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Original Article

GP Clinic: Promoting access to primary health care for mental health service clients

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Abstract

***Objective*:** *To evaluate an innovative rural service offering comprehensive primary health care for mental health service clients.*
***Design*:** *A formative evaluation using mixed methods.*
***Setting*:** *A rural NSW community.*
***Participants*:** *Fifteen health care providers and 120 adult clients.*
***Intervention*:** *A monthly clinic held in a general practice to provide primary health care for clients of the community mental health team.*
***Main outcome measures*:** *Client utilisation and clinic activity data. Provider views of service effectiveness, possible improvements and sustainability.*
***Results*:** *The GP Clinic has operated successfully for 2.5 years without access block. Some 52% of clients had no physical illness and 82% were referred to other health and community services. In total, 40% continued to attend the clinic while 32% went on to consult a GP independently. Client access to care improved as did collaboration between the community mental health team and primary care providers.*
***Conclusion*:** *The GP Clinic is a straightforward and flexible service model that could be used more widely.*

KEY WORDS: *collaborative care*, *health services access*, *primary health care*, *rural mental health*, *rural physical health*.

Introduction

In Australia, there is a need for accessible primary health care services for people with mental illness. About 8% of the population use mental health services at any one time. People with mental illness have a mortality rate 2.5 times higher than the general population largely because of cerebrovascular and cardiovascular disease.[1,2]

The lack of coordination between primary care and mental health services limits access to services for people with mental illness and this is compounded by discrimination and stigma in the health care system and the community.[1,3–5] Controlled trials show that collaborative care can achieve better clinical outcomes and improved service delivery when information is shared between medical and mental health care providers.[6–8]

Australian policies have promoted improved coordination so that mental health care is part of a comprehensive service addressing both mental and physical health problems.[9–13] Furthermore, it has been proposed that people with complex health problems need a 'health care home' under the care of a GP to facilitate access to services, ensure continuous care and build a strong therapeutic relationship.[14]

In Australia, people with mental illness often access care from community mental health teams (CMHT), funded by state and territory governments. These teams are aware of the difficulties people with mental illness have in getting to see a GP, a situation exacerbated in rural areas by workforce shortages and inequitable access to general practices.[15]

This paper reports a formative evaluation of a new service which provides comprehensive primary health care to people using mental health services in a rural mid-western NSW community.

Service design

The 'GP Clinic' was established in a rural town of approximately 8250 people[16] with two group general practices. The local CMHT cares for around 200 clients at any one time and two visiting psychiatrists

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***What is already known on this subject*:**
- *Some community mental health clients have difficulty accessing care for physical health conditions.*
- *These clients have a higher morbidity and mortality rate because of untreated or under-treated physical illnesses.*

***What this study adds*:**
- *An innovative service model developed by rural clinicians that improves client access to comprehensive primary health care and closer collaboration between mental health specialists and GPs.*

visit 1 day each on alternate weeks. The nearest mental health inpatient unit (MHIPU) is 2 hours away by road.

The CMHT, concerned about poor access to general practice services for their clients, approached a local GP about running a regular clinic at the Community Health Centre. Following a suggestion by the GP (C.A.), they agreed to a monthly clinic run by that GP at a local general practice (GP Clinic). The CMHT was responsible for organising client appointments and assisting clients to attend (including providing transport if needed). They also accompanied clients during their consultation. No co-payments were charged and details of the consultation were recorded in the general practice and CMHT client records.

Method

We conducted a formative evaluation using a mixed methods approach.[17] Quantitative data were collected for each client who attended the GP Clinic from its inception in June 2007 to December 2009. Data items included: client characteristics (date of birth, gender, time as a client of the CMHT, primary mental health diagnosis), number of GP Clinic attendances (by month and location) and GP management of client (diagnosis of physical health problems, client referrals for health and welfare services, and arrangements for ongoing access to GP services). Chi square (χ^2) test was used to determine statistical significance ($P < 0.05$).

We invited health care providers and other staff associated with the GP Clinic (CMHT workers, GPs, surgery staff, visiting psychiatrists and community transport personnel) to participate in face-to-face semi-structured interviews. Twenty-four invitations were issued and 15 people interviewed. The interviews sought information on how the clinic was run; the impact of the service on clients (clients of CMHT); the overall performance of the GP Clinic, and possible improvements. We undertook a thematic analysis of the provider transcripts.[18]

Ethics approval for the research was granted by the Greater Western Area Health Service Human Research Ethics Committee.

