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**GPs and Psychiatrists Working Together
Literature Review**

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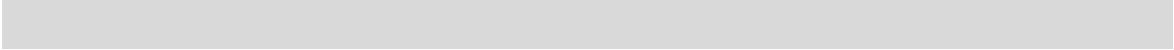
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Index

Background	6
Supply and distribution of psychiatrists: The AMWAC Report	6
Rural and remote considerations	7
The United Kingdom experience.....	7
Psychiatrist consults in GP rooms and manages the patient	8
Consultation Liaison in the UK.....	8
Australian models of GP and mental health service collaboration, consultation liaison and shared care	10
PARC Mental Health Shared Care in Australia 2001 study	10
The Newcastle projects.....	11
Consultation Liaison in Primary Care Psychiatry (CLIPP)	12
General Practice and Psychiatry Partnerships Project (GPAPP)	13
Sustainability.....	14
Other projects at the intersection of general practice and mental health services.....	14
GP Liaison positions	14
Case conferencing pre 2000	15
Case conferencing using EPC items post November 2000.....	16
Telephone advice from MHS Psychiatrists	16
Private psychiatrists and Divisions of General Practice.....	17
Private psychiatrists and consultation liaison	17
Brisbane South Division	17
Royal Brisbane Hospital	17
Adelaide Northern Division of GP joint consultations	18
The St George Model	18
Inner Eastern Melbourne Public and Private Partnerships in Mental Health (Linkages) Project.....	18
Case discussion groups and educational events	19
Peer support.....	20
Balint Groups.....	20
RACGP Quality Assurance and Continuing Professional Development Initiatives	20
Telephone advice.....	21

Telepsychiatry	23
Issues	25
Professional attitudes	25
Organisation, administration and relationships	25
Sustainability	25
Bibliography	27



Executive Summary

This review of the literature covers the ways general practitioners and psychiatrists have been working together over the last fifteen years or so. While some literature from the UK is covered it is primarily Australian in focus.

What has become clear with this review is that General practitioners and psychiatrists do not work in isolation. Both are dependent on systems of remuneration, fee-for-service and Medicare in the case of GPs and private psychiatrists, Government funding from many different 'buckets' for the Divisions of General Practice and State Mental Health funding in the case of publicly employed psychiatrists and mental health workers. Thus working together involves the interaction of professional cultures, systems and bureaucracies, not to mention pharmaceutical companies.

The terminology used to describe the relationship between GPs and other professionals and systems playing a role in the care of a patient, is inconsistent and slippery. What is referred to as 'shared care' in one context is 'consultation liaison', 'collaboration', 'liaison attachment', 'joint consultation', 'case discussion' or 'case conferencing' in another context. There are also a number of different definitions of the terms and several taxonomies which, for instance classify 'consultation liaison' as one variety of 'shared care' or view collaboration and shared care as two ends of a continuum.

This study has looked closely at the relationship whereby a GP is given advice by a psychiatrist on the management of a patient but retains the primary caregiver role. This may include the psychiatrist seeing the patient once for an assessment, the psychiatrist just meeting with the GP, advice by telephone or videoconference, discussion groups for GPs led by a psychiatrist, or advice from a psychiatrist with the mediation of the mental health service. There may be an educative component where the aim is to improve the GPs skills. This is commonly, but not always called 'consultation liaison' (CL). The variety of models used makes comparison difficult however the following findings from the research are noteworthy:

UK studies have shown that

- in comparison with the shifted outpatients model more patients were referred back to the GP for ongoing care (Gask et al, 1997);
- referral to mental health workers in primary care showed a modest improvement in patient outcomes (Gask et al, 1997);
- the CL services were strongly endorsed by GPs and psychiatrists;
- but there is little convincing evidence that CL causes enduring change in GP patient management behaviour (Bower and Sibbald, 2000).

Australian models which have been well evaluated include the Newcastle projects run by Dr Vaughan Carr, the CLIPP program in Victoria, and the GPAPP program in Queensland. Findings from these programs are that:

- the Newcastle project did not bring about an improvement in patient outcomes (Harmon et al, 2000). While patients under CL in GPAPP improved there was no evidence that they improved more than patients having usual GP care. However GP care did not have any adverse effect on patients referred to them by the mental health service (King, 2003).

- there was little improvement in GP knowledge, competence or referral practices in Newcastle (Harmon et al, 2000), In GPAPP there was evidence of GP under-diagnosis of some disorders which did not improve over the life of the project (King, 2003). GPAPP found however reported a subjective improvement in GP confidence.
- CLIPP found good levels of patient satisfaction, improved continuity of care and improvement in the physical health of consumers (Meadows, 1998,1999),
- financial evaluation has shown the CLIPP program to be cost neutral (Meadows, 1999). In GPAPP there was concern that resources were being diverted from the mental health services to service the needs of a group of low priority to the mental health service and this was felt not to be sustainable (King, 2003).

The PARC Shared Care in Australia 2001 study found that relationship building between GPs and mental health services, mutual understanding and familiarity, together with skilled organisation and good communication were the key ingredients for a successful project. Cultural barriers, lack of mutual trust and lack of staff continuity were barriers to be overcome.

All of these programs involved relationships between GPs and mental health services. A few projects organised by Divisions of General Practice have involved private psychiatrists. In some cases psychiatrists provide bulk billed consultation liaison services to GPs during their private practice sessions; in other cases consultation liaison and case discussion groups are funded through project funds or pharmaceutical company sponsorship.

There is limited literature on telephone advice by a consultant to a general practitioner. A number of projects have been carried out by Divisions of General Practice whereby advice is given by MHS psychiatrists. Evaluation is limited and the number of calls varies. There is some anecdotal evidence of reluctance by GPs to contact psychiatrists they do not know. Funding for the service is also an issue and they are typically part of a funded project. The few published articles on telephone advice indicate that payment for consultants providing the advice and medico-legal considerations are the main issues (Jantusch et al, 2000).

Telepsychiatry has a vast literature. Australian studies indicate high levels of patient satisfaction, high inter rater reliability when telepsychiatry and face to face consultations were compared (Simpson et al, 2001), and patient outcomes which were equal to face to face consultations (Ruskin et al, 1998).

Many sources report that both GPs and psychiatrists remain enthusiastic about consultation liaison in its different forms. Numerous consultation liaison projects undertaken by the Divisions of General Practice as part of shared care projects have also reported positive outcomes in terms of subjective improvement in GP knowledge and confidence and positive reception for their programs however outcome evaluations have either not been undertaken, or did not include a control group.

Background

This literature review is about general practitioners and psychiatrists working together in the interest of their patients, how it has been done over the last twenty or so years and what we have learned.

What has become clear with this review is that General practitioners and psychiatrists do not work in isolation. Both are dependent on systems of remuneration, fee-for-service and Medicare in the case of GPs and private psychiatrists, Government funding from many different 'buckets' for the Divisions of General Practice and State Mental Health funding in the case of publicly employed psychiatrists and mental health workers. Thus working together involves the interaction of professional cultures, systems and bureaucracies, not to mention pharmaceutical companies.

Supply and distribution of psychiatrists: The AMWAC Report

The need for a rethink on the ways that GPs and psychiatrists work together has, in part, been prompted by the difficulties GPs have been having in accessing a consultation with a psychiatrist for their troubled patients. The Australian Workforce Advisory Committee on the specialist psychiatry workforce in Australia emphasized in its 1999 report that "access to psychiatrists is inadequate and that three issues have impacted on this situation, namely, an inadequate supply of psychiatrists, maldistribution of the workforce and the work practices of some psychiatrists" (AMWAC, 1999, p 7).

At the time of the report AIHW data indicated that there were 10.6 psychiatrists per 100,000 population in Australia. Above average ratios were found in Victoria (13.4) and South Australia (12.1) while ACT (7.4), Western Australia (7.2), Queensland (8.8) and the Northern Territory (5.3) were below average.

