with that for years!"

CMHN #1: "Yes, and it [the referral from specialist mental health services to primary health care] gives them the feeling that they have accomplished something—to be trusted again. It gives their confidence a giant boost."

On the other hand, there were two issues that the focus groups disagreed on. The first was the perceived threshold for patients to ask for help. The patients and the GP's said this was lower in primary healthcare, whereas the CMHNs and the psychiatrist believed threshold was higher in primary healthcare.

Examples of comments:

Patient #3: "I preferred it [primary healthcare], because it is easier to reach out to the GP's's office when you need help."

CMHN #2: "In this pilot, I thought it [the threshold to ask for help] was even higher."

GP #2: "The location makes the threshold lower. I think it feels better for the patients if they do not have to go to the specialized mental health services building and can just go to their GP's."

The second issue was the possibility for patients to deal with their problems without professional support and to participate in society. The psychiatrist and CMHNs agreed both that problem solving and participation in society improved after referral to primary healthcare; however, the GP's strongly disagreed.

Examples of comments:

CMHN # 2: "Some patients told me they did not want to schedule an extra appointment when they encountered an unexpected problem. Sometimes, the problem then was already solved when they came to their regular appointment."

Psychiatrist #1: "When you refer these patients to less intensive care, they will improve their problem solving and participate more in society." CMHN #2: "Yes" CMHN #3: "I agree"

CMHN #1: "They started doing more [solving practical problems] when I stopped helping them by filling out forms for them."

GP #1: [on the question whether the problem solving and participation in society improved] "No, that is ridiculous." GP #3: "Indeed" GP #2: "agreed"

Theme 3: Possible disadvantages for patients

The third and last theme was related to possible disadvantages for patients. The three focus groups agreed on having fewer and shorter sessions with a healthcare professional in primary healthcare as a disadvantage. They thought that the discontinuity in the pattern of regular sessions with a trusted professional was disadvantageous. However, breaking the pattern with a trusted professional proved not to be problem for most of the patients.

Examples of comments:

Patient #2: "In the end, I found that you get more time in the CMHT than in primary healthcare."

CMHN #1: "One patient was used to calling every week [unscheduled] with the CMHT. The GP's or his assistants did not succeed in putting her at ease when she called, so in the end she went back to the CMHT where she had more intensive treatment."

Researcher TB: "There were some examples where the referral did not go so well, can you talk about what went wrong?" GP #3: "The stability was gone when the psychotic symptoms returned." GP #1: "The continuity of the treatment [in the CMHT] was gone". GP #3: "Yes, the continuity was gone, and she did not like it." GP #2: "The assurance was gone."

Discussion

Of the 32 patients, 27 (84.4%) still received primary healthcare after one year. All members of the focus groups agreed that patients needed to be stable when they were referred from a CMHT to primary healthcare and that patients could not use psychotropic medications that would require complex follow-ups (e.g., regular testing of blood samples). Additionally, the focus group results clarified that patients preferred primary healthcare to a CMHT, mainly because of the absence of stigma associated with the use of mental health services. Members of the focus groups did, however, disagree on some topics, such as (a) whether professional support systems bring additional value and (b) the influence that referrals to primary healthcare have on patients' participation in society, and (c) the threshold perceived by patients to seek help.

In each focus group interview the stability of the patient was mentioned. When probed further on this subject, topics like using complex psychotropic drugs, suicidal ideations and no recent crisis or admissions in a psychiatric hospital were mentioned. This was to be expected, since the mentioned criteria resemble the criteria used to refer patients to primary healthcare in this reorganization of care. The knowledge that it is not (only) diagnosis and treatment history, but mostly social support, the level of symptoms and the quality of life has been known from previous studies (Beckers et al, 2018; Kendrick et al, 2000). Using psychotropic drugs that require complex follow-up, and naming clozapine and lithium specifically, has not been identified earlier as a contraindication for a referral to primary healthcare, although it has been best practice for decades.

A patient characteristic to consider when referring a patient to primary healthcare is whether the patient is dependent on a specific healthcare provider. As the GP's, CMHNs, and consulting psychiatrist discussed in the focus groups, patients with SMI can have difficulty disengaging from their trusted healthcare professional. Thus, when these patients are referred to primary healthcare, there is a risk that they will experience stress from a change in healthcare provider, possibly resulting in an increase in the symptoms of their mental disorder and/or referral back to the CMHT. In the present study, this situation occurred only once. Nevertheless, it is a problem that is recognized as one that should be addressed when mental health services are being restructured (Killaspy, 2012). This dependency on a specific mental health care professional has received little empirical attention and more study on the topic is needed (Geurtzen, 2018).

One pattern clearly stands out throughout the study. Whenever a difference of opinion was expressed among participants in the focus groups, it was always a dichotomous difference of opinion between the GP's and the patients on the one hand, and the CMHNs and the consulting psychiatrist on the other hand. This dichotomy raises the question whether it is possible for healthcare professionals working in a CMHT to judge what patients need when they become more stable. This question arises because there are considerable differences between community mental healthcare and primary healthcare for patients with SMI, such as the intensity and the focus (reduction of symptoms vs recovery) of the treatment. The question whether it is possible for healthcare professionals in a CMHT to judge what patients need when they become more stable has been raised earlier (Godfrey et al, 1997; Turton et al, 2011), and they underscore the importance of patient involvement and shared decision making with

patients and their significant others in a CMHT as well as in primary healthcare when considering care planning (Adams et al, 2007; Deegan et al, 2006; Duncan et al, 2007; Grundy et al, 2017; Joosten et al, 2008).

