

People with long-term mental illness: making shared care work

IN 1973 a rural general practitioner, Arthur Watts, described the care received by 73 schizophrenic patients in his practice over 26 years and noted that only 11% were long-stay hospital patients.¹ He concluded that most schizophrenic patients could live away from the hospital environment. Since then, changes in the structure of health care in the United Kingdom have had an effect on the care of people with long-term mental illness including those with schizophrenia.

The rapid closure of many mental hospitals, particularly over the last decade, has increased the number of patients with long-term severe mental illness living in the community, whether living in private accommodation or in hostels and group homes.² In a London survey a quarter of general practitioners reported an increase in workload resulting from patients being discharged from mental hospitals due for closure.³ Morbidity statistics from general practice confirm the rise in the number of presentations to general practitioners in 1991–92 compared with 1981–82 by patients suffering from severe mental illness.⁴ Despite the corresponding migration of psychiatrists from hospitals to the community, research suggests that patients with long-term mental illness consult their general practitioner more than any other health professional. A London study of patients with schizophrenia in a large mental hospital proposed for closure and of patients in the community served by the hospital revealed that up to one quarter of patients were managed only by the primary health care team.⁵ A follow-up study of schizophrenic patients one year after discharge into the community in central London revealed little use of community facilities but considerable use of general practitioners.⁶ Thus, the general practitioner continues to play an important part in the care of patients with long-term mental illness, though less in isolation from psychiatrists than previously. General practitioner care involves both physical and psychiatric care. Sadly, many schizophrenic patients die young because of coronary heart disease and respiratory problems.⁷

The principles of closing mental hospitals in favour of community care and of psychiatrists increasingly working outside hospitals are broadly welcomed by general practitioners. However, Sims has echoed the anxieties of many psychiatrists and general practitioners over major deficiencies in psychiatric care and the lack of local developments following the rundown of mental hospitals.⁸ In order to plan effective primary care for patients discharged from mental hospitals it is essential to know what is currently happening to patients in the community and how they and their family doctors are reacting to the changes. In this issue of the *Journal*, Nazareth and colleagues report on the care available in 13 London general practices for patients with schizophrenia.⁹ They explore factors influencing patients' use of services and on the attitudes of general practitioners and patients to the care provided. This research not only confirms that family doctors remain closely involved in the care of patients with schizophrenia and with patients' relatives but also that most doctors are eager for increased liaison with secondary care services.

The report of the shared care working group of the Royal College of General Practitioners and the Royal College of Psychiatrists provides a useful consensus in several areas including the shared care of patients with chronic psychoses.¹⁰ This report calls for catchment areas for psychiatric services to be

based on general practice populations rather than on administrative boundaries, and for psychiatric teams to be linked with primary care services. Closer integration of training for both psychiatrists and general practitioners is advocated, as is joint general practitioner–psychiatrist audit of the care of mentally ill people.

Some of the challenges faced by doctors in caring for people with severe mental illness have been examined in 'making shared care work' — twin conferences held in 1994 in London and Llandrindod Wells, sponsored jointly by the RCGP and the Royal College of Psychiatrists and supported by the Department of Health and the Welsh Office. Workshops tackled practical problems of concern to mental health professionals and primary health care professionals, such as recognizing suicide risk in a patient and crisis management. There are difficult questions regarding the interplay between violence, criminality and mental illness. Not every urgent situation involving patients with long-term mental illness to which a doctor is called will prove to be a medical crisis but situations where patients are a danger to themselves or to others present professionals with particular issues in assessment of danger and reaction to danger. While prevention is clearly preferable, it must be admitted that prediction of danger or suicide risk is an inexact science. Risk factors are often more easily recognized in retrospect and can sometimes be used after an event to blame professionals when things go wrong. It is rarely a question of whether or not somebody is dangerous or suicidal, rather it is a question of degree. Multidisciplinary training could help increase effective liaison between members of primary and secondary care teams, thus minimizing the risk of a crisis developing. Audit of 'untoward events' would be a useful educational activity in this area.

