Brief Report

Developing an Integrated Mental Health Care Service:

Description of a Pilot Mental Health Consultation/Liaison Clinic in a Primary Care Centre

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Abstract

To determine if a consultation/liaison mental health clinic in primary care as proposed for Vision for Change, The Primary Care Strategy and the Department of Health is an efficient model of delivering mental health care in Ireland.

Methods: The pattern of service use and the clinical characteristics of new patients attending a pilot consultation/liaison clinic in a local primary care centre were studied.

Results: During the first 16 months of this clinic 1.2% of patients did not attend the initial assessment in the liaison clinic versus 29.75% in the regular Outpatients Department (OPD). Less than one in five (17.1%) required a follow-up review with the clinician in the consultation/liaison clinic compared to almost all patients first seen in OPD secondary care (96.6%). A small minority of patients (6.1%) needed referral to secondary care due to the complexity of their presentation.

Conclusions: A consultation/liaison mental health clinic in primary care results in an efficient use of manpower resources due to the low Did Not Attend (DNA) rates and low proportion of formal referrals to secondary care. As patients seem to favour this type of setting, over traditional outpatient departments, a move towards consultation/liaison clinics in the primary care team should be considered.

Key words: Community mental health services, primary health care, ambulatory care, referral and consultation.

Objective

In Ireland one in seven adults experience mental health or emotional difficulties every year.[1] Most of them will benefit from support within their community, such as that given by family and friends, while others will seek help from their GP if their symptoms persist. Most mental health problems are dealt with within primary care, but a small proportion (4.3%) will require referral to secondary care.[2]

This layered framework of mental health provision (community support, primary and secondary care) requires a degree of flexibility that can respond to the needs of the individual.

Over the past two decades, there has been a growing international interest in assessing the working relationship between primary care and secondary mental health care.[3] The integration between these services is a viable way of ensuring that people receive the mental care they need. A number of interesting models have been proposed ranging from a pure referral model to the primary care training model where formal training sessions, seminars and guidelines are provided by secondary care.[4,5] A collaborative care approach where patients are jointly managed by primary and secondary care, sometimes with the support of a case manager, is another example currently in use in Ireland.[6,7]

Despite the variety of models, there continues to be a lack of evidence regarding which type of interaction is the most clinically effective.[5] The increasing consensus is that the type of integration between primary and secondary care should respond to local needs.[4,8]

In Ireland, both Vision for Change and the Primary Care Strategy promote a consultation/liaison model.[9,10] This involves the community mental health team designating a worker who acts in a consultative capacity to GPs and screens cases if necessary. The purpose of this model is to supplement and enhance the GP's skills in the detection and management of mental illness while enabling the primary care team staff to screen and refer more effectively to secondary care. This type of model has been successfully introduced in other countries.[11-14]

With these considerations in mind, we developed a pilot consultation/liaison mental health clinic within the local primary care centre.

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Method

The primary care team (PCT) operating in Kilkenny city centre is staffed by seven GPs and two GP trainees with the support of four practice nurses and other allied health staff. Three community mental health teams provide mental services in Co Kilkenny, covering a population of approximately 95,000 distributed mostly in suburban and rural areas. Each team provides an initial assessment clinic on a weekly basis.

The consultation/liaison mental health clinic was set up in April 2010. The senior registrar training in the Carlow/Kilkenny Mental Health Services provides a psychiatric liaison clinic one afternoon every two weeks. Referrals are made through the general practice health information system (waiting time is usually no longer than two weeks). Approximately two to four new patients are booked into each clinic. Patients are seen in one of the clinical rooms of the primary care centre, adjacent to the GP rooms.

The criteria collaboratively developed to refer patients to this clinic include those adult patients who were traditionally referred to secondary mental health services for further assessment and care. This includes people living in Co Kilkenny and experiencing complex or unresolved mental health symptoms that have failed to respond to at least one intervention; or when there is a difficulty establishing a diagnosis. As we were interested in assessing if unnecessary referrals could be avoided to secondary care, patients already attending the community mental health team were not referred to this clinic, nor were cases requiring an urgent assessment.

Each assessment takes approximately 30 minutes. At the end of the assessment an oral formulation is given back to the patient. The senior registrar documents in the PCT's health information system the results of the assessment and a suggested management plan for the GP to follow. This typically involves a series of steps regarding management of medication, plus suggestions for appropriate referral to local psychological, social services, peer support groups or appropriate voluntary agencies.

Cases seen in this clinic are discussed with the consultant psychiatrist during the supervision sessions or by phone. The patients remain under the care of the local primary care team.

Results

Over a period of 16 months, 82 patients were referred to the liaison clinic. Of those who attended, 55 were female with an average age of 39 years old (Table 1). More than half of the patients seen (67.1%) presented with a mood or an anxiety disorder (Table 1).

Of those patients that were assessed in the clinic, five (6.1%) were referred to secondary care due to the complexity of their presentation (one patient with a diagnosis of paranoid schizophrenia, two patients with an eating disorder, one patient with severe social phobia and one patient with a severe major depressive episode) see Table 2. Two patients (three percent) were previously attending the secondary care services and were re-directed to these (one patient with a diagnosis of paranoid schizophrenia, and one patient with a diagnosis of generalised anxiety disorder).

