Austin Health

North East Area Mental Health Service, Austin Health: GP Shared Care Program- Discharge Planning Processes

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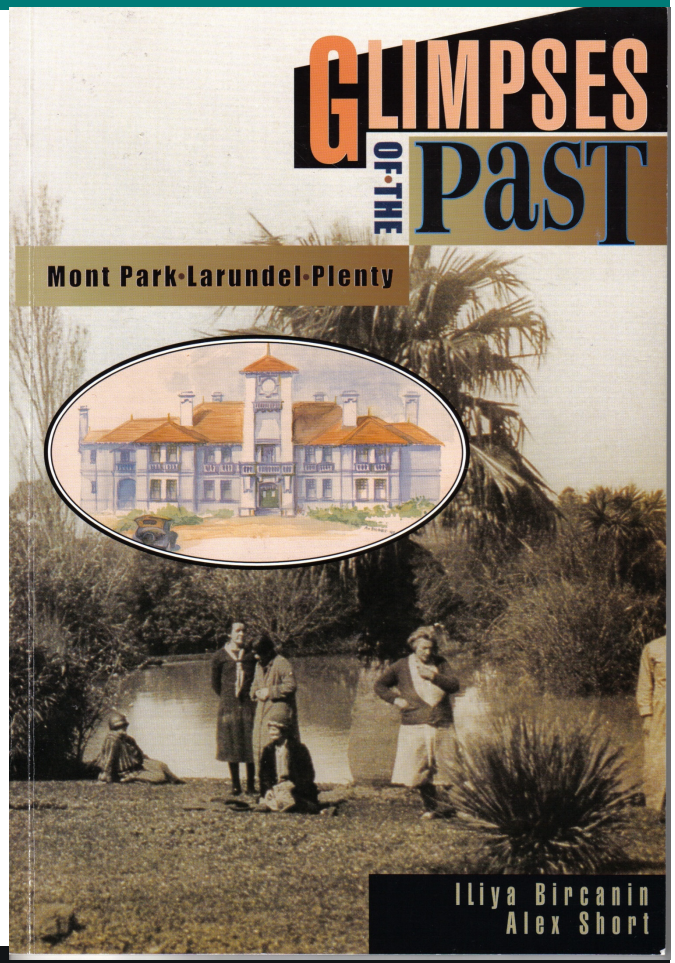
Consultant Psychiatrist
Shared Care Program-NE Area Mental Health

Cultural change

Effects of institutionalization

Shift to community psychiatry
- pharmacological improvements
- disability pensions

Concurrent integration with general medical services



Mainstreaming of services

Integration of services

Pharmacological improvements
- novel psychotropic medication
- efficacy with negative symptoms
- side effect profile -metabolic
  - cardiovascular
  - endocrine
  - haematological

Community Mental Health Services

Integration of community services 1999

Co-location of CATS,MSTS,PMHS
Consumer & Carer Consultants

CCS with sub centre of Shared Care

N.E Community Mental Health Service

Research Findings

Finlay et al 1994
Importance of breaking down barriers between medical & psychiatric care

Dombrowski et al 2004
Circulatory disease, diabetes, obesity, smoking, poor diet & sedentary lifestyle are responsible for most excess deaths in consumers with schizophrenia & BPAD.
Co morbid conditions of addiction, depression and anxiety exacerbates

Research findings cont…

Druss et al 2001
Integrated service for consumers with serious mental illness improves quality of life and outcomes of medical care.

Australian Division of GP's 2000 – 01
11 million visits to GP's are for mental health conditions

Literature Reviews

National Mental Health Plan 1993-1998

Australian Health Ministers policy 1998-2003.

National Mental Health Plan 2003- 2008

Department Human Service discharge planning 2002

CLIPP (Consultation Liaison in Primary Care & Psychiatry) Project by NWMHS – Dr. Graham N Meadows -1995

