

# Liaison psychiatry in general practice: a comparison of the liaison-attachment scheme and shifted outpatient clinic models

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**SUMMARY.** *Most psychiatrists who visit health centres use the shifted outpatient clinic model, the main aim of which is to improve secondary care by providing it in the primary care setting. For five years we have employed a liaison-attachment scheme in which support and advice from the psychiatrist enables general practitioners to improve their care of patients with psychiatric and psychological problems. One of the advantages of the latter model is that the psychiatrist can contribute to the care of patients not seen by the specialist psychiatric service and also to the development of the primary care team. The scheme is cost effective as psychiatrists can advise on the care of far more patients than they could see in formal referrals, fewer patients are taken on for a course of psychiatric treatment that could be provided by general practitioners and the skills of general practitioners and their trainees are enhanced. It is hoped that more general practitioners will adopt this pattern of working so that it can be fully developed and evaluated.*

## Introduction

ALTHOUGH there has been an enormous increase in the number of psychiatrists visiting health centres on a regular basis during the last 15 years,<sup>1</sup> the specific aims of such visits are not clear from the literature. Most psychiatrists visit health centres in order to hold outpatient clinics but the hope has been expressed that this method also improves liaison between the general practitioner and the psychiatrist.<sup>1</sup> Mitchell<sup>2</sup> has warned, however, that visiting a health centre is not synonymous with full liaison; psychiatrists may be changing the geographical site of their work without altering their mode of practice.<sup>2-4</sup>

In this paper we describe our experience as a general practitioner and psychiatrist who have worked in collaboration for five years and we shall put our findings in the context of the published literature. We will focus on the difference between a 'liaison-attachment scheme'<sup>2</sup> which aims to help general practitioners treat their own patients, and the 'shifted outpatient clinic'<sup>1</sup> which aims to improve secondary care by delivering it in a primary health care setting. The latter is the model used by two-thirds of psychiatrists visiting health centres.

## Liaison-attachment model

Our model is based on a liaison-attachment scheme but includes aspects of consultation models that have been described previously.<sup>2,5</sup> The psychiatrist (F.C.) visits the health centre on a monthly basis, primarily for a liaison meeting with the general

practitioners and the primary care team to discuss their patients with psychiatric or psychological problems. This discussion takes approximately one hour (over a sandwich lunch) and is followed by a half session (one and a half hours) during which the psychiatrist sees one or two new cases either as formal referrals or as briefer consultations with the general practitioner and the patient. Time is then spent discussing with the general practitioner how he or she can best continue management.

The hour's discussion is devoted to two or three clinical problems raised by the general practitioner or any other member of the primary care team. These will usually involve patients whom the psychiatrist does not see personally, though a direct consultation is sometimes deemed appropriate. More usually a course of action is suggested to the general practitioner, such as an interview with the patient and his or her partner, a more challenging assessment interview or the trial of a different drug, and the outcome is discussed at a subsequent meeting. In this way the patient can benefit from the psychiatrist's expertise without formal referral and the general practitioner can enhance his skills under supervision. Patients currently under the care of the psychiatrist or patients who are about to be seen as formal referrals are discussed briefly. Other cases provoke more general discussion, such as about the use of antidepressants in the physically ill, problems arising in patients from other cultures and organization of local services. The discussions follow the pattern outlined by Rose (Rose N. Psychiatric liaison meetings with general practice teams: a descriptive analysis of 100 meetings; unpublished paper; 1988).

Formal consultations between the patient and psychiatrist are usually more satisfactory in the practice than at the hospital. The psychiatrist meets the patient after being primed by the general practitioner about the nature of the problem and its background and exactly why the consultation has been requested. Summaries of all previous medical and psychiatric treatment are available in the general practitioner's records and can be examined, and other members of the primary health care team often contribute further information at the liaison meeting. The consultation may therefore be briefer than usual or allow more time for the psychiatrist to engage in therapeutic interviewing rather than simply establishing the history. Having seen the patient, the psychiatrist will usually discuss with the general practitioner ways of managing the problem in general practice.

