UNIT NO. 4

THE SUCCESSFUL COLLABORATION BETWEEN PSYCHIATRISTS, A MENTAL HEALTH INSTITUTION AND GENERAL PRACTITIONERS IN PRIMARY CARE

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ABSTRACT

This paper describes an integrated care programme implemented since 2003 by the Institute of Mental Health (IMH), a tertiary mental health institution in Singapore. The programme is a collaboration between general practitioners (GPs) and IMH, for the detection and management of patients with mental illnesses in the primary care setting. A survey of the GPs and patients in the programme was carried from June to July 2010. The results show satisfaction and good acceptance of the programme.

KEYWORDS: general practice, GP, primary care, mental health

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INTRODUCTION

Mental disorders are increasingly recognised as major health issues burdening a country's health services.[1] It is this burden, both economical and social, that warrants a need to re-look on how mental health services should be delivered. The past model where people with mental illnesses are largely managed by institutions and hospitals places an unbalanced strain on the tertiary health system, when many of these patients who are stable, could have been managed by general practitioners (GPs) in the primary care setting. Compared to specialised care, services provided by GPs for patients with mental illnesses are deemed to be more accessible, convenient, and less costly.[2] GPs are multi-skilled primary care providers supporting 83% of all primary medical care in Singapore[3], and are often the first point of contact for a patient with mental illness.[4] This places the GPs at a crucial role to be able to detect, treat and/or refer a patient presenting with a mental illness. In fact the ease of access as well as the less stigmatising environment at the primary care level provides for a platform for regular follow-ups and co-management of other physical health conditions.

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The focus is now shifting towards integrating mental health into primary care.[5] Several countries have put in place efforts to implement just this form of integration, with the aim of advancing mental healthcare, improving disease outcome and reducing the burden on mental institutions.

In Singapore, the Institute of Mental Health (IMH) has since 2003 implemented an integrated mental health service with the aim of engaging GPs in the detection and management of mental illnesses.[2]

THE GENERAL PRACTITIONER (GP) PSYCHIATRIC PROGRAMME

The aim of this programme was to engage the GPs in the management of stable psychiatric patients based on a long-term and sustainable partnership. The skills gained during the programme would allow the GPs to diagnose and detect with greater confidence when their patients present with mental illnesses, and to start management earlier if necessary.

Hence in 2003, GP Psychiatric Programme set about identifying, training and collaborating with a group of GPs who are interested in and willing to manage patients with mental illnesses, and to right-site the care of these patients from the hospital to the community.

A detailed training programme for the GPs was drawn up which allowed the GPs to obtain the skills and knowledge they required. The psychiatrists also had the opportunity to meet the GPs who would subsequently be managing their patients. The GPs were provided with in-depth, comprehensive training on mental illness, which included an induction course followed by regular refresher workshops and dialogue sessions. They attended ward rounds and were attached to specialists' clinics. Lectures which refreshed them on relevant clinical skills like mental state examination, pharmacological treatment of mental illness and management of psychiatric emergencies were conducted. This training not only provided the GPs with the skills necessary to manage the stable patients within the community, but also improved their capability to detect and manage the mentally ill. This early detection and early management of certain mental illnesses is of particular importance.[6]

The initial pilot phase involved 4 participating GPs and this grew to 50 GPs over the years. An open channel of communication and partnership between GPs and psychiatrists is key to the programme.[7-8] Of equal importance is the development of the drug delivery system. This involved creating a seamless drug management system that is easy to order and efficient in the delivery of medications. Over and above this, the system has to ensure that the cost of medications to GPs is kept low so that

the final cost to patients at the GP clinics is kept as close to that at the hospital as possible.

REFERRAL OF STABLE PATIENTS TO GPS

The exclusion criteria are shown in Figure 1. Proper counselling on the referral process is provided to the patients and their family. With the assistance of the counsellor, the patients select the clinic of a participating GP that is most convenient. With the consent of the patients, his or her information and treatment regime are communicated to the chosen GP and an appointment is made.

Figure 1: REFERRAL CRITERIA

- **Inclusion Criteria**
  a. Patients who are stabilised and requiring just maintenance medication, i.e. under the same medications for the past 3 months with preferably minimum or no dosage adjustments
  b. Patients not hospitalised within the past 6 months
  c. Patients who are employed, hence requiring flexibility of timing
  d. Patients who are prepared to pay the slight price difference for continuation of treatment at GPs

- **Exclusion criteria**
  Patients with:
  a. Substance use and/or forensic history
  b. Disruptive personality disorder
  c. Suicide and aggression risk
  d. Clozapine prescription
  e. Formal psychotherapy
  f. Financial assistance

In order to ensure a smooth transition of care for the patient from hospital to community-based treatment, each patient is allocated a specific case liaison officer. The case liaison officer coordinates all aspects of treatment and transfer of care, provides ongoing support to the GPs and acts as a bridge between the GP and the hospital team.

