What do general practitioners and community mental health teams talk about? Descriptive analysis of liaison meetings in general practice

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SUMMARY

Background. *Liaison meetings between psychiatrists and general practitioners are now well established. Much has been written about their purpose and structure but little about their content.*

Aim. *A study aimed to describe the clinical focus of meetings between a community mental health team and general practitioners and the nature of the professionals' interactions.*

Method. *Audiotapes of six consecutive monthly meetings between a community mental health team and general practitioners in two general practices were analysed.*

Results. *Attendance rates among professionals were over 70%. Over 90% of discussion time was focused on patient-centred clinical matters. Almost two thirds of interactions were focused on patients receiving ongoing joint care; few interactions were devoted to new referrals or to patients who had not been assessed. Psychotic patients, although accounting for 15% of referrals, occupied 54% of patient-centred discussion time. Most interactions consisted of reciprocal information exchange between members of the community mental health team and general practitioners.*

Conclusion. *The high attendance rates indicate that both general practitioners and community mental health team members considered these meetings as high priority. The steady move towards management of severely ill psychiatric patients in the community rather than in hospital requires close collaboration between primary and secondary care teams. The meetings described in this paper appear to be a simple, manageable and sustainable response to this need.*

Keywords: interprofessional relations; general practitioner – psychiatrist relationship; community mental health centres; general practice.

Introduction

SINCE Shepherd and colleagues[1] demonstrated the high prevalence of psychiatric disorders in general practice populations interest in the role of the psychiatrist in liaison with general practitioners has increased.[2,3] One in three psychiatrists in Scotland devote regular time to some form of general practitioner liaison, compared with one in five in England.[4] A collaborative approach in which psychiatrists support and facilitate, rather than replace, the work of general practitioners has gained most support.[5] Several authors have emphasized the importance of liaison meetings[6–8] but few have described the form and content of such meetings in any detail, and those who do so suggest widely differing styles.

Creed and Marks found that participants in these meetings concentrated on clinical problems raised by general practitioners and on patients who had not been referred.[6] Tyrer and colleagues found that liaison contacts usually lasted under five minutes, suggesting a less structured approach.[8] Mitchell acknowledged that meetings varied according to patient group and those attending.[5] He distinguished patient-centred discussion focusing on individual cases and management, and doctor-centred discussion examining the dynamics of the doctor–patient relationship. Mitchell listed five essentials for liaison meetings: regularity, face-to-face contact, sufficient time for understanding, common meeting ground and open communication based on respect and trust.[5] Strathdee[7] identified coordination, continuity and integration of care as key general practitioner requirements from a community service, along with better communication and outreach.

The quality and adequacy of traditional communication between general practitioners and psychiatrists by letter has been questioned[9] and informal contact, both in person and by telephone, is becoming increasingly common.[10] Liaison meetings bring the potential benefits of improved access, increased mutual trust and the opportunity to discuss important non-clinical aspects of a patient's care.

Little has been written about the content of liaison meetings. Should they concentrate on patients already receiving shared care or on unassessed and newly referred patients? Should they be educational or directive? Is it better to discuss one or two patients in detail or cover a larger number briefly? Is there a risk that meetings will be dominated by discussion of 'heartsink patients', or could patients with long-standing psychotic disorders be neglected? There is no agreement about the frequency of meetings, who should attend them, how structured they should be or who should lead them. Should the meeting provide a forum for the general practitioners to pass on information or to ask questions and make requests? Should the psychiatrists present merely listen, provide reassurance and give advice, or should they take the opportunity to learn from the general practitioners?

A preliminary study was undertaken in order to describe the clinical focus of general practitioner–community mental health team meetings and the nature of the professionals' interactions.

Method

Practices and meetings studied

For the past 11 years, monthly liaison meetings between general practitioners and a community mental health team have been conducted in two health centres in south London, following experience in Dingleton Hospital, Melrose.[11] The meetings were instigated by a conviction that both the community mental health team and the general practitioners have roles to play in the care of mentally ill patients, and that the care of any patient must be clinically and functionally determined rather than simply reflect diagnostic categories.

At the time of the study, practice Y had five partners, a general practitioner registrar and a list size of 11 000 patients, operated from adapted premises and was becoming computerized. Practice

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Z had five partners, a list size of 10 500, operated from purpose-built premises and was already fully computerized. Neither was a fundholding practice.