Table 1. Demographic and clinical profile of patients attending the liaison clinic

Demographics	N (%)
Female	55 (67.1)
Average age	39
Diagnosis	**N (%)**
Mood Disorder	30 (36.6)
Anxiety Disorder	25 (30.5)
Other	15 (14.6)
No clear axis I or axis II disorder	6 (9.1)
Substance/alcohol misuse	4 (6.1)
Psychotic Illness	2 (3)

Table 2. Care pathways for patients referred to the clinic

	N (%)
Total of patients referred to the liaison clinic	82 (100)
Not attendance to first assessment ("DNA")	1 (1.2)
Requiring further follow up by Senior Registrar	14 (17.1)
Referred to secondary care	5 (6.1)
Requiring admission to a psychiatric unit	0 (0)

Regarding the number of times these patients attended this clinic, 68 (82.9%) of them were seen on one occasion only, but 14 patients (17.1%) required at least one follow up review by the senior registrar. Only one patient (with a history of post-natal depression) required two further follow up sessions (Table 2).

Of note, only one patient (1.2%) did not attend the initial assessment in the liaison clinic. None of them required inpatient care (Table 2).

In parallel with the development of this liaison clinic, a reduction in the numbers of referrals to the adult mental health teams from this primary care centre was noticed - from 12 patients in the trimester April – June 2010 to two patients in the same period two years later (Fig 1). This is accompanied by a reduction in the DNA rate for first assessment in secondary care to 0% (January to September 2011).

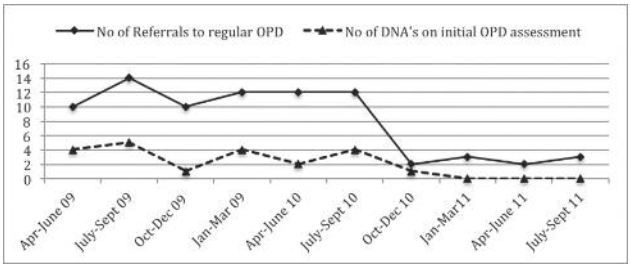

Figure 1: Numbers of referrals from Kilkenny Primary Care Centre to the local regular OPD clinic for initial assessment before and after the establishment of the liaison clinic in April 2010.

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Discussion

Our results show that this type of consultation/liaison clinic could contribute to a better planned and more efficient use of the mental health services due to the low DNA rate and a lower proportion of referrals to secondary care.

The DNA rate at the consultation/liaison clinic is extremely low (1.2%), particularly when compared to a rate of 29.75% in our local secondary mental health service. This DNA rate in our OPD is in line with other national and international services.[15]

The low DNA rate at the primary care centre suggests that patients attending a psychiatric assessment find it easier to do so in their own primary care setting rather than in secondary care. This is in line with previous surveys.[16] A number of reasons may contribute to this. For example, patients invited to attend an appointment in the department of psychiatry could find it stigmatising, therefore may be less likely to attend. Also, patients might find an increased sense of personal care by attending their GP practice and by interacting with familiar staff. Another possible contributor to this rate is that this primary care team centre operates a system of automatic SMS appointment reminders, which has been shown to reduce the rate of missed appointments.[17]

We believe that there are two other factors that make this type of clinic manpower efficient. Firstly, the small proportion of formal referrals to secondary care (6.1%) on behalf of the senior registrar. This referral rate is similar to the mean national rate of referral (4.3%) but was only achieved once the consultation/liaison clinic was set up.[2] A pre-existing higher rate of referrals (from GPs in the primary care team) could be explained by the different characteristics of the local population and/or general practitioner referring style. Secondly, fewer than one in five patients required more than one session with the assessing psychiatrist, in contrast to 96.6% of patients first seen in the regular OPD in secondary care by the local team. This was likely to be achieved by a combination of a clear documented management plan in the IT system and the mutual clinical support between the senior registrar and the local GPs.

This type of clinic could eventually reduce the size of outpatient clinics run in the secondary care setting, allowing the community mental health team to deploy its resources on cases with a higher degree of complexity. In the same line, it could encourage patients to seek help earlier and improve the detection of the early stages of mental illness.

While not formally assessed, the GPs in the primary care team were unanimously satisfied with this model of consultation/liaison clinic. They found the opportunity to interact closely, on a clinical and educational level, with the attending senior registrar very helpful.

From the senior registrar's point of view, it was very helpful to promptly access clinical information in the medical information system as this assisted the assessment of each patient. Additionally, the possibility of documenting a management plan directly in the GP notes aided communication between the specialist and the GP and actually eliminated the administrative effort and associated cost of producing letters.

A number of issues should be considered when analysing the impact of this type of service. To be efficient from a manpower and time management resource point of view, this type of clinic may require a large primary care centre that is a big source of referral to the secondary mental health services. We are aware that this type of centre is not readily available throughout the country. This clinic may need to be adapted to the infrastructure and the needs of the local/virtual primary care team; for example by either running it in a local health centre or in a centrally located GPs' clinic.

A possible limitation when interpreting the results of this pilot project, is that patients seen in this liaison clinic may have not needed referral to the secondary mental health services. A qualitative analysis of patients attending both the initial assessment in the OPD (before and after the introduction of the liaison clinic) might have helped to elucidate if this new clinic was responsible for this drop in the referral rate. On the other hand as Fig 1 shows, the number of patients referred to our traditional OPD fell dramatically once the consultation/liaison clinic was set up. Another possible limitation is that no conclusions could be made regarding the effectiveness of clinical interventions in both settings (e.g. magnitude of response, frequency of remission); this was not the scope of our project.

We are currently developing the second stage of this project that builds on the experience gained so far. This involves shifting the outpatient psychiatric clinic from the local department of psychiatry to the primary care team facility.

Conclusion

Our pilot study suggests that the model of integration proposed by *Vision for Change* is successful. From a service provision point of view, this service is efficient due to the low DNA rate and the small proportion of people that need referral to secondary care. Clinicians in primary and secondary care found this type of clinic to be a relevant and effective way of communicating and providing mental health care. In addition, it seems that patients find that this type of service meets their needs better than the traditional mental health outpatient clinics. Patients may benefit from a more extensive integration between primary and secondary care.

Declaration of Interest

None.

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