PROGRAMME TO DATE

The programme has successfully partnered 50 GPs and referred 894 patients to their care since the inception of the programme in 2003 (as of July 2010). Since 2007, a total of 7 trainings were conducted for the GPs. The trainings include Introductory Training for recruitment of new GP Partners, as well as Refresher Courses targeted at existing GPs in the programme.

We describe in this paper the findings of a survey of the GPs and patients involved in the programme.

METHODS

Questionnaire design:

1. GP Satisfaction Survey

The GP Satisfaction Survey was designed to gather feedback regarding 5 main aspects of the Programme, namely (1) Programme Objective (2) Coordination of Care (3) Level of Support of IMH (4) Overall Satisfaction (5) Willingness to Recommend. GPs were asked to rate each component as (a) Strongly Agree, (b) Agree, (c) Neutral, (d) Disagree and (e) Strongly Disagree.

2. Patient Satisfaction Survey

The Patient Satisfaction Survey aimed to survey patients on aspects regarding (1) Knowledge and Skills of GPs (2) Coordination of Care, and (3) Willingness to Recommend. In addition, information on patient's current health state is also collected to provide update of patient's condition after being referred to GPs. Likewise patients were asked to rate each component as (a) Strongly Agree, (b) Agree, (c) Neutral, (d) Disagree and (e) Strongly Disagree.

Sample/Study group:

The GP Satisfaction Survey targeted all current GPs in the Programme, who have joined the Programme for at least 1 year. A total of 40 GPs were being surveyed.

The Patient Satisfaction Survey aimed to survey patients referred out from the Programme for at least 1 year (i.e. 2005 – June 2010). A total of 622 patients were being surveyed.

Survey:

The GP Satisfaction Survey was carried out via email. It is followed-up by phone-call if no reply is received within a week.

The Patient Satisfaction Survey was conducted via phone as well.

RESULTS

A total of 83 (13.3%) patients and 26 (65%) GPs returned the survey forms.

Patient Satisfaction Survey

Patients' view on Programme coordination of Care

The coordination of care was generally acceptable to the patients, with 97.6-98.8% of respondents not having experienced any problems. This included both the coordination of the initial referral to the GPs as well as referral back to the hospital should a need arise.

Patients' perception of GP's knowledge and skill

General satisfaction was between 94-98.8% in this category which includes doctor-patient communication, doctor's skill, care and knowledge.

Willingness to recommend

At least half (57.8%) of respondents are willing to recommend the GP they are on follow-up with for similar conditions, as opposed to 4.8% who were not willing to.

GP Satisfaction Survey

There was overall satisfaction (81-100%) with the programme, ranging from the profile of patients referred, coordination of patient referral, training programme, and drug procurement. There was a GP (4%) who had trouble with the accessibility of assistance from the hospital as well as improving his ability to care for his patient. However, he did get overall satisfaction in eventually getting support to overcome his difficulties.

More then two thirds (69%) of the GP respondents agreed, with none disagreeing, that they will recommend this programme to their GP colleagues.

DISCUSSION

Despite the general satisfaction by the patients on the coordination of care, there can be further improvement. Evaluation on the problems faced by the patients needs to be carried out, determining where in the process of coordination need improvement, be it the initial referral or the process of being referred back to the hospital.

It is heartening to see that patients do not have an issue with the competence of the GPs who had completed training under the programme.

The reasons behind why patients are not willing to recommend the GP they are consulting with needs to be explored. The disparity between the satisfaction levels and their willingness to recommend may be due to the fact that they are not willing to let others know they are on follow-up for mental illnesses.

Likewise, encouraging signs can be seen from the responses of the GPs. There was overall satisfaction with the programme. However, there were signs that more attention may have to be made to the support for the GPs in the area of providing updates, and professional support by psychiatrists and liaison coordinators.

The positive factor that with more then two thirds of the GP respondents agreeing, and none disagreeing, to recommend this programme to their fellow GPs, the programme can strengthen it's partnership with more GPs in future.

CONCLUSION

The GP Psychiatric Programme has successfully partnered 50 GPs and referred 894 patients to these partners. Although there is general satisfaction with the programme, further improvements can be made, especially to the coordination of care to the patients and professional support to the GPs.

In light of the survey, the programme has launched several new initiatives such as GP clinic visits to update GPs, streamlining the referral processes and increased GP training activities. It is hoped that will further enhancements, the programme will continue to provide patients with a successful mental health service in the primary care setting.

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LEARNING POINTS

- **The GP Psychiatric Programme is a collaboration between general practitioners (GPs) and IMH, for the detection and management of patients with mental illnesses in the primary care setting.**
- **This programme has successfully partnered 50 GPs and referred 894 patients to the GP partners.**
- **It is hoped that will further enhancements, the programme will continue to provide patients with a successful mental health service in the primary care setting.**
- **A survey of the GPs and patients in the programme was carried from June to July 2010. The results show satisfaction and good acceptance of the programme.**