The committee, in a survey of Divisions of General Practice found that " 41.9% of Divisions of General Practice considered access to psychiatry 'specialist treatment' services to be totally inadequate, a further 47.7% considered treatment services to be in short supply, and 5.8% indicated that supply was about right. A greater proportion of rural Divisions considered access to specialist psychiatric treatment services to be totally inadequate than did metropolitan Divisions, while no differences were observed based on State/Territory in which the Division was located" (AMWAC, 1999, P58).

This finding was not limited to the opinions of GPs. After considering the sum of evidence, the committee concluded that the number of practicing psychiatrists is inadequate despite the fact that the numbers are consistent with international benchmarks. The factors leading the committee to this conclusion were:

- "epidemiological evidence of unmet need among the general population and among particular population groups (eg children and adolescents);
- submissions from invited experts indicating serious unmet need among people suffering from a range of psychiatric disorders;
- unacceptably long waiting times for consumers to see a psychiatrist for both an urgent condition and a standard first consultation;
- assessment by State/Territory health authorities and Divisions of General Practice that there was a shortage of psychiatrists;

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- assessment by consumers and carers that access to both public sector and private sector psychiatrists was inadequate;
- maldistribution of the workforce, both by State/Territory and by geographic location, with only 9.1% of the workforce resident in rural areas and evidence that the rural population was using services at a fraction of the rate of the urban population; and
- the number of funded vacancies in the public sector (83), the number of TRDs working as psychiatrists (approx. 28) in 1998 and the number of additional 'consultant' and 'treatment' psychiatrists required to support GPs (approx. 185), as defined by Divisions of General Practice throughout Australia. (AMWAC, 1999 p62)

Rural and remote considerations

The AMWAC report quoted AIHW data which indicated that while there were just under 2,000 psychiatrists practicing in Australia most of these practice in capital cities, with 86.1% of the workforce located in a capital city, 5.4% in a major urban area, 4.9% in a large rural centre and 3.5% in an 'other' rural or remote location. However rural outreach services have been expanding with 14% of metropolitan based psychiatrists providing regular visiting services and/or telepsychiatry services. (Ibid, P52)

PARC has recently undertaken a piece of qualitative research interviewing mental health Program Officers from twelve Divisions of General Practice in remote regions of Australia (Osman et al, 2004). Rural areas were not covered. This, as yet unpublished research found that a lack of psychiatrists is a major problem in remote areas. Many positions in Mental Health Services or hospitals outside the urban areas are unfilled or intermittently filled, and psychiatrists come in on a fly in fly out basis, or need to be constantly traveling to meet all the regional needs. The turnover is high. Divisions complain about the twin issues of no psychiatry services or constantly changing psychiatrists, and in some areas there seems to be underlying culture of distrust between psychiatrists and individual GPs.

Despite the lack of services, telepsychiatry does not appear to be very accessible to GPs with services being run by mental health services and hospitals. Only one of the twelve Divisions is running a telepsychiatry trial, one is talking to the State health department about it and two are waiting for broadband technology. Another had tried videoconferencing psychiatry consultations, but was frustrated by technological limitations and the inhibiting presence of technicians .

The United Kingdom experience

General practitioner and psychiatrist interaction in the traditional form of referral has a long history but the earliest mentions of attempts to find a better way of working together go back to the late 1960s and early 1970s in the UK (Mitchell, 1985) where some UK psychiatrists consulted in GP surgeries. By 1981 the Medical Directory listed approximately one in five psychiatrists as spending some time working in general practices with the majority of these arrangements being initiated by individuals and not by organisations (Strathdee and Williams, 1984). Benefits identified by the psychiatrists included professional satisfaction, improved liaison, earlier referral, prevention of hospital admissions and greater collaboration with GPs. Strathdee and Williams reported a generally high level of enthusiasm and commitment of participants. However, they reported that two thirds of the psychiatrists provided this service in addition to their normal work and argued that this lack of dedicated resources for psychiatrists to work in primary care would almost certainly jeopardise long-term sustainability.

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To understand why this commenced so early in the UK, it must be seen in the context of the structure of the UK health system. UK GPs do not receive fee for service remuneration, but work with capitation based funding and local fund holding. There is a predominance of group practices, with the employment by the practices of staff from a range of disciplines, including counselors and psychologists looking after the health of consumers who are registered with a particular GP (Meadows and Nelson, 1999).

Community mental health centres are run by the NHS through the Mental Health Trusts (which are large decentralised regional outposts of the NHS focused on mental health) and accept patients referred to them by GPs) Most psychiatrists in the UK work in the public sector and therefore do not work within a fee-for-service structure. There are also Primary Care Trusts (NHS outposts managing primary care) and, due to recognition of the need for closer links between primary care and mental health services, there is some indication of a shift towards these taking responsibility for local specialist mental health services and community mental health teams (Department of Health UK, 2001).

This structure underpins the location of mental health workers in the practice and strong links between primary care teams and mental health service teams (Tyrer et al, 1990; Gask et al, 1997). The structure of the group practices and the funding structure make collaboration between primary care and the mental health services reasonably accessible.

Psychiatrist consults in GP rooms and manages the patient

The model whereby visiting psychiatrists operate clinics within GP surgeries has been termed the 'shifted outpatient clinic'. Their practice may be relatively independent of the GP. In their evaluation of various models of working at the interface between mental health services and primary care Gask, Sibbald and Creed (1997) comment that its main benefit may lie in the informal contact between the psychiatrist and the primary care professionals. They quote several UK studies which suggest that this model may reduce admission rates to hospitals but brings about a major increase in the numbers of new patients referred who would otherwise have been treated by their GP alone and that these new patients were not necessarily those who were severely mentally ill. This model made it easier for people to gain access to specialist assessment and treatment.

Gask, Sibbald and Creed (1997) also cited studies which found that patients preferred to attend the primary care clinic rather than a psychiatric out patient clinic and that there was enthusiasm among GPs for this model due to the improved communication, ease of referral and learning opportunities, although they preferred assessment and treatment to be collaborative.

Consultation Liaison in the UK

A seminal and well quoted article from 1981 (Williams and Clare, 1981) suggests three alternative models of GPs and psychiatrists working together: the Replacement model in which the psychiatrist is the person of first contact; the Increased Throughput model, in which more referrals to psychiatrists are encouraged; and the Liaison and Attachment model, which has a number of alternate types of liaison, the shifted outpatient clinic, consultation/advice from a psychiatrist, psychiatrist as educator, and crisis intervention. The Replacement and Increased Throughput models were criticized as unworkable by a number of later writers (Tyrer et al, 1990; Creed and Marks, 1989).

There are a number of different models whereby a psychiatrist provides an assessment and gives advice to the GP on treatment but with the GP maintaining overall responsibility for the patient. In Australia this is commonly referred to as 'consultation liaison' but this terminology

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and Primary Care Mental Health Unit June 2004

covers a number of different models and there does not appear to be any consensus on what 'consultation liaison' means (Bower & Sibbald, 2000). There is considerable variability in whether the GP liaises with a psychiatrist directly or with a mental health service team with access to a psychiatrist, who will provide input as appropriate but is not necessarily the first contact. In the second case this is sometimes referred to as 'shared care' rather than 'consultation liaison', but not always. There is also considerable variation in whether the psychiatrist (or mental health worker) sees the patient alone, in joint consultation, attends a case conference, or discusses the patient with the GP alone. The educational component also varies.

The structure of the UK system supports close working relationships between primary care and mental health services. Tyrer et al (1990) give one example of the team approach and describe a UK project using a "comprehensive collaborative" model designed to devolve as much hospital care as possible to primary care. In this model the team approach was emphasized and primary care team worked closely with the mental health team, with Community Psychiatric Nurses holding clinics in the practice.

