

2 Collaboration between general practice and community psychiatric services for people with chronic mental illness

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General practitioners are often the patient's preferred source of psychiatric care; they can also play a role as coordinators of the care team for patients with complex needs

The general practice context

General practitioners manage 75% to 90% of patients with mental illness in the community.¹ They provide 30% of services to people with severe mental illness, particularly the psychoses.² The number of patients seen with long-term mental illnesses varies considerably between different general practices depending on the prevalence of chronic illness in the area and the nature of the practice,¹ but about 25% of patients with chronic psychoses see only their general practitioner.³

There are major advantages to conducting psychiatric care in general practice rather than a specialist or hospital setting. General practitioners are able to offer rapid and affordable access to comprehensive health care for patients and their families without the stigma that is often associated with attending specialist psychiatric services. Surveys indicate that patients prefer to attend general practitioners for psychiatric treatment.³ The consequent enhanced patient–doctor relationship fosters unparalleled continuity of care, compliance with medication and the opportunity for early intervention when the patient relapses into illness or when psychosocial crises occur.⁴

With the progress of deinstitutionalisation over the past three decades, the vast majority of people with chronic mental illness now live in the community. Most recently, many long-term residents of the “back wards” of mental hospitals have been successfully making the transition to 24-hour intensely supported community residences, staffed by professionals in similar numbers to those in the hospitals. However, these residents are now able to access the full range of community services, including those of general practitioners. The need for general practice psychiatry will continue to increase,¹ and the challenge is to ensure that specialist psychiatric services work collaboratively with the patient's primary health care provider, the general practitioner.

The psychiatric service context

The move away from stand-alone psychiatric hospitals has caused many psychiatric services to change orientation and focus on community services in their local area, using local general hospitals for acute psychiatric admissions.⁴ Community services have developed



Tug-of-war— a joint effort at rescuing the individual from mental distress.

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Synopsis

- ▶ Most people suffering from chronic mental illness now live in the community and receive services from general practitioners as well as psychiatric clinics and psychiatrists. This has advantages in terms of patient satisfaction and cost effectiveness.
- ▶ These patients often need a comprehensive mix of services provided by several different agencies. It is essential for the service providers to coordinate their efforts.
- ▶ Close liaison between general practitioners and community psychiatric services is most appropriate for patients with chronic disorders who have significant psychosocial disabilities, but it can also be useful in acute illness and crises.
- ▶ General practitioners and staff from community psychiatric services can collaborate to care for people with mental illness by using regular contact and an agreed management plan.

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Case history 1: Improving care through collaboration

A 25-year-old single woman with a history of several hospital admissions for bipolar mood disorder was intermittently attending a community psychiatric service. She was taking lithium, but serum lithium estimations pointed to poor compliance with therapy, and she was becoming increasingly depressed.

The patient had a good longstanding relationship with her general practitioner, whom she saw for management of asthma and contraception, but there had been no contact between the general practitioner and the community psychiatric service. This changed when the general practitioner contacted the service psychiatrist and suggested collaboration.

Collaborative care arrangements

An agreement was negotiated between the patient, general practitioner, psychiatrist and a staff psychologist (the patient's case manager at the psychiatric service).

- The patient was to attend her general practitioner (initially every two weeks) to check on compliance with lithium therapy and side effects, and for support and encouragement to take responsibility for mental as well as physical health. She would see the psychologist at the clinic weekly for cognitive psychotherapy to treat depression and the psychiatrist every three months for consultative input.
- The general practitioner and clinic case manager agreed to discuss progress via telephone at two and six weeks and to contact each other immediately if a crisis arose.

As a result of this contact, the general practitioner heard of and began to attend the psychiatric service's bimonthly general practitioner educational meetings.

Improved outcome

Over the next few months the patient's compliance with medication improved and her depression abated. The patient's case management was taken over entirely by the general practitioner, with reviews by the service psychiatrist every six months. The general practitioner now knew the psychiatric service and could obtain advice and assistance as needed.

substantially and in many areas offer assertive outreach (the staff go to the patients), crisis and case management services, with 24-hour availability.

