

Research Article

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A Nurse led Mental Health Liaison Project with General Practitioners

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Abstract

Introduction: The role of the general practitioner (GP) in the care of individuals with mental health is well known and recognised. What GPs need is some advice and support for this work.

Method: This article describes a project with mental health nurses from a tertiary aged mental health service visiting GP practices and offering advice and support to GPs.

Results: Over a period of 18 months 59 GP practices from the Eastern suburbs of metropolitan Melbourne utilised the service to a greater or lesser degree. The Nurses saw a total of 253 patients during this period and the service was well accepted by the practices that utilised the service and only a handful of the patients seen had to be referred to the tertiary mental health service. The feedback from the GPs who utilised the service was positive.

Conclusion: There is a definite role for such a service to be provided to GP practices

Keywords: Nurse, Mental Health, Liaison, General Practitioners

Introduction

The role of the general practitioner in the care of individuals with mental health problems has long been recognised. Pioneering work by Goldberg and Huxley demonstrated that only a fraction of identified mental health problems are referred to psychiatrists [1]. Goldberg & Bridges estimated that between 20 and 25% of a GP's workload concerns mental health with only about 5% referred on to psychiatrists [2]. Shepherd insisted that the only real hope for significant improvement in mental health care lay in the improvement of GP provision because there will simply never be enough psychiatrists [3]. Burns and Bale state that there is much overlap between the work of GPs and psychiatrists [4]. They share a commitment to long-term disorders and both professions emphasise a holistic approach to patient care, with due consideration being given to social and family factors. The clinical interview is the basic tool of the trade for both professions, and although its form is somewhat different, the establishment of a trusting long-term relationship is essential to both practices. As psychiatry and mental health practice become less dependent

on institutional care, the need for close working relationships is increasingly obvious. Regular, face-to-face meetings between mental health teams and GPs have proved to be a time-efficient investment both for improving patient care and for avoiding potential mishaps.

In Australia, the Second National Mental Health Plan, put the spotlight squarely on partnerships between mental health services and general practitioners (GPs), among others, in improving mental health care delivery [5]. However, the form that these collaborative partnerships should take is open to question. While several models have been described, no single approach is likely to be suitable for all situations or all occasions [6]. For example between 1989 and 1996 Carr and Donovan implemented and evaluated the impact of a psychiatry consultation-liaison (C-L) service on several group general practices [7]. In short, senior psychiatry registrars attended each practice weekly, interviewed and assessed selected patients, and prepared management plans in consultations with the GPs. After a promising beginning in terms

of improved accessibility and satisfaction of patients and doctors, they found that this psychiatry C-L model, operating in isolation, had several weaknesses. These included no demonstrable effect on outcomes for mental health problems of mild to moderate severity; excessive psychiatrist time spent dealing with mild, transient psychological problems; inefficiency in changing GPs' knowledge of psychiatry, clinical confidence or referral practices; and failure to facilitate GP involvement in the care of patients with severe mental illness treated by public mental health services [8-10].

The integration of mental healthcare into primary care has been advocated by WHO since an expert committee report on the '*Organisation of mental health services in developing countries*' was published in 1975. Twenty years later, a large international WHO study on '*Mental Illness in general health care*' demonstrated the significance (and treatability) of psychological disorders in primary care across cultures and resource setting, to which new evidence and experiences have been added over time, including publication in 2008 of a joint WHO/WONCA report '*integrating mental health into primary care – a global perspective*' [11]. Primary care is the platform for first-contact and on-going health services and interacts closely with the other platforms for mental health care: self-care, informal health care and specialist mental health care. The key advantages of delivering mental health care through primary care are that it is accessible, affordable and acceptable to people with mental health problems and their families. Most people with mental health problems access primary care and their disorders are more likely to be identified and appropriately treated with less risk of stigma. Furthermore mental health integration in primary care promotes comprehensive, coordinated, and person-centred care for the many people with comorbid physical and mental health problems [11].

There are currently at least five models of working between primary and secondary care, each of which attempts to improve communication across the interface and demonstrates greater or lesser degrees of shared care [12]. These include 1. Community Mental Health Teams which provide crisis intervention and increased liaison with primary care. 2. Shifted out-patient clinics where psychiatrists hold out-patient clinics in primary care health centres. 3. Attached mental health workers where trained mental health staff, usually community psychiatric nurses, work with people with mental health problems in a primary care setting. 4. Consultation-liaison model which gives primary care teams access to the advice and skills of specialist mental health services. 5. Integrated working models based on integrated working create seamless patient pathways through the health system, going one step beyond collaboration to co-ordination, and often co-location of care. Each of these models has strengths and weaknesses.

