

Mental health and general practice: Improving linkages using a total quality management approach

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Abstract

This paper reports on a project to implement total quality management strategies to improve the linkages between general practitioners and specialist mental health services. The project implemented a process of change and objectively assessed the success of the process. The project involved all mental health staff ($n = 100$) in the St George Division of Psychiatry and Mental Health. General practitioners registered with the St George Division of General Practice were invited to participate in the change process. The project showed that the attempts to engage general practitioners in the ongoing care of patients with chronic mental illness is unlikely to be successful until mental health services promote general practitioner linkages as an ongoing service goal, relevant at all levels of delivery.

Introduction

Specialist mental health services in Australia have been criticised for failing to provide adequate continuity of care for persons with chronic and/or disabling mental illness (Andrews & Teeson 1994), although such continuity is part of the National Health Strategy (1993). A judicial review of mental health service delivery in Australia further described these specialist mental health services as having an inadequate emphasis on prevention and treatment of the physical health problems of people with a mental illness (Burdekin, Guilfoyle & Hall 1993). It is also recognised that the majority of patients receiving health care for

mental illness do not access specialist mental health services (Andrews & Teeson 1994), instead relying on primary health care providers who are largely general practitioners (GPs).

It would seem that one obvious solution to these problems is to increase the skills of GPs in managing mental illness in the primary care setting. A second solution would be to improve linkages between GPs and specialist mental health services to ensure that specialist support for GPs with regard to management of mental illness is available when required. The ideal outcome of such interventions would be that GPs coordinate the health care of all persons with a chronic mental illness, resulting in improved continuity of care for mental illness as well as improved management of physical health problems in persons with chronic mental illness. This paper describes the efforts of one public sector specialist mental health service in metropolitan Sydney, in conjunction with the relevant Division of General Practice, to implement such a model of collaborative care.

Literature review

In describing coordinated mental health service delivery, there are several elements which have to be considered. These include integration between hospital and community mental health sectors (Joss & Kogan 1995), seamless interface between acute treatment and rehabilitation (National Health Strategy 1991), coordination between mental health and related welfare and non-government sectors (Bachrach 1993a), and linkages between primary care providers and specialist mental health services (Keks et al. 1997). It is only this latter aspect of coordinated care which is the focus of this current paper, but it must be remembered that all aspects are important within the system as a whole.

Several problems associated with the coordination of care between primary care and specialist mental health services have been investigated in systems outside Australia. These problems have included systems disruption by the processes of deinstitutionalisation (Bachrach 1993b), poor communication between service providers (Patterson, Higgins & Dyck 1995), difficulties in the relationship between GPs and mental health service providers (Falloon et al. 1996), poor continuity of systems of care between primary and specialist mental health services (Jones et al. 1987; Warner et al. 1993; Falloon et al. 1996), problems in GP perceptions of mental health clients (Sylvester & Kastner 1984; Falloon et al. 1996), and the preference of some GPs to manage mental health clients without referral to specialist services (Orleans et al. 1985).

In addition to these systems problems, GP skills in the assessment and treatment of mental illness have been shown to be inadequate, especially in their ability to

conduct sophisticated interviews using advanced communication skills (Millar & Goldberg 1991; Goldberg et al. 1993; Goldberg & Gater 1996; Tobin, Hickie & Urbanc 1997). It is believed that such skills are not acquired simply by years of experience, but require specific learning interventions (Gask et al. 1988; Bowman et al. 1992; Goldberg & Gater 1996).

Despite these problems at several levels, the benefits of improving linkages between GPs and specialist mental health services appear to be considerable. They include reduced hospital utilisation (Patterson, Higgins & Dyck 1995), improved GP satisfaction (Thomas & Corney 1993) and reduced family burden (Francell, Conn & Gray 1988).

There is an imbalance between an extensive literature pertaining to specific factors important in the skill development of GPs working with people who have mental illness, or delineating the nature of the problems in the systems of care, and research relating to the processes of change required to improve linkages between GPs and public sector specialist mental health services. Keks et al. (1997) stated that the essential starting point was the establishment of communication between GPs and mental health services, but the actual mechanisms would depend on local culture. They suggested that joint educational meetings, improved flow of information about each other, and the development of basic protocols for collaborative care would be features of such improved communication.

This paper reports on a project which aimed to implement strategies derived from total quality management theory and practice in an attempt to improve linkages between specialist mental health services and GPs. Joss and Kogan (1995, p 13) define total quality management in the context of the United Kingdom's National Health Service as:

an integrated, corporately led program of organisational change designed to engender and sustain a culture of continuous improvement based on customer-oriented definitions of quality.

These authors listed the essential ingredients for such change as the identification of a vision of the changed service, the development of a long-term corporate plan for the entire service, appropriate and informed changes to policies and procedures, leadership by management, and engagement of staff in the process of change, thereby empowering them. According to these same authors, ensuring staff commitment to the process of continuous improvement is facilitated by stakeholder groups identifying processes under their control which may be improved, appropriate training and education of staff and consumer groups, and the provision of incentives which help to ensure that the new replaces the old.