Community psychiatric services are staffed by a range of disciplines, including nurses, psychologists, occupational therapists, social workers, medical officers (doctors with an interest in psychiatric medicine or trainee psychiatrists) and psychiatrists. These services can perform a variety of interventions that complement the work of general practitioners and private psychiatrists (Box 1).

Many services offer crisis assessment and treatment on an outreach basis so that staff can quickly see the patient at home or in a general practice surgery. Such an assessment is often carried out to decide whether intensive management in the community is a viable alternative to hospitalisation. Some patients must be admitted, but early intervention through community outreach can give effective treatment and support in many circumstances that previously required hospitalisation,^{5,6} or facilitate early discharge for patients who are admitted to hospital.

The most effective assistance for helping patients stay in the community comes from intensive case management services. Here patients, particularly those with chronic psychoses who have experienced frequent hospitalisations and lack social supports, are subject to various types of interventions, often on a daily basis. These interventions include assistance with medications, activities of daily

1 Interventions available from many community psychiatric services

Crisis assessment and treatment

Multidisciplinary teams with 24-hour availability, ready to see a patient at home or elsewhere and able to provide intensive, short-term consultations and specialist assessment.

Consultation and continuing care

Multidisciplinary teams providing assessment and ongoing management on an outpatient basis.

Intensive assertive case management

Multidisciplinary teams with seven-day availability, ready to see a patient at home or elsewhere and able to provide individual management plans, long-term intensive rehabilitation, specialist monitoring, treatment and review.

Community care units

Staffed by specialist multidisciplinary teams on a 24-hour basis; provide secure, supported residential accommodation in the long term and intensive rehabilitation in the patient's local community.

General hospital psychiatric units

Staffed by multidisciplinary teams on a 24-hour basis; provide acute psychiatric treatment and asylum when needed, usually on short-term basis.

Homeless services

Multidisciplinary teams; see patients in hostels, residential hotels and other temporary, unsupported accommodation environments; provide assertive care management with individual management plans, long-term specialist monitoring, treatment and review.

living (e.g., household tasks, banking), problem-solving and access to other services (for recreation, social activity, rehabilitation or medical care). The aim is to enhance treatment compliance and psychosocial functioning.

Needs of patients with chronic mental illness

The treatment of patients with chronic psychiatric disorders has to address not only symptoms, but the consequences of the illness in various domains (Box 2). The way that symptoms affect function in occupational and social domains will determine a large proportion of the impact of the illness on the patient. Interventions may need to be focused on aspects of functioning (such as obtaining accommodation, finances, basic provisions). Similarly, comprehensive management may need to address finances and housing to optimise the outcome.⁷

The interventions needed to address these outcomes require a variety of professional health service providers, as well as input from non-health social services. Patients with chronic psychiatric disorders (particularly chronic psychoses) may require this comprehensive mix of services indefinitely.⁸

Case management

Increasingly, psychiatric services are being organised along case management (or care management) principles.⁶ Although there is no consensus as to what constitutes case management, on an individual patient level it means the coordination of care for patients who require a number of services from different providers.⁹

Case managers coordinate access to the whole range of assessment and intervention services needed by the patient, with the aim of fostering independence and improved quality of life for the patient and carers. Case managers are also known as care managers or key workers.

