General Practice Teams

The Role of the Primary Care Psychiatrist

PHO and DHB Collaboration

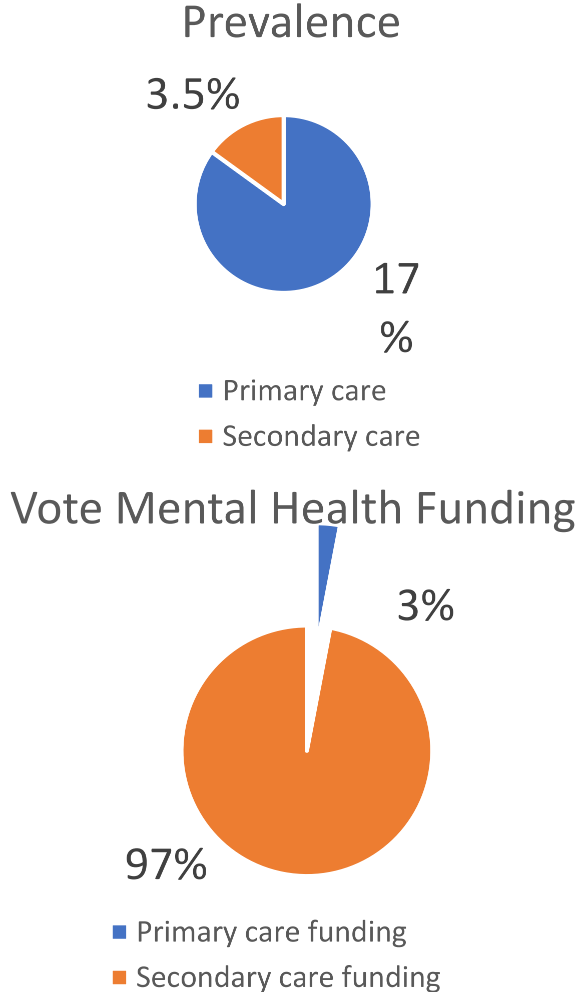
Topics to cover

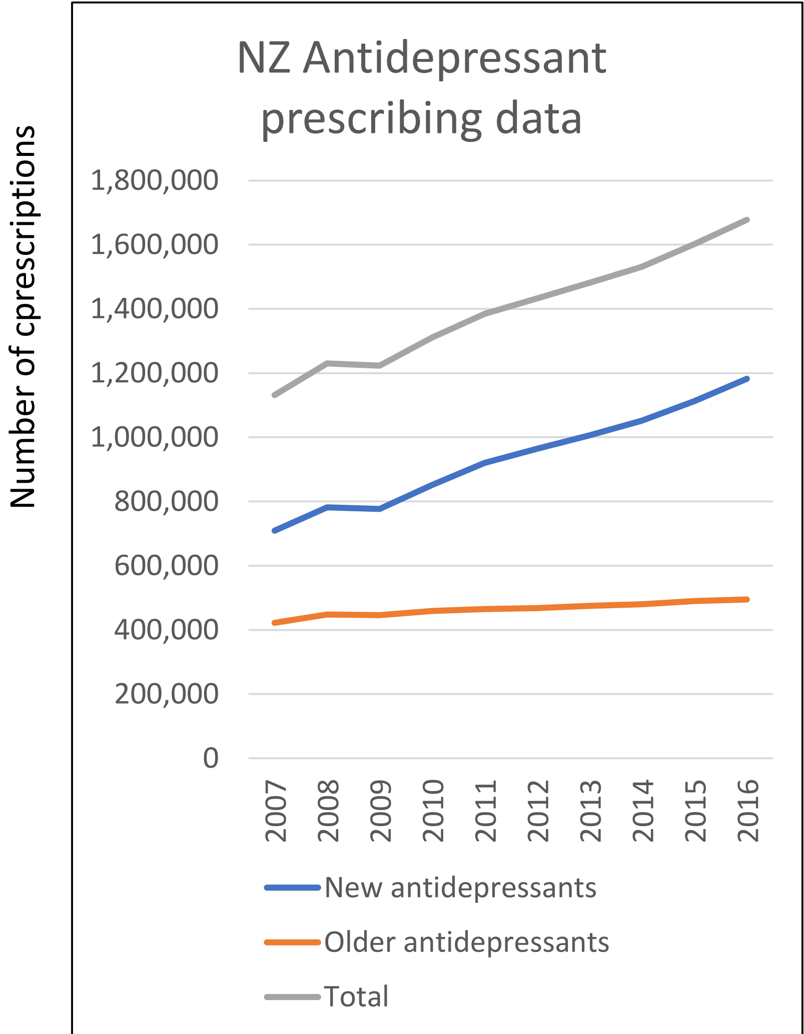
- History, why are we doing this
- What did we do in the Waikato with ‘1 DHB and 3 PHOs’
- What have we learnt from our experience
- What we would do differently (don’t make our mistakes!)