## Advantages of the liaison model

There are advantages for psychiatrists in working with this model. They can influence the care of many more patients than they could see themselves and they can improve the skills of general practitioners in the detection and treatment of psychiatric illness.

The most obvious advantage for general practitioners is the help they receive in treating patients who have psychiatric illness, without making a formal referral. This avoids the delay of an outpatient appointment and provides help for patients who refuse to see a psychiatrist. General practitioners also gain an appreciation of their own strengths and weaknesses in relation to psychiatric patients. The strengths include their personal knowledge of the patient and the family, and the primary care

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Date submitted: 16 December 1988; date accepted 5 April 1989.

© Journal of the Royal College of General Practitioners, 1989, 39, 514-517.

setting in which they work; the weaknesses lie in their lack of training and experience in psychiatry. General practitioners also learn the strengths and limitations of specialist psychiatric treatment.

An unexpected result of including a psychiatrist in primary care team meetings on a regular basis has been the growth of more detailed discussions of the wider psychological aspects of patient care. It has become easier for members of the team to tackle such topics with their patients, knowing that the rest of the team, including the psychiatrist, is available for support. Both the physiotherapist and district nurse, for example, have acknowledged and managed difficult bereavement and sexual problems that previously would have either remained undisclosed by the patient or required referral to another agency. Such discussions have proved to be a valuable educational experience for general practitioner trainees, many of whom have not had postgraduate psychiatric training.

### Minor psychiatric disorder

#### *Patients who would not normally be referred*

Irrespective of the service offered, the majority of patients with 'minor' disorders — anxiety states, depression, adjustment reactions, including those to physical illness — are dealt with by the general practitioner alone, only 5% being referred to a psychiatrist and a further 3% to counsellors, social workers, psychologists or community psychiatric nurses.<sup>6-8</sup> In the shifted outpatient model the presence of the visiting psychiatrist does not improve the care of these patients as the clinic time is spent seeing patients who have been referred to the psychiatrist.<sup>9</sup> On the other hand in the liaison-attachment model, patients who are among the 95% not seen by a psychiatrist and cared for solely by the general practitioner form the main focus of the discussions at liaison meetings (Rose N, 1988).

#### *Patients who would normally be referred for an outpatient consultation*

Patients seen by the psychiatrist in the health centre are in a familiar setting near to their home without the stigma of attending a psychiatry department.<sup>1,9,10</sup> This is the clearest advantage of shifted outpatient clinics over hospital clinics and appears to have improved the attendance rate at some clinics<sup>9,11,12</sup> but not at others.<sup>13</sup>

However, this advantage is very modest compared with that offered by the liaison-attachment model, which may actually modify the referral process. Our discussions often cover the degree of usefulness of formal referrals. With increased awareness, clinically appropriate referrals can be encouraged, the precise reason clearly stated and all the appropriate information conveyed to the psychiatrist. Other situations, especially those where the doctor needs support with a difficult doctor-patient relationship,<sup>4</sup> can be dealt with by direct discussion rather than formal referral.

### Major psychiatric illness

Day hospital treatment is increasingly used as an alternative to inpatient care for seriously ill patients.<sup>14-16</sup> Although not always perceived as such, this is really a form of shared care as patients are exposed to specialist psychiatric care in the day hospital and to general practitioner care at other times. Such care can only be successful if there is good liaison between the two and the liaison meetings at the health centre provide a forum for such discussions.

Similarly, the aftercare of patients discharged from the day or inpatient psychiatric unit is frequently discussed at liaison meetings because the discharge summary is unlikely to include all the information required by the general practitioner when

he or she sees the patient in the surgery. Discontinuity of care may result if communication is poor.<sup>17</sup>

An important group of patients for whom the general practitioner requires advice are those with major psychiatric illness who refuse to see a psychiatrist yet do not warrant admission under the 1983 mental health act. The opportunity to discuss such patients with a visiting psychiatrist is especially welcomed by the general practitioner, who often receives vociferous demands from relatives or neighbours but remains uncertain whether any further action can be taken.