The community mental health team consists of a part-time consultant, a senior registrar (attached for four sessions), a full-time registrar, two community psychiatric nurses, a part-time clinical psychologist, a social worker and a part-time occupational therapist. The team is responsible for outpatient and in-patient care of a settled suburban population of 29 000 in which there are only small pockets of deprivation. The team's approach is community oriented and relies heavily upon close cooperation with general practitioners.[12]

The community mental health team visits both study practices on the same day each month. Meetings are scheduled for one hour but are often shorter. There is no formal agenda but a list of the practice's patients currently in contact with the community mental health team is brought to each meeting. Usually the meeting is opened by the general practitioner whose patient has the most pressing clinical problem or by a general practitioner who has to leave early. Individual general practitioners frequently talk to a team member at the end of the meeting about particular issues.

Analysis of meetings

Audiotape recordings were made of six consecutive liaison meetings at each practice in 1993. A written record was made of the details of the people attending and length of meeting.

The audiotape recordings were rated independently by S M and C G and the meetings divided into a series of 'interactions', defined as the introduction of a new topic to the discussion that led to a measurable verbal interchange between professionals. Each patient discussed elicited at least one interaction.

Earlier discussion with the participating practices determined three categories to which interactions and lengths of interactions were allocated: patient-centred, academic-centred and administration-centred interactions.

Patient-centred interactions were further categorized according to clinical problem and referral status. From subsequent team discussion and prior knowledge of the patient the clinical problems were subdivided into 'psychosis' (schizophrenia, manic depression and all other severe disorders characterized by delusions and/or hallucinations) and 'neurosis' (interpreted broadly to include affective disorders, personality and adjustment disorders, psychosomatic disorders and classical neuroses). Referral status was subdivided into 'not assessed' by the community mental health team, 'newly referred' (assessed in the last month) and 'ongoing' (over one month had passed since assessment and the community mental health team was still involved).

The outcome of each interaction was allocated to one of six descriptive categories, which had also been determined by earlier discussion with the general practitioners: information provided by a general practitioner; information provided by community mental health team; mutual exchange of information; advice given by community mental health team; reassurance given by community mental health team; and decision made jointly.

The number of interactions in each of these six categories was compared. The 'reassurance' category was restricted to exchanges in which the community mental health team specifically reassured the general practitioners that their management was appropriate and that no change was needed.

The length of each interaction and the amount of time that general practitioners and the community mental health team spoke was recorded. Interactions were also divided according to whether they were initiated by a community mental health team member or by a general practitioner.

As this was only a preliminary study, formal inter-rater reliability was not assessed. However, the percentage of interactions allocated to the same categories by the raters and the percentage of outcomes allocated to the same categories were calculated. The Mann Whitney U-test test was performed to determine whether S M and C G were rating interactions or outcomes differently. Mean data were calculated for each meeting and the results for all six meetings at each practice were combined to give the final results.

Results

Inter-rater reliability

In 59% of 366 interactions the two raters allocated interactions to the same categories and in 82% of interactions they allocated outcomes to the same categories. The categories and outcomes to which interactions were assigned did not differ significantly between the two raters.

Attendance

At practice Y, general practitioners attended 73% of 30 potential attendances and at practice Z, 83%. Community mental health team members attended 77% of 48 potential attendances at practice Y and 77% at practice Z. Meetings lasted a mean 47 minutes at practice Y and 41 minutes at practice Z (range over both practices 32–55 minutes).

Allocation of meeting time

Overall, 91% of the meeting time in both practices was devoted to discussions about patient-centred (clinical) matters (80 minutes), 7% to administrative matters (six minutes) and 2% to academic issues (two minutes). Most of the clinical discussion (93% at practice Y and 84% at practice Z) concerned patients in ongoing contact with the community mental health team, just over half (54%) of this time being devoted to patients with psychotic illness. Mean length of discussions concerning psychotic patients (2.3 minutes) was slightly longer than discussions concerning neurotic patients (1.7 minutes) but the difference was not statistically significant. Psychotic patients represented 15% of referrals (32 of 210 patients referred in 1993). As shown in Table 1, the bulk of interactions concerned patients receiving ongoing joint care.

Interactions in which the outcome was information exchange represented over three quarters of all interactions (Table 1). In

Table 1. Outcome of interactions between the community mental health team and general practitioners, and patient referral status in the two study practices.