Results

During the first 30 months of operation, 120 clients of the mental health service attended the GP Clinic. Fifty-nine per cent had their first appointment during the initial 12 month period, with between 14 and 18 new clients (7–9% of the CMHT client population) recruited every 6 months thereafter. There were similar numbers of males and females. Just under half (45%) of the attendees were aged 18–34 years and 28% were aged 35–44 years (Table 1).

Both long-term clients of the CMHT and those recently accepted by the mental health service were referred to the GP Clinic – 20% of attendees had been clients of the CMHT for 5 years or more, 42.5% for between 1 and 4 years and 37.5% for less than 12 months.

Clients referred to the GP Clinic also had diverse mental health problems. Around one third of clients had a diagnosis of schizophrenia and other psychotic disorders, one-third a mood disorder, and the remainder a range of diagnoses including substance use, personality disorders and anxiety.

The number of clients seen at the GP Clinic ranged from 9 to 32 per month, with a maximum of 29 clients seen on any 1 day (Fig. 1). Taking into account multiple appointments, between 38 and 54 individuals (19–27% of all CMHT clients) accessed the GP Clinic each 6 months.

Continuing use of the GP Clinic for primary health care services was recorded for 40% of clients. Proportionately more clients with psychotic disorders relied on the GP Clinic for continuing services compared with clients with mood disorders and other diagnoses ($\chi^2_{2df} = 6.24$; $P = 0.044$). This pattern was also reflected as more clients with psychotic disorders attended the GP Clinic three or more times during the study period (Table 1).

TABLE 1: *Clients of the GP Clinic and their attendance patterns*

Characteristic	Mental health diagnosis					
	Psychotic disorders ($n = 43$)	Mood disorders ($n = 36$)	Personality disorders ($n = 11$)	Substance use ($n = 19$)	Other ($n = 11$)	Total
Age (years)						
18–34	26 (61%)	13 (36%)	6 (55%)	7 (37%)	2 (18%)	54 (45%)
35–54	13 (30%)	14 (39%)	4 (36%)	11 (58%)	7 (64%)	49 (41%)
55+	4 (9%)	9 (25%)	1 (9%)	1 (5%)	2 (18%)	17 (14%)
Gender						
Male	22 (51%)	13 (36%)	3 (27%)	13 (68%)	6 (55%)	57 (48%)
Female	21 (49%)	23 (64%)	8 (73%)	6 (32%)	5 (45%)	63 (53%)
Client of CMHT (years)						
<1	9 (21%)	13 (36%)	6 (55%)	10 (53%)	7 (64%)	45 (37%)
1–4	20 (46%)	17 (47%)	4 (36%)	7 (37%)	3 (27%)	51 (43%)
5+	14 (33%)	6 (17%)	1 (9%)	2 (10%)	1 (9%)	24 (20%)
GP Clinic attendance						
1–2 times	18 (42%)	21 (58%)	8 (73%)	13 (68%)	8 (73%)	68 (57%)
3–9 times	19 (44%)	9 (25%)	3 (27%)	6 (32%)	3 (27%)	40 (33%)
10+ times	6 (14%)	6 (17%)	0 (0%)	0 (0%)	0 (0%)	12 (10%)
Ongoing access to GP services						
GP Clinic	23 (53%)	14 (39%)	1 (9%)	7 (37%)	3 (27%)	48 (40%)
Independently	6 (23%)	16 (44%)	5 (46%)	6 (32%)	5 (46%)	38 (32%)
Usual GP	5 (12%)	2 (6%)	2 (18%)	1 (5%)	1 (9%)	11 (9%)
Moved	9 (21%)	4 (11%)	3 (27%)	5 (26%)	2 (18%)	23 (19%)

CMHT, community mental health teams.