### Differences between liaison-attachment schemes and shifted outpatient clinics

There have been major questionnaire surveys of the views of psychiatrists and general practitioners on liaison psychiatry and a number of reports concerning the characteristics of patients seen in health centre clinics. At present there is more opinion than hard evidence to indicate how the different models operate.

Most of the published data reject the notion that patients seen by psychiatrists in health centres are less severely ill than those seen in hospital outpatient clinics,<sup>9,12,13</sup> though one study does support this view.<sup>18</sup> Differences between liaison-attachment schemes and shifted outpatient clinics are hard to detect because of the limited data available but two indicators are worthy of note.

First, the proportion of patients who had not previously been in contact with psychiatric services varied between the two models (Table 1). Tyrer<sup>9</sup> found that the establishment of a shifted outpatient clinic in a health centre led to more re-referrals of chronic patients with fewer new referrals, whereas those operating a liaison-attachment scheme were referred a greater proportion of new cases. Rose emphasized that most of these new referrals were appropriate — the majority of referred patients had chronic psychiatric disorders that had lasted more than one year, those with schizophrenia had not been seen by the psychiatric services and many of the cases of depression were referred because of concern about suicide risk (Rose N, 1988). Our own experience supports this — 18% of patients seen in the health centre clinic were psychotic and of the patients whose treatment was continued by the psychiatrist, nearly half required admission to the day hospital or the inpatient unit because of the seriousness of their illness. It appears that the liaison-attachment scheme may enable the psychiatric service to reach

**Table 1.** Proportion of new cases (no previous psychiatric contact) among referrals and the proportion of patients who continued to be treated by the general practitioner after one consultation with a psychiatrist.

Author	Model	Percentage of new cases	Percentage treated by GP
Tyrer <sup>a</sup>	Shifted outpatient clinic	20	25 <sup>b</sup>
Browning and colleagues <sup>c</sup>	Shifted outpatient clinic with time for discussion	45	30
Brown and colleagues <sup>d</sup>	Combination of shifted outpatient clinic and liaison-attachment	40	—
McKechnie and colleagues <sup>e</sup>	Liaison-attachment	67	21
Rose <sup>f</sup>	Liaison-attachment	66	72
Creed/Marks <sup>g</sup>	Liaison-attachment	70	64

<sup>a</sup>Ref 8. <sup>b</sup>Estimated figure. <sup>c</sup>Ref 13. <sup>d</sup>Ref 12. <sup>e</sup>Ref 3. <sup>f</sup>Rose N, 1988. <sup>g</sup>Authors of this paper.

patients who merit their attention but who would not normally see a psychiatrist, perhaps because of patient resistance which can be overcome when general practitioner and psychiatrist work closely together.

The second indicator which might differentiate the two models is the proportion of patients referred back to the general practitioner for continued treatment after a single consultation with a psychiatrist. A shifted outpatient clinic apparently operates like a hospital clinic<sup>19</sup> with very few patients referred back to the general practitioner at this stage. In two of the three liaison schemes, however, two-thirds of patients were referred back to the general practitioner (Table 1). This is the same proportion that Johnson reported many years ago;<sup>20,21</sup> he found that 65% of patients were being offered treatment at the hospital outpatient department that could have been provided by general practitioners. Recently, Gask<sup>22</sup> found that advice offered to general practitioners by a hospital-based consultant psychiatrist was often not acted upon, thus perpetuating the gap between the general practitioner and psychiatrist. The liaison-attachment scheme makes it most unlikely that specialist advice would not be acceptable to the general practitioner.

Tyrer and colleagues claimed that the proportion of inpatient admissions was lower when psychiatrists were working in a health centre<sup>19</sup> and a larger Scandinavian study supported this finding.<sup>23</sup> However, in each case other factors may have been responsible, including the increased use of a day hospital and the attitude of the staff. McKechnie and colleagues<sup>3</sup> provided limited data in support of Tyrer's assertion but neither Rose nor Browning and colleagues<sup>13</sup> found that the hospital admission rate was affected by their liaison schemes. Only 10% of the psychiatrists surveyed by Strathdee and Williams thought that this type of liaison prevented admissions.<sup>1</sup> Our own experience suggests that any reduction in the number of admissions reflects a reduction in inappropriate admissions, rather than alteration of the course of major psychiatric syndromes by earlier intervention.

