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A blueprint for shared psychiatric care in the community

PRIMARY care is traditionally the point of first contact for patients with psychological disorders. Between one fifth and one quarter of the workload of the average general practitioner is concerned with patients with mental health problems.[1] Dunn and Skuse, in an analysis of John Fry's patients,[2] found that over a 20 year period three quarters of all women and half of all men had seen their general practitioner about a mental health problem, usually depression. General practitioners also provide continuing care for patients with such problems. The increasingly rapid emptying of the large mental hospitals has further increased general practitioners' involvement, raising new challenges in caring for the larger number of patients with chronic psychoses or with learning difficulties now living in the community and seeking generalist care from their family doctor. These changes have had profound effects on the traditional working relationships between general practitioners and specialists, leading to a re-evaluation of professional roles and of services for patients. For the last two decades psychiatrists have been moving from their hospital base to establish liaison consultation clinics in the community[3] often in health centre premises.

It was in response to these changes that a joint working group was set up by the Royal College of General Practitioners and the Royal College of Psychiatrists to examine shared care with special reference to the management of patients with depression, patients with chronic psychoses, elderly patients with mental illness and individuals with learning disabilities. The working group report, just published, seeks to provide a consensus on general principles from which locally-based protocols may be developed by those providing care directly to patients.[4]

Among the recommendations in the report is the call for catchment areas to be determined by populations registered with individual practices and for community psychiatric teams to be aligned with primary care services. This is to be preferred to catchment areas based on local authority or other geographic boundaries and would avoid practices having to liaise with several different specialist teams, which is particularly awkward when seeking urgent care for acutely distressed patients. Closer integration of training for general practitioners and psychiatrists is recommended. A period of training in general practice is already acceptable as part of the requisite postgraduate experience for membership of the Royal College of Psychiatrists and a joint college statement has recently been published on general practice vocational training in psychiatry.[5] General practice disease registers are advocated for patients at risk from chronic mental illness. This becomes increasingly important as more and more patients are discharged from long-stay psychiatric beds, and such a facility would complement registers already in place for common chronic physical illnesses. Joint continuing education for general practitioners and psychiatrists is advocated, as is the joint audit of the care of mentally ill patients.

The working party has recommended only general principles for shared care, recognizing that local practice should be based on local resources and circumstances. The value of the consensus and the benefit derived by patients from the recommendations will depend on the local application of these principles and their acceptance by general practitioners and psychiatrists alike. For the present, many problems remain in caring for people with mental illness. Supervision and community care for patients with psychiatric illness is often inadequate. General practitioners are well aware of the problems faced by these patients and are equally aware of the enormous emotional strain on carers. It will be important to ensure that new community based services do not care for the less ill at the expense of patients with severe chronic mental disorder.

In 1973 a World Health Organization working party on psychiatry in primary care predicted that '... the general practitioner is likely to play an increasing role in the mental health services'.[6] The prediction has certainly come true 20 years later in the British National Health Service. It is now clear that general practitioners deal with a wide range of mentally ill people who never reach psychiatric services, and have direct and often continuing contact with the families of those affected. Recent legislation and government policies have shifted the balance of health care from hospital to the community. These reforms have given general practitioners the opportunity to influence the pattern of services both in hospitals and the community, as general practitioners in effect 'purchase' the greater part of health care.[7] The new organization and structure of primary care can be used to establish priorities for the types of services provided by secondary care and to develop new ways in which general practitioners and psychiatrists can work together. Liaison should also be improved between the primary are team and other professionals such as community psychiatric nurses and clinical psychologists.

In the transfer of resources from hospital-based to community-based care there must be no overall loss of resources nor should primary care become a dumping ground for patients for whom services are required but which general practitioners are not resourced to manage. This is particularly true for patients discharged from long-stay hospital beds. Studies of schizophrenic patients suggest that many consult their general practitioner more than any other health professional.[8] The present system of patient-initiated consultations in general practice is inadequate for monitoring these patients since the first sign of a relapse of illness may be to cause patients to be inactive and slow to complain.

The report recognizes the essential interdependence of primary and secondary mental health care and the need to develop a shared understanding of local needs and priorities. People who are socially disadvantaged, such as those who are unemployed or living in overcrowded or poor housing and ethnic minorities, are more likely to suffer mental illness.[9] It is difficult and undesirable to separate health care from social care. We should not only recognize the interdependence of primary and secondary medical care but now focus on the trilateral interface between social services and community- and hospital-based mental health care.

ALASTAIR F WRIGHT
Editor of the Journal

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