General Practitioners Clinical Attachments 1998

Primary care partnerships 2005

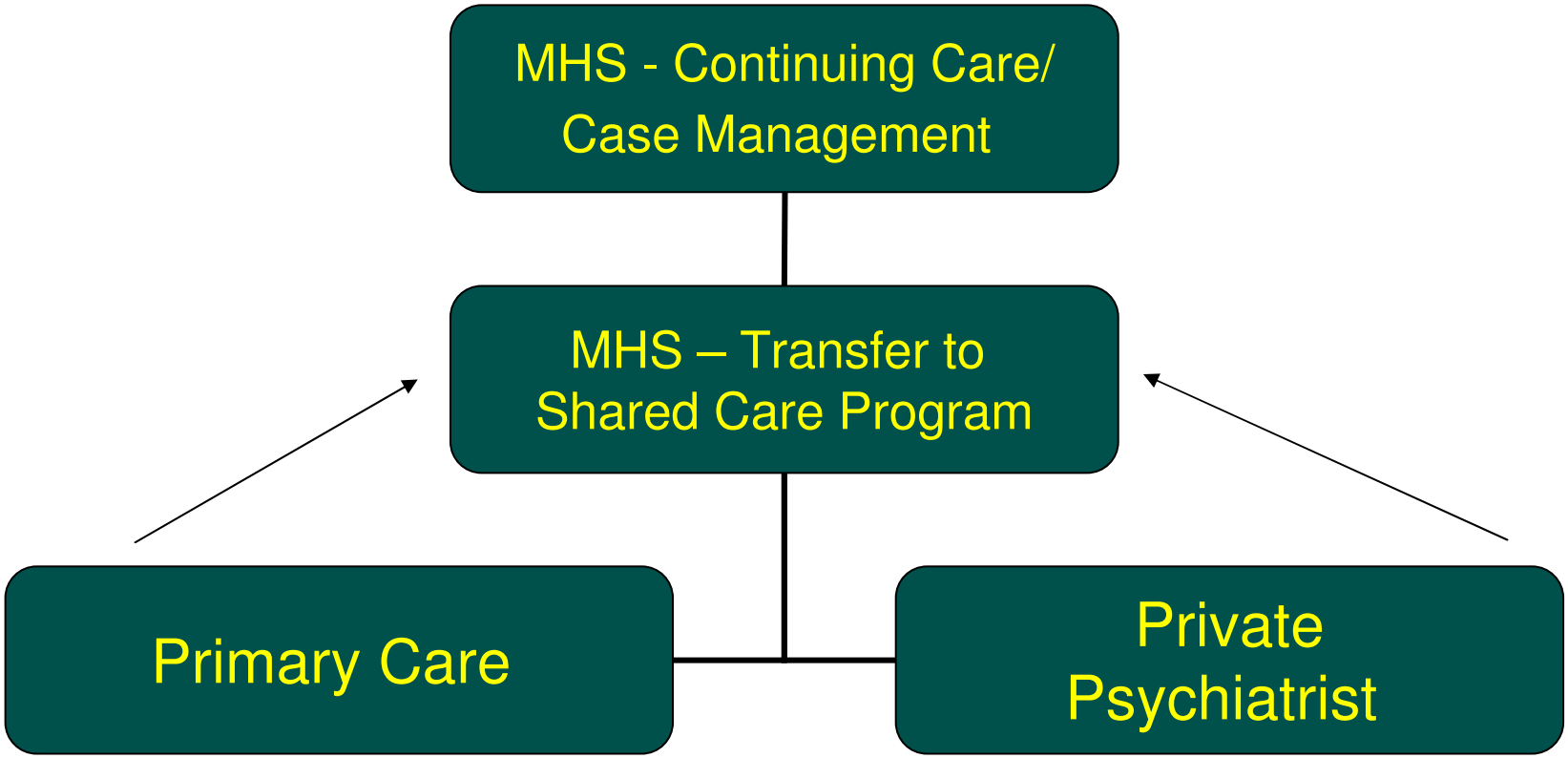
NEAMHS – Shared Care

- 1998 Shared Care policy, protocol and guidelines between North East Valley Division GP and Austin Health

- 2002 Shared Care program in NEAMHS developed based loosely on CLIPP model of care (G Meadows)
- 2005 Clozapine Shared Care developed

- Composition Shared Care Program with GP's
  Clozapine Share Care with GP's
- Composition
  Consultant Psychiatrist: 3.5 / week
  Co coordinator : RPN F/T
  Consumers: 38 GP's: 36