Gask, Sibbald and Creed (1997) also emphasize the role of the team in their definition of consultation liaison (CL). They define CL as having the following components:

- Regular face to face contact between the visiting psychiatrist and the GP and other members of the primary care team;
- Referral of patients to the psychiatrist only happens after discussion at the face to face meeting;
- Some episodes of illness are managed by the primary care team without referral to the psychiatrist but after discussion;
- When referral takes place there is feedback to the primary care team.

In contrast, Creed and Marks (1989), also in UK, describe their 'liaison attachment' model whereby a psychiatrist visits the GP to discuss patients, jointly plan management and see a couple of new cases per visit either alone or in joint consultation. Creed and Marks found that this model can enhance the GP's skills and provide supervision and help without requiring a formal referral. They also found it was time effective in that the psychiatrist can provide advice for more patients than could be seen.

There have been a number of evaluations of UK consultation liaison services. Gask, Sibbald and Creed (1997) provide an overview of the evidence from the evaluation of CL. While few evaluation studies had been carried out at the time of writing, they found that in comparison with the 'shifted outpatient' model, a greater number of patients were referred back to their GP for continuing care, (citing Creed and Marks, 1989). They found no studies looking at the impact on GP skills and, while patients liked a shifted outpatients model, their preferences regarding CL had not been explored. Referral to specialist mental health workers in primary care showed a modest improvement in patient outcomes. Their strongest finding was that the services were enthusiastically endorsed by GPs and psychiatrists.

A few years later Bower & Sibbald (2000) reviewed the literature on the educational effects on consultation liaison in primary care which they define as "a relationship between primary care providers and mental health workers that involves ongoing personal contact between the two providers in the primary care context and the use of explicit interventions designed to change the mental health management behaviour of the primary care provider" (ibid, p85). They found that:

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“There is little convincing evidence that CL interventions cause enduring change in PC behaviour, either after the CL intervention has finished or towards patients under the care of the PCW who are not managed directly under a CL intervention.....the present data suggest that enduring change at the level of the PCP may require intervention additional or alternative to those currently utilized in CL models” (ibid, p84)

Australian models of GP and mental health service collaboration, consultation liaison and shared care

Similar to the UK models, the early Australian models also involved liaison between GPs and psychiatrists with the mediation of mental health services. Unlike the UK models, however, the GP is not as likely to be a member of a primary care team. The intersection of the fee-for-service system, under which GPs and private psychiatrists are remunerated through Medicare, and the State funded mental health services, provide additional complications, which Australian systems must negotiate.

The terminology used to describe the relationship between GPs and other professionals and systems playing a role in the care of a patient, is inconsistent and slippery. What is referred to as ‘shared care’ in one context is ‘consultation liaison’, ‘collaboration’, ‘liaison attachment’, ‘joint consultation’, ‘case discussion’ or ‘case conferencing’ in another context. There are also a number of different definitions of the terms and several taxonomies which, for instance classify ‘consultation liaison’ as one variety of ‘shared care’ or view collaboration and shared care as two ends of a continuum. To complicate matters many projects combine a number of different components into a project package. A plethora of projects and programs have been undertaken by Divisions of General Practice. Many of these have been evaluated. The varying components of their projects, environments and methods of evaluation make comparison difficult. This review will therefore concentrate on the findings of the PARC Shared Care in Australia 2001 study (Holmwood, Groom and Nicholson, 2001), to gain an overview of developments, before moving on to look at the evaluation of three of the largest, most comprehensively evaluated shared care programs and a number of alternative ways mental health services and GPs have been working together.

PARC Mental Health Shared Care in Australia 2001 study

Shared care between mental health services and GPs was developed throughout the 1990s by many Divisions of General Practice and in 2001 PARC undertook a major project looking at the current state of development (Holmwood, Groom and Nicholson, 2001). The project surveyed Divisions of General Practice, performed a review of the literature and interviewed the Development and Liaison Officers of the Primary Mental Health Care Initiative as well as twenty health professionals working in mental health shared care programs in three states. The project found that there was a broad range of activities which Divisions had developed to better integrate and coordinate mental health care and that there was a continuum of levels of engagement with shared care. At the time of the project around 20 Divisions were involved at the level of having discussions and relationship building, 23 Divisions were developing tools for communication, or better referral and discharge and another 20 had developed structured shared care programs.

The project found that:

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“ what can be regarded as “shared care” in this context varies somewhat but the following usually apply:

- There is agreement between groups regarding roles and responsibilities of each group and communication.
- There is adequate support for GPs involved and they in turn provide assistance with aspects of consumers’ care that previously were not well attended to e.g. general medical care.
- There are agreed processes for movement of consumers between professionals.
- These movements are based on consumer needs.
- On-site visits are conducted in GP's practices.
- Consultant psychiatrists provide assistance with one off consultations.
- Mental health workers are available for case conferencing and care planning with GPs.” (Holmwood, Groom and Nicholson, 2001)

Shared care programs require a great deal of organisation and collaboration between Divisions of General Practice and mental health services. Organisational issues can sometimes influence the success of the project. Cultural barriers are common, since the two services developed in parallel and therefore evolved separate organisational structures and processes for caring for consumers/clients. The power relationships, role boundaries and methods of communication that exist between the two groups are thus very different. These differences often lead to both practical and theoretical misunderstandings, turf wars and fears of deskilling and role loss.

A high level of trust and co-operation was thus mandatory to any successful shared care arrangement and the findings showed strongly that personal interaction and time to establish relationships underpins successful collaboration. This meant that people needed to have time built into work schedules which would allow the two groups to meet together both formally and informally.

The project found that funding to employ a person to coordinate the project was vital as was putting channels of communication into place. Memoranda of Understanding were also starting to be developed which formalized the responsibilities of the two organisations within the shared care relationship.

For more detail please see the PARC Review of Shared Care 2001 available on the PARC website <http://som.flinders.edu.au/FUSA/PARC/Publications>

The Newcastle projects

One of the earliest Australian consultation liaison (CL) projects was that developed by Dr Vaughan Carr and his team in the Newcastle area from 1989. The term ‘Consultation Liaison’ applied to general practice at this time aroused some controversy. Gribble in an exchange of letters in the Australian and New Zealand Journal of Psychiatry (1998) defined CL as

” a subspecialty of psychiatry involved in the diagnosis, treatment, study and prevention of morbidity in physically ill patients and those who somatise, and the provision of psychiatric consultation, liaison and teaching for non psychiatric health workers in all types of health setting, but specially the general hospital” (Gribble, 1998 p311)

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The term was firmly used at this time to refer to general hospital psychiatrists consulting on general hospital patients with medical conditions and is still used as such. This form of consultation liaison psychiatry however appears to be in crisis due to the trend towards the early discharge of patients, the employment of psychologists in a number of specialized areas and the fragmentation of the discipline caused by specialization (Smith, 2003; Macleod, 2002). Gribble criticizes Carr for his wrong use of the term to refer to psychiatrists providing advice to general practitioners. In the same volume Carr replies that: "general hospital consultation liaison is particularly vulnerable in these days of decreasing lengths of hospital stay and the rise of day procedures" and argues for a shift in CL psychiatry to ambulatory care including primary care, saying that it is not 'whether' but 'how' CL psychiatry should develop greater involvement with GPs.

Carr's consultation liaison project promoted greater links between GPs and mental health services. It involved psychiatric registrars attending GP practices weekly to assess patients and to prepare management plans with GPs. Harmon et al (2000) describe the early stage of this project as having weaknesses because there was no effect on patient outcomes with patients with mild to moderate illnesses, excess time was spent on patients with mild illness, there was no improvement in GP knowledge, competence or referral practices and it did not facilitate GP involvement in the care of the patients in the mental health service. Carr, in an earlier article (1997) himself expressed doubts about the overall benefit of this CL service relative to usual GP care. He recommended that in order to be effective the CL service needed to be augmented by better links with the mental health service and improved GP education.

