Viewpoint

"Working collaboratively for those 30 minutes and addressing all of the patient's physical and mental health issues made this one of the most memorable consultations I have conducted."

Exemplary collaboration with a GP and psychiatrist

It was a usual day for me going to visit a suicidal patient after booking a room at his GP's practice. As a consultant psychiatrist in a crisis team, nearly all the patients on my caseload have suicidal ideation or have made an attempt to kill themselves.

The patient was a 32-year-old man who had attempted suicide by taking an overdose of 76 over-the-counter paracetamol, ibuprofen, and cetirizine tablets together with 4–5 pints of alcohol, and who had tried to put a plastic bag over his head while wearing handcuffs. He was fortunately unable to end his life as police had been informed by his ex-partner, to whom he had sent a text message about his plans to end his life. He was a high-risk patient: his father had committed suicide by overdose when the patient was 13 years of age and the patient himself had made two unreported suicide attempts in the past. Other risk factors included being single, male, and having experienced a recent separation, probably permanent, from his partner. He was subsequently referred to the Crisis Resolution and Home Treatment team and a plan was made to review him at his local GP's surgery, where he was a newly registered patient.

I was reviewing him along with a community psychiatric nurse colleague when there was a knock on the door. To my surprise and pleasure, it was the patient's GP, who was requesting to be a part of the assessment. I was immediately impressed by this welcome intervention.

The consultation went really well. I explained to the patient that he has emotionally unstable personality disorder, which he accepted, and that he is unlikely to benefit from antidepressant medication. He needed a short-term prescription of zopiclone, which the GP provided. The patient also enquired about smoking cessation, and advice was given by the GP. I could answer all his queries about psychiatric issues but felt out of my depth when he asked to have a 'snip' (vasectomy). I knew he already had a few children from various relationships and that, with his emotional instability and impulsivity, he is more likely to have intense short-term relationships without being able to be an ideal father to his children. Once again, my GP colleague came to my rescue and provided him with the forms to self-refer for the procedure.

Working collaboratively for those 30 minutes and addressing all of the patient's physical and mental health issues made this one of the most memorable consultations I have conducted. With the patient, we made a biopsychosocial formulation and recovery plan to address his needs. This was an exceptionally good example of primary and secondary care working collaboratively to provide holistic care for a high-risk patient.

There was a good outcome, with the Crisis Resolution and Home Treatment team providing the patient with distress tolerance therapy and safely discharging him after a few weeks. My GP colleague was well aware of the contingency plans for this gentleman.

Research shows that prevalence of lifetime unstable personality disorder is about 6%, with high rates of mortality by suicide,[1] and also proves that collaborative care has a persistent positive effect that is preferred by patients over usual care.[2] Consultations in primary care with patients with personality disorders can be extremely time consuming, and collaborative work can better enable GPs to make them more therapeutic. They can assist GPs to understand and explain to patients why antidepressants are not indicated in such cases. This can significantly reduce unnecessary prescriptions, which not only benefits patients by reducing the side effect burden from medication, but also yields longer-term benefits by making the NHS more productive by cutting costs. Non-pharmacological measures can be utilised in primary care by providing, for instance, training to nursing staff to deliver distress tolerance therapy to treat patients.

What stops similar consultations from happening more often? Time constraints, true, but the amount of time that GPs spend dealing with patients' mental health issues can be more effectively and efficiently dealt with if psychiatrists and GPs work collaboratively more frequently than is the case at the moment.

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DOI: https://doi.org/10.3399/bjgp19X706769

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