Piloting Case Conferencing Between GPs and Mental Health Services: Phase II of the Northern Queensland Rural Division of General Practice Mental Health Program

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Phase two of the Northern Queensland Rural Division of General Practice Mental Health program involved the piloting of case conferencing between General Practitioners (GPs) and mental health professionals in three rural communities. The initial findings suggest that this model supports GPs by increasing their confidence in the management of patients with whom they find it most challenging to work. Mental health professionals indicate that the opportunity to consult with GPs on a regular basis is important to their clinical work, and see the primary focus of these consultations as a means for communicating with GPs. The case conferencing also led to modest improvements in relationships between GPs and mental health service providers.

There is an increasing recognition of the role of general practitioners (GPs) in the delivery of mental health services (Australian Health Ministers, 1998; Dowrick, 1992; Holmwood, 1998). However, GPs frequently report feeling unsupported in treating mental health problems (Alsop & Battye, 1999), and Sheehan, Doolan, and Veitch (1996) indicate that the involvement of privately practicing GPs in community health networks has been relatively rare in rural settings.

The Northern Queensland Rural Division of General Practice Mental Health Program, funded through the Department of Health and Aged Care, has been in progress since January 1998. This program aims to involve GPs in working in collaboration with existing mental health services and has two overall goals: 1) to facilitate a higher quality of mental health service provision for people with mental health problems through better integration of GPs and mental health services, and 2) to integrate better GPs and mental health services through the development and implementation of a system of 'increased consultation' in the management of people with mental health problems.

Interviews early in the program with GPs and mental health professionals in the Northern Queensland region (including Townsville) identified barriers to the management of patients with mental health problems (component of phase I of the program). These were categorised into three areas of concern: 1) referral processes, 2) feedback, and 3) general communication or 'cultural' differences between GPs and

mental health professionals (Alsop & Battye, 1999).

In response to these identified problems the University of New South Wales Centre for GP Integration Studies, Townsville Integrated Mental Health Services, and the Northern Queensland Rural Division of General Practice, Mental Health Program piloted a case conferencing model involving a structured consultation framework for collaboration between GPs and mental health professionals in developing management plans for people with mental health problems. The model was implemented with the support of GPs and mental health services in three rural towns, Bowen, Charters Towers, and Ayr where mental health services (psychologist or clinical nurse) had recently been established, replacing an earlier system of fortnightly visits from mental health workers from out of town.

The aim of case conferencing was to:

- increase collaboration between GPs and the Integrated Mental Health Service;
- increase GPs' confidence and knowledge in the management of patients with mental health problems;
- increase mental health professionals' confidence in and knowledge of the management of patients with mental health problems; and
- improve the quality of care for patients with mental health problems.

Case conferencing sessions were held at differing intervals in each town (monthly, bi-monthly and in one community only once) and involved local GPs and mental health professionals. The case conferences were organised by the Northern Queensland Rural Division of General Practice Mental Health Program Coordinator. GPs voluntarily presented cases through an open invitation by the program coordinator, who followed up with each GP to obtain further detail regarding cases for presentation. At each session GPs presented a case to peers, a visiting psychiatrist, and local mental health professionals. They documented patients' presenting problems, the diagnosis and current interventions, and all participants then contributed to developing and documenting a patient management plan. The sessions lasted approximately one hour each. The intention of these conferences was to review one patient in detail during the session. Specific forms were developed as an outline for GPs to follow when presenting a case for discussion. These forms were designed to ensure relevant information was noted, and to provide written documentation of the session. Additional forms included patient consent for release of information, and management plans which were developed through the case conferencing process.

Methodology

The qualitative approach to evaluating the effectiveness of this model included interviews at three stages of implementation: before the sessions, just after the sessions and then six months later. All interviews were conducted by the Mental Health Program Coordinator.

Preliminary, group interviews were held with GPs and mental health professionals in each of the towns prior to the introduction of Case Conferencing. The purpose of these interviews was to:

- develop a base line regarding current communication deficits;
- identify attitudes toward collaborative relationships; and
- generate potential modifications to the proposed case conferencing model to suit local needs.

When case conferences had begun, individual telephone interviews were conducted with GPs (n=10) and a combination of face to face (n =1) and telephone interviews (n=3) were conducted with mental health professionals within one

week of each session. These interviews aimed to identify:

- changes in practice; and
- changes in the relationship between GPs and mental health professionals.