The final step in the continuous loop is the provision of feedback on the change as it occurs, ensuring that the experiences of staff and consumers in the changing processes inform the evolving corporate plan and that any inadequacies in service delivery are identified and acted upon quickly. The overall outcome of a total quality management intervention is to create a culture of change whereby the steps outlined above become 'hard-wired' into service delivery, ensuring that total quality management initiatives are subsumed into the everyday practice of all staff of the service.

The aims of the present project were to implement such a process of change and to objectively assess the success of the process.

Methodology

The St George Division of Psychiatry and Mental Health forms part of the St George Hospital and Community Health Service within the South Eastern Sydney Area Health Service. It has a catchment population of approximately 220 000 people. All mental health staff ($n = 100$) of the division took part in the project. These included medical, nursing professionals and allied health staff (occupational therapists, social workers, psychologists). These staff work across the various aspects of the mental health service, including acute and crisis care in the community, an inpatient unit, community case management and mental health rehabilitation. GPs registered with the St George Division of General Practice ($n = 170$) were invited to participate in the process of change via information provided through their divisional newsletter.

Using the total quality management principles outlined above, the barriers to better linkages were assessed. All mental health staff were interviewed using a semi-structured interview schedule designed to elicit their perceptions of the current system as it related to involvement of GPs, and the potential barriers to change. Approximately 70 GPs responded to invitations in the divisional newsletter to attend a series of three educational seminars on mental health issues. At the end of the formal teaching component, they were asked for their views about the mental health service and for suggestions for improvement. Formal meetings occurred with the executive of the Division of General Practice to elicit past complaints they may have received about the mental health service. A smaller group of 14 GPs also participated in a structured mental health training program over two six-month periods. As these 14 GPs were strongly engaged with the service during their training, their views about the service were regularly sought and added to the information being collected.

Identified barriers to improved linkages

From the sources outlined above, it was determined that mental health staff perceived several barriers to improving linkages between public sector services and GPs. These included a perception that GPs were generally disinterested in chronic mental illness and lacked specific skills, including assessment and treatment of mental illness. It was also argued by staff that patients of the mental health service were not interested in attending GPs. The GPs described a lack of confidence in advice provided by non-medical specialist mental health professionals, an intake and referral system which effectively discouraged them from referring clients early in a mental illness presentation, inadequate feedback regarding patients who had been referred to the specialist mental health system, and lack of information about patients who had been referred back to them. The majority of GPs felt they were not sufficiently skilled in primary mental health care pertaining to serious mental illness and, more specifically, were ignorant of the model and practice of public sector mental health service delivery.

Creating a GP friendly service

In response to this information, the management of the mental health service articulated a vision of what was called a 'GP friendly service', and implemented a number of change management strategies over the subsequent two-year period. These included the specific GP mental health training program which has been described elsewhere (Tobin, Hickie & Urbanc 1997), as well as changes in the organisation and delivery of mental health services designed to establish the GP as an integral component of the system.

The process of organisational change

The strategies used to produce organisational change included feedback of the information gained from the interviews with each group to the other, distribution of lists of GPs interested in mental health to mental health staff, and recurrent mental health staff education in how best to communicate with GPs. This education concentrated on communication with GPs in a manner which addressed the time constraints inherent in a fee-for-service system. Thus encouragement in the use of succinct telephone calls was emphasised, and proforma short letters for staff to use were introduced. Staff were provided with a short training program which demonstrated the usefulness of a package of communication strategies, including introductory letters, follow-up telephone calls, and accompanying patients to their first visit to the GP. Staff were also encouraged to negotiate early afternoon appointments with GPs to maximise the likelihood of a patient attending the appointment and to minimise the risk of

prolonged waiting times in the surgery, which might be frustrating to a patient with an unstable mental illness. The policies of the organisation were changed to reflect the central importance of the GP in the care of the patient with mental illness. These policy changes included:

- automatic identification of a GP at the point of entry to the mental health service unless specific reasons for not doing so were outlined in the clinical file, and including GP notification on the discharge planning checklist
- automatic sending of discharge summaries to the GP at the point of exit from the system
- increasing involvement of the GP in some of the care of the patient during their mental health treatment program.

Using problems to improve the system

Any problems identified by staff which were associated with these changes to procedure were brought to the attention of the management team, one of whose roles was to facilitate problem-solving between GPs and mental health staff. One of these issues was that GPs wanted to speak directly to medical staff for mental health advice about patients. This caused several problems, not the least of which was that the mental health service had a very limited number of hours of specialist medical staff available and the multiple demands on this time meant that direct availability for GPs could not be guaranteed. Additionally, non-medical mental health staff felt offended by this request from the GPs.

The solution involved senior medical staff meeting with GPs to explain the reasons outlined above, to describe the multidisciplinary team structure and function, and to express their confidence in the skills of the mental health staff. GP perceptions of what they required from a mental health service were also obtained. GPs were assured that the service would provide a professional response regardless of the professional discipline of the staff member involved, and a mechanism was also provided for dissatisfied GPs to obtain a second opinion. In response to these issues, an alteration to service policy was made such that written evidence in clinical files of a reply to all GP referrals was made mandatory and a proforma letter was produced to assist staff with this.