What is the challenge we are facing?

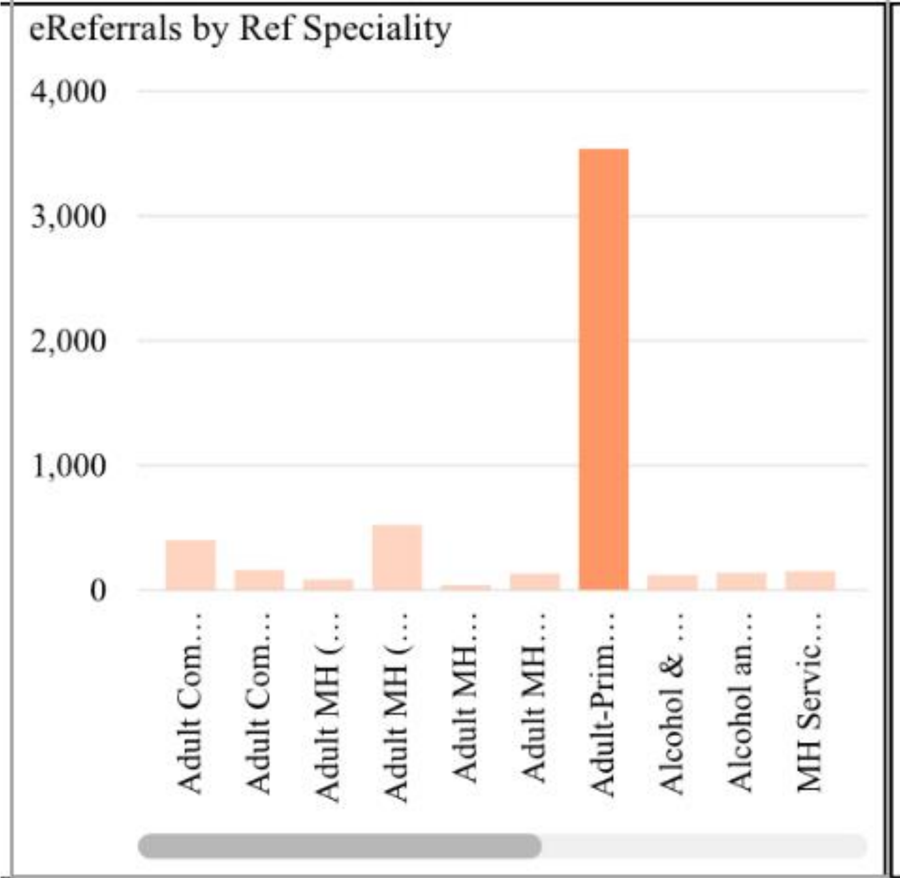
Almost half of all New Zealanders will experience mental health or addiction issues at some point in their lives.

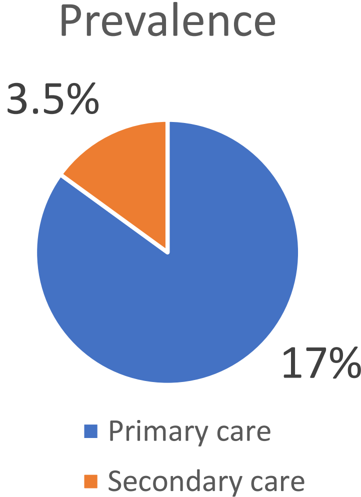
1 in 5 New Zealanders every year

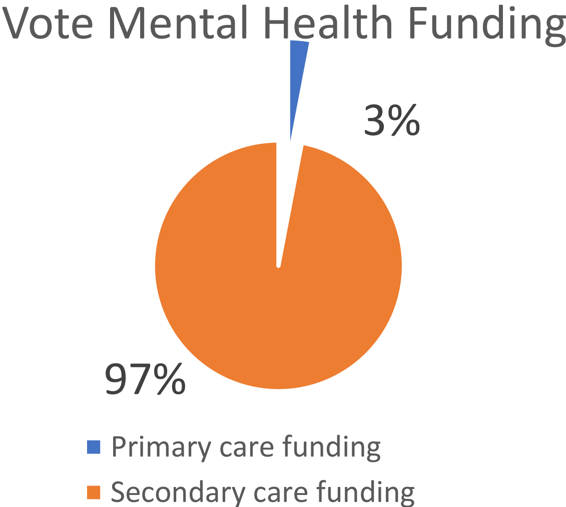




Mental Health Referrals from Pinnacle MHN in Waikato DHB







Back ground – mental health services

- Primary mental health services – MoH service specs
  - Aim - reduce inequity in access to talking based therapies
  - Brief intervention – aimed at mild to moderate distress
  - Priority – Maori, pacific and low income – low utilisation

- Secondary mental health services –DHB inpatient and outpatient service
  - Most severe – top 3%
  - Increasing demand = reduced access for those accessing care in GP

- "Missing middle"
  - The gap between those accessing and benefiting from PMHs and those who access care from secondary care services

Back ground – mental health services

Increased acuity of patients being managed in primary care

- more complicated/co morbidity, more severe, more functional impairment
- Difficulty accessing specialist psychiatric advice when required

Solution?