In a move away from 'consultation liaison' in 1998 a revised 'Integrated' model was put into place in Newcastle for a six month trial period (Harmon et al, 2000). The new model identified a nurse from the mental health service, working under the supervision of a psychiatrist who would accept patients referred by the GPs and provide assessment and feedback to the GPs regarding diagnosis and management, provide short term counseling or psychotherapy and case management in partnership with GPs and perform a liaison function which facilitated communication, co-ordination and bi-directional referral between GPs and mental health services. Two experienced nurses performed this function for 23 GPs from 8 practices. The service was well received, with GPs maintaining a central role in provision of care and as de facto case managers. GPs appreciated the accessibility of the nurses for information, advice and referral. Another finding was that patients with a wider range of conditions and with greater severity were treated.

Consultation Liaison in Primary Care Psychiatry (CLIPP)

A literature review in this area would not be complete without a look at the highly influential Consultation Liaison in Primary Care Psychiatry (CLIPP) service developed by Dr Graham Meadows in North Western Melbourne (Meadows, 1999). The CLIPP model aims to facilitate effective collaboration between GPs and mental health services and includes:

- visits by a MHS psychiatrist to GP practices for a single consultation with selected patients, with feedback and advice to the GP, who retains responsibility for the patient's care;
- shared care between mental health services and GPs facilitated by a liaison case manager who oversees the handover and transfer of patients from mental health services to GPs;

- a case manager, located at the mental health service, who monitors patients, provides case tracking and continuity;
- review of patients, six monthly to yearly, by a MHS psychiatrist at the GP's surgery.

The CLIPP model has been highly successful, achieving patient satisfaction, good levels of continuity of care and improvements in the physical health of consumers (Meadows, 1998, 1999) and a financial evaluation has shown the program to be cost neutral when compared with usual care by mental health services. CLIPP has been widely adopted elsewhere, notably the General Practice and Psychiatry Partnerships Projects (GPAPP) in Queensland.

General Practice and Psychiatry Partnerships Project (GPAPP)

The General Practice and Psychiatry Partnerships Project (GPAPP) was a four year program funded by Queensland Health between 1999 and 2003. It was designed :

”to develop and implement collaborative ways of working between general practitioners and mental health service providers, which were both cost effective and sustainable and would result in improved quality and continuity of care for mental health consumers in Queensland.” (QDGP, 2003)

The program had a Statewide component which provided a focus for the development of collaborative working structures between GPs and mental health service providers across the State and three pilot sites one metropolitan, one provincial and one rural and remote. The GPAPP Pilot programs and their outcomes are described in the GPAPP Program Implementation Report (QDGP 2003).

The Metropolitan pilot trialed two models: a consultation liaison model based on the CLIPP Manual, in which a psychiatrist visited GP practices to consult around patients being managed by the GP with the aim of promoting skills development and improve relationships between the GPs and the mental health services, and a Transfer Model which involved the transfer of suitable consumers from the mental health service into GP care. Funding was provided to remunerate a part time psychiatrist, who conducted three consultation liaison (CL) sessions per week, and a GPAPP Coordinator located at the mental health service (MHS). In some cases a private psychiatrist was employed sessionally.

The project found that the use of MHS consultant psychiatrists provided more consistency, the opportunity for better relationship building, better communication and joint decision making between the nurse GPAPP Coordinator and the Psychiatrist and the programs were implemented more rapidly and with less difficulty. The metropolitan pilot was complex to administer and coordinate, experienced disruptive staff turnover and required a long period whereby all involved became familiarised with the project and developed working relationships.

The evaluation of the Metropolitan Pilot (King, 2003) found that:

“GPs reached similar diagnoses to psychiatrists in most disorders but there was evidence of GP under diagnosis of organic, somatiform and substance use disorders. There was no evidence that quality of GP diagnosis improved across the life of the project. At six month follow up. CL patients were significantly improved but there was no evidence that patients who had a psychiatrist consultation improved more than patients who received usual GP care.” (King, 2003 p4)

King found that psychiatrists were positive about the CL service and rated it as having both clinical and educational value, but qualitative data was not available from the GPs.

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Data from the Implementation report however (QDGP, 2003) showed very positive responses by GPs to the educational component of the CL service, with GPs feeling better supported and reporting an increased competence. There was no evidence that CL improved patients' mental health any more than usual GP care but neither did GP care have any adverse effect on the mental state or level of disability of patients transferred to the GP. Relationships between GPs and MHS improved and patients were generally satisfied.

The Provincial Pilot was a multifaceted approach to facilitating shared care with an emphasis on developing relationships, developing protocols for collaborative mental health care, and providing GP education. This pilot was seen as very successful due to the commitment and energy of the Steering Committee which is continuing to meet beyond the GPAPP project in order to oversee integration across the mental health sector.

The Remote Pilot included consultation liaison visits by Brisbane psychiatrists to GPs, GP education, videoconferencing equipment, and increasing collaboration and improving communication processes between GPs and mental health services. The evaluation reported a substantial change in mental health service culture and practices with greatly improved communication.

Sustainability

The Evaluation of the GPAPP projects (King 2003) indicates that under the funding model used in the Pilot, the consultation liaison model does not appear to be sustainable as it requires a dedicated resource to be allocated from the public sector to GP practices. This resource is allocated to a patient group which is not high priority for the public sector and there is no cost recovery. There is no evidence that the model increases the rate of patient recovery. King also states that consultations are used by GPs to further their clinical skills but this is an inefficient means of achieving this end and that only a minority of GPs are using the consultation as a learning opportunity.

King believes that the Patient Transfer model is potentially more sustainable as many patients do not need specialist services and are able to be managed by their GP. The project has shown no evidence of adverse outcomes for these patients compared with mental health service care, although he expressed concern about the high rate of attrition of patients transferred under GPAPP.

Other projects at the intersection of general practice and mental health services

GP Liaison positions

In order to facilitate better communication and coordination between GPs and mental health services a number of Divisions of General Practice are providing GP Liaison positions within mental health services. There is very little information or literature available about how successful this is in mental health but the PHCRIS Activities of Divisions database records that at least 30 Divisions mention mental health GP Liaison Officers in their business plans.

While their focus was not exclusively on mental health, Lissing and Powell Davies (2000) studied the way in which GP-hospital Liaison Officer positions currently work and evaluated the impact of the positions on the relationship between GPs and hospitals. The main findings were that:

- most GPLOs are GPs working part time;

- more than 60% of positions have been in existence for less than 3 years and have no written plan, committee or support structure;
- funding comes mainly from the Divisions but most positions are located in a hospital;
- most saw their time being most effectively used when focusing on developing systems and relationships than on solving individual problems;
- key informants saw the role as being a facilitator of communication;
- problems included lack of understanding and poor communication between hospitals and general practice;
- it was easier to impact on an organisation than upon individuals therein;
- a need was seen for making the positions more permanent with greater internal supports.

Case conferencing pre 2000

The term 'case conferencing' has been used in a number of senses in the project literature. In some cases it overlaps considerably with consultation liaison in that the GP and one or more other professionals, who may be a psychiatrist or a mental health worker, meet to discuss the management of a patient for the purpose of patient management. Prior to the launching of the Enhanced Primary Care Medicare item numbers in November 1999 case conferencing of this nature was funded through Commonwealth or State project funding. An example of this is the South Australian Divisions Inc Case Conferencing Project between 1997 and 1999 (PARC ID 689, 697, 575). In this project regional case conferences were organised between GPs and mental health services (mental health workers or psychiatrists) by an administration officer. 18 case conferences held over 15 months.

