Overcoming barriers to reintegration of patients with schizophrenia: developing a best-practice model for discharge from specialist care

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ABSTRACT

- Many people with schizophrenia are in regular contact with their general practitioners. GPs commonly play a sentinel role in management, but may require support from Area Mental Health Services (AMHSs).
- The CLIPP (Consultation and Liaison in Primary-care Psychiatry) shared-care model of patient management combines a collocated consultation/liaison service for managing referrals from GPs to specialists with a carefully structured approach to long-term care of patients transferred from AMHS care to GPs.
- The CLIPP model uses the concept of a "relapse signature", involving recognition of early warning signs of relapse, to simplify clinical monitoring of patients with schizophrenia.

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In recent years, in Australia and New Zealand, there have been several reports of intersectoral collaborative care between mental health services and general practice for people with mental health problems.[1-4] I describe here one approach to collaborative care for patients with schizophrenia. The techniques used were developed within the "Consultation and Liaison in Primary-care Psychiatry" (CLIPP) program.

Caring for people with schizophrenia in Australian general practice

For at least 30%–40% of people living with schizophrenia, ongoing management is by their general practitioner alone.[5-8] Many of these people have received care from specialist services in the past and then been formally discharged back to primary care. Others have dropped out of contact with specialist services, subsequently having their care picked up by the GP.

General practice in Australia has definite strengths for managing the long-term care needs of people with mental health problems. These strengths include its accessibility, lack of associated stigma, the possibility of long-term continuity of care, sensitivity to community and family issues, and the ability to integrate the management of multiple problems. Nevertheless, delivering primary care to people with schizophrenia presents some challenges:

- People with schizophrenia are prone to non-compliance with treatment, particularly when their judgement is affected by the disorder;
- Schizophrenia can lead to deficits in cognitive ability and social skills, which may impair the ability to follow through agreed plans of treatment;
- Assessing the present state of the disorder can be difficult without information about previous presentations of the problem in this person, and if their attendance is erratic;
- Time within consultations is limited. This poses a particular problem if the tasks of management are not fully clear to the GP.

These commonly encountered difficulties mean that current models for managing people with schizophrenia include assertive outreach as a component: clinicians based in the community in public-sector mental health services are encouraged to proactively contact people who fail to attend appointments, perhaps going to considerable lengths to support them in gaining access to care. Commonly, these models include case management, to establish a clear duty of care for a specific clinician or team. This duty of care includes, at the very least, a duty to ensure regular contact with services and an active response to non-attendance. Case managers (usually salaried employees who are trained as nurses, social workers, psychologists or occupational therapists) work to ensure that their clients are regularly reviewed, including review by psychiatrists. All staff update client details in a common record. Typically, case managers develop close and continuing relationships with their clients, spend considerable time with them (including visiting them at home) and acquire some in-depth history of their problems and typical presentations in relapse.

Measured against these practices, some of the shortcomings of general practice for managing people with schizophrenia are apparent:

- Lack of a common clinical record, or other robust processes for transfer of information between specialist services and GPs and/or between multiple treating GPs;
- Limited capacity for assertive outreach;
- A funding system that places freedom of consumer choice of GP over a clearly mandated longitudinal duty of care;
- Lack of time;
- Difficulties in interfacing with specialist services to secure regular specialist review.

The UK mental healthcare system and general practice

A number of overseas models for managing schizophrenia, including the UK's Care Programme Approach (CPA), have

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1: The main elements of the CLIPP model[18]

- Collocation of mental health service staff and general practitioners to promote close working relationships.
- Preparation by Area Mental Health Service staff of brief and specifically tailored documentation for use in the general practice setting.
- Use of a "relapse signature" to simplify long-term management of people with schizophrenia by GPs.
- Continuation of a duty of care from the Area Mental Health Service through into long-term GP care.
- The guarantee of regular specialist review of patients, even if required only once a year.

contributed to the development of practice within the CLIPP model. The CPA, introduced in the United Kingdom in 1990, systematises follow-up practice for many people with schizophrenia and provides a model for ensuring long-term continuity of care across service sectors.[9,10] The program explicitly determines and allocates a responsibility for continuity of care for every patient accepted to receive specialist mental health service care, irrespective of who is primarily providing the individual's care at the time, including GPs.[11,12] Although the CPA has been at times an onerous bureaucratic burden for clinicians[13] and has been variably implemented,[14] it remains a keystone of mental healthcare reform and development in the United Kingdom.[13]