Case management tends to be most helpful for patients with multiple needs, and appointment of the manager is often undertaken in a multidisciplinary meeting where the worker with the most appropriate skills can be “matched” to the patient. For instance, if considerable social problems are apparent, a social worker may be the most appropriate case manager (but this is not essential as a case manager can access social work skills elsewhere). The case manager acts as a readily accessible contact point for the patient and

2 Treating the whole problem: targets and interventions for patients with chronic psychiatric illness

People with disorders such as chronic schizophrenia require interventions to improve their social functioning as well as to control symptoms

Target for intervention	Intervention
Psychosis (delusions, hallucinations, disordered thinking)	Antipsychosis medication; counselling—reality reinforcement, support
Social and emotional deficits (flat affect, poverty of thinking, social withdrawal, lack of motivation)	Counselling, encouragement to join activity groups/programs, case management to access rehabilitation activities
Cognitive deficits (poor concentration, memory problems, poor problem-solving and executive function)	Counselling—assistance with planning for goals, memory prompts, assistance in task performance by allied health/nursing professionals
Mood disorder (depression, mania, anxiety)	Medication, counselling, cognitive psychotherapy
Functional deficits (in intimate relationships, social network, occupation, basic living skills)	Assistance to engage in occupational therapy, social skills training, training in activities of daily living, occupational rehabilitation (e.g., job support clubs)
Physical state (including alcohol/drug use)	Assessment, treatment for specific physical disorders (e.g., heart disease and airway disease—more common in alcoholics), nutritional and dental hygiene, encouragement to reduce alcohol/drug use
Effects on carers and community	Support groups (service-initiated and self-help), education about illness, counselling—assistance with problem-solving, psychotherapy (e.g., for the family)
Social handicaps (financial resources, housing, stigma)	Financial assistance, housing, assistance with good attainment (e.g., finding and joining a social program)

carers, ensuring that needed assistance is obtained promptly and that there is continuity of care.

The responsibilities and requisite skills of case managers will vary depending on the nature of the clinical problem and service context. General practitioners are well suited to be case managers for many patients with psychiatric problems. In some respects the issue of who is the case manager may be less relevant than clear understanding and agreement between different agents (e.g., a general practitioner, a community mental health service worker and a psychiatrist) and the patient and carer about who is responsible for what service and in what circumstances.

Ways of collaboration

There are few rigorous prospective trials of shared psychiatric care, and much of the evaluation of innovative programs has been qualitative. There are major challenges in setting up shared care, and research is urgently needed to evaluate different models in various contexts to ensure the most optimal outcomes.

In the United Kingdom (where there is virtually no private psychiatric sector) many psychiatrists have transferred their outpatient work to general practice surgeries. Psychiatrists provide assessment and treatment in the traditional specialist model, with the advantages of a location closer and more familiar to their patients. Other psychiatrists have established consultation–liaison relationships with general practitioners. Here psychiatrists provide secondary and tertiary consultation, including seeing patients together with general practitioners, discussing cases, clarifying difficulties and so on. An evaluation of such a model in an Australian setting found that it enhanced clinical care and offered opportunities for general practitioners to improve their psychiatric skills.¹⁰ Many other services have introduced similar strategies to achieve better communication and liaison with general practitioners.

For many patients with chronic mental illness who require input from different professionals, it is necessary for the general practitioner to establish collaboration not just with a psychiatrist but with a whole multidisciplinary team.¹¹ The approach has involved a variety of professionals holding clinics at general practice surgeries, and interacting with general practitioners in consultations or educational activities.

A more innovative approach (occasionally referred to as the “attachment model”) has involved actually setting up a multidisciplinary primary care psychiatry team within a general practice.¹² In the United Kingdom, fund holding by general practitioners has enabled such development to occur. Surveys have shown that some general practices, particularly in inner city locations, see a large number of patients with chronic psychoses and would be appropriate locations for such primary care services.¹³

In all likelihood, the common pattern of collaboration between community psychiatric services and general practitioners will involve shared, or collaborative, care,¹⁴ in which both parties agree to collaborate on overall service provision. The relationship has some similarity to the traditional general practitioner–psychiatrist collaborative pattern, but differs significantly in that the general practitioner will most likely need to relate primarily to a non-medical case manager or multidisciplinary team.

