Improving mental health services in a local area — an exploratory study

Terry Buchan and Duncan P Boldy

Abstract

The change in the focus of care for people with mental illness from hospital to community has been far from uniformly successful for a variety of reasons. A review of the development of mental health services suggests that the views of doctors and the responses of administrative systems are significant forces in shaping the development of services. This study explored the attitudes of general practitioners, psychiatrists and administrators, with a view to establishing areas of congruence in order to move towards an improved model of service delivery. Recommendations are made in the areas of primary care psychiatry, access, communication and education.

Aust Health Rev 2004: 28(3): 292–300

What is known about the topic?
A number of studies have highlighted the lack of integration in the provision of mental health services, particularly between the hospital and primary care sectors

What does this paper add?
This article provides the views of a sample of GPs, psychiatrists and mental health administrators on the system problems and options for improvement. Areas the participants felt were important to address included an agreed definition of the scope of primary care psychiatry, methods to improve GP access to mental health services, as well as a focus on improving communication and education.

What are the implications for practitioners?
The information provided in this article may help others contemplating methods to improve integration in mental health service delivery.

THE REAL IMPETUS FOR CHANGE to community care for people with mental illness in Western Australia (WA) came with the new *Mental Health Act 1966*, which made provision for the establishment of privately run psychiatric hostels. During 1967 there were 1493 discharges from Claremont Hospital, including 1168 to after care or boarding out; 300 discharges were to the new hostels. For the first time, the number of discharges exceeded the number of admissions, making it possible to reduce the number of beds from 1500 to 1100

Terry Buchan, MA, MB BChir, MSc, Consultant Psychiatrist (retired).
Inner City Mental Health Service, Royal Perth Hospital, Perth, WA.

Duncan P Boldy, PhD, MSc, FCHSE, Professor.
School of Public Health, Curtin University of Technology, Perth, WA.

Correspondence: Professor Duncan P Boldy, School of Public Health, Curtin University of Technology, GPO Box U1987, Perth, WA 6845. **d.boldy@curtin.edu.au**

(Buchan 1991). There were progressive reductions in bed numbers thereafter, to 1008 in 1979 and 723 in 1984 (Annual Reports 1960 – 1984). By the beginning of 1990, Graylands Hospital, the primary psychiatric hospital in WA, was effectively reduced to 280 beds and there were corresponding increases in the number of patients treated in the community; for example there was an increase from 15 643 in 1995 to 20 426 in 1999.

Nevertheless, there have been many critics of community care in the management of people with mental illness. Some years ago in Australia, McDonald (1987) claimed that putting such people back into the community was not working because of a lack of resources. Thousands of Australians with psychiatric problems were being sentenced to the anonymity of dingy boarding houses or crisis refuges (Williams 1987). Mitchell (1987, p. 2) reported: "In Western Australia, Perth's refuges for homeless people are being flooded by psychiatric patients and it is not

known what to do with them." Between 1980 and 1997 the suicide rate among psychiatric patients in WA increased by 3.5% per annum compared with 1.5% for the general population, possibly because of premature discharge and inadequate community supervision (Lawrence et al. 2001).

The Burdekin Report (1993, p. 916) commented: "The inadequacy of existing community mental health services to treat, care for and support people with mental illness living in the community is disgraceful. Those services that do exist are grossly underfunded and under developed."

More recently, Groom and Hickie (2003, p. 1) commented: "A nationwide review of the experiences of those who both use and provide mental health services has documented that current community based systems are failing to provide adequate services. Specifically, these services are failing in terms of restricted access, variable quality, poor continuity, lack of support for recovery from illness or protection against human rights abuses."

In WA, all the members of the Ministerial Task Force (1996) were of the opinion there were major systemic problems in the delivery of mental health services. While there is no consensus about the structure or function of a community-based system, there is general agreement in British and American literature that, ideally, inpatient care, outpatient care, home-based care, day care, residential care and primary care should be integrated. Similar themes are reflected locally in documents such as the National Mental Health Policy (1992) and the Second National Mental Health Plan (1998), the National Mental Health Plan 2003 – 2008, the Burdekin Report (1993), the Ministerial Task Force Report (1996) and the WA Health Department Report *Making a Commitment* (Health Department of WA 1996). There has been a failure to achieve this integration. Specifically, there has been a failure to integrate mental health services with primary care. As the most recent National Mental Health Plan 2003-2008 (2003, draft version 2.4) states: "the primary care sector is now acknowledged as a critical element" (p. 4).

