Psychiatry and primary care

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There is now almost universal recognition that primary care is the place where most mentally distressed people first present for help. However, the pace at which the health system has adapted to this reality varies greatly from country to country, depending on the amount of resource devoted to mental illness services, the way in which primary care physicians have organized their practice, and the inertia of the system. Here we present several models from developed and developing countries and address briefly the issue of training of health workers.

Key words: Primary care, general practitioners, community mental health teams, multi-purpose health workers, training

The de-institutionalisation of the mentally ill has partly been driven by humanitarian impulses, but partly by financial necessity. Developed countries, faced with an ageing population and the demands of high-tech medicine, have closed their large mental hospitals and mental subnormality hospitals; developing countries, faced with the realisation that basic medical services were not reaching much of the rural population, have looked for alternatives in the community as a way of providing basic mental illness services. The large mental hospital in the capital city, dating from colonial times, seems a poor way of doing this.

Whatever the reasons, the results have been the same. An increasing burden of care of those with severe mental disorders has fallen on primary care physicians. But there has also been another, powerful reason why this has been so. The public health burden on a population posed by common mental disorders far exceeds that of severe mental disorders, but it has only been in the past 50 years that this has been widely appreciated (1).

However, the pace at which some changes have occurred varies greatly from country to country, and this variation is partly determined by the amount of resource devoted to mental illness services, partly by the way in which primary care physicians have organised their practice, and partly, of course, by the inertia in any professional system.

CHANGES IN THE UNITED KINGDOM

Fifty years ago, most primary care physicians worked on their own, usually helped by a part-time secretary/ receptionist.

Today doctors work in groups of about six or eight, and they are assisted by many other staff: practice nurses, district nurses, health visitors, receptionists and a practice manager.

The government now looks upon primary care as the key player in deciding health expenditures, and most of the money for health care is given to groups of between 40 and 60 primary care physicians called 'primary care trusts' (PCTs). These have been given most of the resource for health care for the population registered with them. They must pay for all services in primary care, as well as purchase general hospital care and mental health care directly on behalf of their patients.

Even before these fundamental changes in funding, however, mental illness services were working much more closely than they previously did with primary care, and patients in the community with chronic, severe mental disorders would have their care shared between community mental health teams (CMHTs) and primary care.

As early as 1984, Strathdee and Williams (2) described the fact that 19% of English psychiatrists were providing clinics in primary care as "the silent growth of a new service", and by the following year Pullen and Yellowlees showed that 50% of Scottish psychiatrists were doing the same. More recently, Gask et al (3) have described four main ways in which psychiatrists can relate to general practitioners (GPs) in such clinics, and also described attachments by community nurses, clinical psychologists and social workers in primary care. The first is a close association with the CMHT with a single point of referral from primary care, and much closer integration of services between them. The second is the "shifted outpatients" model. The third is the attachment of various members of the CMHT to do clinics in primary care. Finally, the "consultation-liaison" model has the psychiatrist discuss difficult cases with members of the primary care team, and sometimes see patients with them - but the patients remain with the primary care team.

Jackson et al (4) described how CMHT services can relate directly to primary care, and carried out a cost-effectiveness analysis showing that patient satisfaction was greater in such clinics, and the mean cost per case was less. However, the new service resulted in four times as many patients with common mental disorders receiving treatment, so the overall costs of the new service were about the same (5).

The conventional CMHT relates to

primary care in an unsatisfactory way, since new patients are assigned to community nurses depending on which nurse has the smallest caseload, having regard to the degree of experience that the new patient requires from the nurse. This typically results in a system in which each community nurse looks after a set of patients who are under the care of many different GPs, so that a close working relationship between GP and community nurse is difficult to sustain.

Goldberg and Gournay (6) argued that most mental disorders should be looked after in primary care, with severe mental disorders (schizophrenia, bipolar illness and dementia) jointly under the care of mental health services with a "shared care" plan, and other disorders treated by primary care services unless they failed to respond to treatment from the GP. It was suggested that severely ill patients under the care of a particular GP should all, as far as possible, be cared for by the same mental health worker - who would therefore act as a "link worker" between the two services. It would be the responsibility of this worker to act as a culture carrier between the two services, and be responsible for keeping the shared care plans up to date.