	% of interactions	
Category	Practice Y (n = 192)	Practice Z (n = 174)
Patient referral status		
Not assessed	*7*	*16*
Newly referred	*28*	*23*
Ongoing joint care	*65*	*61*
Outcome of interactions		
GP imparts information	*13*	*10*
Team[a] imparts information	*34*	*41*
Shared information	*28*	*28*
Team[a] gives advice	*8*	*10*
Team[a] gives reassurance	*4*	*4*
Joint decision	*13*	*7*

n = number of patient interactions in practice. [a]Community mental health team.

10% of interactions the community mental health team gave advice (for example to adjust medication) and in 10% a joint decision was made (for example to carry out a joint assessment or to formulate a policy to deal with future crises).

General practitioners from practice Y initiated fewer interactions than those from practice Z (30% compared with 44%) and spent fewer interactions discussing patients who had not been assessed (7% compared with 16%). Most interactions were initiated by members of the community mental health team (70% at practice Y and 56% at practice Z), who spoke for more of the time than general practitioners (68% at practice Y and 62% at practice Z)..

Discussion

Joint meetings between the community mental health team and general practitioners in the study practices are always regularly attended despite pressures on the attenders' time, suggesting that such meetings fulfil an important need. This analysis was conducted in an attempt to identify that need.

The most striking finding of the analysis was the amount of time spent in information exchange about patients already known to both the general practitioners and the community mental health team (accounting for more than 60% of interactions).

Discussion of psychotic patients, who represented 15% of referrals but generally have more complex needs, occupied half of clinical discussion time. This was reassuring given a commonly expressed concern that long-term problems might be displaced by less serious but more urgent issues. The meetings were not primarily concerned with unassessed patients, a finding that contrasts with other reports.[6]

The general style of the meetings was of practical, problem-solving discussion between professional colleagues. Members of the community mental health team rarely adopted an educational or consultative role.

Approximately 90% of time was spent discussing patients already in contact with the community mental health team; the bulk of the meetings concerned aspects of current clinical situations. Such discussions rarely led to final decisions. Only one in 10 interactions concluded with a clearly agreed decision (often an arrangement for a joint assessment or a policy for dealing with future crises). Another one in 10 interactions ended by the community mental health team advising the general practitioners on a course of action, typically an adjustment in a patient's medication.

The outcome categories used cannot fully convey the nature of the interactions. Both parties seemed to value the opportunity to share concerns. Information exchange often served as reassurance for both teams involved.

Managing mentally ill patients in the community requires professionals to tolerate considerable uncertainty. For example, one discussion centred on a disorganized and disruptive patient who repeatedly telephoned practice partners and ambulances at night, demanding admission to a psychiatric hospital but then refused to be admitted. All professionals involved in the discussion were aware of the risk of the patient committing suicide. The discussion confirmed what was and what was not feasible in her care. A more important function, perhaps, was mutual acknowledgement of the level of risk involved which dispelled concerns that either side was withholding information or had the definitive solution. The care of this patient was audited several months after her sudden unexplained death, and both teams expressed relief that everything possible had been tried.

The opening and closing parts of each meeting provided useful opportunities to discuss informally issues (both medical and political) that were considered not relevant to the whole team or not suitable for correspondence.

In the meetings described in this preliminary study, information was exchanged comprehensively about patients receiving joint care. This information would, in the past, have been exchanged exclusively by letter.

The government's recent emphasis on detailed needs assessment and providing assertive outreach has altered the demands on and expectations of general practitioners and psychiatric teams. The government's 'care programme approach' requires increasingly comprehensive and complex care plans to be formulated for patients in the community who often have severe and rapidly fluctuating disorders.[12] General practitioners occupy a pivotal role in this process but for their contribution to be fully realized good communication with other involved parties is essential. Exchange of letters is one facet of good communication but regular liaison meetings provide the detailed communication needed for effective coordination of community psychiatric care. In such meetings, the general practitioner can be made aware of the community mental health team's assessment and contribute to the planning process. The opportunity to explore and share the stresses involved in such work ensures greater commitment and a more equal, effective partnership.

The model described here could be improved by involving other members of the primary care team (such as health visitors or the practice nurse) and perhaps by focusing on shared care plans. A patient-centred format, in which the equal partnership of the community mental health team and the primary care team is acknowledged, is most likely to be sustained over a long period. Increased familiarity with each other as individuals leads to mutual trust and improved cooperation.

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