A patient-centred referral pathway for mild to moderate lifestyle and mental health problems: Does this model work in practice?

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ABSTRACT

BACKGROUND AND CONTEXT: The Primary Lifestyle Options Programme was an innovative eight-month, patient-centred, early primary care–based pilot aimed at identifying and promptly enabling people with mild to moderate mental health and lifestyle problems to access a range of free interventions as soon as possible.

PROBLEMS: Mild to moderate mental health and lifestyle issues are easily overlooked in primary care. Patients with these problems, once identified, often need support to choose and access treatment providers.

STRATEGIES FOR IMPROVEMENT: During a GP visit a patient requests help by completing a CHAT (Case-finding and Help Assessment Tool) which assesses depression, anxiety, abuse, anger, exercise level, insomnia, and addictions (gambling, tobacco, alcohol and other substances). Patients subsequently have a 30-minute GP consultation where a range of services to address identified problem(s) is offered; this choice is assisted by a comprehensive resource manual. A programme coordinator facilitates access to services by making appointments and liaising between patients and providers. A follow-up GP consult is available.

RESULTS: 456 patients (6% Maori) aged from 15 to 84 years requested help via the CHAT for one to seven issues per patient, over an eight-month period. Anxiety, depression and insomnia were the commonest reasons for requesting help. A feedback questionnaire focussed on the usefulness and practicality of the pathway, showing widespread approval from patients, GPs and other treatment providers.

CONCLUSIONS: This programme enables a patient to identify and request help for mental health and lifestyle problems at a mild–moderate stage, and to be supported through an intervention pathway that otherwise is unlikely to be available in a busy primary care environment.

KEYWORDS: Primary care, patient-centred, mental health

Background

Mild to moderate mental health and lifestyle problems are ubiquitous and pervasive[1] and can be overlooked not only by patients and their families but also by their primary caregivers. While GPs are well placed to identify such problems, historically they have been thwarted in doing so by time constraints[2] and referral uncertainties. Furthermore, mild or sub-threshold mental disorders can be diagnostically challenging, especially in the absence of concomitant disability.[3] Mental health screening in primary care has been widely advocated to address these concerns. However, reliable means of doing so have been less forthcoming and concerns have been raised about the efficacy of routine screening and the degree to which a single screening tool can be a diagnostic 'gold standard'.[4] In this regard the

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CHAT (Case-finding and Health Assessment Tool), a short, self-administered screening questionnaire, has been developed and trialled in New Zealand to expedite screening of adults for lifestyle and mental health problems in the GP setting.[5] The largest trial was in Auckland, demonstrating high sensitivity and specificity for depression, anxiety and stress, abuse, anger problems, and tobacco, alcohol and other drug misuse, but had lower levels for exercise and eating disorders. The tool also assesses whether patients want help with these issues, which reduces the chance of false positives.[6]

Having detected a lifestyle/mental health issue, what does the GP then do? Case-finding is one thing; prompt and appropriate intervention can be quite another. Traditional referral pathways are to hospital outpatient clinics (depression, anxiety, eating disorders), community clinics (for example community alcohol and drugs clinic or CADs), and private specialists (psychiatrists, psychologists). Often however, and especially in public mental health services, only those patients with significant acute illness will be seen. Private clinics are expensive, especially for multiple visits. Thus, people with mild to moderate lifestyle and/or mental health disorders are often left untreated, adversely affecting their well-being.[7]

The Primary Lifestyle Options programme was initiated to enable people with mild to moderate mental health and lifestyle problems to be reliably identified and then to have access to appropriate services as soon as possible. A sense of engagement in a programme increases patients' likelihood that they will attend.[8] Telephone prompting can also improve attendance rates.[9] The pathway described in this paper is patient-centric—the patient identifies a problem and participates in the selection of interventions appropriate to the treatment of that problem. This evaluation focused on the utility of the model in primary care—is it practicable, does it fit in with general practice workflow, and does it meet patient requirements for choice and timeframes? Is it a viable model for people providing the interventions (those who the GP refers the patient on to)? Essentially, is the Primary Lifestyle Options programme a feasible, sensible workable model of care?

WHAT GAP THIS FILLS

What is already known: The current public mental health system focuses more on patients with significant illness. Those with mild–moderate mental health and lifestyle issues are often overlooked in primary care, and have a limited choice of interventions and/or support. The CHAT (Case-finding and Health Assessment Tool) has been validated as a reliable screening tool for many of these issues. A sense of engagement in a programme increases patients' likelihood that they will attend, and telephone prompting can also improve attendance rates.