In this changing context the Royal College of Psychiatrists (7) commissioned a survey of both PCTs and mental health trusts, asking to what extent they were working together, and how they saw services developing in the future. This revealed that about 68% of PCTs had 'shared care plans', and that GPs contributed to these plans in 84% of them. A shared care plan is drawn up for each patient with a severe mental disorder (schizophrenia, bipolar illness or dementia) treated by the CMHT in the care of the practice, and is jointly agreed by the two services. It states - among other things - the diagnosis, treatment plan, drugs prescribed and who prescribes them, alternative drugs, likely symptoms in relapse and name and contact details of the 'key worker' (or link worker) in the CMHT.

Of the 59 PCTs replying to the question, it was of interest that 11 had now altered their practice to the pattern of working with a single 'link' worker relating to each GP. Of these, 91% were satisfied with the collaboration, compared with only 54% who had the traditional arrangements (Fisher's exact p-value = 0.038).

The most striking finding of the survey was that over 90% of both PCTs and mental health providers predicted that the routine care of well controlled cases of schizophrenia and bipolar illness would pass to primary care in the future, with assistance only sought from the mental health services should need arise.

Closer collaboration between the two services can bring advantages to patients, to primary care staff and to mental health staff. In one study, patients reported much greater satisfaction with the service based in primary care compared with controls seen by the hospital based service, GPs were pleased to have specialised treatments made available to the patients who had failed to respond to first line treatment, and mental health staff were pleased to have access to a wider range of patients than the dangerous and disruptive psychotic patients that may form the bulk of routine referrals to a specialised service (5). Some studies have shown a reduction in admission rates to psychiatric inpatient beds as a result of closer working (8,9), but others have not found this effect (4,10).

Other ways of improving collaboration between the two services include shared care registers (11). These include all patients on prolonged psychotropic drugs as well as those with severe mental disorders, and the use of electronic referrals and transfer of information between the two services.

PATTERNS OF COLLABORATION BETWEEN PRIMARY CARE AND MENTAL HEALTH SERVICES

When group practice is the norm

In some countries, like Sweden, Denmark and the UK, and in health maintenance organisations (HMOs) in the USA, doctors work in group practices accompanied by many kinds of primary care workers: these include practice nurses, practice managers and a variety of other health technicians, which vary from place to place.

In these countries, with the smaller number of GP surgeries to serve, it becomes practicable for mental health professionals to work collaboratively with primary care workers on the practice premises. Thus, not only psychiatrists and clinical psychologists, but also community psychiatric nurses offer clinics as part of the primary care services. These developments are possible because a given community mental health service (CMHS) has a small number of group practices in the area that they serve.

Thus, closely integrated services have been described by Kates et al in Canada (12) and the benefits of closer working have been described by Katon et al (13) in an HMO in Seattle. Benefits of closer integration of services were only seen with more severe cases of depression, with usual care by the GP being just as effective with mild depression. Schulberg et al have shown real advantages of treatment by psychiatrists, albeit in a selected group of patients, and with more intensive psychiatric input (14).

Simon (15) has described various ways in which psychiatrists can supplement the work of primary care physicians, and argues for a 'minimal effective dose' of psychiatric intervention, targeted on the more difficult cases.

In Iran, an entirely different pattern of collaboration is represented by having a tier of service below primary care, with responsibilities for both physical and mental disorders. These are called 'health houses', and health workers manning them screen the people living near them for four common mental disorders (called minor mental illness), major mental illness, mental retardation and epilepsy, as well as recognising stress related conditions and using simple stress reduction methods. Cases are referred by them to the group prac-

tices in health centres, and cases given treatments are followed up in the health houses (16).

When single handed practice is the norm

In contrast, a close working collaboration is more difficult in countries where doctors work on their own, usually accompanied only by a receptionist, as there are too many of them for the CMHS to relate directly to all of them on the practice premises. In countries such as France, Germany and much of the USA, primary care services and CMHS are virtually independent services, which relate to one another by means of formal referrals.

Gersons (17), for example, has written of the intrinsically competitive relationship between mental health and family practice, since in a fee for service system they are both competing in the same market. Quoting Balestrieri et al's (18) earlier finding that mental health treatment only produces results that are 10% better than those in primary care, he writes "it is not surprising that a number of GPs doubt the need for special training by psychiatrists or for increasing their referrals to the mental health system".