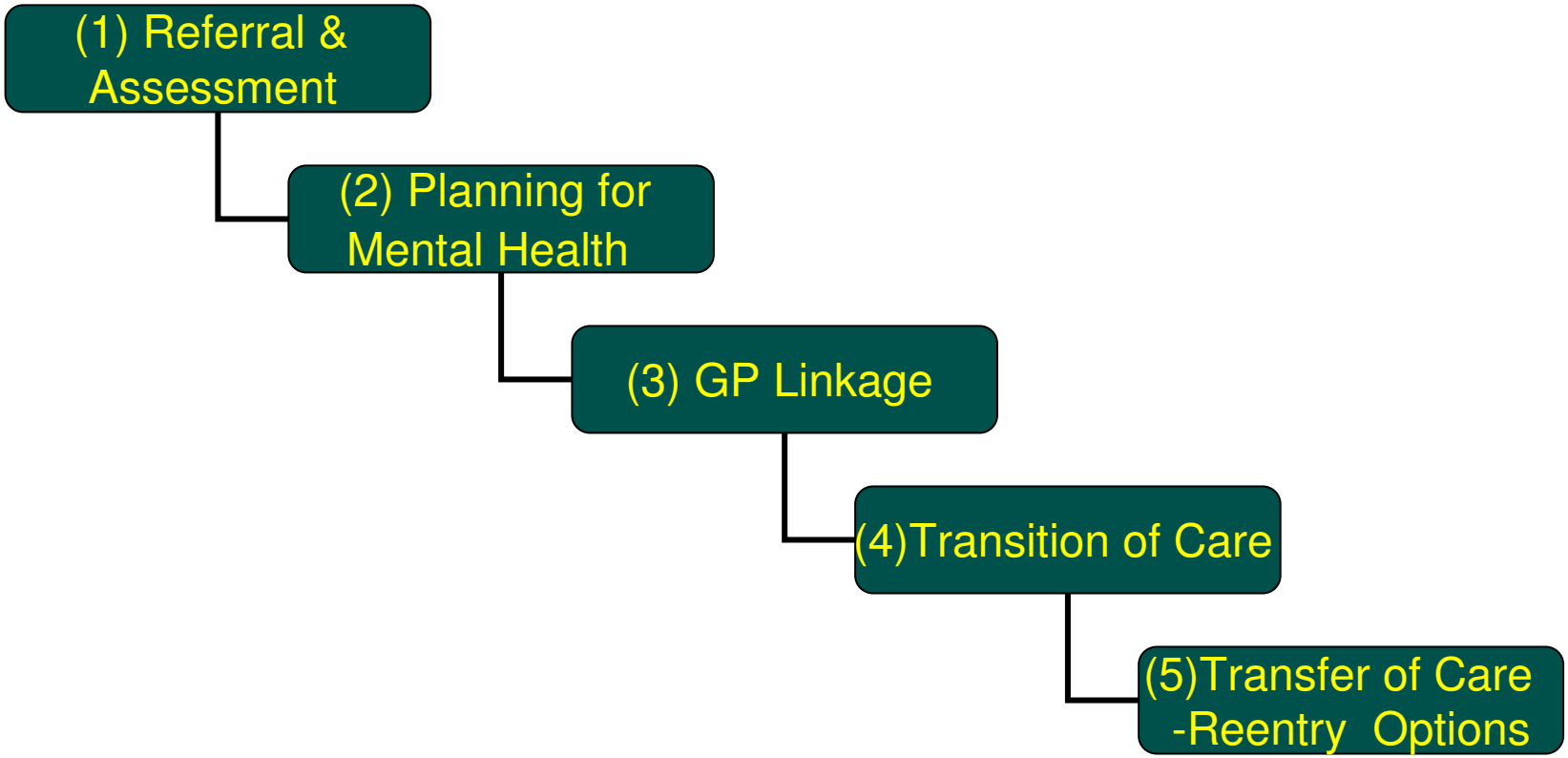
Process of Shared Care - ‘Stepped’ Approach



Aims and Objectives – Shared Care

- Collaborative care – Primary and Mental Health Services
- Reducing stigma
- Integration of medical and psychiatric health services
- Smooth transfer of consumers to GP's & other service providers
- Maintain access – manage demand for case management resources
- Sustainable treatment and management of consumer in primary care
- Discharge to GP – planned, supported, easy re-entry

Phases of Shared Care Program



(1) Referral: Selection Criteria

- Stable mental state min 6-12mths
- Not currently managed under Mental Health Act
- No hospitalizations or CATS intervention for past 6-12mths
- Adherence with treatment, appointments and not requiring prompting
- No major medication change in previous 6-12 months
- No case management issues
- Identified as suitable from multidisciplinary Continuing Care Service from clinical discussion

