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# THE ROLE OF CARE COORDINATORS VERSUS DOCTORS IN THE MANAGEMENT OF CHRONIC MENTAL ILLNESS IN THE COMMUNITY

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***SUMMARY***

*Doctors play an important role in a multidisciplinary team, however therapeutic relationships are not limited to between a doctor and a patient. In Community Mental Health Teams, patients are allocated a care coordinator - usually a community psychiatric nurse or a social worker - and they usually become the healthcare provider the patient is most regularly in contact with. Similarly, a practice nurse in General Practice may be the healthcare professional a patient is most familiar with. In these instances, the patient-provider relationship may be stronger than the doctor-patient relationship. Non-doctor and patient relationships play an increasingly important role in improving the patient experience and contributing to information gathering, shared-decision making, and establishment and adherence to treatment plans. Care coordinators may be in a more superior position than doctors to accurately recognise the ongoing and changing needs of a person with mental illness. Patients value continuity of care, compassion, and mutual trust and respect: these qualities can potentially all be provided by any trained healthcare professional. In this paper, we will review the literature on the emerging role of the care coordinator and other healthcare professionals in the management of chronic mental illness in the community.*

***Key words:*** *care coordinator - case manager - mental illness - therapeutic relationship*

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## Introduction

Mental illness in the community describes people with severe mental illnesses that are managed outside of a hospital setting and living within the community, as well as people with milder conditions that are managed in a primary care setting. Historically, doctors have played a key role in a patient's psychiatric treatment and an emphasis placed on the importance of the doctor-patient relationship in this setting. The doctor-patient relationship is built on mutual participation, respect, shared decision making, and trust (Fugelli 2001, Kaba & Sooriakumaran 2007). Especially with a trusting relationship, patients may feel more obliged to seek care, comfortable in sharing sensitive information, adhere to treatment and improve outcome (Hall 2002). A review of the literature has shown that the quality of the therapeutic relationship in the treatment of severe mental illness is a reliable predictor of patient outcome in mainstream psychiatric care (McCabe & Priebe 2004). However, therapeutic relationships are not limited to between a doctor and a patient. Patients value warmth, empathy and expertise (Lambert 2001, Johansson & Eklund 2003), and therefore, other adequately trained healthcare professionals may all engage with patients in a meaningful way (Cameron 2005, Scanlon 2006, Sudbery 2002). Furthermore, in a system where patients with mental illness in the community may only see their doctor on a monthly to yearly basis, patients may in fact, build a stronger therapeutic relationship with healthcare professionals other than doctors that are involved in their care and whom they see more frequently.

The community mental health team (CMHT) is a multidisciplinary team formed of many different healthcare professionals, including psychiatrists, nurses, psychologists, occupational therapists and social workers. Key aims of the CMHT are to keep patients in the community for as long as possible and reduce the number of hospital admissions and length of stay. Patients may also have a Care Programme Approach (CPA) plan in place with a care coordinator as their key healthcare professional worker, usually a community psychiatric nurse or social worker (Burns 2007). The CPA, a form of case management, was first introduced in 1991 to improve the delivery of healthcare for serious mental illness in the community (Department of Health 1990). It has since been revised and refocused, although the fundamentals remain the same: each patient must have a written care plan, and an allocated care coordinator (Department of Health 1998, The Kings's Fund 2008). The role of a care coordinator is to ensure regular contact with the patient, coordinate care with mental health specialists, monitor any changes in the patient's condition and adherence to treatment, initiate change when treatment is not effective and offer psychosocial support (Katon 2001, Von Korff & Goldberg 2001). Due to care coordinators being in regular contact with their patients, they will often form a strong therapeutic relationship with the patient. Likewise, in primary care, a practice nurse may be more familiar with a patient than the patient's usual doctor (Laurant 2018). In these instances, the patient-provider relationship may be stronger than the doctor-patient relationship. Therefore, other healthcare professionals may be in a superior position to

doctors to more accurately recognise the ongoing and changing needs of the person with mental illness in the community, and reduce hospital admissions.