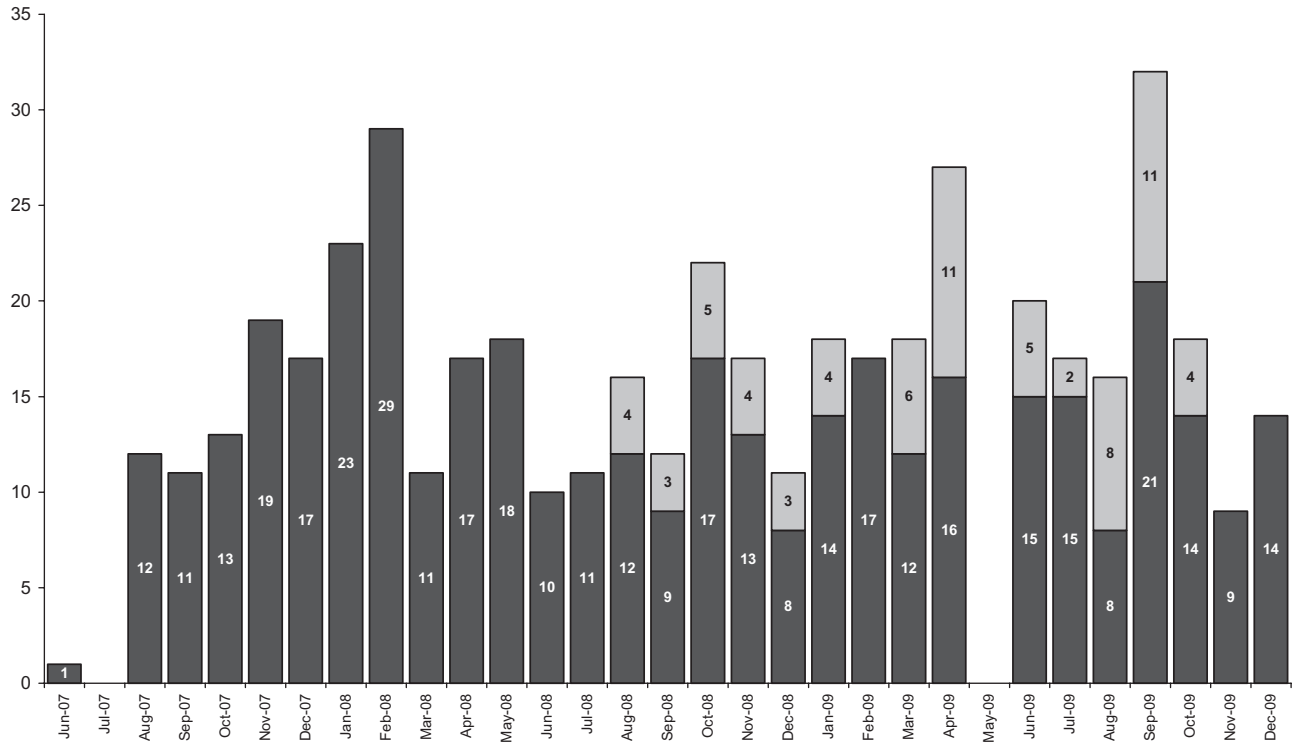

FIGURE 1: *Mental health client attendance at the GP Clinic in rural NSW, June 2007–December 2009. (■) Mudgee clinic; (□) Gulgong clinic.*

Around half (52%) of the clients did not have a physical health illness when assessed by the GP and most (79%) were referred to other health and community services (Table 2).

Provider views

The providers said that the GP Clinic was not a complex service to develop and that it was straightforward to run. They indicated that it was successfully integrated into the normal operations of the general practice and financially viable, making use of existing funding mechanisms only.

> it's not really rocket science. (A3)
> [the Clinic day is] a day as per any other day [in the practice]. (B3)
> I think overall it is cost neutral. (B6)

The GP Clinic was credited with improving access for mental health clients to general practice services. Its main purpose was to support those clients who did not have a GP and those unlikely to seek out primary health care services themselves. The CMHT indicated that the GP Clinic was acceptable to their clients and that no one referred had refused to use the service.

