

or undertake temporarily a greater commitment to home care and parenthood.

But, as all general practitioners know, much of the work is not strictly clinical and the need to share care with paramedical and non-clinical colleagues is evident and realistic. Social workers, counsellors, elderly care visitors, physiotherapists, dietitians, as well as practitioners in the complementary therapies, will be vital to provide a truly holistic community based caring system.

But where are the resources and finances to come from to achieve this new world of community based health care? The Department of Health, if truly committed, will need to encourage a loosening of the restrictions on size of practice premises and the rentals paid for them. Reductions in hospital budgets as a result of contraction or closure of outpatient facilities and antenatal and postnatal clinics, and with many wards open only from Monday to Friday, should ultimately provide large sums for redistribution in the community. Family health services authorities will need to fight for more money in order to reimburse the justified increases in team staffing, as well as helping finance expansion of premises.

To provide expanded premises, large long term loans (for example, 30 years) may well become the lot of practice partnerships. Benefits accruing from improvement grants, tax relief, realistic rents and a higher income from larger lists and expanded performance related activities (such as minor surgery and undergraduate and postgraduate teaching) will have to be set against lesser expectations of increasing value of property, customarily a benefit for doctors in recent decades. Investment in premises may be to generate a large income from the activities within them rather than for any potential increase in value of the premises themselves. All this will need careful consideration by the review body when considering general practitioners' global finances and the levels of payment for expanded services, teaching and research activities. Variations in practice style and types of care, appropriate to the environment in which they work, will be much greater than at present and long overdue.

District health authorities will need to encourage the placement of health visitors, community nurses and other clinical workers into practices to provide community based care via primary health care teams. Above all they will need to resist the swing back to geographical patch working which was an unfortunate and unsuccessful feature of community care in the 1960s and earlier.

Not since the post-charter<sup>7</sup> years of the late 1960s and early 1970s has general practice had such an opportunity to change, to promote itself and to become the major clinical force in British medicine. If it takes up this challenge it will not only upgrade the health of the community but also fashion a fascinating and absorbing way of work for doctors and their professional colleagues.

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## Interface between primary care and specialist mental health care

PRIMARY and secondary care for patients with mental disorders have traditionally been clearly separated, with communication between the two being mainly by doctor's letter.<sup>1,2</sup> Poor communication between the services, and the general practitioner's perception that those working in specialist psychiatric services are unaware of the familial and social context of patients' symptoms have been major and long standing problems.<sup>3</sup> Specialist services only see a small proportion of the people with psychological problems: between 5% and 20% of those known to the general practitioner are referred.<sup>4</sup> Younger patients, male patients and patients with psychotic illnesses are preferentially referred. The low referral rate is partly because of stigma, and partly because general practitioners consider that the psychiatric service offers treatments with little relevance to the problems of patients in primary care.<sup>5</sup>

The closure of mental hospitals and the development of community mental health policies has encouraged the expansion of specialist care into the community. This has taken place in three ways: an increasing number of psychiatrists have moved their outpatient services out of hospital bases and have established

clinics in primary care; community mental health centres, staffed by multidisciplinary teams, have been established in some places; and elsewhere, community psychiatric nurses and psychologists are establishing their own independent links with local primary care services.

Although many psychiatrists now conduct outpatient clinics in primary care, the commonest pattern of work is the 'shifted outpatient' model, in which the psychiatrist conducts a normal outpatient clinic in general practice premises, often during a time when the general practitioners are not in the practice and contact with them may, therefore, be infrequent. The consultation-liaison attachment developed by Creed and Marks<sup>6</sup> is a model in which the psychiatrist attends a primary care meeting to discuss management of several difficult patients with primary care staff, after which the psychiatrist sees several patients, often with the general practitioner. The general practitioner continues to provide treatment for the patient, but is able to benefit from joint management plans, as well as to seek advice about patients whom he or she does not wish to refer. This allows specialist advice to be available in a flexible way according to the needs

of the case and to reach a much wider variety of patients.

One effect of the development of community services is that general practitioners alter their referral practices. In south Manchester an evaluation was undertaken of a community mental health service based in primary care and staffed by a multidisciplinary team: it was found that referral rates had increased by more than three times in the first year.<sup>7</sup> The bias against referral of women, married people and employed people was reduced and more patients with depressive illnesses, anxiety states and adjustment disorders entered specialist care. The mix of patients seen by specialist services therefore comes to resemble more closely that seen in primary care. Most studies evaluating the new community services have found general practitioners to be much more satisfied, finding the services to be more responsive to the needs of patients and better at liaising with primary care.<sup>8</sup>

This raises the issue of what is the most appropriate way for specialist services to be involved with the care of patients with anxiety and adjustment disorders and chronic neuroses. There are concerns from within the psychiatric establishment that the new community based services are caring for patients who are less severely ill at the expense of those with severe chronic mental disorder and these claims have been, to some extent, substantiated by recent audits of community mental health teams.<sup>9</sup> On the other hand, for many general practitioners a major source of dissatisfaction with traditional psychiatric services has been the perceived reluctance of these services to share the care of patients with chronic neuroses and personality disorders which represents a major burden on primary care staff.