Selection Criteria cont…

- No identified ongoing risks including history of forensic issues
- Consumer and carer pleased with transfer to GP
- Stable accommodation and supports
- Identified GP
- Consumer consents for release of information to GP
- Ability to meet costs of medication

Assessment

- Stability of illness – residual symptoms? Comorbidity? Medical?
- Insight – current and past (use of depot, CTO?)
- Current stage of rehabilitation
  - ADL's, recreation, vocational issues
  - Independence, social isolation
- Current supports
- Psychiatric treatment
  - Past medication trials/reasons for changes
  - Last medication change, tolerability of current treatment
- Risk Assessment

(2) Planning for Mental Health

- Identifying potential barriers to transfer of care
- Development of relapse prevention plan
- Identifying ‘Early Warning Signs’/ ‘Relapse Indicators’
- Risk Assessment
- Specific issues:
  - Clozapine treatment
  - Metabolic issues
  - Depot antipsychotic medication-long-term monitoring
  - General Health
  - Substance Use
  - Upcoming psychosocial changes

(3) GP Linkage – The Shared Care Coordinator

- Shared Care Coordinator manages and coordinates transfer of consumer to GP
- Attends with consumer & carer at initial consult with GP
  - » comprehensive handover
  - » arranges appointment frequency & timing
- Training & education on clozapine
- Coordinator: ongoing point of contact
- Trouble shooting, Secondary Consultation
- Coordinates reviews with consultant psychiatrist 3 - 6 mths
- Refers back to case management / CATS if needed

Role of Consultant Psychiatrist

1. Comprehensive assessment of mental health status
   - Reviews current medication efficacy & side effects
   - Reviews early warning signs & relapse prevention including self-coping strategies, PRN medication use
2. Telephone liaison with GP
   - Recommendations, change of treatments & investigations, side effects monitoring - Abnormal Involuntary Movement Scale –AIMS
3. Comprehensive written reports forwarded to GP
4. Provides secondary consultation when needed

(4) Transition of Care (no specific timeframe)

- Review with consultant psychiatrist 3 - 6 mths
- ‘Tapering’ of direct contact with Mental Health Services
- No Specific Timeframe
- To establish sustainable pattern of ongoing care through GP or private psychiatrist

(5) Transfer of Care

- No issues, all supports stable
- Medication and appointment adherence
- GP pleased to provide full care
- Services and supports involved informed
- Discharge from service with documentation to GP & NGO
- Discharge summary
- Early warning signs & relapse prevention plan
- Details on re-accessing service