> [it] stops patients from slipping through the net. (B5)

TABLE 2: *GP Clinic clients: physical health problems and referrals*

	Number	Per cent
Physical health diagnosis		
No physical illness	68	57
Vascular disease/Diabetes	12	10
Gastrointestinal disorder	8	7
Other physical health diagnosis	33	28
Client referrals†		
Psychiatrist	52	43
Psychologist	22	18
Drug and alcohol services	16	13
Other specialist medical services	45	38
Government or legal services	28	23
No referrals	22	18

†Multiple responses possible – percentage refers to the proportion of all clients. Multiple referrals included: two referrals – 42 clients; three referrals – 10 clients; five referrals – 1 client.

> [It's] providing general health care for . . . patients [who] don't tend to engage in that themselves. (A5)

The providers reported benefits for both clients and service providers; these included a perception that

admission rates to the MHIPU had fallen dramatically because of improved management of both physical and mental health problems. The psychiatrists were also considered to be working differently; with the GP now managing client issues, the pattern of referrals for specialist opinion had changed and there was a clearer division of roles between GPs and specialists.

> [Our workload has become] more manageable not responding to 'crises' all the time. (A3)
> there is that bit of continuity and relationship stuff. (A2)
> . . . the waiting list for the psychiatrists has changed . . . [they're not] reviewing and writing scripts . . . they are now doing more pointy end stuff. (A6)

The issue of sustainability was considered in the context of the solid agreement underpinning the service and the providers indicated that the flexibility of the service model allowed for improvements and kept it relevant and manageable.

> [There is a good] working relationship between the surgery and community mental health team. (C2)
> [Replacing the current clinic GP if he should ever leave] is not a general concern because of the commitment of the local surgery to maintain the service. (B2)
> We've changed and modified it a little bit along the way . . . [such as] when we [recently] dropped back the frequency of visiting out [at a second surgery] because the demand dropped off. (A3)

Discussion

Mental health services play a crucial role caring for people with mental illness. Nonetheless, there is a need for collaborative models of care between mental health services, GPs and other providers to address the physical health needs of their clients.[13] There are few published accounts of innovative service models providing both mental and physical health care in Australia.[19] The GP Clinic is a working model of how one group of health practitioners has addressed this need.

The evaluation found that the GP Clinic has operated successfully for 2.5 years and is now established in the community, with an average of 16 clients attending each month. Feedback from providers indicated that the GP Clinic was not difficult to develop or operate and could be run within existing resources and funding streams. The benefits of the new service were improved access for clients to primary care services and better collaboration between providers. The fact that the same GP conducted the clinic each month might have contributed to its success by providing improved continuity of care and a strong therapeutic doctor-patient relationship, as well as a consistent approach to managing and developing the collaborative arrangements.

There are a number of elements of this service model that contribute to its effectiveness, sustainability and its possible transferability. The service was developed incrementally without external funding or formal project plan. Simply put, the general practice provided a consulting room for the GP Clinic each month, a GP volunteered to conduct the clinic, and the CMHT arranged for and supported clients to attend.

With around 200 clients managed by the CMHT at any one time and a limited number of appointments available each month, the selection of clients to attend the GP Clinic is important. People referred to the GP Clinic reflected the diversity of the client population; it included long-term clients and those recently accepted by the CMHT, of all ages, and with low and high prevalence mental health conditions.

Many clients attending the GP Clinic did not have a physical illness, and for them the objective was to establish a 'health care home' in general practice and to treat their mental illness. For others the goal was to investigate or treat one or more physical health problems. The empowerment of clients, where possible, to independently organise their own general practice appointments allowed the targeted use of the clinic for clients not otherwise receiving primary health care services thus keeping the clinic to a manageable size while maintaining relevance and reach, and preventing access block.

The evaluation was limited to an assessment of feasibility, service operation and some consideration of the potential benefits for both clients and providers. Questions remain as to whether this model will benefit patients in the longer term by improving health outcomes and changing their use of other health services. A further study is planned to address these questions and to further examine the systemic components of collaboration.[20] There might also be opportunities to improve the collaborative model through greater involvement of the psychiatrists in the collaboration and the development of formal models of shared care to further improve physical and mental health care, and through better support for the GP in developing a special interest in mental health care.

This GP Clinic demonstrates the possibilities of local collaborative service developments in situations where GPs and CMHT leaders have the scope to build responsive services with support of senior management. Incremental service development within existing funding models might benefit clients with mental health conditions who need comprehensive continuing health care.

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