Guidelines for care of people with schizophrenia in general practice

In 1997, a UK group led by Professor Tom Burns of St George's Hospital, London, published consensus guidelines for care of patients with schizophrenia in general practice.[15] The authors commented that "entirely evidence-based guidelines ... cannot be derived for the management of schizophrenia in primary care". Some five years later, there is still no substantial empirical evidence to support a change in this conclusion. In the absence of such evidence, guidance for GPs in managing schizophrenia must be based on judicious selection of aspects of specialist practice that are suitable for adoption in general practice. In this regard, the UK guidelines may be usefully supplemented by relevant Australian publications.[16,17]

Shared care in the CLIPP model

The CLIPP shared-care model (Box 1)[18,20] combines a collocated consultation and liaison service for managing referrals from GPs to specialists with a carefully structured approach to long-term care of patients transferred from Area Mental Health Service (AMHS) care to GPs.[18,21]

A psychiatrist visits each involved general practice about once a fortnight. The specialist is available to respond to requests from the GPs to discuss assessment or management of patients with mental disorders who present to the GPs in their clinics. The psychiatrist also provides direct assessments of these patients and discusses them with the treating GPs.

Participating GPs also agree to take on the care of some patients transferred from the AMHS (most typically, patients with schizophrenia). Transfer from the AMHS to shared care is accompanied by a carefully structured management plan, prepared by AMHS staff, that is tailored to the requirements of general practice and makes substantial use of the "relapse signature" (described below) as a framework for management.

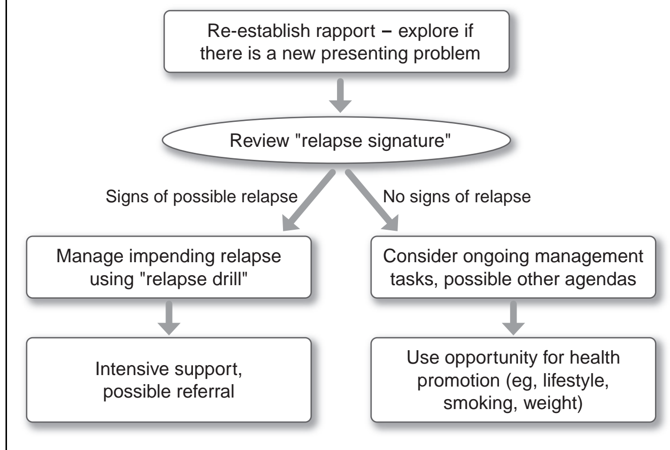
The "relapse signature"

For many people who are currently in remission from a psychotic disorder, but vulnerable to relapse, it is useful to consider possible early-warning signs of relapse. The term "relapse signature" denotes the specific set of symptoms or signs, often subtle and specific to the individual, that warn that the person is at high risk of impending relapse. The warning signs may include low-grade psychotic phenomena, such as "hearing voices", but will often also include relatively non-specific signs and symptoms, such as sleep disturbance and social withdrawal, which commonly present before more frank signs of psychosis emerge. Detection of these early signs and symptoms may give a few weeks' warning of an impending relapse, presenting a window of opportunity for intervention that may prevent relapse or at least lessen its severity.

A relapse signature can be ascertained systematically, and there are several formalised approaches for doing so.[22] Essential to the process is the establishment of a shared spirit of enquiry with the patient in looking for signs that he or she may be becoming sick again and recalling the sequence of events that preceded relapses in the past. This may be complemented by the use of specific checklists of common early warning signs. However achieved, the goal is to identify a clear set of events that suggest the impending probability of a relapse. Good rates of symptom remission can often be achieved by providing fairly low-dose medication regimens, regularly monitoring warning signs, and increasing positive coping strategies, including increased medication dosages in response to these changes.[22,23] (Lambert and Castle [*page S57*][24] discuss drug treatment in more detail.)