Two six-month interviews were conducted with GPs and mental health professionals together in group interviews in Ayr and Charters Towers following the implementation of the model. The post interview concerned the:

- effectiveness of the case conferencing model;
- strategies for maintaining the model; and
- benefits/deficits of the model.

Information was recorded and collated by the interviewer/program coordinator who also observed the process of case conferencing. Data was analysed through the process of identifying major themes and categorising responses according to identified themes.

Results

A total of 10 case conferencing sessions were held in the region over a six month period. Six of these were in Ayr, three in Charters Towers and one in Bowen, the differences reflecting the GPs' decision to meet monthly or bi-monthly and the availability of psychiatrists in each town. Overall, a total of 24 (out of 32) GPs participated in the case conferencing initiative. The findings of the evaluation fall into three main categories: 1) the organisational or structural issues involved in establishing case conferencing 2) the actual content of the sessions, and the types of cases reviewed, and 3) the results from the evaluation process as outlined in the methodology.

Organisation

GPs and mental health professionals indicated that it was essential to have a psychiatrist present at the case conferences. However, this was not easy to achieve. The shortage of psychiatrists and the heavy workloads of psychiatry registrars who were visiting rural communities became more pronounced during the implementation of this pilot. Ayr was one rural community, located one hour south of Townsville, a larger provincial/urban centre, that was the least affected by this shortage and received steady, fortnightly visits from a consultant psychiatrist. Charters Towers also maintained a fairly stable service from visiting psychiatrists, However, mid year, the introduction of a 'fly-in, fly-out' psychiatry service, resourced by various psychiatrists from an urban, Brisbane-based Health District, replaced the previously regular fortnightly visits from a consultant psychiatrist in Townsville. In Bowen, that was located two hours south of Townsville, the commencement of case conferencing was severely delayed. Although visiting psychiatry services were available in Bowen, the workload, and an agreed upon time for case conferencing to occur, being in the evening, were difficult to wed. This shortage of psychiatrists in the region has affected the success of piloting the model on a broader basis.

Description of sessions

The types of cases that GPs frequently presented included individuals with the following conditions: personality disorders, psychosomatic complaints, Munchausen syndrome by proxy, drug seeking behaviours, alcohol dependency, and depression (including reactive depression, and post-natal depression). Other psychological and social problems included issues such as grief, loneliness, and pain management, however, these issues were of secondary clinical focus.

Through the process of consultation, in the majority of cases, medical interventions were not expected to produce a cure. Many of the patients that were presented had been on a range of medications over the course

of several years or more. In all but one case, the recommendations, or treatment plans involved engaging the local mental health professional (clinical nurse or psychologist) to work with the patient as a method of minimising harm and modifying behaviour through psychotherapeutic interventions. The following vignette illustrates both the content and process involved in case conferencing.

Evaluation

Preliminary group interviews

The initial group interviews with GPs identified a range of anticipated barriers and benefits to establishing effective case-conferencing, including:

- heavy work loads
- lack of time
- potential lack of availability of visiting psychiatrist
- the acknowledgement that case conferencing requires a leader or 'driver' in order to be sustainable
- GPs' unfamiliarity with working in a group
- difficulties between public health care versus private health care practices
- uncertainty as to how case conferencing meets the needs of general practice

The benefits of case conferencing were expected to be: consistent, coordinated care, best practice treatment, learning from other professionals, the opportunity to increase the quality of patient care, ability to identify role delineation/responsibilities for patient care, knowledge of individual professionals, and gaining assistance in day to day practice for patients that might be challenging or high risk. Participants also identified that over time, the case-conferencing model had the potential to solve or improve on a range of

Vignette: Reflection on the Completed Suicide of a patient

Presenting Problem: A GP presented a patient he had been seeing for several years. The GP described Mr X as a 37-year-old male who reportedly suffered from a personality disorder, substance abuse, and chronic depression. 1-2 months ago Mr X indicated that he 'wanted to get off alcohol'. In the past, the GP had previously supported him in a few unsuccessful attempts at home detoxification. Locally, there are limited Alcohol and Drug Services available. 1-2 days prior to the case conferencing session, Mr X committed suicide. The GP wanted to discuss the best process of supporting Mr X, and now, how his suicide may have been prevented. Other questions included issues regarding the effectiveness of home detoxification, and/or alcohol and drug rehabilitation.

