COMMUNICATIONS BETWEEN PSYCHIATRISTS AND GENERAL PRACTITIONERS IN LEARNING DISABILITY - A CLINICAL AUDIT

T. N. Markar

Introduction

General practitioners and psychiatrists communicate mainly by letters (Pullen and Yellowlees, 1985) although telephone communication is now becoming increasingly popular. The quality of care offered to patients depends largely on the effectiveness of this communication (Wright, 1997). With the closure of long stay hospitals and the concept of “normalisation” the majority of people with learning disabilities are now resident in the community. Provision of psychiatric care to these individuals is either by the general practitioners or psychiatrists in learning disabilities. In the UK, the general practitioners are responsible for the primary care of their patients - both physical and psychological. More complex patient problems are referred to the specialist learning disability service which is led by a consultant psychiatrist. There is close and regular communication between the general practitioner and the specialist community team. The majority of people with learning disabilities are unable to communicate satisfactorily and hence effective communication between the professionals is of vital importance. There are two main studies in general adult psychiatry that have addressed the issue of communication between general practitioners (GPs) and psychiatrists (Pullen and Yellowlees, 1985; William and Wallace, 1974). The key information that the GPs requested in these two studies were (1) diagnosis, (2) treatment recommended, (3) assessment of suicide risk if appropriate, (4) follow-up arrangements, (5) prognosis, (6) concise explanation of the condition.

These findings contrast significantly with a similar study in the learning disabled population (Markar and Mahadeshwar, 1998). To the best of the author’s knowledge, this is the only published study in this particular group of patients and the findings indicate that the GPs require much more detailed information than in general adult psychiatry, based on the Maudsley guidelines (The Department of Psychiatry and Child Psychiatry - 1987). These include

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the presenting complaint and duration, past medical history, past psychiatry history, family history, personal history, forensic history, premorbid personality and mental state examination. Perhaps the main reason for these differing requirements is that patients who are learning disabled often fail to give a coherent history and general practitioners depend on accurate and comprehensive clinical information provided by the specialists.

All of the above studies refer to new out patient appointments. There are very few studies in psychiatric follow-up clinics in either general psychiatry or learning disability. In people with learning disabilities, there is only one published study on follow-up clinics (Thalayasingam et al., 1999). The authors of this study recommend that all follow-up clinic letters to GPs should include information on current medication, diagnosis, the mental state and follow-up arrangements. Their aim was to provide a letter which, as far as possible, gave complete and precise information regarding patients’ diagnosis and treatment. A similar study in the general adult population showed that the GPs in Oxford favoured a letter following each outpatient visit, which gave details of significant recent events and management changes (Margo, 1982).

The North Hertfordshire district covers a population of approximately 200,000. The learning disability team is mainly community based and provide a service for the individuals living in the community. However, if they require hospital care, admission is made to the general psychiatric admission unit. This comprises two assessment and treatment beds for these patients. The learning disability team consists of a single consultant, specialist registrar and staff grade psychiatrist in addition to community nurses, psychologists and therapists.

Two parallel clinics are held weekly, by either the consultant or specialist registrar and the staff grade psychiatrist. The clinics are community based and held at the health centres in Stevenage and Baldock. The community nurses attend all clinics and liaise regularly with the general practitioners to ensure effective communication.

Aim of Audit

The aim of this audit was to assess the quality of letters sent to the GPs following routine outpatient follow up clinics.

Method

Stage 1

The initial audit was carried out during the six-month period December 1996 - May 1997. A total of 49 letters were audited using the checklist below

1. Demographic data.
2. Complaint or brief history which is currently relevant.
3. Mental state examination.
4. Other problems e.g. aggressive behaviour, self-injurious behaviour
5. Quality of life e.g. attending day centres, college, participation in community activities.
6. Medication and dosage.
7. Follow-up arrangements.
8. Copy of the clinic letter was sent to relevant learning disability team members who were involved in the patient’s care e.g. community nurse, psychologist.
Standards were set for each item in the checklist following consultation with other psychiatric colleagues and community staff. These were based on clinical needs and practices within the local service. This audit measured the results obtained against these standards.

**Stage 2**

Based on the results from Stage 1 of the audit, certain changes were made to the clinical practices to ensure that the required standards were fulfilled. The audit was repeated a year later (December 1997 - May 1998) to determine if these aims had been achieved. A total of 52 letters were audited using the original checklist.

