Attitudes of inner-city GPs to shared care for psychiatric patients in the community

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SUMMARY

The role of the general practitioner (GP) in shared care is critical. This study sought to investigate the views of inner-city GPs and compare them with those of previously surveyed GPs working in a predominantly suburban region.[1] Sixty-five GPs working in inner London were surveyed using a 15-item self-report questionnaire to ascertain attitudes towards care of patients with serious mental illness (SMI). Inner-city GPs reported having more SMI patients on their practice lists than the mainly suburban GPs. Though shared care was favoured by the majority in both studies, this was significantly less common among inner-city GPs who were also less inclined to organize overall care. These findings could not be explained by methodological differences. The attitudes of inner-city GPs towards the care of the mentally ill appear to differ from their suburban colleagues; their needs clearly merit special consideration.

Keywords: inner city; suburban; shared care; GPs; mentally ill.

Introduction

THE role of shared care in psychiatry remains contentious. Recent guidelines[2] advised general practitioners (GPs) to limit their role in the care of seriously mentally ill patients to assessment and referral. However, critics have warned that the specialist mental health services might become overloaded with routine monitoring as a result, making them unable to deal with the most demanding and difficult patients.[3]

There is no consensus about how responsibilities for shared care between specialist mental health services and GPs should be distributed,[4] and opinions on the most effective forms of care for severely mentally ill patients have varied.[5] GPs working in inner cities are likely to encounter more patients with serious mental illness than those working elsewhere.[6]

The aim of this study was to compare the attitudes of a sample of inner-London GPs towards shared care with those of (largely suburban) GPs in the South West Thames Region, as surveyed by Kendrick *et al*[1] in the only previous study concerning the attitudes of GPs towards shared care in psychiatry.

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Method

All GPs in two inner-city sectors were surveyed by post. These sectors comprised 10 electoral wards, with UPA scores[7] ranging from 30.8 to 64.3.

The 15-item questionnaire was based on that devised by Kendrick *et al*.[1] The one main difference was that the term 'serious mental illness' (SMI) was preferred to the term 'long-term mental illness'. SMI was defined as schizophrenia, manic-depressive psychosis, other types of psychosis, and severe depression. Questions also covered the responders' backgrounds and the number of patients with SMI on their lists. Results from the two studies were compared using chi-squared tests.

Results

Of 83 GPs surveyed, 65 returned completed questionnaires: a response rate of 78.3%. Twenty-three (35.4%) responders had at least six months of specialist psychiatric experience, compared with 23.3% of the sample of 369 GPs surveyed by Kendrick *et al*[1] ($P = 0.06$).

Forty-five (69.2%; 95% CI = 57.8 to 80.7) responders in our sample estimated that there were at least 16 patients with SMI on their practice lists, compared with 17.2% (95% CI = 7.8 to 26.6) reporting more than 16 patients with 'long-term' mental illness in the study by Kendrick *et al*[1] ($\chi^2 = 92.2$; df = 1; $P<0.0001$).

In both studies, over 80% of responders agreed that psychiatrists should be responsible for the overall care of patients with serious mental health problems, and that GPs should screen these patients for physical problems (Table 1). However, significantly fewer responders in our study agreed that care should be shared between GP and psychiatrist, that GPs should organize care with psychiatric backup as necessary, and that psychiatrists should monitor patients for relapse.

All 21 responders with psychiatric experience were significantly more likely to agree that care for SMI patients should be shared between GP and psychiatrist, compared with 72.5% (95% CI = 58.9 to 86.1) of those without psychiatric experience (two-tailed Fisher's exact test; $P = 0.01$). More recently qualified GPs were more likely to agree that care for SMI patients should be organized by GPs.

Discussion

Inner-London GPs appear to be seeing many more patients with severe mental health problems than those working in more suburban parts of the region; nearly four times as many GPs reported at least 16 patients with SMI on their lists. Nevertheless, the reported prevalence of SMI within practices did not relate to any particular attitudes to care, and GPs in both samples were overwhelmingly in favour of shared care.

Our results do, however, indicate that inner-city GPs hold less positive attitudes towards shared care than their suburban counterparts. There are several possible explanations for this. Mentally ill patients in the inner city are more likely to experience greater social difficulties, such as isolation and poor housing, than those in more suburban areas. These factors may contribute to worse outcomes, which may deter GPs from sharing care. Similarly, the greater number of providers with which to

Table 1. Proportion of GPs in the present study who agreed with statements about responsibility for physical and psychiatric care of seriously mentally ill patients, problems associated with this care, and the prognosis of such patients, compared with findings from the study by Kendrick et al.[1]

Seriously mentally ill patients	Present study % agree (n)	Kendrick et al[1] % agree (n)	P-value
Overall care			
Should be the primary responsibility of the psychiatric team	89.1 (57)	83.1 (301)	0.31
Should have care organized by GP with psychiatric back-up as necessary	7.5 (8)	42.1 (151)	<0.0001
Should have care shared between the psychiatrist and GP	80.6 (50)	91.5 (333)	0.02
Should be monitored for relapse by psychiatrist	87.1 (54)	73.7 (261)	0.04
Should be monitored for relapse by GP	43.3 (26)	50.0 (178)	0.41
Physical care			
Should be screened for physical problems by psychiatrist	42.9 (27)	38.1 (138)	0.57
Should be screened for physical problems by GP	79.0 (49)	80.2 (287)	0.97
Problems			
Create a lot of work for the practice	85.9 (55)	70.6 (250)	0.02
Often come to the attention of the GP only when there is a crisis	87.5 (56)	79.3 (287)	0.17
Rarely cause major difficulties for their families or carers	6.3 (4)	10.4 (38)	0.44
Prognosis			
Have a poor prognosis whatever is done for them	27.4 (17)	40.2 (145)	0.08

liaise may make shared care more cumbersome and less appealing. Finally, inner-city patients are more likely to be mobile, thus making continuing shared care more difficult.

Slightly different terminology was used in the two studies. The main difference between 'long-term' and 'serious mental illness' is that the former term was partly defined by the need for 'long-term supervision' and includes severe neuroses and personality disorders. Arguably, our (diagnostically) more restrictive definition may actually have led to the under-reporting by GPs of numbers of patients with serious mental health problems in this study.

Differences between the two samples cannot explain our findings. While our GPs had slightly more psychiatric experience, this was associated with a more positive attitude toward shared care. Nor can our findings be attributed to the unwillingness of single-handed GPs to share care, since only four of our sample were from single-handed practices. We cannot exclude the possibility that our findings reflect secular changes in GPs' attitudes, possibly resulting from the considerable changes in the National Health Service, or in the numbers of seriously mentally ill patients registered with GPs over the five years between surveys, though the latter seems improbable.

Given the greater social deprivation in the inner city where psychiatric services have been most stretched in meeting population needs,[6] the role of the inner-city GP may well be qualitatively different from that of a rural or suburban GP, and merits special attention.

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