Using the relapse signature in general practice

Once a relapse signature has been developed for an individual patient with schizophrenia, the task of monitoring the person's clinical status for early signs of relapse is simplified. The patient's characteristic warning signs and symptoms can be briefly and regularly assessed, providing a relatively speedy check on whether the patient's schizophrenia is still in remission. The use of the relapse signature within a consultation structure is shown diagrammatically in Box 2. In most cases (probably over 90%) there will be no signs of relapse. Savings in consultation time with this relatively streamlined approach can be used to attend to other psycho-



2: A plan for monitoring patients with schizophrenia in remission in general practice

social or physical issues. These may include supporting the family in accommodating the needs of the person with the disorder; keeping stress levels contained by offering counselling about life changes and decisions; and attending to physical health issues such as overweight, smoking and other risk factors for cardiovascular and respiratory disease.

Strategies implemented in response to the warning signs of relapse, if present, constitute the "relapse drill".

Transfer of care

In the CLIPP model, transfer of care is achieved through a case conference (one of items 740–744) at the general practice clinic to discuss the details of care to be delivered after transfer. The case conference involves the individual with schizophrenia in remission, carer(s) and/or other community service staff, the GP and AMHS staff, including the psychiatrist, who has the task of ensuring that the GP clearly understands what is required for ongoing monitoring of the patient. The transfer documentation reflects considerable time investment from AMHS staff, particularly the nurse on the clinical team. It describes the relapse signature and also individualised components of the relapse drill, including, for example, suggested changes in medication or other measures that may be initiated in response to signs of impending relapse.

After the case conference, the GP takes over as the primary professional involved with the patient. The GP typically sees the patient every 2–4 weeks, or more often if signs of relapse indicate the need for more intensive care.

Following up, following through: an adaptation of the Care Programme Approach

Once AMHS clients have been transferred through CLIPP to a GP, the GP manages the patient with reference to information about relapse signature and relapse drill.

The psychiatrist visiting the practice regularly reviews the GP's case notes to ensure that the patient is still attending the GP and that key management tasks are continuing. Non-attendance, even if missed by the GP's recall systems, will therefore be picked up by AMHS staff and will trigger assertive follow-up from the CLIPP program nurse clinician. Sometimes a phone call will suffice to re-engage the patient; sometimes a visit from the GP, AMHS staff, or both, will be necessary. A clinical case register maintained at the AMHS supports this process, and also monitors performance on the basis of a six-monthly to yearly review by the psychiatrist. This process is similar to the UK's CPA, with the added benefit of the specialist's regular attendance at the primary care clinic.

The AMHS's commitment to maintaining an interest in its clients transferred into GP care and actively monitoring their progress is an enduring one. If necessary, it continues for life. This approach achieves high follow-up standards and a loss-to-follow-up rate consistently below 1% per annum.

More general lessons from the CLIPP model

Elements of this program could be incorporated into general practice in areas where CLIPP or similar models are not operating. For example, the process of deriving the relapse signature and using it to facilitate management could also be done by an interested and skilled GP, particularly if there was some collaboration available with a local AMHS. This approach — based on medical-model concepts such as remission, relapse, and warning signs — is already familiar to GPs.

For GPs who are accredited to use them, recently introduced Medicare Benefits Schedule items for mental healthcare (the "three step mental health process" — items 2574–2578)[25] encourage giving more time to people with mental health problems. Other items (740–744) also provide for the possibility of case conferencing. GPs caring for people with schizophrenia could consider reviewing each patient using the three-step structure (assessment, mental-health plan and review). This could be complemented, if appropriate, with a case conference. At such a conference, the GP might present a draft relapse signature and relapse drill for discussion with mental health specialists, with a view to improving the patient's management in the future.

Conclusions

In Australia, over the past decade, there has been substantial investment in developing service models for long-term shared care of patients with schizophrenia. The accumulated experience suggests that, if close attention is paid to improving communication and coordinating disparate services, the risk of losing patients to follow-up can be largely averted. New federally funded initiatives for general practice are encouraging GPs to invest more time in mental healthcare. It is to be hoped that an increasing number of GPs will become involved with this aspect of primary mental healthcare.

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Competing interests

None identified.

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