In other cases, 'case conferencing' refers to a gathering of GPs with a psychiatrist or other facilitator with an educative purpose. An example of this is the Logan Area Division of GP 1996 Case Conferencing Project, also Commonwealth funded, (PARC ID 700, 528) in which a series of six case conferences were organised by the Division between 12 GPs and two psychiatrists. In these sessions a patient was interviewed by a psychiatrist in the presence of the GPs. Discussion of the case followed. Additional aims of the project were to enhance relationships between GPs and the mental health service and to promote the shared care of jointly managed patients. Evaluation showed improvements in the GPs subjective confidence and knowledge. This project was also an important precursor of a later shared care project and helped to build the relationships which made the later project successful.

Another project was run, with Commonwealth funding, by Northern Queensland Rural Division of GP from 1998 (Alsop et al, 2000). The aim of this project was to increase collaboration between GPs and the mental health service and provide education in mental health management for GPs and mental health service staff. Case conferencing discussion groups were held in a number of regional towns in the area. GPs were invited to present cases for discussion by the group which included a psychiatrist from the mental health service. While GPs believed it was essential that a psychiatrist attend sessions, the shortage of psychiatrists and their commitments in visiting rural communities meant that this was not easy to achieve.

These projects have in common an advice on patient management component, an education component and a relationship building component, linking them with ideals of collaborative or shared care. They are also all accomplished with dedicated project funding.

Case conferencing using EPC items post November 2000

In November 1999 the Commonwealth Government introduced a new range of Medicare Item numbers as part of a new Enhanced Primary Care Package, which included health assessments, multidisciplinary care plans and case conferences. A case conference is intended to include the patient, the GP and two other care providers from different services (RACGP website , www.racgp.org.au/folder.asp?id=556).

A number of writers have questioned the utility of the item numbers for case conferencing. Uptake of the items has been poor. Mitchell et al (2002) undertook a study to find out why, giving figures that, in 2001, 11,095 case conference item numbers were claimed compared with 1,555,486 multidisciplinary care plans over the same period. Focus groups were held with 29 Queensland GPs during 2001. Findings were that:

- GPs found it hard to justify the effort in organizing and participating in case conferences compared with the informal telephone liaison already done regularly;
- there was confusion over the rules applying to MBS item numbers;
- there was concern that patients would be reluctant to be billed for a service when they were not present;
- and it was difficult to arrange times and locations for case conferences, particularly when physical attendance was required.

Harris (2002) in an editorial to the Medical Journal of Australia agrees that it is difficult to synchronize times when all participants are available but adds that, while GPs and private physicians are remunerated for the case conference, allied health professionals and non government organisations such as HACC are not and have conflicting demands on their time. Harris also comments that consultation liaison, case management and even two separate phone calls may achieve many of the same objectives as a case conference. Harris concludes that the answer lies in developing integration between health services, as the difficulties in implementing case conferencing may be a demonstration of the lack of effective multidisciplinary team building in primary care. Case conferencing not only facilitates integration, it depends on it.

The EPC items focus solely on the case conference planned to coordinate patient care. It does not have an educational or relationship building component. A number of Divisions have harnessed the EPC items as a means of funding case conferencing as part of a wider shared care program. Divisions which have done this include Adelaide Northern (PARC ID 930), Canning (PARC ID 1012), Fremantle (PARC ID 1218) and Hunter Rural (PARC ID 1021).

Telephone advice from MHS Psychiatrists

No reports or articles are available on telephone advice provided by mental health services psychiatrists to GPs although the Illawarra and Sutherland projects (below) are written up in the 2003 Alliance of NSW Divisions publication *State of the Art*. The following projects are those we know about:

- ACT Division of GP: MHS provides a psychiatrist for telephone advice to GPs and one off patient assessment.

*Primary Mental Health Care Australian Resource Centre
and Primary Care Mental Health Unit June 2004*

- Southern Adelaide Division of GP : Telephone support from the MHS and CAMHS
- Central Highlands Division of GP: MHS provides telephone advice. Evaluation suggests that low use is due to GP reluctance to contact strangers for advice.
- Central Coast Division of GP: MHS offers an advice line during business hours.
- Sutherland Division of GP: MHS sets up a teleconference with ten lines for one hour per week. GPs can call in and contribute to a group discussion during which they can obtain advice. GPs didn't use it to a great extent and the service had only 32 calls in 27 weeks.
- Illawarra Division of GP: MHS provides phone support for one hour per day Monday to Friday. Patient's name is not provided and it is not intended for referral or assessment. The cost is borne by the MHS but private psychiatrists are sometimes used to provide the service.
- Murrumbidgee, Border, Riverina and Murray Plains Divisions of GP jointly run a Telephone Consultancy Service in alcohol and other drug support for GPs. The project coordinator receives the calls and is responsible for facilitating a speedy response including arranging referrals, making appointments, providing information and liaising with an expert providing clinical support. Feedback from GPs using the service is very positive (from PARC Update newsletter March 2004, Issue 10).

Private psychiatrists and Divisions of General Practice

Private psychiatrists have been involved in many projects run by the Divisions of General Practice. In many cases mental health services or Divisions employ private psychiatrists, using project funding, to participate in consultation liaison visits, telephone advice services, and various educational initiatives.

Private psychiatrists and consultation liaison

Brisbane South Division

A good example of a project using private psychiatrists is one run by Brisbane South Division (described in their newsletter Southside Snippets in May 2004). Eight psychiatrists employed by the Princess Alexandra Hospital will see patients referred by GPs during their private practice sessions. All patients are bulk billed. The service is for non urgent psychiatric assessment and management opinion. The psychiatrist does not provide ongoing management and the GP will provide ongoing care.

Royal Brisbane Hospital

A similar "Psych Opinion" project is being run by the Department of Psychiatry at Royal Brisbane Hospital (Emmerson et al, 2003). In this project five full time psychiatrists from the Royal Brisbane Hospital set aside one hour per week to assess, but not treat, patients referred by local GPs. All patients are bulk billed and GPs receive a typed assessment of the patient which clarifies a diagnosis and provides management advice. The psychiatrist will speak with the GP on the telephone if indicated. The service is available with a one to two week wait.

Adelaide Northern Division of GP joint consultations

Adelaide Northern Division Shared Care project commencing in the mid 1990s (Paterson et al, 2000) involved a number of related activities. These were: case conferences using the MBS items, clinical attachments, lunchtime clinical meetings, continuing medical education, and "joint consultations" which in the context of this review is being considered as "consultation liaison" as the psychiatrist visited the GP, saw the patient in a joint consultation and then discussed treatment options with the GP. The project worked with the mental health services who allocated one session per week of psychiatrist time. However the project also funded a session of private psychiatrist time per week. Both the GP and private psychiatrists were paid by the project for the consultation as EPC items were unable to be used due the consultation only involving two practitioners. Evaluation showed improvements in the mental health of patients seen under the program but the sample was small and there was no control group.

The St George Model

The St George Division of Psychiatry and Mental Health is part of the St George Hospital and services South Eastern Sydney. This project (Paton et al, 1999) involved integration between the inpatient unit, GPs and a private psychiatrist who set aside sessions for patients referred. Patients discharged from the hospital had ready access to the mental health team for crisis assessment, but routine care was undertaken and coordinated by the GP with assistance from the private psychiatrist. This freed public psychiatrist time to attend to acute assessments. The psychiatrist and the mental health service maintained a close working relationship so that referrals back to the service could be easily achieved and continuity of care could be maintained. This occurred because the psychiatrist working on the project was previously part of the public sector but set up a private practice for the project. Some patients were bulk billed by the psychiatrist but this could not be extended to all patients and the project recommended exploring other ways to fund a co-payment.