What this study adds: The Primary Lifestyle Options programme provides a patient-centric prompt intervention pathway—the patient identifies and requests help for a problem and participates in the selection of treatment options. Feedback from patients, GPs and other treatment providers indicate that this is a practicable, timely, and useful model in primary care.

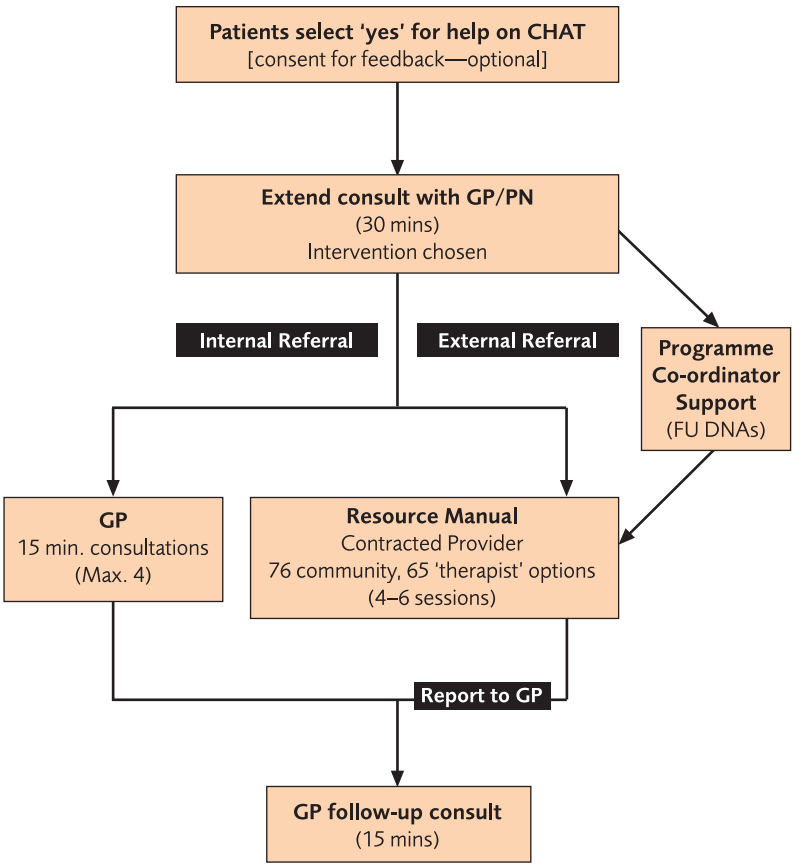
Purpose

To identify those people with mild to moderate mental health and lifestyle problems attending their GP and to follow this with prompt access to appropriate services, within available resources.

Model

Patients who were school leavers and older were asked by their GPs to complete a CHAT Lifestyle Assessment Tool. This was slightly modified from the original CHAT by replacing Eating Disorders with Insomnia, a known risk factor for, and consequence of, depression.[10] Selection of these patients was at the discretion of the GP. The patient discussed the completed CHAT with the GP. Those patients who answered 'Yes' to the question 'Do you want help with this?' were asked whether they would like to make a 30-minute appointment to see the GP, to discuss intervention options for the mental health/lifestyle problem revealed by the CHAT assessment. GPs were assisted in this by a comprehensive Resource Manual. Intervention, either internal or external (see below) was started within one month of referral and completed within three months. A programme coordinator based at Harbour Health PHO assisted at various stages in this process by (1) providing information and support to patients, GPs, practices and service providers; (2) facilitating patient access to services, and (3) following up

Figure 1. Primary Lifestyle Options referral pathways



PN = Practice nurse; FU = Follow-up; DNA = Did not attend

Table 1. External treatment provider examples

	Provider examples only (full list given to GPs in Resource Manual)
Exercise	Green Prescription Waitakere or North Shore; 10 weeks' local gym
Smoking	Smokefree Harbour Health; Quitline; Asian Smokefree
Alcohol/ illicit drugs	Individual sessions with psychologist/psychotherapist/counsellor; Community, Alcohol and Drugs Service (CADS); Alcoholics Anonymous (AA); The Alcohol and Drug Helpline etc.
Gambling	Individual sessions with psychologist/psychotherapist/counsellor; Problem Gambling Foundation hotline or Internet
Depression/ anxiety	Individual sessions with psychologist/psychotherapist/counsellor; Essentially Men Weekend Course; Youthlink Family Programme; Life Line; Youth Line; Phobic Trust and many other family and community service organisations
Violence, abuse, anger	Individual sessions with psychologist/psychotherapist/counsellor; Victim Support; Man Alive; North Harbour Living Without Violence; North Shore Women's Centre
Insomnia	Refer for CBT—four sessions, or five if extra GP consult used

those patients who did not attend these services. Those patients requiring or already receiving secondary care–level mental health interventions were not eligible. The overall pathway is summarised in Figure 1.