However, in some countries with predominantly single handed practitioners there is now a movement towards closer collaboration, and this can take a number of forms. In Warrnambool, in Victoria, Australia, the CMHT prescribes only for patients while they are in the inpatient unit. All medical treatments are under the supervision of the GP, so that the mental health staff are only involved in psychological and social interventions, with the aim always being to make the patient independent of the service, so that any ongoing treatment is the responsibility of the GP. Patients are seen over a wide predominantly rural part of Australia, and GPs feel themselves intensely involved in the service.

In Bologna, Italy, because of the single handed working habits of GPs, it was not possible to introduce the kinds of within-practice clinics described in the earlier section: instead, the CMHS has set up a primary care liaison service (PCLS), that is based on the CMHC and has a staff of two psychiatrists and a psychologist who provide GPs with a prompt written report about patients referred to them. Shared care interventions include the initiation of pharmacological treatments, the provision, where necessary, of short-term psychotherapy and the availability of a telephone liaison service (19). Regular meetings are held with the GPs concerned with improvements to the service, and continuing education courses are provided. Most patients improved on 6 month follow-up, attendance at the GP's office tended to decrease, and 93% of the GPs expressed moderate or marked satisfaction with the service.

The developing world

The colonial era left many developing countries with only a small number of indigenous psychiatrists mainly concentrated on the capital city, and often served by a single large mental hospital. Such services left the majority of the population without access to any kind of mental health service, so that it became clear that an altogether new approach to the provision of services needed to be made. The World Health Organisation (WHO) set up such services in general medical clinics in four developing countries, with training to medical officers and multipurpose health workers in basic mental health skills, and support from interested local psychiatrists (20).

The supply of psychiatrists in developing countries is very much smaller than that in the developed world (typically below 0.4/100,000 versus 9-25/100,000 [21]), and virtually predicates that primary care must be the main provider of mental health care for all forms of disorder. However, many developing countries are not only short of psychiatrists - they are short of physicians. These shortages are especially acute in many African countries, some countries in the East Mediterranean Region, and some countries in South America (22).

This has meant that many countries - for example, Tanzania (23) - have found it necessary to train a cadre of assistant medical officers to carry out basic triage in primary care. The bulk of the additional mental health burden in most developing countries is taken up by multi-purpose health workers (MPHWs), who fulfil the function of community psychiatric nurses in the developed world, albeit with many additional functions in general health.

Shortly after the WHO had set up its first pilot project, the general model was proposed by Wig et al (24), and has since been introduced in most places where there are shortages of resources, and large numbers of the population have little or no access to psychiatric services (25).

Inevitably, the model has been adapted to fit local services, the availability of pharmacological agents, and the public health burden posed in each country. Wang et al (26) describe a three tier system in a rural area in China, with 'village health workers' at local level referring patients to medical officers in local clinics, with overall supervision from the county hospital. Services in South America are described by Levav et al (27), and Brazilian services are described by Iacoponi et al (28).

In both India and Pakistan, community mental health services are delivered at village level in primary care, but both governments have produced multiphase plans for the eventual provision of mental health services to the greater part of their vast populations. In India, Murthy (29) described that the major task is to implement district CMHS to provide cover and advice for the medical officers in the field, themselves supported by small psychiatric units in the local general hospital.

In Pakistan, Mubbashar (25,30) describes a well developed and highly ambitious system supported by major training initiatives. These extend well

beyond the basic need for medical officers and MPHWs, to the provision of training to lady health workers, to local religious healers and to public health physicians. Somewhat similarly to Iran, the lady health workers have a broad remit within mental and general health, and each have 100 local families to see annually in their house, which is re-designated as a 'health house'. They are trained to refer potential cases to the local basic health unit, where more experienced staff are available to offer treatments. The mental health service has also been extended to the schools, and research has demonstrated the effectiveness of this action (31). Mental health case finding in rural Pakistan is performed by MPHWs on their door to door visits, by local religious healers, and by school children alerted by the schools programme. It is also given a fair wind by public health administrators and the local mullahs.