- Increase the capacity and capability of general practice
- How?

Primary Care Psychiatrist Role Examples

How do we improve access to psychiatric ‘support’

- Call a DHB 2nd care psychiatrist between 12-2 on Tuesdays
- Dedicated psychiatrist within DHB to take calls and liaise with GPs
- Employ a dedicated primary care psychiatrist to work within PHOs to provide support direct to GPs and shape new models of care – East Tamaki Health Care

Primary Care Psychiatrist Role (Waikato)

What the contract stated

Key expectations of this role would be to assist with:

- *Advice in relation to individual client concerns / input into medication and treatment plans.*
- *Provide training for primary care practitioners, nursing and allied health staff across the district to assist management of this client group. This may be generic across all practices or specific to individual clinicians or groups seeking additional support.*
- *Provide support in the function of a liaison role between primary care and secondary care where appropriate,*
- *Provide support to primary care in prioritisation tools for packages of care*

Develop and shape new ‘models of care’

Benefits to the system:

- Access to management advice to manage patients in real time
- Reduce need for secondary care team involvement acutely
- Upskill GPs in management by giving case based advice
- Increase confidence and capability of general practice teams to manage MH conditions with appropriate support
- Early intervention and management – better outcomes for patients
- Improve across sector collaboration – improve understanding/relationship

Waikato Primary Care Psychiatrists

- 1.2 FTE split across the two large PHOs in Waikato DHB
  - 2 psychiatrists working 0.6FTE
- Provide 5 day a week 8-5 telephone support to GPs
- Visit GP practices to provide education, case discussion, case review
- Involved in across sector collaboration, improvements in system to improve care – includes Health Pathway work

How did it work in practice

What do they do all day?

- Taking Phone calls
- Written referrals via BPAC
- Practice visits (GP registrar tutorials, one off clinics/patient review)
- Education (GPs, Prac Managers, PNs and medical students)
- DHB liaison
- Regionalisation of Health Pathways
- Suicide Post-vention , Community debrief & planning
- Travel time is a biggie in Waikato

GP experience

- Easy access
- Timely definitive management advice in acute setting
- Empowering for GP to be able to “do something”
- Education and support for GP
- Improvement in work flow for GP in accessing advice at time of consultation – improved efficiency
- Enhanced delivery with aid of joint virtual consultation with psychiatrist and patient.
- Clinical safety and oversight – management of risk
- Recognition and valuing of the knowledge GPs hold about psychosocial aspects

Patient Experience

- Needs met on the spot in their GP practice with people/environment that are familiar – mental health with physical health
- Improved care – early intervention
  - Better sooner
  - Stay at home with family
- Increased confidence in their GP team to meet their needs
- Improved relationship with GP team – better engagement with the team for screening and physical health needs
- Empowered by ease of access to care needed
- Use of virtual consultation methods to enhance patient care

Psychiatrist experience

- Rewarding working with GP colleagues – grateful for ‘small’ input
- Getting used to structuring thinking (responses) and giving options ‘at a distance’ with patient sight unseen. Measures are helpful! PHQ9, GAD7, DASS21
- Need to be comfortable with consult liaison role where GP remains the responsible clinician.
- Medical model of care is a poor fit for most MH problems – asking about and enhancing psychosocial aspects of patient care is key
- Engaging every patient in some degree of self help/monitoring is necessary (see non medical management strategies for depression and anxiety).

Case examples

Case Study One - History

- 55yr old female
- Diagnosis chronic paranoid schizophrenic disorder
- Stable – shared care for some years
- GP prescribing and physical health + mental health follow up
- On aripiprazole – stable
- Discharged from secondary care for long term follow up with GP (7/8/18)
- One week later seen by GP – plan made for regular follow up
- Social – lives with her mum, smoker, minimal meaningful activities

Case Study One – Presentation

- One month later
- Presents with her mother
- Acute exacerbation of “the voices” 9 day history, distressing content
- - “the mobsters are coming for you”, “they’re going to kidnap and kill you”
- Hypervigilant– sitting with phone ready to all 111
- Admits to being paranoid, compulsively locking house
- Mother states – she’s driving me crazy!