Another contrasting observation we made was on the topic of the referral to primary healthcare itself. On one side the community mental health nurses, the psychiatrist and partly also the patients expressed the point of view that the referral to primary healthcare is an accomplishment and a sign of recovery. On the other side, the GP's saw the referral as little more than a practical change, which is an observation that has been made before (Mcleod, 2017). When asked for tangible differences after the referral to primary healthcare, the GP's only identified practical differences (like nearer to home or getting less time from the healthcare professional). The discrepancy between the different views can be attributed to the (medically oriented) perspective of the CMHTs, where simply not needing their care is seen as an accomplishment. The GPs on the contrary look at the complete picture and reported that they did not see any differences in the wellbeing of the patient.

In the introduction we have described two motives for referring patients with SMI to primary healthcare: the financial motive and the recovery motive. As most of the included patients have been successfully referred to primary healthcare, the financial aim appears accomplished, since primary care is cheaper than treatment provided by a CMHTs. On the other hand, it remains questionable whether the recovery goal is also accomplished, since neither of the participants provided compelling information on the topic during the interviews. Since it appears that the recovery goals are not accomplished, it seems advisable to pay more attention to recovery when referring individual patients with SMI to primary healthcare or when developing specific

programs to refer patients with SMI to primary healthcare. Additional attention could however be aimed at having or finding meaning in life and having sufficient social support, as can be derived from comments of the GP's and from earlier studies (Leamy, 2008; Webber, 2017). Further research should be aimed at (interventions to support) the personal recovery of patients with SMI that are referred to primary healthcare.

Comparison to existing knowledge

The scientific knowledge on the topic of care planning and coordination is currently insufficient and care planning is largely dictated by policy (Jones, 2018; Hannigan, 2018). The available knowledge is mostly focused on the start of the care, like for example the Threshold Assessment Grid (Slade, 2003). Also, studies are aimed at closely related topics, like patient involvement in care planning, or professionals' view on the need of planning (see introduction). Only few studies are aimed at reducing the intensity of care (for example referral from CMHT to primary healthcare) and how patients and mental health care providers value this step, a gap where this study fits in. However, there is still more research needed before reducing care intensity can be fully based on scientific knowledge.

Strengths and weaknesses

This study had some strong points. Despite many studies on the effectiveness of primary mental healthcare, to our knowledge, this is the first study in which patients with SMI were referred to primary healthcare after having been treated in a CMHT. Another strong point of the study is its mixed-methods design. It provides insight in the experiences of patients as well as mental health care providers and their opinions about which patients can benefit from referral from a CMHT to primary healthcare. Last, the focus group discussions included all stakeholders who were involved in the process of referring patients from a CMHT to primary healthcare.

The limitations of this study were its small sample size and that it was conducted under specific circumstances (executed within the catchment area of one specialized mental health service, only three GP's were involved). Because of the specific circumstances under which the study is done, the results are more generalizable to healthcare systems like those of the UK and the Netherlands than to other healthcare systems.

Conclusion

This study shows that patients with a SMI can be successfully referred from a CMHT to primary healthcare under the condition that they are stable and are not using psychotropic medications that require complex follow-up. Referrals from specialized mental healthcare services to primary healthcare were practically and financially successful, but there was little regard for the personal recovery of the patient. More attention for personal recovery is needed when referring patients with SMI to primary healthcare, especially with regard to the social support system. Additionally, all participants discussed that some patients can be dependent on a specific mental healthcare professional and that being referred to a different mental healthcare professional can destabilize them, causing the referral to be unsuccessful.

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Table 1: difference between the care from a CMHT and care from primary healthcare

	CMHT or FACT-team	Primary healthcare
Involved professionals	Team of professionals: psychiatrist, specialised nurses, psychologists, social worker, vocational specialist and peer workers	GP and Community mental health nurse
Key clinician	Mental health nurse or psychologist	Community mental health nurse
Responsible doctor	Psychiatrist	GP
Time between sessions	2-4 weeks	6 weeks
Location of sessions	Office of CMHT	Office of GP
Focus of sessions	Treatment of mental disorder	Supporting problem solving

Table 2: Patient characteristics, N=32

Variable	Mean (±SD) *or* N (%)
Age (in years) at start of study	47 (±10.8)
Gender: male/female	18 (63%)/14 (38%)
BPRS-score at start	1.77 (±.74)
CAN score at start: met items	4.71 (±3.86)
CAN score at start: unmet items	4.00 (±3.85)
Number of diagnoses (DSM-IV-TR)	1.75 (range: 1-4)
Mood disorders	17 (53%)
Personality disorders	14 (44%)
Schizophrenia or another psychotic disorder	9 (28%)
Anxiety disorders	7 (22%)
Alcohol abuse	5 (16%)

BPRS = Brief Psychiatric Rating Scare, CAN = Camberwell Assessment of Needs

Figure 1: Clusters and sub-clusters