Inner Eastern Melbourne Public and Private Partnerships in Mental Health (Linkages) Project

This project (Pirkis et al, 2004) aims to improve linkages between the public mental health system, GPs and private psychiatrists. There are a number of components to the project including supervision and training of mental health staff, discussion groups for GPs, case conferencing and consultation liaison or joint consultations with private psychiatrists for GPs. Activities are coordinated by the Linkage Unit, which is located in the mental health service. Funding allows for private psychiatrists to submit invoices to the program for program related work. This area in the inner eastern suburbs of Melbourne has a high number of private psychiatrists per capita, however the evaluation indicates that there are still long waits for appointments with psychiatrists, and private psychiatrists are having difficulty getting patients admitted to inpatient units. The evaluation also found that there were major professional cultural barriers to be overcome (Gill, 2003)

"The planning phase encountered resistance and skepticism from some groups particularly from some private psychiatrists, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and some public sector clinicians. As indicated in the Final Evaluation Report, there was considerable fear and misunderstanding that this Project was about introducing "managed care" and that consumers with complex mental health needs would be "dumped on" the private psychiatrists. Many in the public sector had doubts that private psychiatrists had appropriate skills for involvement with public patients. Overcoming these misunderstandings to engage stakeholders in the project took considerable effort throughout the Project, from the planning phase and through the full 2-years of

Primary Mental Health Care Australian Resource Centre

and Primary Care Mental Health Unit June 2004

implementation. In the public mental health service there was also resistance and misunderstandings from some staff about the project and its impact on them." (Gill, 2003 p 4)

The evaluation (Pirkis et al, 2003) was cautiously positive however that during the course of the project significant headway had been gained leading to increased understanding between public and private sector providers. "By altering systems and structures, changing attitudes and behaviour, fostering inter-sectoral relationships, and linking with existing and future activities, the Project has maximised the likelihood of its achievements being sustained beyond its life (although there is an acknowledgement that strong leadership and commitment will be necessary for current gains to continue)." (Pirkis et al 2003)

Case discussion groups and educational events

Both public and private psychiatrists participate in a number of different types of groups in which GPs participate. Groups can be convened for a number of different purposes. As described above, groups can focus on clinical advice, case coordination, relationship building, GP education, supervision or on peer support. Groups can also be funded in a number of ways. Case conferencing, if purely for case coordination, can be funded through the EPC item numbers (Canning, PARC ID 1012; Hunter Rural PARC ID 1021; Adelaide Northern PARC ID 930), if it also involves relationship building and education it may be funded as part of a funded shared care, case conferencing or consultation liaison project, or through Divisions' core funding (Riverland DGP, PARC ID 1074).

Private psychiatrists present different funding problems to Divisions when their role is not specifically related to patient care. Case discussion groups or seminars, led by a psychiatrist for the purpose of education, are very popular among GPs and are organised frequently by Divisions of General Practice. There are also examples of groups which operate independently of Divisions. Methods of funding the psychiatrist's time are not often reported however the PARC Electronic Library has the following records.

Many groups are organised as part of funded shared care programs with mental health services, as described above.

Other groups and events are funded by Divisions from core funding (Riverland PARC ID 1074; Mid North Rural SA PARC ID 1071).

There are examples where a psychiatrist donates their time to the group (Mornington Peninsula, PARC ID 1114) or is paid an honorarium (Northern Sydney PARC ID 965).

A greater number of CME and case discussion groups however are, or have in the past, been funded by pharmaceutical companies (Adelaide Southern, PARC ID 1065; Barwon, PARC ID 1033; NW Slopes, PARC ID 1031; NSW Central West PARC ID 504; SE NSW PARC ID 1089; Sunshine Coast, PARC ID 1085; Western Sydney, PARC ID 1027; Knox PARC ID 553; Central Sydney, as documented in *State of the Art* by NSW Alliance of Divisions).

Pharmaceutical companies also fund visits to GP surgeries by psychiatrists for educational purposes (Adelaide Central and Eastern, PARC ID 1040)

The extent to which GPs are paid to attend case discussion groups is unrecorded and therefore unknown, but it is believed that a proportion of Divisions fund GP attendance through project or other funding.

Peer support

In late 2001, as part of a project undertaken by PARC looking at the potential for peer support for GPs providing mental health care, (Jackson-Bowers and Holmwood, 2001) Development and Liaison Officers from the Primary Mental Health Care Initiative were asked to compile information on the range of peer support activities in their home states. Details of what was happening in each state were sketchy and incomplete; however a collation of the information provided indicated that nearly all groups are led by a psychiatrist and that the vast majority focus on case discussion. Case discussion type groups outnumber Balint Groups 2:1.

There were single examples only of groups that focused on journal reading, reflection/discussion or cognitive behaviour therapy. Only a few groups were led by a psychologist, Mental Health Worker or GP Mentor. Payment for the group was infrequently reported. However there were two examples of groups being subsidised by a drug company, one where the GPs share the full cost of the psychiatrist's time and another where a mental health service pays the psychiatrist and the Division pays the GPs for their time.

In 2002 the Commonwealth made Incentive Funding available through the Primary Mental Health Care Initiative for Peer Support Groups however information on the extent, type of group or success of these groups has not been collated.

Balint Groups

Balint groups were initiated by Dr Michael Balint - a psychoanalyst in London during the 1950's. He worked with groups of GPs to discuss the psychological aspects of their patients' illnesses and the impact that working with these particular people and their problems was having on the GPs. Unlike a case discussion group, the Balint group, which is traditionally run by a psychiatrist, concentrates only on the relationship between the presented patient and his/her doctor. Unlike a support group, Balint groups do not consider the GPs personal difficulties in relation to colleagues, family or personal psychological history.

Balint groups recognise that a doctor is a person and that he or she can find some cases personally troubling. Some do not cope well with difficult and distressing matters, some exhibit defensive behaviour, some become overwhelmed, others over-identify with the patient or exhibit inappropriately cheerful behaviour. (Samuel 1989)

While PARC are aware of at least six Australian Balint Groups, the extent of Balint groups in Australia is unknown. However there are some enthusiastic exponents among Australian psychiatrists and GPs. (See the PARC newsletter PARC Update Issue 8 October 2003.)

RACGP Quality Assurance and Continuing Professional Development Initiatives

All general practitioners who are Fellows of the RACGP recognised by the Health Insurance Commission as Vocationally Registered medical practitioners have a legislative requirement to participate in, and meet the minimum requirements of the RACGP Quality Assurance and Continuing Professional Development Program.

The aim of the program is "to assist general practitioners in Australia maintain and improve the quality of care they give to patients and guarantee the highest possible standards of care to the community" (RACGP 2001)

Of relevance to this review is the RACGP Small Group Learning option. "Small Group Learning" is a process by which groups of GPs utilize peer support, interaction and reflection to enhance their own clinical competence (knowledge, skills and attitudes) and performance" (RACGP 2001). Characteristics of these small groups are that they consist of 4 to 10 GPs with a facilitator. It is not known how many of these facilitators are psychiatrists, but PARC is aware of at least one Division (Adelaide Southern Division) which has groups for GPs attended by a psychiatrist.

Telephone advice

While there is a large body of work exploring the use of telephone advice lines and consultation by patients with doctors, there is little about the use of the telephone for consultation between general practitioner and specialist.

There is a growing body of literature around telephone triage services, particularly since the advent of NHS Direct in the United Kingdom. NHS Direct offers a one-number contact for patients to access advice from nurses who use automated decision support software. In 2006 it will become an integrated service and respond to 16 million calls a year.

