Management of patients with schizophrenia in general practice

THE presumption that general practitioners concern themselves with patients with anxiety and depressive disorders and leave patients with psychoses to the psychiatric team is being rapidly eroded. The rundown and closure of the large mental hospitals in the United Kingdom, developments in community psychiatry and changes in the purchasing powers of general practitioners are challenging this division of labour between psychiatry and general practice. Many patients with chronic psychoses, most of whom have schizophrenia, are now living in private accommodation, hostels or group homes and have immediate access to a general practitioner. Although schizophrenia is an uncommon disorder in comparison to the neuroses, it may present some of the most demanding mental and physical problems for primary mental health care. What is the role of primary care in the management of patients with schizophrenia, what is the burden of care for doctors, what pattern of liaison between general practitioners and psychiatrists will bring best results for patients and how might we investigate this further?

Data collected from the 1960s to the 1980s indicate that general practitioners were closely involved in the management of patients with schizophrenia, sometimes without assistance from the psychiatric services. Between 9% and 11% of patients with acute schizophrenia were treated entirely in primary care.[1,2] Reports consistently demonstrated that up to 25% of patients with schizophrenia discharged from mental health facilities were managed only by their family doctor.[3-5] Studies of patients with schizophrenia in the community, rather than after discharge from hospital services, reached similar conclusions: up to one quarter of patients were managed only by the primary care team.[6]

General practitioners have borne a sizeable burden of the care of long term mentally ill patients, sometimes without assistance from other services. However, recent evidence shows that almost all patients presenting to the general practitioner with an acute psychosis are eventually referred for psychiatric treatment.[7-9] Data reported in the 1990s are less consistent as regards management after discharge from psychiatric inpatient services. A recent follow-up study of severely impaired patients one year after discharge into the community in central London revealed little use of community psychiatric facilities or social services but considerable use of general practitioners.[10] Conversely, a detailed follow-up study of patients with schizophrenia discharged between 1975 and 1985 established that community services were having an important impact, reducing the burden on both family and family doctor.[11] In the study, 13% of patients were cared for only by their general practitioner compared with 25% of a similar cohort in the same area of London followed up some 10 years earlier.[5]

An increase in numbers of such patients has brought this matter into sharper focus. There is evidence that patients with chronic schizophrenia place heavy demands on general practitioners' time, attending the surgery up to three times more often than the average attender,[12] even when living in group homes where there is already considerable medical input from psychiatrists.[13] Physical problems, possibly as a consequence of nutritional neglect and substance abuse, are more common among patients with chronic mental illness,[14] which may account, at least in part, for the higher rate of attendance. A recent questionnaire study of general practitioners in London revealed that one quarter of doctors had noticed an effect on their practice, usually an extra workload, from increasing numbers of patients discharged from mental hospitals in the process of closure.[15] A wide definition of chronic mental illness was taken in this study, to include chronic psychoses, neuroses and personality disorders, which makes the findings less precise. Nevertheless, doctors were enthusiastic about shared care with mental health professionals, the consultant psychiatrist taking responsibility for monitoring psychiatric health and the community psychiatric nurse functioning as key worker, coordinating overall management.

There is little information about what takes place in the consultation between general practitioner and patients with chronic psychoses. General practitioners seem to favour dealing with physical rather than psychological complaints,[15] but patients may be confused or unable to differentiate between general practitioner and psychiatrist.[13,16] Although few practices have specific policies for the care of severely mentally ill patients, particularly patients with schizophrenia,[15] policies for other chronic illnesses are also a relatively recent innovation. Attempts to pilot shared management between primary care and psychiatric teams received universal acclaim by patients but were less popular with mental health professionals, who particularly objected to patients carrying shared care cards containing clinical and social information.[17]

