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HOW SHOULD PSYCHIATRISTS AND GENERAL PHYSICIAN COMMUNICATE TO INCREASE PATIENTS' PERCEPTION OF CONTINUITY OF CARE AFTER THEIR HOSPITALIZATION FOR ALCOHOL WITHDRAWAL?

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SUMMARY

Background: *There are medico-psycho-social indications to apprehend the alcohol use disorder (AUD) as a chronic problem for which a continuous care is necessary. The perception of continuity of care is also associated with positive outcomes on the patient's health. Communication between caregivers is essential to maintain a good continual care. In order to put patients back into the center of care, we asked them the question: "why should the psychiatric department (PD) and general physicians (GP) should communicate about AUD patients"?*

Subjects and methods*: After a week of hospitalization for alcoholic withdrawal, we used a qualitative approach with 4 open questions to explore AUD patients' point of view (N=17) about the best way of communication between psychiatrists and GP to improve care continuity. The data collection was carried out in the psychiatric department of the University Hospital of Mont-Godinne, Belgium.*

Results: *AUD patients consider that the GP is the first line actor that will be consulted after hospitalization and have a privileged relationship with him. These arguments justify him being informed. Concerning these patients, communication is useful to have a continuous treatment and project care, for purposes of symptoms' evolution follow-up and so as to help the GP to understand them better to follow the evolution of symptoms and to help the GP to understand them better.*

Conclusion: *From AUD patients' point of view, communication between psychiatric department and the GP is useful for a perspective of continuity of care at discharge from the hospital. This communication seems to be at the service of the GP and his patient rather than for the psychiatrist himself. Mainly because of the GP's role as a privileged first-line care, but also thanks to the specific relationship relating him to his patient.*

Key words: *alcohol use disorder – continuity of care – communication – general physician*

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INTRODUCTION

Alcohol abuse is a major health issue in our modern society. According to a World Health Organization report, «it is a causal factor in more than 200 diseases and injury conditions" (World Health Organization 2014). In 2012, 5.9% of all global deaths could be explained by alcohol (World Health Organization 2014). AUD's population is more vulnerable because it shows greater mortality risks compared to the general population (Roerecke & Rehm 2013). In Belgium, 10% of the population is affected by AUD (Gisle & Demarest 2014).

In response to this major public health issue, politicians and scientists provide the below recommendations:

- The theoretical framework to which we refer in this article gives an important place to the concept of "continuity of care" (COC) that was proposed by Bachrach (1993) and developed by Haggerty et al. (2003). Several authors have studied the link between continuity of care experience and patient health outcomes. Perception of continuity of care (PCC) is "the way in which care is experienced by a patient as consistent and time-bound; this aspect of care is the result of good information transfer, good interpersonal relationships and coordinated care" (Reid et al. 2002).
- Haggerty et al. (2003) refer to three types of continuity of care: Informational Continuity, Management Continuity, Relational Continuity. In all of them, communication and collaboration between caregivers is essential. The reference scale used to assess the patient's perception of continuity of care (e.i. the Alberta Continuity of care scale: ACCS-MH) also refers several times to the communication between the psychiatric service and the GP (Digel Vandyk 2016). Other authors report deficits in communication and information transfer between hospital-based and primary care physicians, which may have implications for the patient's safety and the patient's continuity of care (Kripalani et al. 2007).
- The patient's PCC is resulting into positive effects on the patient's health (Bekkering et al. 2016). For example, PCC is associated with adherence to treatment, a decreased emergency room visits and hospitalization (Joyce et al. 2010). Lack of continuity of care is referenced as a major factor for patient dissatisfaction and disengagement (Puntis et al. 2015). In the area of mental health, continuity of care is significantly related to the number of hospitalizations, the severity of the patient's symptoms, the social functioning and the service satisfaction (Puntis et al. 2015). About AUD, PCC is associated with lower alcohol consumption (Adair 2005).

- Concerning Belgian policy, there was in 2010 a reform of the law relating to hospitals (the so-called "reform 107") which encourages the outpatient care and the creation of care networks for mental health problems. This reform targets both patients suffering from acute psychiatric problems and chronic ones, such as AUD. It helps to meet the needs of these patients and it is also an alternative to hospital care.
- At scientific level, the current trend is to propose continuous care for AUD (Bekkering et al. 2016) simply because there is a bio-psycho-social indication to apprehend this disorder as a chronic problem (McLellan et al. 2000). In order to give continuous care to the patient, the collaboration between the different care providers is essential.
- To put it in a nutshell, patients suffering from AUD often require a complex combination of professionals who are having diversified trainings in the bio-psycho-social fields (Digel Vandyk et al. 2013) so as to provide tailored care (e.g., hospitalizations, outpatient psychiatric care, primary and emergency care) (Digel Vandyk et al. 2013). Collaboration between such services is a major challenge (Digel Vandyk et al. 2013) where communication is a prominent component (Way et al. 2000). However, even if the importance of communication has been reported, there is a theoretical lack concerning the modalities of this communication (Bekkering et al. 2016).