Research has indicated that NHS Direct provides improved access for white middle class patients. (Chapman, Zechel et al. 2004; Ring and Jones 2004) The evidence also supports the reliability of using nurses instead of medical practitioners, but does suggest that there is no reduction in general practitioner workload. (Chapman, Zechel et al. 2004; Mark and Shepherd 2004) There is however concern that special populations of patients require specific services. It has been suggested that nurses with paediatric experience should provide advice to parent ringing about children. (McLellan 2004) The proportion of patients who follow the advice is surprisingly low. Just under two thirds (64.2% of callers) of patients advised to go to Accident and Emergency Departments proceeded to do so. (Foster, Jessopp et al. 2003)

Telephone triage has been evaluated in other areas. An analysis of the impact of nurse triage in a United Kingdom general practice revealed the rate of general practitioner consultation was unchanged. (Richards, Meakins et al. 2004) The same study indicated an associated increase in the complexity of the consultations by the general practitioner.

Several studies have examined telephone triage in paediatric practice. Generally there was little difference in the rate of following nurse or paediatrician advice, (Lee, Baraff et al. 2003) nor was there increased delay in seeking advice after discussion with nurses. (Lee, Baraff et al. 2003)

The only negative finding has been around the use of non-medically trained answering services for out of hour's calls. Relying on the patient to determine the acuity of a problem resulted in errors in about 50% of calls. (Hildebrandt, Westfall et al. 2003)

Bacon, from La Trobe University School of Nursing, reviewed the use of telephone triage by nurses for mental health problems in emergency departments. He notes there has not been any research comparing nurse triage with that of medical practitioners, although in other areas there are suggestions that nurses are at least as effective, if not superior in their assessment. He argues strongly for a high level of orientation of the triage nurses to the local area, particularly to other services available in the region. Bacon also raises issues of medico-legal responsibility and explores some of the ramifications and possible methods to overcome the limitations – mainly protocols and training.

*Primary Mental Health Care Australian Resource Centre
and Primary Care Mental Health Unit June 2004*

Web and telephone counselling were discussed in a recent editorial in the Medical Journal of Australia. (Christensen, Hocking et al. 2004) The editorial highlighted the rapid growth in the use of the internet and the telephone in allowing patients to access advice and to monitor patient progress. The authors note that most of these services sit outside the medical system and in many ways have created a parallel system to medicine. They argued for closer contact between crisis lines and medicine.

Car and Sheikh have written extensively on the skills required by doctors to hold telephone consultations with patients. They summarised the literature (Car and Sheikh 2003) in 2003 and highlighted the patient convenience and possible cost savings of telephone consultation. They also noted the evidence of patient and practitioner satisfaction, but did not note the practitioner concern about medical-legal issues. The authors recommended documentation of all telephone consultations.

In a separate paper (Car, Freeman et al. 2004) they argue that telephone consultation should be part of training in the medical profession and that the training should be specific to the specialty.

There have been few documented programs where consultation between general practitioners and consultants by telephone has been analysed. In 1994 Power and Williams (Power and Williams, 1994) reported on the rural access line established in Western Australia. The service was based at Fremantle Hospital and provided immediate access to hospital staff for rural general practitioners. On most occasions the consultant took the call, although occasionally a junior registrar was required to respond. Over 90% of general practitioners found the advice potentially reduced the need for referral. All general practitioners were positive about the service and did not feel it would impact on regionally developed referral patterns. The consultants were all in favour of continuing the service. Psychiatry was not included in this service.

In 1996 Connor et al (Crocker, Burns et al. 1996) described a statewide service in New South Wales to provide telephone advice to health professionals about drug and alcohol problems. They also indicated a similar service had been established in Victoria in 1994. The NSW service used an 1800 number and provided prompt response. Eighty two percent of the 110 practitioners who rang for clinical advice reported that the clinical situation had evolved as predicted by the consultant. Where the evolution had been different, further advice had been sought. Most (97%) of the practitioners would use the service again and 98% would recommend it to a colleague.

Kates et al (Kates, Crustolo et al. 1997) described a service in Canada where a psychiatrist visited 5 family practices fortnightly and also provided an emergency/urgent telephone service for the practices. The five practices had 18 family physicians and also provided a counselling service in each practice. Over a 12-month period the psychiatrist received 128 calls, 84 (63%) from family physicians. Fifty of the calls related to patients in crisis or urgent situations. Of the remaining, 48 calls related to patients not previously seen by the psychiatrist and related to medication issues (27), other management issues (15), and community resources (6). The presenting problems for the non-urgent calls were depression (22), psychosis (15), family problems (13), organic brain syndrome or dementia (8), hypomania (3), eating disorders (3), and other (10).

The average duration of a telephone call was 8 minutes. The majority of calls (116) were responded to on the same day, ten on the next day and two within 48 hours. The results of the service were highly positive, but arose in an unusual situation where the psychiatrist visited the practices on a fortnightly basis.

Hollins et al (Hollins, Veitch et al. 2000) reported on the “utility and satisfaction with telephone consultation” between general practitioners and consultants. The study was carried out in northern Australia and the general practitioners all practiced in rural environments. There were a limited number (15) of calls analysed. Both general practitioner and consultant supported the process of telephone consultation. General practitioners indicated the choice of specialist was a major factor influencing satisfaction. Consultants who visited the town of the general practitioner were preferred. Ease of access and ability to influence admission of patients also rated very highly.

A recent article (Jantusch, O'Donnell et al. 2000) reviewed a physician access line (PAL) established in the Children's National Medical Center (Washington DC) for paediatric infectious disease. The PAL received 320 calls in seven months and was well supported by users. They raised two significant issues, funding and liability. They noted that funding was an issue, as the use of PAL did not lead to a reduction in referrals. The legal liability issue is informed by a legal case in the USA where a “kerbside” consultation between two doctors occurred and the patient had a poor outcome. The courts decided that the doctor asked to provide advice was offering it to a professional who was managing the patient. The primary treating doctor was found to be responsible for implementing any changes to management. The court concluded, “... it does appear ... that curbside consultations are useful, desirable and generally legally safe.”

The final paper reporting direct consultation between consultant and general practitioner examines the use of telephone reporting of findings. (Haldis and Blankenship 2002) The authors discussed telephone reporting of the results of cardiac catheterisation to primary care physicians (PCP) by telephone. Contact with the PCP was made in about two thirds of attempts. Only 4% of PCPs declined interruption to take the call. The average duration of the call was about 4 minutes and 86% of PCPs were very pleased or pleased with the service with only 5% regarding the telephone calls as an interruption.

The literature indicates widespread use of telephone consultation, particularly between patients and health care providers. Overall the evidence indicates positive outcomes and strong support for patient initiated telephone consultation. The major issue that is unresolved relates to medico-legal issues arising from the advice offered.

There is a limited literature relating to telephone consultation between consultant and general practitioner. What literature exists indicates a high level of satisfaction and efficiency from such a method. The main issue is payment for the consultants providing the advice. The medic-legal status appears more safe following protection of the advisor in the courts in the USA.

There is support in the literature for using advice based on knowledge of the local region. This is particularly so in relation to consultation between general practitioner and specialist.

Telepsychiatry

Telepsychiatry is the conduct of a psychiatric consultation through videoconferencing where the patient and psychiatrist are in different sites. It has generally been used where there are large distances between patient and therapist, particularly between rural and urban centres. It has also been used in the United Kingdom between urban general practices or community mental health services and central psychiatric services.

The largest collection of information about telepsychiatry is contained in the Telemedicine Information Exchange (TIE) (<http://tie.telemed.org/>). This contains the Telemedicine Bibliographic Database (<http://tie.telemed.org/biblio/>) which currently contains 14,997 citations. The database was last updated in January 2004. Other areas of the TIE site are updated more frequently.