### Cost effectiveness of liaison psychiatry

Tyrer and colleagues reported that three and a half sessions a week were required for five health centre psychiatric clinics, serving a population of 78 000, instead of the previous two sessions per week in the conventional hospital outpatient clinic.<sup>19</sup> On the other hand, Browning and colleagues reported that clinics for a population of 15 000 required two sessions per week,<sup>13</sup> so 10 sessions per week would be required for Tyrer's population and this would be impracticable. Mitchell<sup>24</sup> has spent two sessions per week at a health centre serving a population of 40 000 and one session per month at another serving 12 000, but he also describes two health centres which he has visited regularly without seeing patients except on an occasional basis.

Clearly there is no set pattern of working which can be universally recommended and much will depend on whether there are other services available in the health centre, such as community psychiatric nurses or psychology clinics. But psychiatrists must decide whether to spend their time seeing new patients, seeing follow-up patients or discussing cases with general practitioners. Tyrer's detailed description of a shifted outpatient clinic<sup>8</sup> makes it clear that much of a psychiatrist's time is spent in continuing care — one quarter of the patients referred to that clinic over an 18 month period were still attending at the time of the study and thus fewer new patients were being seen. The one hour liaison meeting, however, allows the psychiatrist to advise the general practitioner on three or four patients whereas only one could be seen during that time. If patients are discussed and not referred this is cost effective, provided it can be shown that the outcome of treatment is similar. The time spent in personal discussion prior to a consultation is also cost effective if it results in a shorter consultation and in the patient receiving treatment

from the general practitioner, leaving the psychiatrist to advise on the care of other patients.

### Problems of liaison psychiatry

At present psychiatrists become involved in health centre work largely at the invitation of general practitioners who are likely to be those most interested in this area of their practice. Tyrer reported that it was in the health centres where additional psychiatric input appeared to be most needed that it was least welcome.<sup>8</sup> Our own experience would support this view. In addition, it is much easier for a psychiatrist to negotiate a shifted outpatient clinic than regular liaison meetings, which require a change in working style. The general practitioner must be prepared to share aspects of his or her clinical work, and the psychiatrist must give advice without seeing the patient.

This type of consultation work can be difficult and most psychiatrists have not been trained to do it. However, it should be strongly recommended to psychiatrists involved in the training of general practitioner trainees.<sup>25,26</sup> In this context we have found the joint consultation (psychiatrist, general practitioner trainee and patient) an invaluable teaching tool.

A single model will not serve all needs and our own liaison-attachment scheme is balanced by community psychiatric nursing clinics which form the focus of continued care for the chronically mentally ill in the health centre. Perhaps the rapid growth of the shifted outpatient clinic in preference to the development of liaison schemes reflects the pressing need to improve the continued care of such patients. However, Tyrer set no time aside for discussion with general practitioners and came to recognize that a better balance would be maintained if he offered less of a direct clinical service and spent more time in discussion with general practitioners, thereby acknowledging the value of a liaison model.<sup>8</sup>

### Conclusion

The liaison-attachment scheme that we have operated over recent years appears to have several advantages over the shifted outpatient clinic so popular with many psychiatrists now working in health centres. Outpatient clinics clearly improve liaison between general practitioners and psychiatrists who have never met before, but if the system were to be widely adopted then a great opportunity will have been lost to establish a true liaison service in general practice.

Research must now address the issues raised here to obtain objective evidence of the advantages of one model over the other. It is hoped that more general practitioners will be prepared to invite a psychiatrist to come to their health centres for liaison meetings and that psychiatrists will offer this type of shared care so that the liaison-attachment model can be widely tested.

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