Intervention referral options

(1) Internal

Patients with lifestyle/mental health conditions could be seen by a GP for up to four consults (in addition to the first 30-minute and 15-minute follow-up consults) for problem-solving or behavioural change management.

(2) External (Table 1)

Approximately 150 different providers were available for selection, including individual, group, community and support services specifically for Maori, Pacific Island, and Asian patients.

This new model therefore introduced four processes to primary care:

1. Patient identification of problem area(s) and request for 'help' using the CHAT questionnaire.
2. A 30-minute extended GP consultation.
3. A PHO-based Programme Coordinator.
4. A 15-minute GP follow-up appointment after the intervention stage.

All services were free for patients. The pilot, a joint initiative between Harbour Health and HealthWEST Primary Health Organisations (PHOs), was funded by the Waitemata District Health Board (DHB) and was approved by their Ethics Committee.

Results

Utilisation

Sixty-nine GPs participated in the pilot, each enrolling from one to 35 patients. Between 15 October 2007 and 30 June 2008 a total of 456 patients were referred for one of the interventions. Of these:

- 357 patients (78%) were referred to external providers.
- 99 patients (22%) were referred internally (i.e. GP or practice nurse); 20 of these were for smoking cessation and eight for Green Prescription/exercise counselling.
- 91 (20%) completed the full course of interventions and the 'exit consult' with their GP. Approximately 40 had not attended their final 'exit' consult with their GP despite completing their interventions, by the time this report was prepared.
- 60 (13%) patients had not attended any intervention session by the time this report was prepared.

People requested help in all 10 problem areas on CHAT (only one for gambling, but there have been several more requests for help with this since 30 June 2008). The commonest amongst the 839 listed reasons for referral were depression (37%) and anxiety (26%). Sixty-seven percent of referred patients had depression as at least one of their referral reasons, and 35% had anxiety as at least one of their reasons (Figure 2). Fifty-seven percent of patients had two or more reasons for referral; the commonest (35%) coexisting conditions were anxiety–depression.

Table 2. Enrolled patient demographics

		N	%
Gender	**Female**	292	64
	Male	164	46
Ethnicity	**Asian**	8	1.8
	Maori	26	5.7
	NZ European	379	83.1
	Pacific	5	1.1
	Other	38	8.3
Age in years	**15–24**	72	15.8
	25–34	117	25.7
	35–44	116	25.4
	45–54	74	16.2
	55–64	52	11.4
	65–74	14	3.1
	75–84	11	2.4

Figure 2. Reasons for referral; N=839

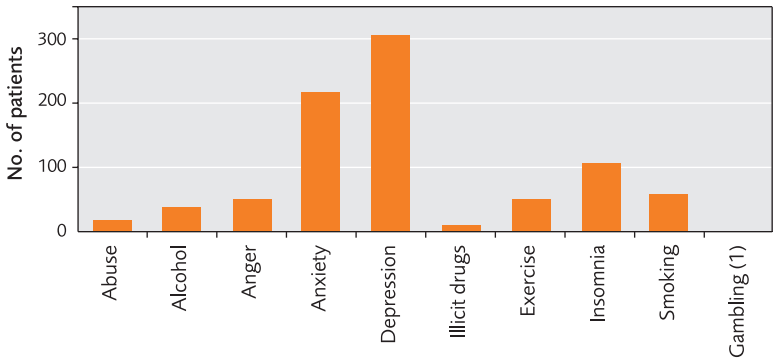
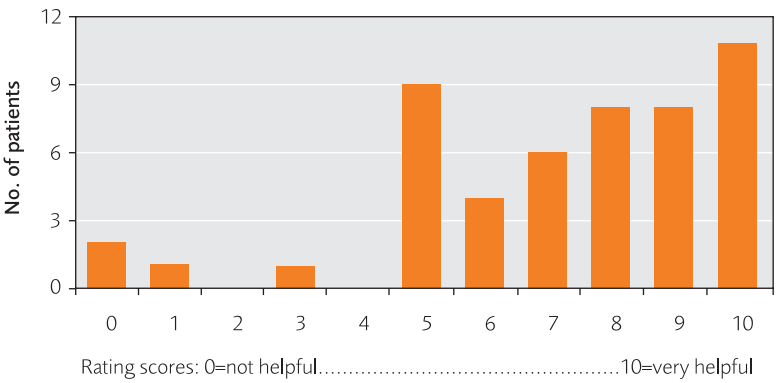


