

First, build the foundations: Practical considerations in general practitioner–mental health service liaison

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Abstract

The co-working relationship between general practitioners and local mental health services lies at the heart of the success of recent changes in mental health care. These changes have seen large-scale deinstitutionalisation, a shift to primary and community care, and a government policy of prevention and partnerships. This article outlines a liaison project developed jointly by the South-East New South Wales Division of General Practice and the Southern Area Mental Health Service to address these issues. We describe the development of a protocol of basic standards which were practical, pragmatic and possible and, when fully established, would be the foundation of effective, efficient and efficacious shared care in mental health.

Introduction

In recent years many justified criticisms have been levelled at the degree of co-working between general practitioners and mental health services, especially in the management of care for people with enduring mental illnesses. Andrews and Teeson (1994) have cited the poor continuity of care; Burdekin, Guilfoyle and Hall (1993) have criticised the lack of preventative strategies and coordination of services. While Hickie (1999) has noted that general practitioners are not, nor should try to be, specialist psychiatrists, Tobin

and Norris (1998, p 100) have warned that ‘...no quality improvement measures are likely to be successful until mental health services promote general practitioner linkages as an ongoing service goal, relevant at all levels of delivery’.

Many models of shared care have been proposed, but few have been fully implemented. Fewer still have been evaluated and reported in the literature. In 1998 the Southern Area Mental Health Service, in collaboration with the South-East New South Wales Division of General Practice, initiated a clinical improvement project based on the identification and implementation of fundamental standards of general practitioner–Southern Area Mental Health Service liaison and collaboration which were:

- agreed to be the minimum that could be reasonably expected from both general practitioners and Southern Area Mental Health Service
- based on researched and justified needs
- capable of implementation with reasonable resource demands and time-scales
- subject to monitoring and evaluation
- in line with the best available evidence.

The project was not designed to be the ultimate system in the best of all possible worlds. It had to be firmly grounded in practical considerations, concerned with workable solutions to problems and within the power of the health service and the Division to achieve.

Literature review

The National Mental Health Strategy Evaluation Steering Committee (1997, p 5) stated that:

...Australian general practitioners see three-quarters of the people who seek help for mental health problems and mental disorders, yet are overlooked as mental health service providers. They have few tools to use, limited training for their broad roles and often receive little or no support from specialist services.

Tobin and Norris (1998) describe two principal strands in the literature. One concentrates on the development of general practitioner skills in managing mental illness in the primary care setting. This approach recognises that many, perhaps the majority of people with enduring mental illnesses are cared for in the primary health care setting through general practitioners. In addition, general practitioners are recognised as the most common first point of referral for people experiencing a mental illness (Goldberg 1984; Andrews & Teeson 1994; National Mental Health Strategy Evaluation Steering Committee 1997).

The second major thrust has been to improve the links between general practitioners and specialist mental health services. This recognises that both general practitioners and mental health services have specialised and complementary functions in the

management and treatment of mental illness. It is inefficient and inappropriate to equip each to do the job of the other. However, it may be possible to develop seamless mechanisms of referral and collaboration which ensure clients receive the best possible, and most appropriate, care for their illness (National Health Strategy 1991; National Health Strategy 1993; Keks et al. 1997; Australian Health Ministers 1998; New South Wales Department of Health 1998; Tobin & Norris 1998).

Nevertheless, there are problems associated with each strategy. The skills of general practitioners in recognising, assessing and treating mental illness (whether acute, sub-acute or enduring) have been shown to be variable at best, and often inadequate (Gask et al. 1988; Miller & Goldberg 1991; Bowman et al. 1992; Goldberg et al. 1993; Goldberg & Gater 1996; Tobin, Hickie & Urbanc 1997). There may be an assumed ability of general practitioners to conduct sophisticated mental-state assessments whereas these skills may only be acquired through specialised training over many years. This is to the detriment of all parties. It may overload general practitioners with unrealistic expectations and responsibilities, it may distance specialised mental health services, and it may prevent and delay the client from receiving the best possible care in the shortest possible time.