## The Importance of the Care-Coordinator-Patient Relationship

In the modern era, non-doctor and patient relationships play an increasingly important role in improving the patient experience and contributing to information gathering, shared-decision making, and the establishment and adherence of treatment plans (Girard 2017). The importance of such relationships should not be underestimated, with evidence suggesting that building and maintaining a strong patient-provider relationship can be a catalyst for change in itself and lead to positive treatment outcomes (Leach 2005, Leichsenring 2002). Continuity of care also benefits the service user, with greater adherence to medical advice, better take-up of health promotion, and greater trust developed between the patient and the healthcare provider (Mainous 2001). With greater trust, patients are more honest and more likely to disclose sensitive information. Case coordinators are able to provide continuity of care and form long-term relationships with their patients, maintaining contact with them both during crises and periods of stability. Through this, care coordinators are equipped with the knowledge to be able to recognise the patient's 'relapse signature' and arrange for appropriate interventions at an early stage, thus preventing a more detrimental crisis from occurring (Watkins 2001, p115). Relationship building is important for mental illness healthcare where lack of patient engagement can be a significant barrier to treatment (Dixon 2016). Care coordinators are in an ideal position to foster and nurture these important relationships.

Not only do care coordinators have a risk-assessment role to establish when a patient's condition may be deteriorating, but they can also play a role in enhancing treatment. Research has shown that patients view their relationships with their care coordinator as central to their recovery, and some patients feel that their care coordinator in fact provides most of their healthcare (Simpson 2016). The importance of the care coordinator role has been numerously described as crucial to the future of chronic mental illness (Burns & Santos 1995, Faulkner 2017, Goodwin & Lawton Smith 2010). The primary goal of people living with chronic mental illness has been reported to involve service users feeling empowered to sustain and take control of their own mental health (Kaj & Crosland 2001). The smaller caseloads that care coordinators have also allows them to be more proactive and less reactive in the management of their patients (Simpson 2003). Care coordinators also often come from a more empathetic background (Fields 2004) with a greater propensity for a holistic approach to healthcare (Laurant 2008). Hence, care coordinators may be more equipped than psychiatrists to support patients to achieve their aim. There is limited literature regarding the importance of the care coordinator role and we recommend more research to be done to explore the power of this therapeutic relationship and its effect on patient outcome.

## From the Community Mental Health Team to Primary Care Services

It is not only for severe mental illness where nurses and other healthcare providers may be taking over the role of a doctor in the formation of effective therapeutic relationships. In an ageing population, chronic disease is becoming more prevalent. The link between chronic disease and common chronic mental illness such as depression and anxiety is well recognised and people with one or more chronic diseases are at increased risk of mental illness (Chapman 2005, Katon & Schulberg 1992, Moussavi 2007, Noël 2004, Scott 2007). While 90% of people with mental health problems are cared for entirely within primary care (England 2017), general practice has been criticized for inadequately recognizing and managing depression. Therefore, there has been an increasing push for primary care to implement chronic illness management and collaborative care models to better manage depression (Von Korff & Goldberg 2001). Practice nurses are increasingly involved in the care and follow-up of patients with chronic disease, and therefore effectively placed to form therapeutic relationships with this at-risk group of patients (Waterworth 2015). Depression and anxiety may often present atypically in elderly patients (Hodkinson 1973) and a healthcare professional who knows the patient well may be better equipped to spot the first changes which may indicate that a patient is beginning to suffer from a mental illness. With the appropriate support, primary care nurses may also be able to screen for common mental illnesses using standardised tools and providing psychosocial support and lifestyle advice (McKinlay 2011).

Nurses may be utilised not only in the detection of mental health illnesses but also in their treatment. Studies where primary care nurses become care managers for the treatment of patients with both chronic disease and depression have shown an improvement in depressive symptoms and an increase in patient satisfaction (Ekers 2013). Similar to a care coordinator role, a case manager makes regular contact with the patient, monitors the progress of the patient's condition and adherence to treatment, initiates changes when treatment is unsuccessful, offers psychosocial support and coordinates the care with the primary care provider with or without mental health specialist support (Gilbody 2003, Katon 2001, Von Korff & Goldberg 2001). This form of collaborative care has been shown to be effective in primary care (Archer 2012). Within general practice, there is an indication of decline in physician-led continuity of care (Baird 2016). Studies have shown that nurses can make suitable substitutes for doctors in diverse areas of primary care, including diabetes management and blood pressure monitoring (Jackson 2018,

Laurant 2018). Perhaps in the future, we will be seeing nurses replacing doctors in the management of chronic mental conditions too, and also become increasingly reliant on nurses to form therapeutic relationships that are so central to effective mental healthcare.