Case Study One – Management

- Discuss management options
- Recently discharged from MHS
- Reports misses keyworker support but otherwise happy to be cared for in primary care
- Discuss with primary care psychiatrist

→ Olanzapine 5mg at 7pm, additional 5mg if not asleep at 9pm

Case Study One – Management

- Written advice from psychiatrist follows phone call
- Continue dose of olanzapine that resulted in resolution of symptom for at least 4-6 weeks (up to 3m)
- Wean by 2.5mg every 4-8w
- Increase again if relapses

Management Options for Acute Exacerbation of Psychotic symptoms

- Treating acute distress from psychotic symptoms especially at night
  - anxious and agitated
- Olanazapine – agent of choice

  Has replaced thioridazine/chlorpromazine used historically

What about

- Risperidone
- Quetiapine
- Benzodiazepines
- Increasing Aripiprazole

Case study one – outcome

- Follow up phone call next day

  - Slept well, less distress from voices, plan continue olanzapine
- Phone call one week later

  - Improving, less hyper vigilance, talked to mum, happy with improvement
- Face to face review 2 weeks after initial presentation

  - Much better, voices no longer bothering her,

  - Feeling slowed down by olanzapine
- Face to face review for WINZ medical certificate at 4w

  - Reduced olanzapine to 2.5mg, follow up planned for 4-6w
- Phone call review 1m later in response to script request

  - Has stopped olanzapine doing well

Case study one - Outcome

- Ongoing care

  - Practice able to access funding to provide practice nurse support through transition to primary care programme

- Practice nurse provides

  - phone support, encourages engagement in community through exercise and voluntary work and relaxation strategies using FACT principles

- Mental state - remains well
- Strengthening of primary care relationship results in her engaging in CVD screening and accepting smoking cessation support

Wins

- Specialist supports care remaining with the GP team
- Timely advice and treatment vs access to advice/care via secondary care routes
- Improved patient experience – easy access to help, patient feels we are able to care for all aspects of their health
- Builds trust and relationship
- Allows us to engage with them in preventative care
- Practice nurse support focus on function vs symptoms - improves quality of life
- Normalising mental unwellness

Case study Two - History

- 25yr old Male
- New patient
- Requesting repeat script for methylphenidate
- No notes
- Advised to return when notes arrived

Case Study Two - History

- Notes Reviewed
- Adult mental health service letter 2yrs previously confirms diagnosis of Adult ADHD
- Methylphenidate treatment for 2yrs
- No evidence of diversion, regular attender for reviews/scripts
- Co-morbid anxiety and depression
- Poor response to fluoxetine and venlafaxine previously

Case Study Two - Presentation

- Face to Face Review
- Transferring from student health - recently quit university, quit job and moved home to parents
- Reports ADHD diagnosed when started university
- Stimulants had resulted in improved functioning initially, not sustained
- Last 6m increase in Anxiety debilitating
- Spending 10 hours a day gaming, gained weight, socially isolated
- Repeat given
- Plan discuss with Primary care psychiatrist

Case Study Two - Management

- Discussion with primary care psychiatrist

  - Confirm right diagnosis

  - Management question – are the stimulants making him anxious?

Case Study Two - Management

- Psychiatrist reviewed report form secondary team and was happy with diagnostic workup
- Start atomoxetine 40mg mane initially
- Increase to additional 40mg late afternoon after 1w,
- Once daily dosing better for compliance
- SSRI with weak antidepressant properties
- Shown to have benefit in ADHD
- Used as single agent

Case Study Two - Outcome

- Improvement

  has given up gaming,

  engaging socially
- Considering options re study or work

- Would like to have some stimulants to have in addition to atomoxetine for when really needs to focus
- Advised by psychiatrist no to con current treatment
- Increased dose further to 60mg bd

Case Study Two - Outcome

- Ongoing care

  Support for non medical management

  Exploring what matters in addition to what's the matter

  Exploring what interests are currently and previously

  Encouraged to continue exercise social activities and to move towards meaningful activities

Summary

What have we learnt

- It takes time
- Strong GP leadership important
- Mental Health in General Practice is different
  - Less reliance on biomedical model
  - More depth to the psychosocial elements
- Important to value GP, psychiatrist and patient perspectives as “experts”
- Value to system is more than the saved time to secondary MH services

What we'd do better

- Psychiatrist role within the primary MH team needs a planning & evaluation dimension. Better utilisation of psychiatrist skills beyond the purely case based clinical.
- Capacity for some f2f consults with GPs – use data to identify high need areas (practices)
- Identify GPs with special interest in MH and provide extra input, teaching, support (RNZCGP + RANZCP)
- Establish a workplan, including enhanced PMH options for Practices and communities eg, groups, Stanford self management, anxiety & depression, Mindfulness

What we would do differently (i.e. don’t make our mistakes)

- Underestimate the amount to time it would take to convince funders the role was necessary
- Underestimate the amount of time it would take to negotiate the contract
- Believe we know the ‘markers of success’ prior to commencing