It should also be recognised that the co-working relationships of general practitioners and mental health services are heavily influenced by historical and contextual factors (Keks et al. 1997; Royal Australian College of General Practitioners & Royal Australian and New Zealand College of Psychiatry 1997; Philip 1998). Professional preciousness has been cited as an impediment to fully integrated care in that each service may feel that it owns the client, or at least particular client information, and may be unwilling to share. If each service sees itself as a stand-alone care provider, the coordination of client care is made extraordinarily difficult. In addition, simple communication protocols acknowledging referrals, consultations and treatment regimes were often ill-used or missing all together (Philip 1998). A local needs analysis within Southern Area Mental Health Service (Philip 1998) revealed that:

- general practitioners often perceived difficulties in accessing mental health services
- there was unclear role definitions between general practitioners and mental health services, and
- there was a generalised dissatisfaction among general practitioners, mental health services, consumers and carers concerning the continuity of care and the co-working relationship.

Australian and international reports indicate that fully integrated, seamless care provision may improve:

- the confidence of each service in the other (Falloon et al. 1996)
- routine engagement and communication between the services
- significant returns in terms of client care for the time invested
- a reframing of the concept of the caring team to include general practitioners (Tobin & Norris 1998)

- reduced hospitalisation (Patterson, Higgins & Dyck 1995), and
- reduced family burdens (Francell, Conn & Gray 1988).

The advantages of each strategy, when fully and properly implemented, are clearly articulated, but it was deemed both impractical and unrealistic to develop the sort of long-term general practitioner education and training program which would equip general practitioners to acquire and practice high-level specialist skills in mental health care. However, it was within the purview of the South-East New South Wales Division of General Practice and Southern Area Mental Health Service to establish agreed basic standards, procedures and protocols for shared care of mentally ill people in their area. To this end, the General Practitioner–Mental Health Integrated Care Project was established in April 1998.

Project design

Southern Area Mental Health Service serves a population of a little more than 180 000 and covers a predominantly rural area in the south-eastern quadrant of New South Wales. It stretches from Young in the north-west to Eden in the south-east and surrounds the Australian Capital Territory. It is divided into three administrative sectors (the Southern Tablelands, Monaro and the South Coast) and is roughly contiguous with the area covered by the South-East New South Wales Division of General Practice. There is only one psychiatric inpatient unit with 20 gazetted beds for the whole area. This is in Goulburn, which is up to seven or eight hours drive away from some parts of the area, and is managed separately from the community services. There are approximately 145 general practitioners in the area covered by the Division, about 80% of whom are members.

The project came from the recognition by Southern Area Mental Health Service and the South-East New South Wales Division of General Practice of joint concerns in the delivery of mental health care. It built on a previously commissioned local needs analysis (Philip 1998) which had identified concern in the general practitioner community in regard to:

- difficulties in accessing mental health services
- poor communication and feedback between the services
- unclear role delineation, and
- the levels of expertise, knowledge and experience of those providing specialised mental health care.

This report made a series of recommendations to address these concerns. These recommendations formed the basis of the working hypothesis of the project; that is, that mental health service delivery would be improved through the identification and implementation of basic standards of general practitioner–mental health services liaison, especially in these primary areas of concern.

However, it was noted that most previous studies of liaison between general practitioners and specialist services had taken certain amounts and types of communication for granted, and had not critically examined that assumption (Reilly & Morgan 1996). Consequently it was hypothesised that following the articulation and implementation of relevant basic standards there would be measurable quantitative change in the communication between mental health services and general practitioners, as evidenced by documented letters, progress reports and discharge summaries found in client records. Furthermore, there would be measurable change in the number of clients whose general practitioner was recorded in their records.

The issues concerning role delineation and qualitative measures were more difficult to identify, but were considered to be in the spirit of continuing cooperative joint initiatives in education, training, case conferencing and shared care.

A project steering committee (consisting of representatives from the Southern Area Mental Health Service, the South-East New South Wales Division of General Practice, the general practitioner community, project consultants and the project officer) was convened to draft a series of basic standards, monitor the progress of the project, and oversee its interim and final implementation and management.

The committee also served as a forum for debate and supervision, and was the conduit through which a wider coordinated approach to care provision could be ensured.

In keeping with the complexity and contextuality of the continuing review process, a triangulation method was used, gathering:

- quantitative data (file audits from each mental health service site and surveys of local general practitioners)
- qualitative data (semi-structured interviews with senior mental health service management and Division representatives), and
- anecdotal data (informal consultation with primary stakeholders including mental health services staff, general practitioners, clients and carers).