The development of mental health services suggests that the views of doctors and the administrative framework for service delivery are significant forces, both enabling and constraining innovation. With these considerations in mind, the present study sought to examine the views of doctors in primary care (general practitioners) and those of doctors (psychiatrists) and administrators in mental health services. These three groups were perceived to be the principal motivators of change in developing improved services. The intent was to establish some kind of congruence of views to facilitate the integration of a mental health service with local general practitioners. It was recognised that the views of other health professionals and consumers would be very important, but their consideration was outside the scope of the study.

Aim

The aim of the study was to determine the views of general practitioners, psychiatrists and administrators regarding the key elements of a best practice, integrated, community-based mental health service and how these elements might be implemented. Specifically, the study focussed on integration with primary care.

Study design

For this exploratory study, which was approved by the Curtin University Human Research Ethics Committee, a qualitative approach with purposive sampling was adopted. The main reasons for this were:

- The probability of a poor response from GPs to a more structured approach — for example, a survey of morbidity management and treatment by GPs conducted by a university department in three eastern states produced only a 37% response rate in metropolitan areas (Britt et al. 1993).
- The relevance and depth of information obtained with a structured questionnaire is a reflection of the questions asked. A loosely structured interview with ample opportunity

1 Interviews of psychiatrists and administrators by service setting		
Service setting	Psychiatrists interviewed	Administrators interviewed
Teaching hospital with community based services and informal inpatient beds	3	1
Teaching hospital with community based services and authorised beds	1	2
District General Hospital with community based services and authorised inpatient beds	3	2
District General Hospital with community based services	4	1
Stand alone community clinics A, B & C	4	3
Mental Health Division	–	2
Total	15	11

for the free expression of views provides much richer information and provides the respondent some scope in shaping the questions.

An inner city area of Perth, Western Australia, was chosen as the study location for two complementary reasons. Firstly, it was thought to have a relatively high level of psychopathology because it is an area of low socioeconomic status with a high proportion of unemployment and one-person households (Australian Bureau of Statistics 1998). Unemployment and living alone have been found to be significant mental health risk factors in Australia (Andrews et al. 1999). Secondly, the area had a comparatively new mainstreamed mental health service that had not achieved a high level of integration (Ash et al. 2001). Specifically, there was a low level of cooperation with GPs.

Twenty-four GPs (14 practices) were purposively selected. The views of psychiatrists and administrators were sought from a range of settings, as well as those of two senior administrators from the Mental Health Division of the State Health Department. The service settings and the numbers interviewed are indicated in Box 1. Ten of the 15 psychiatrists were males. Among the 11 administrators, six of whom were female, two were GP Liaison Officers with nursing backgrounds, two others had nursing backgrounds; two were from medical administration, two from social work and one from medicine.

Twenty participants (11 GPs, 6 psychiatrists and 3 administrators) were interviewed individu-

ally, with the other 30 preferring to be interviewed in small groups of 2 to 4 persons. The latter was usually because of the convenience of holding interviews at the time of a scheduled professional meeting.

Interviews were conducted between January and May 2000. Each lasted about 40 to 50 minutes and was tape recorded after written consent had been obtained, with the exception of one GP who preferred that notes be taken. Interviewees in all three groups were asked six open-ended, non-leading questions, these being based on a pilot study of 27 GPs carried out in the Bentley/Armadale area of Perth by the first author and a colleague during 1998–99.

The six questions were:
- What do you understand by primary care psychiatry?
- What do you believe is its relationship to community mental health services?
- What do you believe is your role in primary care psychiatry?
- What special skills do you bring to this area?
- What assistance do you need, if any, to enhance your performance in this area?
- How do you think the mental health services might be improved?

