Professional Practice Guideline

Best practice referral, communication and shared care arrangements between psychiatrists, general practitioners and psychologists

Authorising Committee:	Board
Responsible Committee:	Private Practitioners Network Special Interest Group
Document Code:	**PPG Best practice referral communication**

Background

The Better Access to Psychiatrists, Psychologists and General Practitioners was introduced in November 2006 in response to low treatment rates for common mental disorders (for example, anxiety, depression and substance use disorders). It introduced a series of new item numbers on the Medicare Benefits Schedule to provide a rebate for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists [1].

As the number of service providers in the private sector has increased, new processes for coordination and collaboration have emerged. It is recognised that collaborative care can significantly improve patient outcomes in the case of depression and anxiety, provided that good communication exists between the treating health professionals [2].

However, shared care agreements are not appropriate for all patients, and clinicians should use their judgement to determine their eligibility for such care. Some patients are better served by a single clinician with the right composite of therapeutic skills.

In 2013, the Royal Australian and New Zealand College of Psychiatrists endorsed the Private Mental Health Alliance *Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers* (the Principles). The Principles document acknowledges that while it would go 'some way to supporting referral and communication between providers of mental health services in the private sector' there was more work required [3].

The RANZCP Private Practitioners Network (PPN) Special Interest Group has identified a number of emerging practice issues that carry the risk of fragmentation of care. Without a practical guide to improving communication between the treating health professionals, there is a risk to the quality of treatment and safety of patients, as well as increased liability for all clinicians.

Introduction

This practical guide for communication between clinicians is important given the number of mental health services provided in Australia in Table 1.

Table 1: Number of MBS-subsidised mental health services provided, by provider type, 2006-07 to 2011-12[1]

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Psychiatrists	1,986,533	1,949,702	1,967,222	1,983,481	2,009,411	2,058,777
General practitioners	618,915	1,257,962	1,622,347	1,835,094	2,131,299	2,194,530
Clinical psychologists	189,946	649,377	904,835	1,087,169	1,270,250	1,378,089
Registered psychologists and other allied health professionals	478,956	1,323,166	1,734,728	2,082,807	2,337,592	2,302,879

There are clear opportunities at all stages of treatment for improved communication leading to increased efficiency of the referral processes, treatment and liaison between all general practitioners, psychologists and psychiatrists. This document was developed by the PPN in consultation with a number of stakeholders in the field of allied mental health and general medicine.

This guideline aims to assist communication flow, clarification of patient management, patient care and safety. It outlines steps for best practice in referral, communication and shared care agreements between the GP, psychologist and psychiatrist [3, 4].

Scope

While psychiatrists may refer their patients to a number of health professionals such as mental health nurses, occupational therapists and social workers, this guideline focuses on the communication between general practitioners, psychologists and private psychiatrists as main providers of mental health care in the community.

Principles

Improved communications generally promotes improved patient outcomes. To support best practice communication between general practitioners, psychologists and psychiatrists, it is important to ensure that:

- all clinicians treating the same patient:
    - communicate with each other about the patient's clinical management, to facilitate collaborative multidisciplinary care
    - agree that a shared care agreement suits the patient
    - understand the modalities of intervention that other health professionals can provide to ensure the best patient care possible
- clinicians know that good communication can prevent delayed referrals, which can lead to sub-optimal patient care
- team-based mental health care does not lead to the fragmentation of the types of mental health services provided to the patient

Best practice guidelines for referral, communication and shared care arrangements between general practitioners, psychologists and psychiatrists

1. General practitioners (GP)

1.1 Completion of a GP Mental Health Treatment Plan for the patient is required to enable psychologists to access the Medicare rebates. Regular feedback reports from the psychologist are an obligatory part of the Medicare item number, and communication will assist GPs in providing the best care possible.

1.2 A GP Mental Health Treatment Plan is **not** required for referral to a psychiatrist. The letter of referral should explain the reason for the referral, and wherever possible, specify the following information:

- the person initiating the referral; for example, the patient, the GP or the psychologist and if it is the psychologist, their specific concerns should be included
- the main issues, presented as a summary of the problems, perceived contributors and safety concerns
- history of the relevant medical and mental health treatment that has been provided to the patient.

1.3 A psychiatrist should provide communication to the referring GP following psychiatric assessment as part of good clinical care. The conditions for using Medicare Item 291 mandate a two week response time for that item number.

1.4 If a GP considers that a patient has not significantly improved six months after referral to a psychologist, it may be appropriate to refer the patient to a psychiatrist for a second opinion. This can be arranged through utilisation of Medicare Item 291, a transfer of care or a shared care arrangement.

1.5 Given that simultaneous referrals from a GP to both a psychiatrist (for both psychotherapy and medication) and psychologist (for psychotherapy) can create confusion about treatment, it is recommended that this practice be given careful consideration on a case-by-case basis.

1.6 In instances where a GP is considering referring an active patient of a psychiatrist to a psychologist, it is important for the GP to discuss the arrangement with the psychiatrist prior to making a referral to the psychologist.