This method was able to elicit pre- and post- measures of recording and liaison practices in relation to the defined standards, attitudes towards and reflections on the most desirable and pragmatic basic standards, and informed and contextual opinion concerning the most desirable and most pragmatic practices.

Evaluation was carried out using similar measures. A second comprehensive case file audit was carried out throughout Southern Area Mental Health Service (Inpatient and Community) to ascertain the degree to which the standards were being implemented. Repeat surveys of general practitioners were carried out. Senior mental health service management was re-interviewed and other major stakeholders were re-consulted.

A third stage, involving further refinement of the implemented standards and the final development of an integrated strategic training and education program is planned for 1999–2000.

Discovering the basics

Through a process of wide consultation and surveys in the Southern Area Mental Health Service and the general practitioner community, reference to the literature and critical review by informed stakeholders, six major themes were identified. They concerned:

- general information among general practitioners about the mental health services, their function and how to access them
- making referrals to the mental health services
- admissions to the inpatient unit
- the care of individuals experiencing an enduring mental illness
- joint education and training
- strategic planning, policies and guidelines.

Specific actions to address these also conformed to the overall project criteria of being mutually agreed and needs-based, having supportive evidence, and being pragmatic and susceptible to critical evaluation.

Formulating the basics

In order to systematically address each area of concern, a series of basic standards was drafted with concomitant strategies for implementation and evaluation.

Standard 1: General information regarding mental health services and how to access them

- All general practitioners to be provided with a desktop flow chart which details the intake and triage procedures within Southern Area Mental Health Service, the services provided by Southern Area Mental Health Service, eligibility criteria and a brief ten-point mental health screening tool.
- Southern Area Mental Health Service and South-East New South Wales Division of General Practice to develop a joint service agreement.
- Southern Area Mental Health Service to develop and distribute a local service directory.

Standard 2: Referrals to mental health services

Clinical guidelines and protocols to be developed which require general practitioners to be advised of the case manager and the outcome of the initial assessment in a professional and timely manner.

Standard 3: Inpatient admissions

Clinical guidelines and protocols to be developed which require recorded general practitioner details and emphasise the importance of timely and professional contact, consultation and clinical involvement with a client's general practitioner including, as a minimum, a discharge summary and agreed follow-up arrangements.

Standard 4: The care of individuals experiencing an enduring mental illness

Clinical guidelines and protocols to be developed which require recorded general practitioner details and emphasise the importance of timely and professional contact, consultation and clinical involvement with a client's general practitioner including, as a minimum, general practitioners to be advised of significant changes in a client's mental state (including routine half-yearly summaries) and routine general practitioner involvement in all case conferences.

Standard 5: Joint education and training

Southern Area Mental Health Service and South-East New South Wales Division of General Practice to jointly sponsor initiatives including formalised education, Continuing Medical Education-related activities, exchange placements, research activities and conferences.

Standard 6: Strategic planning, policies and guidelines

- Southern Area Mental Health Service and South-East New South Wales Division of General Practice to develop a memorandum of understanding.
- Representation from each on planning, strategic and project development committees to be sought routinely.
- Southern Area Mental Health Service to establish a formalised and accessible system for the prompt processing and resolution of complaints and concerns.

Initial findings

A review of the degree of existing, pre-implementation compliance with the basic standards was conducted across all sectors of Southern Area Mental Health Service between April and November 1998. On all measures the performance was unacceptable. There was an audit of 642 adult community, 187 children and adolescent, and 85 inpatient files. Findings of particular interest included the following.

- There were no clear written guidelines for referral, eligibility or access mechanisms to the mental health services, and the functions of the intake service were poorly understood.

- There were no formal processes for consultation or routine involvement of general practitioners in ongoing care.
- Fewer than 80% of all community clients had a nominated general practitioner (47% of inpatients). In less than 65% of cases was this clearly recorded in the case file (27% of inpatients).
- In only 27% of cases was there evidence that a client's general practitioner had received any feedback of the mental health assessment, and in only 11% was this written (none at all for inpatients).
- Seventy-two per cent of individuals with an enduring mental illness had a nominated general practitioner, and in only 22% of these cases was there evidence of any ongoing communication between the mental health services and the general practitioner.
- There was no evidence at all of general practitioners consulting with inpatient medical staff, nor any evidence of a general practitioner opinion being included in the formulation or diagnosis.
- Thirty-nine per cent of inpatients had a discharge summary forwarded to their general practitioner, although it is not clear how more discharge summaries were forwarded than there were clients with nominated general practitioners. It was assumed that in some cases the general practitioner details were known but never recorded.