*Figure 3. Patient rating of CHAT Lifestyle Assessment Form; N=48**



* Two people could not recall; two did not answer.
Where people indicated a range e.g. '7–8', the lower of the two was recorded

Patient feedback

Fifty-two of the 91 patients who had completed the PLO programme gave feedback via a confidential written questionnaire.

- Most patients rated the CHAT assessment form as being 'helpful or very helpful' (Figure 3).
- 89% felt that the initial 30-minute consult with their GP was enough time to discuss options for getting help.
- 87% rated the assistance to get appointments with external providers as being 'helpful or very helpful'.
- Most patients (82%) referred to external providers were seen within two weeks, and 91% felt that the waiting time to be seen was acceptable.

Patient comments about use of the CHAT tool mainly related to it being simple to use and helpful in identifying problems:

'Helped me to positively identify the areas where I was not coping and required focus.'

'Simple questions—all part of the realisation process that there was something wrong. It was good to not have too long with the form to think too deeply, better to just answer straight away.'

'General questions were asked, nothing too over the top. It was helpful because it was on paper, sometimes it's easier to write things down.'

'Helpful in the way that it asked you a short, to the point relevant question for you to respond with a simple YES/NO answer.'

'It covered a broad range of questions. It was quick and easy to fill out.'

'Helped to specify problems, to identify stressors—made me think about it.'

Some patients remarked that the CHAT form should be made more available:

'I felt a little under pressure at the doctor's because of how I was feeling; maybe if I had taken the form home to consider it would have been more comfortable.'

'Having forms in the waiting room would have been good.'

'An idea might be [to put] these forms on display to increase awareness.'

Patient comments regarding the programme coordinator's role were all favourable and related to proximity and timing of referrals:

'Being new to Auckland, every assistance was given in finding an appointment close to where I lived.'

'The whole process was very quick and easy—superb that help could come close to home. All organised well.'

'I didn't have to do anything. If it was left up to me I wouldn't organise anything.'

'The extra time spent and care shown made me feel that somebody cared about me when I was very depressed.'

Many patients made very favourable, often quite heartfelt remarks about their involvement in this programme.

'I hope the programme keeps running—I don't know what I would have done if something like this wasn't available.'

'This programme made a huge difference to me and my family. I felt throughout that I was being looked after (from my doctor onwards) and the results were awesome...Huge thumbs up for the programme from me!'

'I am very grateful that it exists and that it was available to me. It made me feel that financial hardship was dealt with in a sensitive way that recognised the need for treatment despite this barrier.'

GP feedback

Thirty-seven of the 69 GPs who enrolled their patients in the PLO programme gave feedback via a confidential online questionnaire.

- 90% felt that the steps in the programme were clearly described, and 81% felt they were easy to implement.
- 76% felt that the programme's Resource Manual was 'useful' or 'very useful' and a further 21% indicated that 'some parts were useful'.
- 71% introduced the CHAT form to their patients during the course of a consult; the remainder indicated that their practice nurse introduced this to a proportion of the patients. Practice receptionists were not involved.
- 70% (of the foregoing 71%) gave the CHAT to those patients they thought would benefit, i.e. opportunistically. However, a further 22% selected patients specifically and invited their participation. No GP gave the form to every waiting patient.
- 57% felt that the initial 30-minute PLO

consult was 'easily' long enough, and a further 41% felt that it was 'just' long enough.
- 80% felt that the referral process to outside providers 'went smoothly'.
- 36% felt that the final 15-minute follow-up consult was 'plenty' and 55% felt it was 'just' long enough.
- Most felt that the role of the programme coordinator was helpful, with 39% regarding this as 'essential'.
- The invoicing/payment system relating to the PLO programme was generally regarded satisfactorily by GPs, with 79% rating this as 3 or more out of 5 (where 5 was 'very easy').
- 94% of GPs felt that this programme enabled their patients to access appropriate interventions, and 85% felt that this was within suitable timeframes.
- 95% indicated that they would continue their involvement with this programme, and 74% would increase their involvement if funding permitted.