### Results

The results of Stage 1 were presented to the multidisciplinary team (MDT). It was agreed that the standards of practice should improve in the following areas:

1. Documentation of medication and dosage
2. Assessment of mental state
3. Documentation of other problems and quality of life.

If no specific enquiries were made regarding the latter two items the carers might not volunteer such information, as there is always the risk that “unacceptable behaviour” may be deemed “normal” by inexperienced carers. It was agreed that the community nurses would automatically

### TABLE I

**Results of the initial audit done during the period of December 1996 - May 1997.**

<table>
<thead>
<tr>
<th>Checklist Items</th>
<th>Standards</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Demographic data</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(2) Complaint or brief history</td>
<td>80%</td>
<td>85.4%</td>
</tr>
<tr>
<td>(3) Current mental state</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>(4) Other problems e.g. behavioural</td>
<td>100%</td>
<td>66.6%</td>
</tr>
<tr>
<td>(5) Quality of life</td>
<td>100%</td>
<td>55.10%</td>
</tr>
<tr>
<td>(6) Medication and dosage</td>
<td>100%</td>
<td>83.6%</td>
</tr>
<tr>
<td>(7) Follow-up arrangements</td>
<td>100%</td>
<td>95.9%</td>
</tr>
<tr>
<td>(8) Copies of letters sent to relevant members of the MDT</td>
<td>80%</td>
<td>29.1%</td>
</tr>
</tbody>
</table>

### TABLE II

**Results of Stage 2 of Audit December 1997 - May 1998**

<table>
<thead>
<tr>
<th>Checklist Items</th>
<th>Standards</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Demographic data</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(2) Complaint or brief history (currently relevant)</td>
<td>80%</td>
<td>98%</td>
</tr>
<tr>
<td>(3) Mental state</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>(4) Other problems e.g. behavioural</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(5) Quality of life - e.g. attending day centre, participation in activities</td>
<td>100%</td>
<td>92%</td>
</tr>
<tr>
<td>(6) Medication and dosage</td>
<td>100%</td>
<td>92%</td>
</tr>
<tr>
<td>(7) Follow-up arrangements</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(8) Copies sent to relevant professionals</td>
<td>80%</td>
<td>96%</td>
</tr>
</tbody>
</table>
receive copies of all clinic letters to further facilitate their liaison work with the GPs.

The results of the repeat audit were presented at the monthly audit meeting. The results show that there has been a significant improvement in all of the items identified following Stage 1 of the audit.

**Conclusion**

The bar chart of FIGURE 1 indicates that the standards of practice have improved in the areas of assessing mental state, identifying problems like disturbed behaviour and assessing the quality of life.
Although the set standard for assessment of mental state, quality of life, medication and dosage were not fully achieved, the changes are clearly significant and in the required direction. We recognise that further improvement is required to achieve the set standards in all of the above criteria.

A previously published study on the same subject (Thalayasingam et al., 1999) has also identified similar deficiencies in communication with GPs. These authors proposed a standardised letter to be sent to all GPs stressing the importance of the medication and its dosage being mentioned in each letter. This would enable easy follow-up and early detection of any discrepancies in relation to drugs and/or dosage.

The author would agree with this proposal, although it would be relevant to include other items such as quality of life and behaviour problems in such letters. The author also believes that any changes to medication or dosage should be printed in bold lettering for easy identification. It would also be useful to send copies of all such letters to the community nurses.

Such a standardised letter would provide clinically relevant information to the GPs in a consistent manner. It is recommended that the standard letter should include the following subheadings:

1. Diagnosis - Multiaxial classification
   (Cooray, Tyrer et al., 2000)
2. Current problem
3. Mental state
4. Quality of life
5. Medication - with dosage
6. Follow-up arrangements
7. Comments

Finally a word of caution in the use of such standardised letters. Patients are all individuals who have a variety of different problems which can range from financial and housing to relationships and medication side effects. In such standardised letters this individuality is often lost. For this reason the author would suggest a seventh item 'comments' which would enable the treating psychiatrist to add these issues. This can also include a brief note, if applicable, on admissions and in-patient treatment.

### Summary

This audit assessed the standards of practice and communication between specialist psychiatric services and the general practitioners. The initial audit identified deficiencies in the documentation of essential clinical information. Based on these results certain changes were recommended and implemented. A re-audit has now demonstrated a significant improvement in the deficient areas. The author has also suggested that all general practitioners should receive a standardised letter that provides information on the diagnosis, current problems, follow-up arrangements and comments. This would ensure that the general practitioners always receive the essential clinical information following an out-patient appointment in the consultant psychiatrist clinic.

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References