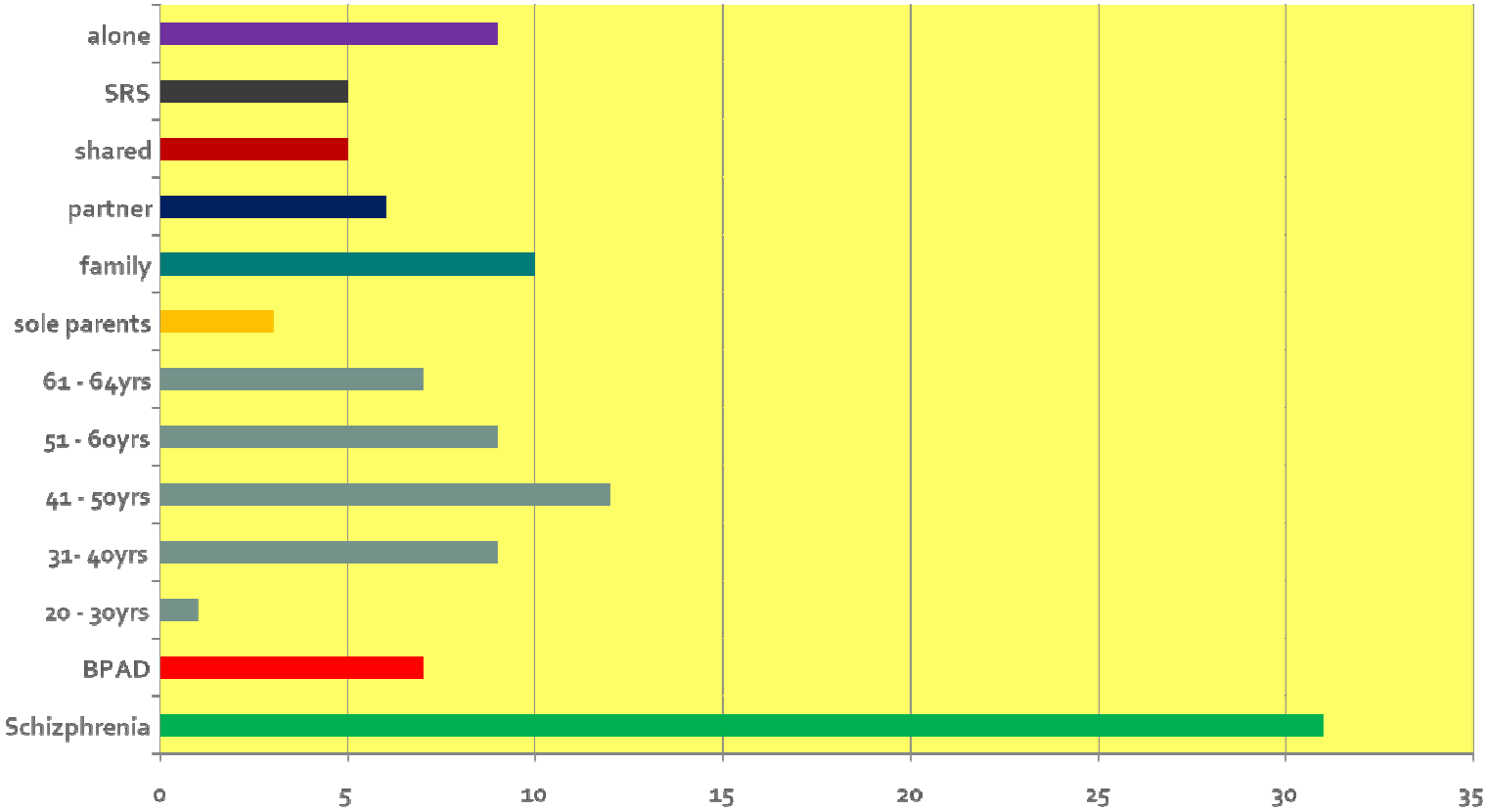
(5) Transfer of Care

- Full discharge to GP or private psychiatrist
- Facilitated Re-entry to Mental Health Services (duration?)
  - Crisis: Triage or CATT
  - Elective: Shared Care Program (Secondary consultation on request from GP 12 - 24 mths)
- Facilitated Re-referral (ongoing?)
  - Based on GP request, independent of Triage assessment

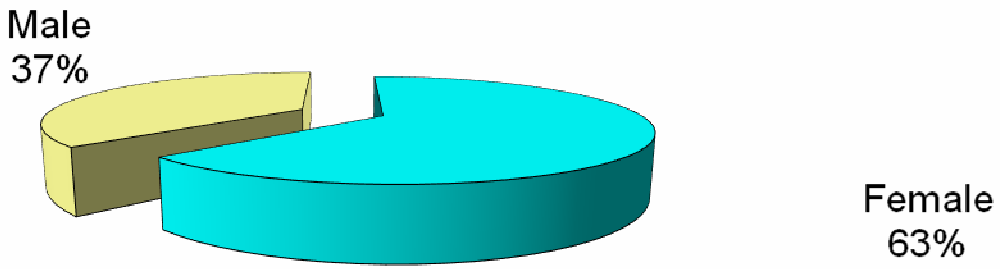
Sustainability: indications for re-entry to MHS