A recurring theme throughout the conferences on making shared care work was the need for reliable information, whether from supervision registers, general practice disease registers or joint records of shared care. Joint records seem to be acceptable to patients¹¹ but less so than to their doctors.⁹ The effectiveness of shared care will depend crucially on improved communication although doctors, nurses and managers share concerns over issues of confidentiality and patient consent. It may be appropriate to designate a member of the primary health care team to take particular interest in mental health issues and in liaison.

Providing good quality information to patients and their families is equally important and may be the single most important issue for carers.¹² Survey data about users' views of mental health services highlight a lack of provision of information about their mental health problems and the purpose and side effects of treatment.¹³ Clear advice about diagnosis, treatment and prognosis is the province of the professionals concerned but patients and carers need to know about services available locally and possible benefits payable. Voluntary organizations may be more aware of these additional needs and better placed to put the information in terms that would help the patient and the carer. Thus, patients and carers should be encouraged to access the help of voluntary organizations.¹⁴

The National Health Service and community care act 1990 laid down the organizational structure for community care. The general practitioner is a key identifier of need and is a link between the local authority and the health authority. The emphasis

has shifted away from services run by local authorities towards purchasing services from the voluntary and private sectors.¹⁵ Purchasers' requirements are increasingly shaping the direction of mental health services, and fundholding general practitioners are using contracts to detail what they expect from secondary care. Anxiety has, however, been expressed that fundholding will result in the inhibition of the coordination of services for patients with long-term severe mental illness.¹⁶

Nazareth and colleagues are rightly concerned by the burden of care placed on general practitioners by people with chronic mental illness, particularly in inner city practices.⁹ General practitioners in inner city areas have spoken of new community services caring for patients who are less severely ill at the expense of those with severe chronic mental disorders.¹⁷ Coid has also drawn attention to the failure of community care in inner London, where hospital psychiatric inpatient units are full and the proportion of emergency and compulsory admissions is four times the national average.¹⁸ If people with long-term mental illness are to be properly cared for in the community, sufficient hospital inpatient psychiatric beds and suitably trained staff must be retained.

We should not lose sight of the humane vision of caring for mentally ill people away from institutions, at home and close to their neighbours, but the over-enthusiastic application of political policy and professional dogma can also seriously damage health. Many hospitals have closed but the careful evaluation of patient outcomes and use of community care services is lagging far behind.

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Conveying the benefits and risks of treatment

A NECESSARY part of every general practitioner's continuing medical education is critical reading of the medical literature. Most medical reports, trials and guidelines now contain quantitative data. Understanding the methods of data presentation is essential if the results of studies are to be interpreted correctly and incorporated into normal clinical practice.

The most reliable way of assessing a medical intervention is by means of the randomized controlled trial.¹ Reports of randomized controlled trials and quantitative syntheses (meta-analyses) are becoming increasingly common.² The results of such trials and meta-analyses can be presented in several ways, the most common summary measurements of efficacy being a relative risk reduction, an absolute risk reduction and the number of patients who need to be treated in a specified time period to prevent a single adverse event occurring (NNT).^{3,4}

Unfortunately, all too often when the results of randomized controlled trials are reported only one summary measurement of efficacy is used, most commonly the relative risk reduction. The problem with this approach is that the relative risk reduction

gives the reader no idea of the baseline event rate, that is, the susceptibility of the population to the outcome of interest. Does this matter? There is evidence that it does. In several studies hospital doctors and general practitioners have been given the results of a randomized controlled trial expressed as either a relative or absolute risk reduction and have been questioned on their decision to treat on the basis of the results.⁵⁻⁸ These studies have shown that giving relative risk reduction as the summary measurement of efficacy makes a decision to treat more likely than for other methods. Thus, when relative benefits are substantial the absolute value of treatment may not be considered. Quite often this problem is confounded in secondary reports and subsequent editorials which also emphasize relative differences at the expense of absolute benefits. As Feinstein states 'clinicians are much impressed by the bigger numbers of the relative changes than by the smaller magnitudes of the absolute changes for the same results'.⁹

For this reason the most versatile method of presenting the results of randomized controlled trials is in the form of the NNT.