There is an urgent need for more information on the management of patients with chronic schizophrenia in primary care. What are the major reasons for consultation and what can practicably be provided for such patients? General practitioners usually continue to prescribe drug regimens initiated by the psychiatrists, rarely altering the dose or type of drug. Mental state assessments are carried out less often than analogous assessments of other patients with chronic physical disorders.[12] Once this information is established, decisions can be taken on the type of primary care that is feasible for such patients. Protocols for mental and physical state assessment and packages of treatment in primary care can be put to the test in clinical trials. Unfortunately, a lack of appropriate outcome indicators is an obstacle to this work. Although major indicators such as prevalence of schizophrenia and rates of hospital readmission, employment and suicide can be utilized,[18] more detailed indicators such as changes in attendance rates, out of hours contacts, mental state, application of mental health act sections, levels of medication and communications with the mental health team, are needed to demonstrate efficacy of planned interventions.[12]

Work of this nature has already begun but with little consensus on the content of care packages or on the degree of responsibility transferred to the general practitioner. In order to gain the cooperation of general practitioners it is crucial that treatment plans recommended are practicable, not overly ambitious and aim to share care with mental health services rather than replace them.

Liaison psychiatry, in which psychiatrists work directly within general practice settings, has been expanding rapidly in England and Scotland.[19,20] Closer links will ensure better communication between psychiatrists and general practitioners and smooth the path towards further attempts at shared care. Although governments tend to overlook the general practitioner in planning services for mentally ill patients, as exemplified by the relative neglect of general practice in recent documents on community care,[21,22] new powers for budget holding general practices to buy in services will enable general practitioners to become

an important focus on which community care efforts may be based. Suffice to say, psychiatrists will need to provide a service worth buying. Although this will not be easy for either discipline, improved treatment for patients must remain the goal.

There may be confusion about who carries clinical responsibility, particularly if the general practitioner has an interest in psychiatry.[13] The Royal College of General Practitioners, although somewhat equivocal in its recommendation, favours overall responsibility by the general practitioner.[23] When asked, however, most general practitioners prefer clinical responsibility for patients to remain with the psychiatrist.[15] Guidelines are needed, preferably at local level, whereby clinical responsibility for physical and psychiatric problems, as well as out of hours emergencies, is clear and unambiguous.

Lastly, shared care needs to be worked out at a college level and fortunately this is already under way. Over the past 12 months a working party, incorporating members of the RCGP and Royal College of Psychiatrists, has been meeting to formulate joint recommendations for the shared management of patients with chronic mental illness. Members of this working party plan to produce a document that will outline how the two specialties might best work together in the future, as well as detailing ideas on shared care that can be applied to local services to enhance the care for patients with chronic mental illness.

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Desktop laboratory technology for general practice

DESKTOP analysers are becoming increasingly available in general practice and a comparison of the use of four such analysers appears in this issue of the *Journal*.[1] This increasing availability should make us think again about the clinical information needed to make diagnoses and solve problems in the surgery. The main sources of information are the patient's history, the examination and the results of tests. Will the availability of on site tests alter the balance between these categories?

Tests extend our clinical skills by allowing us to analyse body fluids and in effect to see inside the patient. Our profession has been party to an effective public relations campaign, which over two generations has persuaded many patients that science can solve the mysteries of health and disease. This means that even ordering a test can be therapeutic, whatever the result. We must beware of pseudo-science; tests often give a numerical result which implies a comforting, if spurious, accuracy for our clinical reasoning which is so often beset by uncertainty. Such apparent precision is seldom offset by feedback from expert colleagues in the laboratories who are more aware of the limitations of their techniques.[2] On the other hand experienced general practitioners do seem to be aware of the limitations of tests; full time general practitioners use fewer tests than part time general practitioners or trainees.[3]

Until recently most laboratory testing has been carried out in hospitals without budgetary consequences for the general practitioner. General practitioners have come to assume that open access to tests is their right but any assumption that more necessarily means better, which seemed appropriate when general practitioners had to fight for access, should now be challenged.

With open access, the only deterrents to ordering tests are the inconvenience to patients, especially if they have to attend hospital for venepuncture, and the inconvenience for doctors and nurses of collecting specimens and arranging transport to the laboratory. Tests using desktop laboratory technology bring increased convenience and, with the advent of fundholding, they may also be financially attractive if they can be provided cheaply enough. However, Hobbs and colleagues point out that the latter