3 Patterns of collaboration between psychiatric service providers and general practitioners

Shifted outpatients

Psychiatrists, psychiatric nurses, allied health workers hold clinics at general practitioner surgeries

Consultation

Psychiatrists consult with general practitioners at surgeries, see patients together, problem-solve

Liaison–attachment

Psychiatric multidisciplinary teams work from general practitioner surgery base

Primary care teams

Multidisciplinary workers are employed by a general practice or a Division of General Practice, with vertical links to specialist services

Shared or collaborative care

General practitioners and psychiatric service providers formulate an agreed management plan which specifies roles and responsibilities of various providers

4 Typical components of a coordinated care agreement between a general practitioner and an area mental health service for a patient with chronic psychosis

- Names of and methods to contact general practitioner, responsible psychiatrist, case manager, others involved, emergency outreach team
- Protocol for antipsychotic treatment: whether managed by general practitioner or psychiatrist, reviewed at what frequency, symptoms and side effects targeted
- Rehabilitation needs: from what provider, at what level
- Basic living needs: plans for accommodation, finances, safety (usually via case manager)
- Frequency of monitoring by case manager
- Date for review of plan (e.g., six months later)
- Plan for crisis management: who is called; protocol involving general practitioner, case manager, crisis outreach team.

Essential aspects of collaboration

First of all, the area psychiatric service and the local general practitioners must establish communication. Education meetings jointly sponsored by the service and the local Division of General Practice are a useful opportunity for such networking. Contact is especially important for those general practitioners whose patients are being seen by the service, and for those with a special psychiatric interest who would be able to take cases referred by the psychiatric service. In our experience the best kind of collaboration occurs when general practitioners and community psychiatric service staff get to know about each other's roles and stay in personal contact.

There are many ways of fostering communication and collaboration between general practitioners and area psychiatric services. Much depends on local factors and personalities. The Divisions of General Practice may constitute the best single organisational link through which collaboration with psychiatric services can be initiated. An example of collaboration is being trialled in Melbourne through an ongoing agreement between the Inner South East Melbourne Division of General Practice and the Department of Community Psychiatry at the Alfred Hospital. Strategies to facilitate a communication network, including an educational program and consultation meetings/case conferences, were endorsed by participants. Basic protocols for collaborative care were developed. General practitioners joined the psychiatric service in providing shared care for patients, most with chronic psychoses, over a period now exceeding two years.

For a particular case it is essential that a joint management agreement is established.¹⁵ Ideally, this agreement should be based on a case conference. At such a meeting the patient's problems and needs can be considered within that individual's context and preferences, and matched with available treatments, professionals, services and resources. The agreement should be a written plan which specifies the personnel responsible (general practitioner, case manager, psychiatrist, etc.), the responsibilities of the various parties, the plan for handling crises, and date of review¹⁶ (Box 4). The patient's consent to the plan and to participation in the collaborative care relationship should be obtained by each of the service providers.

Because of the complexities involved, it may be necessary for collaborative relationships to be supported by a coordinator. Mental health service staff are salaried, whereas most general practitioners depend on Medicare payments. It is necessary to compensate general practitioners for the time spent beyond face-to-face contact with the patient, such as case conferences, which are critical to good patient care (either through changes to the Medicare schedule or some other mechanism of State or Federal funding). The absence of appropriate payments to general practitioners will militate against the success of collaborative care.¹

There are many possible patterns of service provision within shared care agreements. For many patients, it will be most appropriate for the general practitioner to coordinate consultations and services from other agencies. An agreed care plan may specify consultative reviews by a psychiatrist at an appropriate interval, a protocol for crises/emergencies and a list of other contributing services. The illness or disability characteristics of some patients may require that care coordination be provided by psychiatric service workers.

It is entirely possible that changes in the patient's illness and circumstances alter the preferred mechanism for service delivery. The

Case history 2: Return to the community

A 42-year-old single man who had a long history of chronic paranoid schizophrenia with marked functional deficit was receiving a disability support pension and living in a shared rented flat; his elderly mother lived nearby. He had been hospitalised four times in the last three years. He saw his general practitioner regularly, receiving depot fluphenazine decanoate 25 mg intramuscularly every two weeks. However, he was lost to follow-up by the general practitioner for two weeks, his condition deteriorated and he was admitted to hospital via the police.