Background of Project

The Aged Person's Mental Health Service of Eastern Health in the state of Victoria, Australia decided to undertake a project which fitted model 4 mentioned above. The aged person's mental health service serves a catchment of 6 Local Government Areas of Eastern Melbourne with over 130,000 persons aged 65 and over living in the catchment. There are over 300 General Practice (GP) clinics in the catchment. GPs require information about potential referral options and if they have diagnostic/management issues for discussion in relation to psychiatric disorders. However GPs have difficulty accessing the right service for the client within the public and private sectors and there is difficulty navigating systems to access appropriate mental health services for older persons (65+). The aim of this project was to provide such services in a non-stigmatising

environment (GP Clinic) and at an early stage of an illness episode. The service would provide bio-psycho-social assessment and interventions primarily to the GP and if necessary to the consumer in a primary care setting. It also intended to enhance GPs capacity to provide interventions via secondary and tertiary consultation if necessary. The anticipation was that through the project, GPs would be supported to develop their skill and knowledge on mental illness via education, training and health promotion. It would provide early intervention focus (early illness and early in episode) with an avoidance of unnecessary introduction of consumers into another treatment system i.e. Tertiary Mental Health Services. The project was initially funded for 12 months by the Eastern Region Primary Health Network. The project was later extended for a further 6 months. Ethics approval for the project was obtained from Eastern Health's Ethics Committee.

Materials and Method

Initially the service was targeted to just 12 GP practices within 3 metropolitan cities but this was later extended to any GP practice within the catchment. A total of 59 GP clinics did utilise the service and referred patients. For primary consultation, the referrer (GP) needed to be willing to participate in a collaborative arrangement, including provision of rooms in which assessments/interventions could take place. Any referral of persons 65 and over and younger persons suffering from dementia were accepted. The consumer also needed to consent to the involvement of the specialist mental health professional. Secondary consultation service was available to the GP where they required information about potential referral options, or there were diagnostic or management issues for discussion in relation to psychiatric disorders. Advice was also provided to GPs who had difficulty accessing the right service for the consumer within the public and private sectors and where they found difficulty navigating systems to access appropriate mental health services.

The service was provided by 2 Senior Clinical Nurses (SCN) with sessions provided by a Consultant Psychiatrist who provided clinical leadership. The base of the service was the Peter James Centre where the aged person's mental health service was located and there was close working relationship with the aged persons' mental health access team. Teleconferencing and video conferencing facilities were available.

The SCN's initially visited GP practices in the catchment area to inform GP's and Practice Managers of the new service. Leaflets and magnets with contact details for the service were also handed out to the GP practices. Referrals were accepted directly via telephone, fax and email or via the APMHS triage. All referrals were acknowledged. Referrals were discussed daily at a morning meeting with the Consultant Psychiatrist before a plan was put into place to act on the referrals. It was the responsibility of the GP practice staff to make appointments with the patients referred and to make provision for a room for the assessment to take place. Assessments would take place along with the GP concerned or the GP was involved later with the assessment findings and to inform the patient of the recommendations. All patients were seen in GP practices and the only exceptions were patients who were in Aged Residential Care Facilities. When necessary the consultant psychiatrist would be contacted by phone for advice especially as regards pharmacotherapy. On occasions the consultant psychiatrist did see the patient for a further assessment for diagnostic clarification. Further discussion of the patients took place daily at the morning clinical meeting and management plans made with the consultant psychiatrist. The GP was then send written information by fax of the assessment findings and treatment

plans. The bulk of the referrals were seen only once but some who needed follow-up or short term psychosocial interventions were seen more than once. GPs could re-refer to the service at any stage as required. If deemed necessary or appropriate, referrals would be passed on to the Aged Community Mental Health Team for on-going management or to the acute inpatient unit for further assessment and treatment. The numbers that needed this extra layer of care were minimal.

Along with the primary and secondary consultations to the GPs, education sessions were provided to Practice Nurses by the SCNs and there were 4 formal education session for GPs on topics including, Depression in Older Persons, Suicide and Safety Planning, Psychotropic Medication and Management in Older People and Managing Behavioural Problems in Dementia.

Results

Total referrals during the period of the project were 253 from 59 GP practices

Gender of referrals

Males 57 and Females 196

Age of referrals

Below 65: 3

Aged 65 - 70: 42

Aged 71 - 75: 44

Aged 76 - 80: 50

Aged over 80: 107

Diagnostic categories

Organic Psychiatric Disorders including dementia 59

Functional Psychiatric disorders 194 as follows;

- Anxiety disorders: 35
- Depressive disorders: 115
- Bipolar Affective Disorders: 17
- Schizophrenia/Schizo-Affective/Delusional: 16
- Personality disorders: 11

Action following assessment: Advice (including psychotropic medication advice) was given to general practitioners following assessment of their patients. In addition;

- 24 patients were also advised referral to the newly established Stepped Care Service
- 69 patients were also advised referral to a private psychologist
- 12 patients had to be referred to the tertiary aged mental health community team and one patient had to be admitted to the acute aged psychiatry inpatient unit

Formal Education Sessions: The following formal education sessions were provided to the general practitioners and practice nurses:

- Depression in Older Persons – 30 participants
- Suicide and safety Planning – 35 participants
- Psychotropic Medication and Management in Older Persons– 50 participants
- Managing Behavioural Challenges in Dementia – 31 participants.

In addition informal education was provided to practice nurses during practice visits by SCNs.