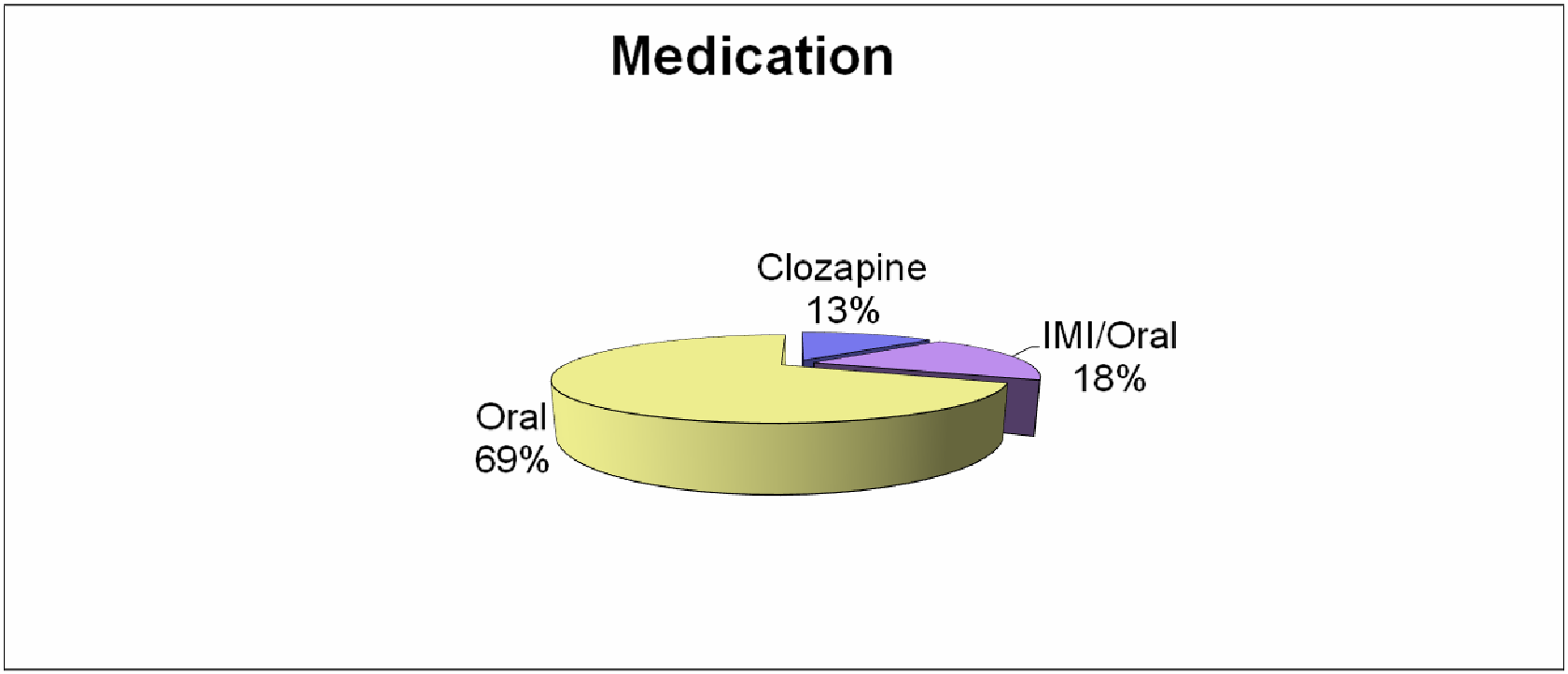
- Deterioration of mental state (Early Warning Signs)
- Decline in functioning
- Need for specialist psychiatric review (GP request)
- Not attending GP – risk of relapse
- Discontinuation of maintenance treatment
- Recurrent need for case management

Demographics



Gender Distribution




Medication
Clozapine
13%
IMI/Oral
18%
Oral
69%

Shared Care Program

Consumer

- Increased options and satisfaction –adherence to treatment
- Decreased stigma and increased accessibility
- Physical health needs addressed
- “One stop shop”

Carer

- Decreased stigma
- Increased involved with treatment
- Understanding of illness & early warning signs
- Increased ability to access help

Shared Care Program

GP

- Skills in intervention & management of mental illness.
- Accessibility of mental health services
- Implment'n-MH Care Plan/Chronic Dis.Management Plan

Clinical Services

- Collaboration with primary care givers
- Increased secondary consultation
- Fostering independence of consumer & carer

Non government services

- Collaborative approach / Coordinated care
- Increased awareness of Early Warning Signs and Relapse Prevention Plan

Challenges

- Solo practitioner
- Bulk billing GP's
- Stable consumer Vs treatment resistant
- Time constraints of GP
- Rising costs of medication
- Need for ongoing support

Future recommendations

- Local policy and procedure requires review
- Evaluation of Consumers' response to Shared Care
- Evaluation of Carers' response to Shared Care
- Evaluation of GP's experience of Shared Care
- Further resources: clinical/research/education

References

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2. Bridging general medicine and psychiatry: providing general medical and preventative care for the severely mentally ill. A Dombrovski et al 2004 Curr Opin psychiatry 17:523-529

3. Discharge planning for Adult community Mental Health Services DHS 2002

4. The Australian Health Ministers [1998]. Second National Mental Health Plan. Canberra
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