GP criticisms related to too much paperwork/too many forms/needs to be electronic (x3), slow feedback from external providers (x2), and the funding period not being long enough (x2).

Provider feedback

Forty-four of the 49 external providers who had patients referred to them through the PLO programme gave feedback via a confidential online questionnaire.

- All respondents indicated that the referrals made by GPs were 'entirely' (84%) or 'mostly' (16%) appropriate to the particular service they provided, and most felt that the referring information was always (34%) or mostly (58%) adequate.
- Respondents felt that the timeframe between the patient seeing the GP and then being seen by the provider was 'very timely' (36%) or 'timely (61%).
- 78% felt that the role of the programme coordinator was 'very useful' in assisting them, with 68% indicating that the coordinator was 'very useful' in following up patients who did not attend appointments.
- Overall, 55% of providers felt that the PLO programme was 'very useful' as a model of care, and a further 29% that it was 'quite useful'.

'I believe the programme only touches the surface of the true need. It is evident to me most of the people that came for counselling would not have accessed help if they did not have this programme. The outcomes for the clients appeared in the main to have made a significant difference to their lives.'

Lessons and messages

This pilot programme did not seek to demonstrate efficacy (upskilling, manage problems, reduce escalation). Rather, it focused on the utility of the model in primary care—is it practicable; does it work as a referral pathway within primary care? It introduced a number of new processes for both GPs and patients. Firstly, it utilised a now well-validated screening tool, the CHAT,[7] and, secondly, it gave the GP 30 minutes of dedicated time to discuss this and work with the patient to select a treatment provider. Thirdly, a coordinator facilitated the patient's entrée to a wide choice of treatment providers external to their GP, and was available to deal with any follow-up issues with the provider. Fourthly, the pathway was able to be 'wrapped up' by the patient seeing their GP for a dedicated follow-up consult to review progress. The whole process was funded, thereby enabling people who otherwise could not access this amount of treatment time to do so, at an earlier stage in their mental health/lifestyle problem than would otherwise be possible under existing referral pathways. It is a novel approach to an old problem. Does it work in practice?

Feedback from all parties concerned has clearly shown widespread approval. Patients regarded the programme favourably, and some poignant comments were given in their feedback. It was important that the processes were practicable from the GP perspective, and generally the participating GPs rated the process well; 95% indicated they would continue their involvement with the programme. Likewise, external treatment providers—counsellors, psychologists, etc.—were generally approving of the programme, with 84% rating it as 'very' or 'quite' useful and

100% felt they were referred appropriate patients for the services they provided.

As such, the basic model does not require major changes as all processes were acceptable and practicable for the majority of patients, providers and GPs. However, there are some caveats to address if this programme is to move forward. Some patients felt under pressure at the time of consultation, preferring to take the CHAT home to answer; in future they need to be given this option. Completion of the programme by attending the follow-up GP consult was variable, and has continued to be so post–30 June. This appears to be redundant for those who were referred internally, i.e. consulted their GP for interventions or when they have had their needs adequately met by an external provider who has written a report to the GP. In future, this will be an optional component of the model. Moving to an online version was suggested by a number of GPs, so this too will be available in the next iteration.

In conclusion, the Primary Lifestyle Options pilot appears to be well regarded by participants—patients, GPs and other treatment providers—and is realistic and practicable. It could be easily taken up by other PHOs, requiring only local adaptation of material in the Resource Manual. This programme enables identification in the primary care setting of mild to moderate mental health or lifestyle problems and initiation of a treatment pathway that, in many cases at least, would not otherwise occur.

ACKNOWLEDGEMENTS
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COMPETING INTERESTS
None declared.

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We were shocked to hear of Jill Calveley's tragic, unexpected death on 30 December. As well as her role as the Clinical Director of Harbour Health PHO, Jill has made significant contributions in numerous parts of the health sector as a rural GP, within primary and secondary care organisations, the Accident Compensation Corporation and NGOs. As well as general practice, Jill had qualifications in epidemiology, public health and philosophy and was able to engage with the health sector from a wide range of perspectives. She passionately believed that the sole purpose of the health service is to improve the health of people. She brought her compassion and her critical appraisal skills to all her many roles. Her legacy is huge and she is sadly missed—Editor.