Tape recordings were transcribed verbatim with only minimal editing of non-content phrases, such as "You know what I mean?" These were then read and comments assigned to categories, then subcategories. The subcategories were chosen on the basis of the number of comments

2 GPs' views — access to mental health services	
Subcategory	**Comments (*n*)**
Difficulties with access	17
Use of the private sector	15
Use of the Emergency Department	15
Difficulty with delays	12
Total comments	59

3 GPs' views — primary care	
Subcategory	**Comments (*n*)**
Role of general practitioners	35
Use of a community team	14
Difficulties in practice	13
Counselling given by GPs	11
Total comments	73

elicited, which was taken to be an indication of the level of concern among stakeholders, and on a subjective judgement of their significance based on the literature and experience.

While the above process was entirely carried out by the first author, the category structure was validated by having a clinical psychologist independently derive her own structure from a reading of the transcripts. Broad agreement was found between the two sets of categories, with no items in the second list that were not represented in some way in the first. Accordingly, it was deemed appropriate to proceed with the initial category structure.

The views of general practitioners

The GPs made a total of 347 comments. The four major categories were: access to mental health services (95); primary care (92); education (61); and communication with mental health services (41).

Access

Comments were mostly prompted by Question 6: 'How do you think the mental health services might be improved?' The four subcategories comprising 10 or more comments are set out in Box 2.

Difficulties with access included problems with catchment area boundaries and the selective entry criteria for some community teams, which seemed to limit access to the floridly psychotic or actively suicidal. Consequently, most GPs preferred to use the private sector as a first choice whenever possible. Few would use the Emergency Department, except as a last resort, because of the general chaos and the long wait for patients whose illnesses were not immediately life threatening. Several GPs made the point that they rarely made referrals until their own resources were exhausted and the situation had become urgent. Long delays for outpatient appointments were very frustrating in these circumstances, and one-off consultations might be a partial solution.

Primary care

In this category, comments were largely prompted by the first four questions: What do you understand by primary care psychiatry? What do you believe is its relationship to mental health services? What do you believe is your role in the area of primary care psychiatry? What special skills do you bring to this area?

The four key subcategories with 10 or more comments are set out in Box 3.

Many GPs had difficulty in perceiving primary care psychiatry as extending beyond the boundaries of general practice; they did not seem to perceive any role for multidisciplinary teams or non-government organisations. Consequently there was general dissatisfaction with the performance of the community teams, which were perceived as unresponsive to general practice needs. Difficulties with diagnosis were common, especially disorders such as somatisation, which have fleeting symptoms. Some GPs did their own counselling, despite the financial disincentives, but some were concerned about the lack of ready access to 'quality counselling'.

Education

Comments were mostly prompted by Question 5: What assistance, if any, do you believe you need

<table>
<tr><td colspan="2">**4 GPs' views — education**</td></tr>
<tr><td>**Subcategory**</td><td>**Comments (n)**</td></tr>
<tr><td>Need for information about services</td><td>19</td></tr>
<tr><td>Responses to the need for education</td><td>15</td></tr>
<tr><td>Content of GP training</td><td>11</td></tr>
<tr><td>Adequacy of undergraduate training</td><td>9</td></tr>
<tr><td>Total comments</td><td>54</td></tr>
</table>

5 GPs' views — communication with mental health services	
Subcategory	**Comments (n)**
Need for advice	16
Lack of communication (unspecified)	13
Lack of feedback	7
Problems with changes of medication	5
Total comments	41

to enhance your performance in this area? The four key subcategories are set out in Box 4.

Most GPs expressed a need for more education. Many saw this as a need to know more about the services available, including target populations, cost and referral protocols. Educational programs run by Divisions of General Practice were seen as valuable. Some GPs expressed a need for training in counselling and several commented on the inadequacies of their undergraduate training as a preparation for general practice. They complained that the focus was on major mental illnesses, such as schizophrenia and bipolar affective disorder, to the neglect of high prevalence disorders such as anxiety and depression.

Communication with mental health services

Comments were mostly prompted by Question 6: 'How do you think mental health services might be improved?' The four key subcategories are set out in Box 5.