## Conclusion

Although a therapeutic role was not originally designed or portrayed to be a central feature of the CPA care coordinator's remit, over the past quarter of a century, it is clear that the care coordinator role has evolved to have therapeutic potential. Doctors are a necessary part of the multi-disciplinary mental health team to diagnose mental illness, prescribe medication and ultimately recommend treatment. Care coordinators and care managers must be able to work collaboratively with doctors to appropriately escalate interventions to match a patient's needs. Overall, psychiatrists and general practitioners may still build strong doctor-patient relationships with service users the but the trust and in-depth knowledge which can be built between the patient and care coordinator/care manager is invaluable to the success of mental healthcare in the community.

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***Contribution of individual authors:***

Xingyue Maria Wang conducted the literature search and drafted the paper.

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## References

1. *Archer J, Bower P, Gilbody S et al.: Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews, 2012*
2. *Baird B, Charles A, Honeyman M, Maguire D, Das P: Understanding pressures in general practice. London: King's Fund, 2016*
3. *Burns T: Community mental health teams. Psychiatry 2007; 6:325-328*
4. *Burns BJ, Santos AB: Assertive community treatment: an update of randomized trials. Psychiatric Services 1995; 46:669-75*
5. *Cameron D, Kapur R, Campbell P: Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse-patient relationship. J Psychiatr Ment Health Nurs 2005; 12:64-74*
6. *Chapman DP, Perry GS, Strine TW: The vital link between chronic disease and depressive disorders. Prev Chronic Dis 2005; 2:A14*
7. *Department of Health: The care programme approach for people with a mental illness referred to the specialist psychiatric services. HC(90)23/LASSL(90)11. London: Department of Health, 1990*
8. *Department of Health: Modernising mental health service: safe, sound and supportive. London: Department of Health, 1998*
9. *Dixon LB, Holoshitz Y, Nossel I: Treatment engagement of individuals experiencing mental illness: Review and update. World Psychiatry 2016; 15:13–20*
10. *Ekers D, Murphy R, Archer J, Ebenezer C, Kemp D, Gilbody S: Nurse-delivered collaborative care for depression and long-term physical conditions: A systematic review and meta-analysis. J Affect Disord 2013; 149:14-22*
11. *England L: RCGP position statement on mental health in primary care. Primary Care Mental Health Steering Group, 2017 Sep*
12. *Faulkner A: The importance of relationships: care planning and care coordination in mental health. Journal of Psychiatric and Mental Health Nursing 2017; 24: 335–6*
13. *Fields S, Hojat M, Gonnella J, Mangione S, Kane G, Magee M: Comparisons of Nurses and Physicians on an Operational Measure of Empathy. Eval Health Prof 2004; 27:80-94*
14. *Fugelli P: James Mackenzie Lecture. Trust - in general practice. Br J Gen Pract 2001; 51:575–579*
15. *Gilbody S: Improving the detection and management of depression in primary care. Quality and Safety in Health Care 2003; 12:149-155*
16. *Girard A, Hudon C, Poitras M, Roberge P, Chouinard M: Primary care nursing activities with patients affected by physical chronic disease and common mental disorders: a qualitative descriptive study. J Clin Nurs 2017; 26:1385-1394*
17. *Goodwin N, Lawton-Smith S: Integrating care for people with mental illness: the Care Programme Approach in England and its implications for long-term conditions management. Int J Integr Care 2010; 10*
18. *Hall M, Zheng B, Dugan E et al.: Measuring Patients' Trust in their Primary Care Providers. Medical Care Research and Review 2002; 59:293-318*
19. *Hodkinson HM: Non-specific presentation of illness. Br Med J 1973; 4:94–96.*
20. *Jackson G, Smith V, Edelman D et al.: Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants. Ann Intern Med 2018; 169:825*
21. *Kaba R, Sooriakumaran P: The evolution of the doctor-patient relationship. International Journal of Surgery 2007; 5:57-65*
22. *Kai J, Crosland A: Perspectives of people with enduring mental ill health from a community-based qualitative study. Br J Gen Pract 2001; 51:730–736*
23. *Katon W, Schulberg H: Epidemiology of depression in primary care. Gen Hosp Psychiatry 1992; 14:237-247*
24. *Katon W, Von Korff M, Lin E, Simon G: Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. Gen Hosp Psychiatry 2001; 23:138-144*
25. *Lambert MJ, Barley DE: Research summary on the therapeutic relationship and psychotherapy outcome. Psychotherapy: Theory, research, practice, training 2001; 38:357*
26. *Johansson H, Eklund M: Patients' opinion on what constitutes good psychiatric care. Scand J Caring Sci 2003; 17:339-346*
27. *Laurant M, Hermens R, Braspenning J, Akkermans R, Sibbald B, Grol R: An overview of patients' preference*