Collaborative care after discharge

After a period in hospital, his condition improved. The general practitioner, area psychiatric service psychiatrist and case manager planned for his discharge from hospital in a five-minute conference call.

During this consultation, the responsibilities of the general practitioner, case manager, psychiatric service and psychiatrist were defined, and a case review was arranged for three months later.

The psychiatric service obtained the patient's agreement to the management plan and he was discharged from hospital. For the first few days a clinic worker (a nurse) visited the patient at home to assist with basic living needs and medication. He was then assisted to visit the general practitioner every two weeks for continuation of medication; the general practitioner also reviewed physical state, side effects and mental state.

After seven weeks the patient was able to attend the general practitioner by himself and also attended the service psychiatrist for review.

The general practitioner noted the development of akathisia and called the psychiatrist, who recommended reducing the dose of fluphenazine decanoate and introducing propranolol (which can be useful for control of akathisia) for short term therapy of about two weeks.

The case manager continued seeing the patient frequently to help sort out problems, including finances and rent arrears, preventing a psychosocial crisis. The patient was still living in the community and continuing to receive care two years later, despite fluctuations in his illness.

focus of care coordination and the services required may need to shift between the general practitioner and the community mental health service. After a period of intervention, the need for specialist input may diminish or disappear. Many patients with chronic mental illness prefer to receive all necessary treatment from their general practitioner.³

Difficulties in establishing shared care

General practitioners vary in their psychiatric skills, abilities and interests. Various aspects of psychiatry also hold different challenges and some general practitioners are much more able to intervene in acute mood disorders than to address the complex issues posed by chronic psychiatric illness.

It is important that postgraduate education in general practice assists the practitioner to address the whole range of common psychiatric illness in various phases, and that the time-consuming interventions often needed in chronic psychiatric illness are appropriately funded.

Doctors and allied health professionals are trained in disparate and at times conflicting models of care; this can create barriers and breakdowns in communication. For example, in contrast to the conventional medical model, many multidisciplinary mental health teams adopt a rehabilitation model that focuses on patient capabilities rather than deficiencies, and which operates on a very different time frame to the standard medical consultation. Strategies that facilitate communication and common understanding between general practitioners and staff in community psychiatric services are essential for collaborative care.

Rural settings

Special problems may affect the possibility of collaborative arrangements in rural settings: distance, disadvantage of many patients, lack of medical and psychiatric services. In contrast to urban settings, it is usual for rural general practitioners to see all the patients with serious mental illness in their area.

The case for developing multidisciplinary mental health teams through a general practice base is especially strong in rural settings. A successful program has been piloted in Victoria. The lack of services in rural settings for patients with drug/alcohol and personality problems is also a great concern and could be addressed by such developments.

In isolated rural areas, access to specialist assistance by teleconferencing or videoconferencing may be a useful option.

Educational and service development needs

Many general practitioners identify a need to improve their psychiatric skills.¹⁷ In the recent past, major efforts have been made to improve skills, particularly in the recognition and treatment of mood disorders. Continuing medical education about treating psychoses in primary care remains a major need.¹⁸ In many locations, Divisions of General Practice and

area psychiatric services have combined to sponsor ongoing educational programs.¹⁴

Although the management of psychoses such as schizophrenia requires specialist consultation, much of the medical management is readily carried out in general practice. Innovative means of meeting general practitioner training needs have included attendance at clinic sessions, joint interviews and case discussions.¹⁴ Brief protocols for managing patients with chronic psychoses in general practice are much needed,³ as are area-specific service access guides.¹⁴

Mental health services, which have had their origins in totally self-contained institutions, also have to address the training needs of staff in order to improve their abilities to collaborate with general practitioners (especially communication skills).¹⁹

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