Many GPs expressed a need for telephone advice. They often had patients whom they believed they could probably manage, but they needed a discussion with a psychiatrist to ensure that the management plan was appropriate, which might avoid a referral. The lack of communication from the mental health services was widely deplored. Difficulties included a lack of notification of admissions and discharges and lack of discharge planning, inefficiencies in the triage system, and lack of information about management plans. Specific difficulties mentioned related to the lack of feedback following an outpatient appointment and failure to notify the GP of changes in medication.

The views of psychiatrists and administrators

The administrators made a total of 157 comments and the psychiatrists 177. There were 6

6 The views of administrators and psychiatrists

Categories	Total comments	Administrators' comments	Psychiatrists' comments
The need to deal with GP's problems	69	28	41
The need for training for Mental Health Service staff	54	27	27
Factors in good relationships	39	21	18
Problems in communication	37	20	17
Primary care psychiatry	33	13	20
Barriers to change	33	7	26
Total	265	116	149

7 The need to deal with GPs' problems		
Subcategories	**Administrators' comments**	**Psychiatrists' comments**
Consultation/Liaison	10	–
Innovative consultations	9	10
Education of GPs	7	10
The importance of shared care	–	14
Total comments	26	34

8 The need for training for mental health service staff		
Subcategories	**Administrators' comments**	**Psychiatrists' comments**
Working in the community	18	–
Undergraduate medical education	–	13
Postgraduate medical education	–	14
Total comments	18	27

major categories common to both groups. These are set out in Box 6.

There was some overlap in the subcategories used by the two groups but there were also some marked differences. The most numerous subcategories for the two groups are set out in Boxes 6 to 11 and discussed below.

The need to deal with GPs' problems

The key subcategories are set out in Box 7.

Administrators: Raised two important issues apropos of consultation/liaison. Firstly, it is important to have a designated GP liaison person, whom they can telephone and who will not be too busy to deal with their call with reasonable dispatch. It was also suggested that a community team member should be the designated contact person for particular surgeries. Apart from the development of familiarity and trust, this might have the advantage of making staff available for case conferences in terms of the new Medicare item numbers. The mental health services were perceived to be endeavouring to provide training for GPs with grossly inadequate resources, leading to an undue reliance on drug companies. There was felt to be merit in GPs having attachments to mental health services.

Psychiatrists: Were mostly in favour of shared care arrangements, but some foresaw difficulties in establishing the boundaries of professional responsibility. They also generally agreed that GPs should receive education in mental health management strategies, but there was no consensus about the format to be adopted; possibly GPs should lead the process. Most psychiatrists

also agreed that there was room for innovation in the consultation process: for example, telephone consultations, a single consultation with referral back to the GP, and case conferences.

The need for training for mental health service staff

The key subcategories for each group are set out in Box 8.

Administrators: Comments tended to be influenced by their own disciplines, but there was a general impression that much of their training was in hospitals which did not equip them for working in multidisciplinary teams in the community.

Psychiatrists: Were generally aware that there were important differences between general practice and hospital care. This raised two important issues: firstly that education in psychiatry at this level needs to be community focused and secondly that systems of diagnostic classification need to be appropriate for general practice. Seven psychiatrists commented that postgraduate education is still too reliant on institutional placements.

Factors in good relationships

The key subcategories for each group are set out in Box 9.

Administrators: Believed that it is not possible for the mental health services to manage all the people with mental health concerns. Support for GPs was therefore considered essential and would result in better outcomes for patients. A

9 Factors in good relationships		
Subcategories	**Administrators' comments**	**Psychiatrists' comments**
Provision of support	6	–
Memorandum of understanding	5	–
Skills in managing relationships	4	18
Total comments	15	18

10 Problems in communication		
Subcategories	**Administrators' comments**	**Psychiatrists' comments**
Lack of understanding	12	5
Lack of feedback	5	–
Inadequate documentation	–	8
The importance of information technology	–	4
Total comments	17	17

memorandum of understanding between a mental health service and the local GPs was seen as a fruitful approach to defining the differing roles and responsibilities. The different needs and resources of particular areas would define local variations of the memoranda. Work to establish relationships with GPs would be needed at both personal and Divisional levels.