Aim and research questions

In this perceptive of continuous care, there is a need to better understand the communication between the different providers of care at all the stages of their treatment (admission, detoxification and care in the hospital, outpatient care) (Bekkering et al. 2016). To do so, we asked the following question: "How should the psychiatrist and the general physician communicate in order to increase the patients' perception of continuity of care after their hospitalization for alcohol withdrawal?"

Since the current trend in mental health is working with patients suffering from chronic diseases to manage their care (Karazivan et al. 2015), we included patients-as-partners in this reflection and we asked the opinion of the patients hospitalized for an alcohol withdrawal.

SUBJECTS AND METHODS

We used a qualitative approach to explore the AUD patient's point of view. The data collection was carried out in the psychiatric department of the University Hospital of Mont-Godinne, Belgium. The duration of hospitalization in this department is 12 days. After a week of hospitalization, at the occasion of a consultation with their referring psychologist, patients were informed about the goals of this study (i.e. to better understand the collaboration between the psychiatric department and the general physician) and were free to participate or not. All 17 patients agreed to participate and were asked to answer 4 open questions: 1) "Why should the psychiatric department communicate with your general physician?" 2) About what they should communicate? 3) When should they communicate? 4) How should they communicate?

Participants

Seventeen Caucasian participants hospitalized in our department during 12 days between April 2018 and May 2018 were questioned. All of them were admitted after 3 pre admission consultations. The participants must meet DSM-V criteria for an AUD and have no history of other psychiatric disorders on Axis I of the DSM-V (APA 2013).

The sample mean age was 43-58 years (std: 12.12). The youngest subject was 21, and the oldest 62. The gender ratio was 6 females for 11 males. 70,6 % of the participants (12/17) had already been hospitalized for alcohol withdrawal and 76.5% of them (13/17) consume tobacco.

RESULTS

Taking into account that we asked an open question, for purposes of the current research, we grouped together patient patient's answers by themes in order to interpret the results more effectively. Please note that Patients can give several arguments for the same questions:

- *"After hospitalization, why should the psychiatric department communicate with your general physician?"*
  Patients' point of view : The GP has a role of "information centralization" and "follow up" about patient health (8/17), the GP is the first line actor that will be consulted (4/17), the patient considers having a privileged relationship with his GP that justifies the fact for him to be informed (4/17), aiming at helping the GP to better understand the patient (4/17), giving the possibility to the GP to being able to manage drug treatment (4/17).
- "*What they should communicate?"*
  Patients' point of view: Evolution of the patient's condition, symptomatology and diagnosis (7/17), objectives, care pathway and care project (5/17), content of psychological interviews and psychological assumptions (5/17), information about the treatment and the medical examinations (4/17), situations at risk of relapse and corresponding action plan to avoid them (2/17), direct answers to the specific questions of the GP in order to optimize its efficiency (2/17).
- *"When should they communicate?"*
  Patients' point of view: Quickly after the end of the hospitalization (10/17), at the end of the hospitalization (6/17), before the hospitalization or at the beginning of the hospitalization (5/17), in case of problem or in case of risk of relapse (4/17).

- *"How should they communicate?"*
  Patients' point of view: By post (8/17), by e-mail (8/17), through the patient (3/17), by phone 2/17, not by use on the phone because the GP is not easily reachable by phone (5/17).

DISCUSSION

This study is only a first step to explore the AUD patient's point of view about communication between the psychiatric department and the GP after hospitalization.

According to our observations, patients seem to understand the importance of communication between the psychiatric department and the GP. Our results confirm that the GP have a role of "information centralization" and "follow up" about patients' health. They seem to be the first-line caregivers preferred by the AUD patients in case of relapse. Furthermore, patients keep a privileged relationship with their GP and the psychiatric department can help such GP to better understand them and to be more effective for continuity of care. The patient is aware of restrictions of availability of his GP and therefore considers that collaboration by post is the most appropriate, while wishing to be involved in the exchange of information between the psychiatric department and the GP. In the patients' mind, this communication should be at the service of the GP leading to more continuity after hospitalization due to the fact that the transmission of information goes systematically from the psychiatric department to the GP.

CONCLUSION

This paper confirms the importance of communication between the psychiatric department and the GP because he has a central role in the perception of continuity of care for AUD patients.

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Contribution of individual authors:

All authors made a substantial contribution to the design of the study, and/or data acquisition, and/or the data analysis and its interpretation.

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