1.7 If a GP is referring a patient to a psychiatrist and that patient has already been referred to a psychologist, it is recommended that the GP inform both parties of the referral.

1.8 If a GP is concerned about the safety of a patient they have referred to a psychiatrist, it is recommended that verbal contact be made to the psychiatrist informing them of the reasons for the concern so that steps can be taken to ensure patient safety. It is not recommended that a letter be solely relied upon to convey urgent information.

2. Psychologists

2.1 Upon receiving a referral from a GP and following consultation with the patient, the psychologist is obliged to provide regular progress reports under the terms of the Medicare item number.

2.2 In instances of a shared-care agreement or transfer of care, the psychiatrist should be informed about the type of psychotherapy the patient has received and the response to that psychotherapy along with observations about the patient's mental state during sessions that were attended.

2.3 If a psychologist is invited to enter a shared care agreement with a psychiatrist, a written shared care agreement is recommended. Refer to Section 4 of these guidelines for more information on shared care agreements.

2.4 It is important to consider recommending a patient who has not improved over a six month period for a psychiatric review (i.e. Item 291 opinion and management recommendations), or transfer of care to a psychiatrist or be considered for a shared care agreement.

3. Psychiatrists

3.1 Following a referral from a GP, psychiatrists need to ensure that a response is provided to the GP within two weeks in accordance with the conditions under Medicare Item 291.

3.2 In instances where a GP has made a referral to both a psychiatrist and psychologist, the psychiatrist will need to make a determination whether to recommend or undertake a shared care agreement or transfer of care.

3.3 If the psychologist and psychiatrist agree that shared care is required, a written shared care agreement is recommended and the patient is provided with information on what treatment to expect from each clinician.

4. Shared care agreements

4.1 A formal agreement can assist to delineate the roles, functions and areas of clinical focus for each health care professional, increase communication and assist them to work collaboratively to optimise treatment in the best interest of the patient [4].

4.2 All parties to a shared care agreement should commit to communicate regularly, verbally or in writing, at a frequency that matches the clinical need.

4.3 Significant changes in the patient's progress may be valid triggers to instigate communication, particularly changes in any of the following:

- management (e.g. medication, modality of psychological intervention)
- mental status assessment
- risk of self-harm or harm to others
- level of cooperation with the treatment plan or if the patient has ceased to attend treatment.

4.4 In instances where patients exhibit personality disorder traits or have a primary or co-morbid personality disorder, there will be a tendency to engage in splitting behaviours that can affect the cohesion of the treatment team. All members of the treating team should have a high index of suspicion and open mindedness when patients express criticisms or concerns about one of their treating clinicians to another clinician in the shared care arrangement. Potential splitting can be reduced by regular communication amongst clinicians.

4.5 For therapy to be effective, it is important that members of the treating team do not express or imply criticism of another clinician or their treatment with the patient and their family.

4.6 Professional respect is integral to good patient outcomes in a shared-care model. Some good practice recommendations include:

- recommendations or suggestions by a psychologist regarding medication should be made directly to the treating psychiatrist or GP for consideration, and not to the patient
- concerns expressed by patients or their families about a member of the treatment team are best addressed directly with the clinician concerned
- consulting with the treating clinician (psychologist or psychiatrist) before referring to an alternative clinician to mitigate the impact of such a referral on the therapeutic relationship between the patient and the treating clinician [4].

4.7 Clinicians should not be bound to a treatment that does not meet their professional standard of care regardless of whether the treatment conforms to the standards of some practitioners in the community. In such instances, a clinician should respectfully resign from the treatment in a time frame that allows the patient and the other clinicians to make appropriate alternative arrangements. The patient's best interests should guide which clinical misgivings or disagreements between clinicians are disclosed directly to the patient [5].

Stakeholders

This document has been developed in consultation with key external groups, including representatives of the following:

- Australian Clinical Psychology Association (ACPA)
- Royal Australian College of General Practitioners (RACGP)
- Australian College of Mental Health Nurses (ACMHN)
- Private Mental Health Alliance (PMHA) Collaborative Care Models Working Group (CCMWG), which included representatives of the Department of Health and Aging (DoHA), the Australian Psychological Society (APS), RANZCP, Australian Medical Association (AMA) and consumer groups such as the Private Mental Health Consumer Carer Network.

REVISION RECORD

Contact: General Manager, Practice Policy and Projects

Date	Version	Approver	Description
03/2013	1.0	N/A	Document drafted by PPN
19/02/2014	2.0	N/A	Significant revisions to structure and tone of document by Practice, Policy and Projects
5/04/2014	3.0	B2014/2	Revisions and structures of document approved by the Board

References

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3. Group, P.M.H.A.C.C.M.W., *Principles for collaboration, communication and cooperation between private mental health service providers*, P.M.H. Alliance, Editor 2013: Kingston ACT.
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5. D, M. *Split Treatment and Coordinated Care with Multiple Mental Health Clinicians: Clinical and Risk Management Issues*. Primary Psychiatry, 2002. 9, 59-60.