Feedback Received from General Practitioners

Generally the feedback received was very positive and here is a selection of the feedback received.

- Being able to carry out MH review at GP clinic where trust is already established is very important to them
- Everyone in our clinic appreciated the help received
- Easy access and only a phone call away. Consultant always ready to help with advice.
- Team arrived on time and it was helpful they attended all appointments
- We learned about management and treatment of mental health issues
- Facilitated alternative pathways and assisted with advising appropriate referrals elsewhere.
- Particularly helpful with complicated cases, behavioural issues and mood problems
- Service option enhanced their management of OPMH by collaboration and easy access to specialist services, it provides alternatives
- Excellent support provided by the team who helped on multiple occasions
- Helpful to have an expert which is easy to contact
- Clinic room availability an ongoing issue
- Referral was helpful as it provided alternative opinion/viewpoint
- Felt less stigmatising and service easy to access
- Very friendly team that helped the patients on site, patients provided positive feedback to GPs

Discussion

Though there were over 300 GP practices in the catchment area only about 15% utilised the liaison service to varying degrees. The information about the project was sent out to a wide group of GP practices but we found that the best outcome was when there was face to face contact with the GPs to introduce the project. Face to face contact with GPs depended on practice managers who were the gateway to the GPs in the practice. Many were not interested as they felt that it was an extra impost on their time and resources. We found that a major factor was the philosophy and model of the practice concerned. Bigger practices with a “business” model with GPs who are encouraged to see as many patients as they can were less interested in spending time with patients with mental health issues or to be involved in a project as it was financially less rewarding. Smaller practises which had more personal relationships with their patients were more inclined to be interested. The other major issue for GP practices was as regards availability of interview rooms and to be able to accommodate our project nurses to assess patients. There was also reluctance to get involved with the project as over the years there have been different mental health initiatives that have been put into place by the government but as GPs were getting used to the new services they were pulled back, for example, Primary Mental Health Care Teams and Mental Health Nurse Practitioners. There was therefore reluctance to get involved in yet another time limited service and changing their systems to fit in with a new model of service. This is a major issue that governments need to take into consideration when funding time limited projects.

The patients referred were predominantly females. This is not a surprise as it is well known that more females are generally referred to any aged persons mental health service. However what was surprising was that females referred were two and a half times more than males. This could be due to the fact that GPs tended to deal with more high prevalence disorders like anxiety and depression which is usually more prevalent in older females and/or older females tend to seek help when suffering from these disorders compared to older males. There was a higher ratio of patients aged 80 and over referred to the service but this could

partly be to the fact that out of the 51 patients referred from aged residential care facilities 35 patients were aged 80 and over. It is well known that nursing home residents are usually an older cohort. As would be expected, the vast majority of referred patients were either depressed and or anxious.

Of the 253 referrals seen by the liaison team only 12 had to be referred to the tertiary mental health service as they were too unwell to be managed by the GP. This is only around 5% of the total referrals and it is impressive that 95% of the referrals could be managed by the GP with advice from the GP Liaison team. This is a major reason to advocate for the success of such teams in keeping patients from being referred to tertiary mental health services, emergency departments and acute inpatient units.

A major learning from the project was the importance of accessibility, agility and flexibility. The project team had the freedom to be agile rather than be stuck with the way that established mental health services work. GPs in their feedback were appreciative of the responsiveness of the team. The other leaning for us was that GPs do manage complex mental health patients and would prefer to manage their patients. Tertiary mental health services often have the impression that GPs are not keen to manage mental health patients and prefer to refer them on to tertiary mental health services. There was also the assumption that GPs were too busy to discuss their patients and this might often be the case when GPs are contacted by the telephone. However our SCNs found that all the GPs that were met face to face always made time to discuss their patients. This would also speak of the importance that GPs place on the “relationship” with service providers. GPs appreciate accessible and responsive advice when necessary so that they can continue managing their patients rather than referring them on. The responsiveness of our project nurses to assess patients and also the prompt advice as regards psychotropic prescribing from the consultant psychiatrist when needed were the standout parts of service that the GPs appreciated. Anecdotally GPs learnt from observing mental health assessments being carried out by our SCNs and the formulation of management plans for their patients.

Conclusion

The GP practices that were involved in the project appreciated the service. The main problem was to recruit GP practices as they were not keen to change their model of practice for the sake of a short term project. They were disappointed that several past mental health initiatives were pulled after a period of time. There is no doubt that there is place for a mental health service that can be provided by specialist clinicians within a GP practice that is accessible, responsive and agile without getting caught up in the bureaucracy of tertiary mental health services. The answer might be to have a GP liaison service built into the model of care of a tertiary mental health service. The challenge would be to work out clinical governance and where the clinical risks sit with such a service.

Limitations

The measures in exploring the baseline factors and then being able to compare this to post project outcomes were not sufficiently formulated. Given the poor return of questionnaires and feedback, measuring the effectiveness of the project therefore became limited. As this was a pilot project, there are many areas for reflection and improvement that can be considered as part of any future endeavour.

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