There is a vast literature concerning telepsychiatry and the following primarily reflects that which is relevant to Australia. A review of telepsychiatry services in 2001 (Lessing and Blignault 2001) indicated 25 separate programs around Australia. Many have described the establishment of such services (Kavanagh and Hawker 2001; Sjogren, Tornqvist et al. 2001; Tucker, Segal et al. 2001; Yellowlees 2001; Hawker 2003) with most indicating a difficult implementation with the requirement for significant training of general practitioners and psychiatrists and the necessity of obtaining support from the services managing mental health problems.

Telepsychiatry has been used successfully in rural Australia (Lessing and Blignault 2001), Sweden, (Sjogren, Tornqvist et al. 2001) Canada, (Simpson, Doze et al. 2001) the United States of America (Ruskin, Reed et al. 1998) and inner city London. (Bose, McLaren et al. 2001) Networks have also been used for supervision and teaching. (Yellowlees and Kennedy 1996; Starling, Rosina et al. 2003) Specialised services in child and adolescent psychiatry have also been established. (Dossetor, Nunn et al. 1999; Gelber 2001)

More recently studies have examined acceptability to practitioners and patients, diagnostic accuracy and outcomes. Acceptability by referrers has been high as indicated in a study of 28 rural general practitioners and 30 Rural Community Mental Health workers in South Australia reported by D'Souza. (D'Souza 2000) He concluded as follows.

“The use of telemedicine for assessing and managing psychiatric patients in rural and remote areas is greatly appreciated by the providers of health care. Telemedicine has an important place in the provision of psychiatric clinical practice ... in rural and remote areas.”

General practitioners have rated assessment more useful than ongoing management. (Clarke 1997) Studies have also indicated high levels of patient satisfaction. (Ball, McLaren et al. 1995; Simpson, Doze et al. 2001) The Simpson et al study indicated 89% satisfaction with the process and 29 of 31 patients “preferred telepsychiatry to waiting for a consultation”, and would use the service again. Twenty-five of these patients would prefer telepsychiatry to travelling for a consultation, 15 would prefer face-to-face consultation. Ruskin et al (Ruskin, Reed et al. 1998) report a complex study where two psychiatrists each interviewed 30 patients. Fifteen patients had one of these interviews conducted using telepsychiatry. Inter-rater reliability was high and almost identical between in-person and remote interviews. Ten of the 15 subjects who had a remote interview preferred the face-to-face interview while 5 had no preference. Twelve of the fifteen would prefer the remote interview with a psychiatrist to an in-person interview with a general practitioner. The authors concluded “... that when audiovisual technology was used, four common psychiatric diagnoses were arrived at with the same reliability as an in-person interview and with high levels of patient satisfaction.”

Kennedy and Yellowlees (Kennedy and Yellowlees 2003) examined outcomes (over 12 months) in 124 patients receiving mental health care. Thirty two patients received the care via telepsychiatry. They measured outcomes using practitioner administered Health of the Nation Outcomes Scale (HoNOS) and patient administered Mental Health Inventory (MHI).

*Primary Mental Health Care Australian Resource Centre
and Primary Care Mental Health Unit June 2004*

The concluded "Individuals who used and did not use telepsychiatry all had improved health outcome scores on the HoNOS and the MHI during the study period. Telepsychiatry was as effective as face-to-face care." In summary telepsychiatry is an established method providing high user satisfaction and good outcomes.

Issues

Professional attitudes

Issues of professional scope and control between GPs and psychiatrists are a subtle theme in this review. However few overt comments are available in the published literature and those that do may not be representative or current. A few comments, however are worth reporting as an indication that there is an issue of professional control which needs to be further explored and taken into account. Keks (cited in AMWAC, 1999 p70) considers that:

"while some aspects of collaborative care can be interpreted as strategies for psychiatrist replacement, the result of attempts to construct services without strong psychiatrist input will lead to delivery of inferior services. Collaborative care offers major advantages in care provision, but it must be intensively supported by psychiatrists in order to deliver those benefits." (From AMWAC Report p 70)

Smith (2003, p318) takes a similar view. In referring to the recommendations of the 1997 JCC Report, "the implementations of which would make general psychiatrists out of general practitioners", he stresses that "Psychiatry must maintain intellectual leadership here".

Conversely Barber and Sved-Williams (1996) reporting on a GP survey of 603 South Australian GPs about their attitudes towards working with psychiatrists found that many had reservations about the weakening of the GP primary care role. While being positive about closer relationships with psychiatrists, they were wary of practices which could undermine the GP role and cause them to lose control of the patient. Of a number of different models presented 62% preferred Psychiatric assessment and short term management by the psychiatrist as their first preference. A similar position was taken by Emerson (2003) who commented that psychiatrists are perceived by GPs to 'take over' their patients.

Organisation, administration and relationships

The PARC Shared Care in Australia 2001 study (Holmwood et al, 2001) found that collaborative shared care between mental health services and GPs required a great deal of trust building and that this was accomplished through ongoing relationship building, shared educational events, placements and becoming familiar with each others ways of working, regional meetings and social events. The process of developing a memorandum of understanding was often more important than the document developed.

Administrative difficulties have also caused problems within projects. Staff turnover causes much lost momentum, lost relationships, and lost project knowledge. Communication protocols to facilitate referrals and discharge summaries and process agreements need to be put in place and continually reinforced.

Sustainability

A number of issues have been recurring in the above discussion. One is sustainability. Projects set up to bridge the gap between GPs and mental health services or GPs and private psychiatrists provide funding in addition to that available through Medicare or State

mental health service funding. This has enabled structures such as consultation liaison or case discussion to occur for which there is currently no channel for remuneration of the parties involved. It has also enabled the extension of the scope of mental health services to encompass shared care of patients who they would not otherwise regard as core customers.

An issue is the growing tendency for pharmaceutical companies to fill the funding gap, particularly in the area of GP education, case discussion and, in one case, educational visits to a GP surgery.

Despite the popularity of consultation liaison among GPs and psychiatrists three studies have had ambivalent findings about the educational value and the patient outcomes of consultation liaison.

Bower & Sibbald (2000) found that:

“There is little convincing evidence that CL interventions cause enduring change in PC behaviour, either after the CL intervention has finished or towards patients under the care of the PCW who are not managed directly under a CL intervention” (ibid, p84)

Harmon et al (2000) describe the early stage of the Newcastle consultation liaison project as having weaknesses because there was no effect on patient outcomes with patients with mild to moderate illnesses, excess time was spent on patients with mild illness, there was no improvement in GP knowledge, competence or referral practices and it did not facilitate GP involvement in the care of the patients in the mental health service.

King in his evaluation of the Queensland GPAPP projects (King, 2003) found that:

“GPs reached similar diagnoses to psychiatrists in most disorders but there was evidence of GP under diagnosis of organic, somatiform and substance use disorders. There was no evidence that quality of GP diagnosis improved across the life of the project. At six month follow up. CL patients were significantly improved but there was no evidence that patients who had a psychiatrist consultation improved more than patients who received usual GP care.” (King, 2003 p4)

King (2003) questions the benefits of continuing the GPAPP consultation liaison service due to the extra costs borne by the mental health service in providing services for customers who do not come within their usual scope. This issue was also raised in the context of the CLIPP program in Melbourne, however a financial evaluation has shown the service to be cost neutral when compared with standard care by the mental health service (Meadows, 1997, 1998).

Both Bower and Sibbald, King and Meadows report that both GPs and psychiatrists remain enthusiastic about consultation liaison. Numerous consultation liaison projects undertaken by the Divisions of General Practice as part of shared care projects, such as Adelaide Northern (PARC ID 930) Nth Melbourne (PARC ID 599) and Rockingham Kwinana (PARC ID 1038; Kisely et al, 2002) have also reported positive outcomes in terms of subjective improvement in GP knowledge and confidence and positive reception for their programs however outcome evaluations have either not been undertaken, or did not include a control group.

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