There were no joint education or training initiatives, nor a memorandum of understanding or protocols for routine consultation or representation in strategic planning.

Second-stage evaluation

After a six-month period of implementation of the basic standards, the same measures were repeated and 708 adult community, 203 child and adolescent, and 54 inpatient files were audited. In many cases a significant improvement was recorded, but in some this was still not regarded as sufficient. Items of particular interest included the following.

- A flow chart with clear written guidelines for referral, eligibility or access mechanisms to the mental health services, and the functions of the intake service had been written and distributed. However, the levels of knowledge change, understanding and satisfaction have not yet been evaluated.
- Formal protocols and processes for consultation or routine involvement of general practitioners in ongoing care had been developed, and were in the implementation process in the other mental health quality improvement projects across the Area.
- A memorandum of understanding had been developed and ratified by Southern Area Health Service and the South-East New South Wales Division of General Practice.

- Ninety per cent of all community clients had a nominated general practitioner (65% of inpatients) and in 91% of cases this was clearly recorded in the case file (59% of inpatients).
- In 40% of cases there was evidence that a client's general practitioner had received feedback on the mental health assessment, but in only 24% was this written (only 7% for inpatients).
- Eighty-eight per cent of individuals with an enduring mental illness had a nominated general practitioner and in 59% of these cases there was evidence of ongoing communication between the mental health services and the general practitioner.
- There was now evidence of general practitioners consulting with inpatient medical staff. There was evidence of a general practitioner opinion being included in the formulation or diagnosis in 7% of inpatient files.
- Forty-one per cent of inpatients had a discharge summary forwarded to their general practitioner.
- Joint education and training through a Continuing Medical Education-accredited mental health series for general practitioners has been established in two centres in the Area, and there are advanced plans to extend this.
- The project had presented a paper at the South-East New South Wales Division of General Practice Mental Health Conference (Canberra 1999), and a formalised program was identified as a priority for Stage 3 of the project.

Discussion

The General Practitioner–Mental Health Services Liaison Project hypothesised that the identification and implementation of basic, fundamental standards would have a measurable, positive effect on the levels of communication and practice of both general practitioners and the mental health services. To date the basic standards have been developed by the joint committee, and the cycle of continuous self-monitoring and refinement has commenced. Even at this early stage there have been significant improvements in the number of mental health services clients whose general practitioner was noted, fully recorded, provided with regular and pertinent, documented reports, was involved in the long-term care planning and, in a more general sense, has become a recognised member of the care-giving team.

However, there was also a subtext to the project. This was concerned with nurturing collaborative approaches to care, inclusive rather than exclusive perceptions of significant stakeholders, and a culture of continuous, reflective quality review and improvement.

To this end the project was implemented concurrently with several other quality improvement initiatives in Southern Area Mental Health Service, including:

- the review and standardisation of assessment procedures and protocols (which resulted in all mental health services assessment reports received by general

practitioners being in a standardised format, using common terms and thus more readily understandable and comparable)

- the review of the care processes and planning for people with an enduring mental illness (for whom general practitioners play a major role in continuing care)
- the review of the inpatient unit practices and protocols (including the routine involvement of the responsible general practitioner in care planning and case reviews, and mechanisms to ensure all discharge summaries are forwarded in a timely manner)
- the establishment of a centralised intake system and procedures to inform general practitioners of referrals and progress.

Conclusions

The General Practitioner–Mental Health Services Liaison Project had a number of complementary aims and objectives. It was hypothesised that, although each step would have its own intrinsic and identifiable value, the collective values would be even greater. Thus, the implementation of each standard operated on two levels, the quantitative measures and the qualitative value statements. The project has identified quantifiable steps that can be taken to improve general practitioner–mental health services liaison practices, and has set in train processes of quality improvement informed by articulated values and criteria.

The project represents a considerable investment by the mental health services and the general practitioner community, but the rewards may be significant. The long-term sustainability of the gains of the first and second phases of implementation is still to be tested. However, the commitment of the Southern Area Mental Health Service and the South-East New South Wales Division of General Practice to the project's aims bodes well. Future research may build on the foundations laid by this project, and investigate the further hypotheses concerning the improvements in clinical outcomes for the clients shared by mental health services and general practitioners.

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