What is the role of the psychiatrist in primary care?

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SUMMARY. Psychiatrist services are currently in a state of flux because of a change in philosophy towards care in the community. There is much disquiet among psychiatrists about the lack of resources needed to effect this change. However, the most appropriate focus of community care already exists in the form of the general practitioner's surgery, but at present it is rarely used to its full potential because liaison between general practitioners and psychiatrists is poor. Ways of improving the liaison between psychiatric and primary care teams are outlined that if implemented would enable community psychiatry to flourish.

Introduction

MANY general practitioners will be aware that they are having more contact with psychiatrists than they used to. In the past when mental health care was more institutionalized psychiatrists and general practitioners were less than flattering about their respective functions.[1,2] It is now common knowledge that most patients with psychiatric problems are treated in primary care[3] and although early work established that general practitioners could cooperate well with psychiatrists in this context[4] it is only recently that this has become commonplace.

The creation of district general hospital psychiatric units has improved liaison with all medical disciplines and has been associated with a significant drop in the population of psychiatric patients in hospital (a decrease of 25% in the last 10 years). District general hospital psychiatric units have stimulated the growth of community psychiatry or more particularly the development of extramural services including day hospitals, outpatient clinics and the community psychiatric nursing service. This process has been accelerated by the policies of the present government and now psychiatric hospitals are threatened with closure in many parts of the country. The speed of this change has led to protests in the profession[5,6] because community services are not available for the patients discharged from these hospitals. However, it is not strictly true that there are no community psychiatric facilities for such patients. The general practitioner's surgery is still the first port of call for almost all psychiatric patients. Should it become the main focus for community psychiatry in the future, particularly in areas where a surgery or health centre has an approximate catchment area in which most of the patients registered with that practice live?

Community psychiatry in general practice

Many psychiatrists have difficulties in adjusting to professional life away from a hospital base because it involves a new style of care.[7] When a physician superintendent of a psychiatric hospital is moved into the community he lacks his authority and is very vulnerable. A closer alliance with the general practitioner may involve loss of consultant status but is necessary for successful collaboration. There are several ways in which such a collaboration can be practised. Williams and Clare[8] correctly reject two of the possible options: that psychiatrists should take over a large part of primary psychiatry from the general practitioner, or that more patients ought to be referred to the psychiatrist in his specialized clinic. What is needed is more liaison between general practitioner and psychiatrist so that continuity of psychiatric care can be achieved. Mitchell[9] describes five sorts of liaison: regular and coordinated home visits; psychiatric clinics at health centres or surgeries; visits to the health centre or surgery to see selected patients; regular group discussions in the health centre or surgery; and joint consultations in primary care.

Psychiatric consultations in primary care are preferred by patients because of easier access and the removal of the stigma of attending a purely psychiatric facility.[10] One in five psychiatrists already has contact of this nature with general practitioners[11] and this is likely to expand further. Nevertheless, there has been no overall plan for these developments. Most contacts have been based on personal initiatives; sometimes a need for genuine liaison is perceived, but sometimes clinics in general practice are arranged purely for geographical convenience.

The growth of community psychiatry has led to greater contact between patients with the more severe forms of mental illness and general practitioners. Twenty years ago patients with schizophrenia and manic depressive psychosis may have been seen initially by the general practitioner but would subsequently have spent long periods in hospital and would only have been discharged when really well. With the growth of the 'revolving door' policy many of these patients are discharged earlier and then readmitted; during their period in hospital they see the general practitioner frequently. At the other end of the scale the psychiatrist hopes to carry out a preventive role by seeing patients when their disorder is at an early stage in the hope that chronicity can be prevented. In the past such patients were normally supported by the general practitioner until a crisis led to breakdown and subsequent psychiatric referral. There is now a much greater interface between psychiatry and general practice than in the past (Figure 1). For successful liaison both the psychiatrist and the general practitioner need to develop additional skills in the areas that were formerly considered unnecessary.

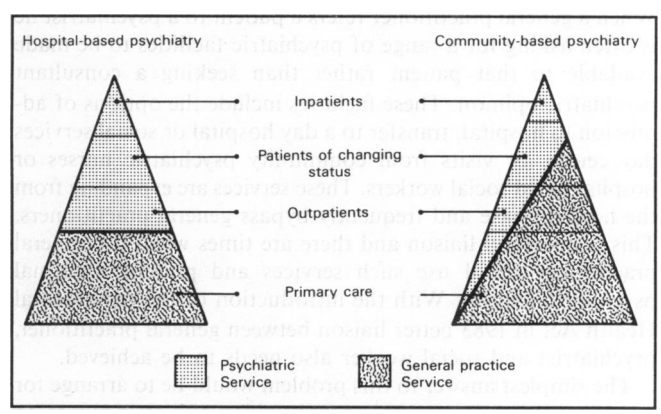

Figure 1. *The interface between general practice and psychiatry in hospital and community psychiatry.*

Requirements for successful liaison

Successful liaison can only be achieved through changes in training, financial resources and personnel.

Training

To date the training of general practitioners has been more relevant to the development of community psychiatry than that of

psychiatrists. Psychiatry is a common option in many vocational training schemes for general practitioners. Six months spent in a psychiatric service providing comprehensive care is invaluable if it is accompanied by additional teaching. Unfortunately, however, a psychiatric attachment is not a mandatory part of general practitioner training. Even if a general practitioner attempts to insulate himself from psychiatric problems he will inevitably come across a significant proportion of psychiatric patients in his daily work. Similarly it is unlikely that newly-appointed consultants in psychiatry will have postgraduate experience in general practice or even community psychiatry.