Consultation Process: The visiting Psychiatrist indicated that Mr X presented to her one year ago. At that time Mr X was 'malodorous, dishevelled, intoxicated and rambling incoherently'. Mr X was experiencing financial difficulty, abused his defacto so severely that she was hospitalised, demonstrated violent outbursts, engaged in multiple substance abuse, and was 'extremely dysfunctional'. He repeatedly cancelled appointments with the psychiatrist. The local Psychologist, working in the community for 14 months now, indicated that she had never seen Mr X, nor had she had any referrals to see him.

The GP and other local GPs, including the hospital medial superintendent were also familiar with Mr X, and indicated that he would present to the local rural hospital requesting 'Valium and a 'sharps disposal''. The local hospital also considered admitting Mr X for detoxification. However, the hospital was unable to provide this type of medical service on a regular basis. Previous experience with local hospital detoxification had been ineffective for most patients.

The psychiatrist indicated that it was unrealistic to consider home detoxification as a successful option for Mr X, and believed that alcohol and poor impulse control were contributing factors to his recently completed suicide.

Locally, there are no alcohol and drug services. Though the local psychologist has experience in working with Alcohol and Drug services, mental health services and Alcohol and Drug services work best in collaboration. People seeking alcohol and drug treatment are required to travel one hour north to receive intervention, and must be highly motivated to do so. The Townsville General Hospital also provides detoxification in the hospital. However, there is a high demand on the availability of these beds, and a long waiting period.

One GP challenged his colleagues and expressed frustration at the inability of health professionals to support patients with these types of social-emotional problems. However, all case conferencing participants conceded that though they care for their patients, and are upset by this loss, sometimes there are limitations to medical, psychological and social interventions that may be applied. At times it is difficult, if not impossible, to predict an incident of a suicide.

barriers including issues regarding patient referral and follow-up.

In order for case conferencing to be effective, mental health professionals and GPs identified that the case conferencing sessions must be of a high quality to be worthwhile. They further identified that all participants must be committed to the process, and the presence of a psychiatrist was of great importance to the potential success of the model.

Individual interviews

Following the case conferencing session, the GPs and Mental Health Professionals were interviewed individually.

General Practitioners

GPs indicated that the case conferencing session met their needs and provided them with reassurance and support. As one GP stated, the case conferencing session.

> *helped reinforce for me that what is being done is appropriate'. As another GP stated, the process 'helps to affirm that you are doing the best you can for complicated patients.*

Other comments indicated that the process:

> *helps GPs deal with their own frustration with long term patients who may have long term problems even if the plan is to just affirm that you are doing your best (GP).*

These comments suggest that the case conferencing is achieving one of its primary aims which is to increase GPs' confidence in their management of patients with mental health problems. At this stage, they generally did not report any significant changes in the management of their patients, or any changes to their referral patterns. Changes would have been represented by GPs reporting any different types of referrals or different referral processes such as GPs providing more information with each referral, or increasing referrals to local psychologists rather than psychiatrists.

There was a mixture of comments about GPs' relationship with mental health professionals. Most GPs indicated that the process of consultation was beneficial in enhancing the their understanding of the patient and in enhancing their own relationship with mental health services, as illustrated by the following comment:

> *I can now see that issues and problems require a broader-based approach - multi-factorial problems need more input.*

Some GPs reported that they had had negative interactions with mental health professionals in the past. The case conferencing process seemed to repair these relationships. GPs were generally grateful for the services that were available. Other GPs expressed disappointment when not all of the mental health professionals were able to attend the case conferencing session.

Additional benefits for patients were noted by GPs. These benefits included the introduction of new information and the ability to develop a consistent response to patients' needs:

> *Other people become aware so that a consistent view was developed.*

> *patients seek out help without telling you. I was surprised at what they do.*

Mental Health Professionals

Responses from individual mental health professionals were obtained at various stages following the case conferencing session, some being interviewed after having participated in several case conferencing sessions, and others being interviewed within one week of a relevant case conference. Mental health professionals indicated that they gained a new perspective on the GPs' management of patients:

> *I was surprised by the amount of medication that was being administered.*

I tend to have a different approach, the medical model focuses on medication. It seems a bit much.

The patient identifies more with their GP. The patient has a better relationship with the GP and hospital doctor.

GPs seem to manage so much on their own .