Providing better information about the service

Another component of the management strategy included the provision of information to GPs about the mental health service. This was achieved by advertising the service's policies and procedures in relation to GPs in the divisional newsletter. The involvement of the 14 GPs in the specific mental

health training program with non-medical mental health staff during both routine and emergency assessments of patients with mental illness, whilst limited to a small number of occasions, provided valuable insight to both groups about the skills of the other. There was an expectation that the individuals involved helped to communicate these insights to a wider audience.

Leadership from psychiatrists

Throughout the change process which continued over two years, consultant psychiatrists involved with the mental health teams continued to liaise with staff regarding the improvement of GP linkages, reinforcing the interventions outlined above.

Continual improvement process

Periodically, random audits of the clinical files were conducted to assess for evidence of GP engagement with the service and the results were relayed back to staff, usually with further encouragement to increase their contact. Feedback from staff about the process was continually sought and new problems identified. Staff themselves initiated changes in clinical policy and practice, especially at the intake or discharge points, which assisted the division to move forward.

Evaluation

To assess whether there was any progress being made towards the goal of a service with improved GP linkages, it was decided to use written evidence of GP–service communication in patient clinical files as a measure to assess the success of the total quality management interventions. It was hypothesised that improved GP–service linkages would be evidenced by increased documentation of communication between the two parties. Reilly and Morgan (1996) reported that most studies of communication between GPs and specialist services assume the use of written communication, and such studies have audited mainly quality rather than describing baseline levels of written communication.

Random file audits

A random clinical file audit of all current patients being managed by the St George community mental health teams was undertaken. The files were examined for written evidence of registration of a GP for each patient, and of GP–service collaboration in the form of copies of correspondence between GPs and the staff, or written clinical notes relating to verbal agreements about care reached with GPs. Before the beginning of the project, audits were conducted

of all clinical files ($n = 600$) and thereafter repeat audits occurred at one year (a random 1 in 3 files for a total of $n = 200$ files) and at two years (a random 1 in 5 files for a total of $n = 120$ files).

Results

At the beginning of the project, only 10% of clinical files had registration of GPs and in only occasional cases (less than 10%) was there evidence that any communication between the GP and the service had occurred, a rate similar to that previously found by Reilly and Morgan (1996). At the end of one year, 40% of files had a registered GP and 30% had written evidence of communication having occurred. At the end of two years, 60% of files had a registered GP and 42% had written evidence of communication having occurred.

Discussion

The project described in this paper sought to evaluate whether the continuity of care between GPs and public sector mental health services could be improved within one service setting by specific targeted strategies using a total quality management approach. Over a two-year period, it was demonstrated that registration of GPs in client files and written evidence of communication had substantially improved. We believe that this indicates that more community mental health staff were considering the GP in their care of the patient and that a significant number were actually communicating with them about that care. However, it is also possible that this change simply reflected more accurate recording of GP involvement, in the context of the service initiatives described above.

It is apparent that considerable time and management input is required to facilitate the improvement of GP–mental health service linkages. A 30-year history of separation between GPs and public sector mental health services in metropolitan centres will not be broken down in short time frames. However, given the high morbidity associated with chronic mental illness, and the fact that most people who have such conditions are living in the community, we believe that it may not be an unreasonable goal that 100% of such patients have some form of shared care plan with an identified GP. Therefore, this significant investment of management time is warranted.

The degree and type of shared care will differ within different services. A modest goal may be as simple as a system of routinely informing their local community that the mental health service will, at the point of contact with the service, link

a client with a GP of their choice, whose role it will be to provide general health assessment, monitor the progress of the mental illness, and educate and support the family in collaboration with the mental health team. At the present time it is apparent that many public sector mental health services create an expectation in their client groups that they will provide a comprehensive range of care for the life of the illness and that they are equipped to do this alone. The authors suggest that this culture has outlived its usefulness as an organisation of a system of care.

Conclusions

The improvement of linkages between public sector mental health services and the primary care sector is a national health strategy, and is widely regarded as an important goal for mental health services. However, objective measurement of the achievement of this goal has rarely been reported. The total quality management methodology and objective measurement techniques reported here indicate that the implementation of national health strategies is a realistic goal of all mental health services.

We believe that the present project has highlighted several important issues. The attempt to engage GPs in the ongoing care of patients with chronic mental illness is unlikely to be successful until mental health services promote GP linkages as an ongoing service goal, relevant at all levels of service delivery. The history of separate and parallel systems of care necessitates careful planning and implementation of such management goals before significant change will be achieved. Future research may utilise methods of validating the nature and extent of GP–service linkages other than the file audit methodology used in the present project. Further, this research may investigate whether improvement of GP–service linkages improves clinical outcomes, as well as creating changes in the perceptions of each group towards the other.

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