*for, and satisfaction with, care provided by general practitioners and nurse practitioners. J Clin Nurs 2008; 17:2690-2698*

28. *Laurant M, van der Biezen M, Wijers N, Watananirun K, Kontopantelis E, van Vught A: Nurses as substitutes for doctors in primary care. Cochrane Database of Systematic Reviews, 2018*
29. *Leach M: Rapport: A key to treatment success. Complement Ther Clin Pract 2005; 11:262-265*
30. *Mainous AG, Baker R, Love M, Pereira Gray D and Gill JM: Continuity of Care and Trust in One's Physician: Evidence From Primary Care in the United States and the United Kingdom. Fam Med 2001; 33:22-7*
31. *McCabe R, Priebe S: The Therapeutic Relationship in the Treatment of Severe Mental Illness: A Review of Methods and Findings. International Journal of Social Psychiatry 2004; 50:115-128*
32. *McKinlay E, Garrett S, McBain L, Dowell T, Collings S, Stanley J: New Zealand general practice nurses' roles in mental health care. Int Nurs Rev 2011; 58:225-233*
33. *Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B: Depression, chronic diseases, and decrements in health: results from the World Health Surveys. The Lancet 2007; 370:851-858*
34. *Noël PH, Williams JW Jr, Unützer J, et al.: Depression and comorbid illness in elderly primary care patients: impact on multiple domains of health status and well-being. Ann Fam Med 2004; 2:555–562*
35. *Scanlon A: Psychiatric nurses perceptions of the constituents of the therapeutic relationship: a grounded theory study. J Psychiatr Ment Health Nurs 2006; 13:319-329*
36. *Scott K, Bruffaerts R, Tsang A et al.: Depression–anxiety relationships with chronic physical conditions: Results from the World Mental Health surveys. J Affect Disord 2007; 103:113-120*
37. *Simpson A, Hannigan B, Coffey M et al.: Recovery-focused care planning and coordination in England and Wales: a cross-national mixed methods comparative case study. BMC Psychiatry 2016; 16*
38. *Simpson A, Miller C, Bowers L: Case management models and the care programme approach: how to make the CPA effective and credible. J Psychiatr Ment Health Nurs 2003; 10:472-483*
39. *Sudbery J: Key features of therapeutic social work: The use of relationship. Journal of Social Work Practice 2002; 16:149-162*
40. *The King's Fund: Paying the price. London: The King's Fund, 2008*
41. *Von Korff M, Goldberg D: Improving outcomes in depression. BMJ 2001; 323:948-949*
42. *Waterworth S, Arroll B, Raphael D, Parsons J, Gott M: A qualitative study of nurses' clinical experience in recognising low mood and depression in older patients with multiple long-term conditions. J Clin Nurs 2015; 24:2562-2570*
43. *Watkins P: Mental Health Nursing: The Art of Compassionate Care. Oxford: Butterworth-Heinemann, 2001*

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