Financial resources

Greater liaison between psychiatrists and general practitioners has financial implications. The general practitioner who is keen on psychiatry will see more patients with mental disorders for longer periods, and make less use of the hospital services than a colleague who has little interest in the subject. Similarly, psychiatrists who have little or no interest in liaison will be of no help to the general practitioner in his work. The relative space occupied by general practitioners and psychiatric services shown in Figure 1 will therefore vary considerably.

This would matter less if general practitioner and hospital services were funded from the same source. However, family practitioner services are likely to remain financially independent of hospital services. Thus, a general practitioner who lends his surgery to a psychiatrist in order to carry out liaison work should charge the psychiatrist for that privilege. The situation is different in many health centres where the health authority contributes part of the funding.

Although arrangements can be made to patch up these difficulties it is preferable to have a separate budget for community psychiatry that is available to both general practitioners and psychiatrists. The proportions available for each discipline would depend on the service provided. The budget could also fund community psychiatric developments in advance of further hospital cuts.

Personnel

When a general practitioner refers a patient to a psychiatrist he is often asking for a range of psychiatric facilities to be made available to that patient rather than seeking a consultant psychiatric opinion. These facilities include the options of admission to hospital, transfer to a day hospital or social services day centre, or visits from community psychiatric nurses or hospital based social workers. These services are expanding from the hospital base and frequently bypass general practitioners. This is not good liaison and there are times when the general practitioner could use such services and prevent a formal psychiatric referral. With the introduction of the new Mental Health Act in 1983 better liaison between general practitioner, psychiatrist and social worker also needs to be achieved.

The simplest answer to this problem would be to arrange for some personnel, for example community psychiatric nurses, to be attached to general practice and to function independently of the psychiatric service. This would only work well with general practitioners who were interested in psychiatry and it would create problems for community psychiatric nurses, who lack a satisfactory career structure, and need to be in touch with developments in psychiatry.

These personnel should be available for consultation by both general practitioners and psychiatrists but should also retain some degree of autonomy. Thus community nurses or social workers would be at liberty to turn down a referral which they thought was inappropriate from either a general practitioner or a psychiatrist. In areas where general practitioners see most of the psychiatric cases the community nurses would have greater liaison with them and where the psychiatrist was particularly active more referrals would come from the psychiatric sector. Such personnel should be funded by the community psychiatric budget.

It should also be possible for the psychiatrist to have links with the primary health care team, particularly district nurses and health visitors. In particular, there should be good liaison between community psychiatric nurses, district nurses and health visitors as their functions often overlap.

Evidence in favour of a new approach

Some general practitioners may feel that these proposals should be tested before they can be considered seriously and may also be concerned about psychiatrists invading their territory. There is understandable concern about the limited number of psychiatrists to whom general practitioners can refer their patients. If the general practitioner only has one or two psychiatrists based at health centres to whom he can refer patients, and he does not get on with either of them, how does he proceed? To overcome these difficulties psychiatric teams of adequate size are needed that can receive direct referrals. In Nottingham a psychiatric service based on general practice has been in operation for six years and most general practitioners regard the new service as an improvement (Ferguson B. General practice psychiatric clinics: the general practitioners' view. Paper given at quarterly meeting of Royal College of Psychiatrists, April 1985).

General practitioners are also concerned about the amount of time that may be necessary to achieve better liaison. It is commonly recommended that a psychiatric consultation should take at least 60 minutes. This is rarely appropriate in general practice and a combined consultation between general practitioner and psychiatrist for this length of time is not practicable. Often the general practitioner just needs a quick word with the psychiatrist when faced with an acute problem but psychiatrists are not used to this form of consultation and this sometimes creates difficulties.[12] This is another example of the need to develop community psychiatry as a separate discipline rather than transplant hospital psychiatric methods to the community setting.

There is also a danger that any type of community service is considered an improvement on the old. The best form of delivering community psychiatry has yet to be found but the advantage of a service based on primary care is that it is involved with all types of psychiatric patients. It deals with the chronically ill as well as those with acute problems[13] and is therefore superior to community mental health centres in the USA, which have been criticized because they have a bias towards the young and those who have relatively mild psychiatric disorders.[14]

There are also difficulties in areas of low population where the personal contact between general practitioner and psychiatrist is limited. In many inner city areas patients come into contact with the psychiatric services without being registered with a general practitioner. Close evaluation of the developments in different settings is necessary to determine which type of care is most effective.[15]

Some general practitioners are also reluctant to become involved in multidisciplinary teams, which are often seen to be inefficient and as lacking leadership. However, if community

psychiatric services are to expand it is important that the concept of the multidisciplinary team is accepted. The need to refer a patient to a psychiatrist in order to contact another member of the psychiatric team is inefficient and when direct access is available to other members of the team more referrals tend to be made.[16] Psychiatric nurses working in the community are both well-trained and effective[17] and are well able to decide on the merits of a referral. Similarly, health visitors have considerable experience of psychiatric problems[18] and could well be of help to a psychiatric team in their work.

General practitioners can be assured that their use of these resources is likely to be beneficial[19] and, in the long term, would probably reduce the amount of time spent on psychiatric problems in the surgery. If general practice psychiatry is effective it should lead to a reduction in the use of inpatient beds and already there is some evidence that this is so.[16,20] If the outcome is seen to be a success, community psychiatry will flower, and it is likely to grow most healthily in the fertile soil of the primary care plot.

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