In south Manchester, it was found that allowing general practitioners to work more closely with a multidisciplinary mental health team resulted in far more patients entering specialist care and a perceptible lightening of the doctor's perceived load: but the new service costs considerably more than the traditional hospital based service.<sup>7</sup> It was also disappointing to find that the greater contact between the general practitioners and the mental health staff did not lead to any improvement in the general practitioners' own skills in helping these patients. Indeed, it was the availability of an alternative service for patients with chronic neurosis and family problems which the general practitioners appreciated most, since it reduced the demands these patients made on the practice.

Neurotic illness is expensive in general practitioner time and patient lost productivity,<sup>10</sup> and a limited specialist service for these patients may well be cost effective. Research available so far has shown only limited improvements in outcome from the provision of counselling from specialist agencies while the provision of formal training to enhance general practitioners' own skills in the detection and management of psychiatric disorders appears more promising.<sup>11,12</sup> It may be that the role of specialist services should be in supporting general practitioners by providing training in skills and clear guidelines for management, by being available for one-off assessments and by offering continuing advice and possibly making available resources for general practitioners to use, such as information material for patients.

Another development in psychiatric services which has implications for primary care is the fall in the long stay inpatient population leading to an increased number of patients with long term severe mental illness living in the community. Clearly it is the primary responsibility of the psychiatric team to arrange for follow up and rehabilitation of these patients, but studies of such patients suggest that many consult their general practitioner more than any other professional and the general practitioner is therefore likely to play an important part in their care.<sup>13</sup> In addition, in many cases the primary care team is

responsible for the administration of depot medication and the general practitioner is usually involved in prescribing. In the south Manchester evaluation, it was found that the primary care based community team achieved more for their chronic psychotic patients in terms of meeting more of their needs than the hospital based service, but once more this desirable result was achieved at greater cost.<sup>7</sup>

In spite of their involvement in the care of patients with chronic mental illness, very few practices have as yet developed policies for their care,<sup>14</sup> few have registers of such patients and the numbers of patients which general practitioners identify fall short of those predicted by surveys of prevalence in primary care, suggesting that they may be unaware of some of the patients and their needs. This contrasts with the situation for chronic physical disorders, such as diabetes or hypertension, where increasingly practices have patient registers and have laid down management protocols. The importance of accepted standards of care for patients with chronic mental illness is that the system of patient initiated consultations in general practice may not be adequate for the monitoring of these patients where clinical experience is that the first sign of a relapse of illness may be that the patient withdraws from services.<sup>15</sup>

The World Health Organization has recognized the importance of providing clear management guidelines for general practitioners by formulating the revised mental disorders section of the 10th revision of the *International classification of diseases* specially adapted for use in primary care.<sup>16</sup> In the future, workers in primary care will be provided with clear diagnostic guidelines for a restricted set of common mental disorders, each accompanied by a management protocol. However welcome this development may be, it will not do away with the need for specialist psychiatric services readily available to the general practitioner.

If mental health services are to be provided in primary care settings, it remains to be agreed who should pay for them. If the customer-contractor principle is to be more than empty rhetoric, a district health authority may choose to spend its money in this way, provided that there is pressure to do so from surveys of need from community health councils and from the consumers themselves. The consumers, of course, include the general practitioners as well as their patients, and general practitioners do not speak with one voice on this issue. Those that have experienced a good community service may well be more appreciative than those who feel that they can get along on their own. There are strong advantages to the patient in offering a coordinated, multidisciplinary community mental health service, yet fragmented services are becoming the norm in many places.

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**MRCGP EXAMINATION – 1992/93**

The dates and venues of the next two examinations are as follows:  
 October/December 1992

Written papers: Tuesday 27 October 1992 at centres in London, Manchester, Edinburgh, Newcastle, Cardiff, Belfast, Dublin, Liverpool, Ripon, Birmingham, Bristol and Sennelager.

Oral examinations: In Edinburgh on Monday 7 and Tuesday 8 December and in London from Wednesday 9 to Saturday 12 December inclusive.

The closing date for the receipt of applications is Friday 4 September 1992.

**May/July 1993**

Written papers: Wednesday 5 May 1993 at those centres listed above.

Oral examinations: In Edinburgh from Monday 21 to Wednesday 23 June and in London from Thursday 24 June to Saturday 3 July inclusive.

The closing date for the receipt of applications is Friday 26 February 1993.

MRCGP is an additional registrable qualification and provides evidence of competence in child health surveillance for accreditation.

For further information and an application form please write to the Examination Department, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Telephone: 071-581 3232.

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The next examination will begin on 13th October 1992. Application forms, together with the necessary documentation, must reach the College by Friday, 4th September 1992.

Candidates must either have held a post approved for professional training in a department specialising in the care of the elderly, or have had experience over a period of 2 years since Full Registration or equivalent in which the care of the elderly formed a significant part.

Further details and an application form may be obtained from:

**Examinations Office**  
 Royal College of Physicians of London  
 11 St Andrew's Place  
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The closing date for applications is Friday 28 August 1992.