Psychiatrists: Those who made comments (*n*=7) all agreed that skills in managing the relationship with GPs were fundamental. Essentially they recognised that the traditional concept that 'the specialist knows best', together with the implicit condescension, should be discarded.

Problems in communication

The key subcategories for each group are set out in Box 10.

Administrators: Some believed that GPs often had no conception of what mental health services have to offer or how they function. On the other hand, mental health staff, especially psychiatric trainees with no experience in general practice, had little perception of the GPs' difficulties. Specifically, staff sometimes thought that the purpose of GP education was to provide better referrals. There was a mutual lack of feedback and it would be good practice to audit written communications.

Psychiatrists: Generally complained of the lack of information from GPs, especially the lack of any indication of their expectations. It was not usually clear whether a GP expected, for example, a brief medication review and referral back, or the mental health service to take over full management. The situation was further obfus-

cated by the lack of a common language and inadequate electronic communication.

Primary care psychiatry

Administrators: There were ten administrators' comments on the nature of the target population. The administrators perceived that the scope of primary care psychiatry was wider than general practice, especially in rural areas where nurses were sometimes the only clinical resource. They also believed that perhaps 70% of all patients with mental health problems who present in primary care could be dealt with at that level, and comparatively few need to be referred for specialist care.

Psychiatrists: There were 17 psychiatrists' comments on the nature of the target population. The psychiatrists were aware that the patients who presented to GPs were mostly suffering from high prevalence disorders such as anxiety and depression. Many of them do not reach the threshold for a formal diagnosis and very few are admitted to tertiary institutions. Some psychiatrists also believed that the scope of primary care psychiatry is wider than general practice and should include clinical psychologists and non-government organisations.

Barriers to change

The key subcategories for each group are set out in Box 11

Administrators: perceived that many specialists did not accept that the high prevalence disor-

11 Barriers to change		
Subcategories	Administrators' comments	Psychiatrists' comments
The need for adequate resources	–	8
The lack of a theoretical framework	–	7
Problems in the mental health systems	7	6
Total comments	7	21

ders were part of their responsibility, which is a real barrier to change.

Psychiatrists: A few saw the need for GPs to be given financial incentives for psychiatric work, while others saw the lack of stability in mental health staff as inhibiting the development of personal relationships. Two psychiatrists commented that GPs have limited time with their patients. They work more on problems than specific diagnoses and often do not make a definitive diagnosis. Comments on the problems in the mental health system mostly focused on the bureaucratic frustrations experienced by GPs.

Recommendations

Themes derived from the subcategories were analysed for congruence between the groups of interviewees. Four areas of common concern were identified corresponding with the major categories derived for the GPs. A series of recommendations was drawn up for each of these areas, as follows:

Primary care psychiatry

Negotiations should be undertaken between clinical and administrative representatives from the Mental Health Services and the local Divisions of General Practice to draw up a Memorandum of Understanding that will serve as a plan for the implementation of an optimal

service. The following aspects will need to be considered:

■ The scope of primary care psychiatry, with specific reference to patient populations, clinical boundaries and responsibilities.

■ The involvement of the multidisciplinary team with GPs, with specific roles defined for non-medical personnel and non-government agencies.

■ Special efforts to foster informal personal relationships between the multidisciplinary team and GPs, with a view to developing models of 'shared care'.

Access

A number of working parties involving both multidisciplinary teams and GPs, should be established to discuss ways of improving GP access to mental health services. Topics should include:

■ Improved performance and consistency of duty officers, by agreement on standardised training in the use of algorithms developed in conjunction with GPs.

■ Better information for GPs on the structure and functioning of mental health services.

■ Examination of the internal communication systems of mental health services, to improve their speed and efficiency.

■ The development of innovative responses to GP referrals, such as one-off consultations, telephone consultations and case conferences.

■ The development of services for 'quality counselling'.

Communication

■ There should be a concerted effort by senior clinicians to change the attitudes of condescension and non-involvement with GPs that still persist in some mental health service units.