The responses obtained from mental health professionals generally indicate an enhanced relationship with GPs, as the following comments show:

Much better relationship here than where I previously worked. [We have a] *respectful relationship with GPs.*

[Case Conferencing] *allows me with the opportunity to meet with them [GPs] that I would not otherwise have.*

Mental health professionals also indicated that they thought that the case conferencing sessions were likely to have enhanced patient care:

Better practice to share information, this way I am able to constantly monitor medication of patients referred to GPs.

I was able to support [offer consultation] *on a patient with alcohol and other problems, treating the symptoms of personality disorder requires structure and consistency.*

A number of patients already had psychiatry services involved, in some cases adapting a biological approach could have caused harm.

Therapy and medication should go together.

However, some problems were identified with the referrals received from GPs. There was only limited success in addressing this, with comments suggesting that referrals continued to lack detailed information.

Six-month group interviews

The results from the group interviews conducted after the six-month trial indicated general satisfaction with the structure of the case conferencing sessions. GPs and mental health professionals indicated that the sessions had provided them with the opportunity to familiarise themselves with other health professionals whom they would not generally get to know. The GPs highlighted how their familiarity with mental health professionals increased their confidence in referring patients to mental health services and professionals. These comments were reciprocated by the mental health professionals who indicated that the communication they had with GPs through case conferencing made it easier to suggest GPs refer patients to the service. One GP also indicated that the sessions increased her confidence in managing difficult patients.

Participants did not identify any barriers to continuing the case conferencing, although they recognised that the lack of time was an ongoing difficulty, there was little that could be done to overcome this problem. Most participants were satisfied with the setting, and time of day for the sessions. The group also agreed that the clinical focus to the case conferencing was of the greatest benefit.

Discussion

Thomas and Corney (1993) found that GPs who were more closely involved with mental health professionals were more satisfied with the service and were more likely to refer to that service. The results of the case conference pilot in Northern Queensland support these findings. Despite the difficulties associated with establishing and maintaining the case conferencing sessions, due to the lack of available psychiatrists in the region, case conferencing appears to be a highly effective tool for supporting GPs in their management of patients with mental health problems.

Other limitations to the case conference involve the sustainability of GP payments. Currently, the Northern Queensland Rural Division of General Practice, funded through the Department of Health and Aged Care, has been able to support GP participation in case conferencing by providing remuneration for GPs' clinical or after hours time. the GPs' response to the consultation process has been positive, and it is likely that the model could be sustained simply through interest, GP remuneration is a critical component for the long term sustainability of 'case conferencing'. As Thomas and Corney (1993) indicate, enhanced relationships between GPs and mental health professionals is efficient and also desired by GPs. However, the sustainability, policy, and funding related to these initiatives need to be examined in conjunction with the evolving role of both mental health services and primary care (Jones, Parlour, & Badger, 1982).

There are a number of benefits to the model. Not only is the model an educational opportunity, but it is also highly relevant to the clinical practice of GPs and mental health professionals. By providing a structured framework to the case conferencing sessions, there is a clear focus to the session, and an effective use of time. By reviewing cases that are relevant to both GPs and mental health professionals, there is also less demand on the educational process. That is, there is less need for mental health professionals to prepare materials for a didactic lecture. This framework also provides GPs with the best opportunity for applied, problem-focused learning and an opportunity for peer review.

The model also has potential benefits for the education and training of student health professionals during their community-based placements. The value of general practitioners working with a range of health professionals for a range of health issues needs to be instilled early in GPs' medical careers. The concept of case conferencing could also be applied to other aspects of health.

Further evaluation and future directions of case conferencing need to consider patient outcomes, the inclusion of other relevant community agencies that might be involved in supporting patients' needs, and the broader dissemination or expansion of case conferencing to include a wider range of GPs. The introduction of the use of clinical audits and psychological measures or protocols such as those used in the widely recognised SPHERE depression management program (Hickie, et.al., 1998) can be utilised to demonstrate efficacy rates for a particular subset of patients. Such measures if applied in a meaningful way would further enhance the merit of case conferencing. There is also evidence that the engagement of patientís and carers in the process of self-regulation and self-management of symptoms leads to greater level of success for patients (Weinman, 1999). Strategies for utilising the 'case conferencing' as an extension of treatment, by which patients and their families can be involved in the process of consultation should be incorporated into the model.

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