■ There should be discussions about improving personal contacts.

■ There should be regular audit of correspondence.

Education

Undergraduate medical education: There might be value in local Divisions of General Practice

approaching university Departments of General Practice with a view to having input into the development of new undergraduate curricula.

Postgraduate education for GPs: Educational programs for GPs should be driven by local Divisions; however the following topics might be useful:

- Diagnostic criteria and the skills involved in the detection of mental disorder.
- Information about treatment strategies, especially non-pharmacological interventions.
- The skills involved in carrying out non-pharmacological interventions.
- The local resources available for treatment.
- The placement of GPs in mental health services.

Concluding comments

This study has provided useful information to assist in improving mental health services in WA. A number of useful initiatives have commenced as a result of this study that have the potential to improve service integration. Consistent with the findings of this study, the focus has been on further defining primary care psychiatry, improving access, and working on communication and education.

Competing interests

None identified.

References:

Ash D, Burvill P, Davies J, Hughson B, Meadows G, Nagle T, Pargiter R, Rosen A, Singh B & Weir W 2001, Mental health services in the Australian states and territories, in G Meadows and B Singh (eds), *Mental health in Australia, collaborative community practice,* Oxford University Press, Melbourne.

Andrews G, Hall W, Teeson M & Henderson S 1999, *The mental health of Australians: national survey of mental health and wellbeing, Report 2,* National Health and Medical Research Council Psychiatric Epidemiology Research Centre, The Australian National University.

Annual Reports 1960–1984:

Western Australia: Report of the Inspector General of Mental Health Services for the years ended December 31st 1960, 1961.

Report of the Acting Director of Mental Health Services for the year ended December 31st 1962.

Report of the director of Mental Health Services for the year ended December 31st 1963.

Report of the Director of Mental Health Services for January 1st to June 30th 1964.

Report of the Director of Mental Health Services July 1st 1964 to June 30th 1965.

Annual Reports of the Director of Mental Health Services July 1st to June 30th for the years 1966–1983.

Australian Bureau of Statistics 1998, *1996 census of population and housing; selected family and labour force characteristics for statistical local areas,* Canberra.

Britt H, Miles DA, Bridges – Webb C, Neary S, Charles J & Traynor V 1993, A comparison of country and metropolitan general practice, *The Medical Journal of Australia,* vol. 159(suppl), S9-64.

Buchan T 1991, Some problems in the management of residents in psychiatric hostels in Western Australia, *Psychiatric Bulletin,* vol. 15, pp. 557-9.

Burdekin Report 1993, *Human rights and mental illness: report of the National Enquiry into the Human Rights of People with Mental Illness,* Human Rights and Equal Opportunities Commission, AGPS, Canberra.

Groom G & Hickie I 2003, *Out of hospital, out of mind! A review of the mental health services in Australia – 2003,* Mental Health Council of Australia.

Health Department of WA 1996, *Making a commitment: the mental health plan for Western Australia,* HDWA.

Lawrence D, Holman CDJ, Jablensky AV, Fuller SA & Stoney AJ 2001, Increasing rates of suicide in Western Australian psychiatric patients: a record linkage study, *Acta Psychiatrica Scandinavica,* vol. 104, pp. 443-51.

McDonald D 1987, Mentally ill need help from society, *Border Morning Mail,* Albury, Tuesday June 8, p. 8.

Ministerial Task Force 1996, *Report of the Ministerial Task Force on Mental Health,* Mental Health Task Force.

Mitchell N 1987, Living hell for ill, *Daily News,* Warwick, May 19, p. 2.

National Mental Health Policy 1992, *National Mental Health Policy,* Australian Health Ministers, Canberra.

Second National Mental Health Plan 1998, *National Mental Health Strategy,* Australian Health Ministers, Canberra.

National Mental Health Plan 2003–2008 (draft version 2.4) 2003, May, Australian Health Ministers, Canberra.

Williams G 1987, The mentally ill we've abandoned, *The Melbourne Age,* September 24, Good Weekend suppl, pp. 30-6.

□