THE WPA TRAINING PACKAGE ON DEPRESSION

The World Psychiatric Association (WPA) has produced a set of training packages on depression (8), and has recently added a skills learning package for general practitioners and physicians. This uses videotapes to model desirable behaviours using real general practitioners and role-played 'patients'. The videotapes are accompanied by an explanatory commentary, and followed by role-plays, where general practitioners have an opportunity to rehearse the behaviours they have seen on the tape. The videotapes supplied with the package were made by GPs in Manchester and London and deal with depression, unexplained somatic symptoms, psychosis, chronic fatigue and dementia. The intention is that teachers in other countries should make their own tapes, in the idiom of their own country.

The Virtual Group

Teachers in 13 countries have been recruited into a 'Virtual Group', which communicates by e-mail. These include Australia, Austria, Denmark, Holland, India, Italy, Pakistan, Romania, the Russian Federation, Singapore, Spain, the USA and the UK. The opportunity has been taken to discover the nature of changes in respect of mental illness services in each country. Teachers were asked to give details of the way in which mental health and primary care services related to one another in each country, and in particular whether cases of seven common mental disorders would be treated in primary care or would be referred to mental illness services.

In 11 of these countries mental health services were free at the point of delivery, but in Australia and the USA there is only partial reimbursement of fees.

Shared care between mental health services, reported by 68% of primary care trusts in the UK, was said to be 'sometimes' present by our respondents in Australia, Holland and Spain, and by some of the respondents in Denmark and the USA: it was rare or absent elsewhere.

It was evident that mental health staff are now working directly in primary care in many different places: only Austria, Italy, Romania, Russia, Singapore, Spain and some Danish respondents reported that no such clinics took place in their country. Psychiatrists were reported as doing clinics within primary care by Australia, Holland, Spain, the USA, the UK and by some Danish respondents; psychologists by Australia, Holland, Pakistan, the USA and the UK; psychiatric nurses by Holland, India, Russia, Singapore, the USA and the UK.

Home visits by mental health staff at the GP's request were reported as not available in India and by some of our respondents in Australia and the USA. Everywhere else they were available, usually by both psychiatrists and community nurses, but in Singapore and Spain only by nurses.

Respondents were asked whether cases of seven different disorders were usually treated in primary care, or would be routinely referred to the mental illness services. The seven conditions were acute episodes of depression, depression that has not responded to first line treatment, phobic illness, acute psychosis, chronic schizophrenia in stable clinical state, chronic bipolar illness in stable clinical state and drug dependence.

There was general agreement, in all countries, that new cases of acute psychosis, cases of drug dependence, and treatment resistant depression should be referred to mental illness services. Everywhere except in the Russian Federation and Romania acute episodes of depression would be treated in primary care.

However, there the resemblance ends. Cases of phobic illness, and bipolar illnesses in remission, are treated in primary care in five of the countries, and cases of well-controlled chronic schizophrenia are treated in primary care in the UK, Austria, Pakistan, Spain and some of our informants in USA, Denmark and Australia. Even if some of the informants have painted an over-optimistic picture, it is clear that the UK is not alone in transferring much routine care of chronic patients to primary care.

FINAL COMMENTS

There is now almost universal recognition that primary care is the place where most mentally distressed people first present for help, and also an acceptance that, even in physical disorders, the proper psychological management of distress is an important component of treatment. Most medical schools throughout the world do not provide enough instruction to future physicians in the management of common mental disorders, preferring to emphasise the much rarer major mental disorders. Those entering general medical practice therefore have an unmet need for supplementary training, and the speed at which the Virtual Group acquired enthusiastic members is testament to this need.

As has been emphasised, the training need goes well beyond the ranks

of physicians, and extends to community nurses and social workers in developed countries, and to MPHWs and health workers of various sorts in developing countries. The need is great, but is poorly met by the provision of textbooks backed up by didactic lectures, because clinical skills are not learned in either of these ways. Fortunately newer teaching methods can provide demonstrations of clinical skills followed by practice in role-played sessions. Other methods - such as asking a doctor to become their own most difficult patient, and getting another doctor to interview him or her in front of a class - are also very effective.

The prospects for the mentally ill have changed almost out of all recognition in the past 50 years, with the availability of more effective psychological interventions, as well as more powerful and less toxic drugs. The medical services are slowly availing themselves of more effective teaching methods, and widening the remit of providing care well beyond their own ranks. These changes, accompanied by the greater availability of self-help manuals, support groups and non-governmental organisations assisting in the provision of chronic mental health care, offer a future of unprecedented hope to those in mental distress. And hope is probably the most important of all therapeutic ingredients.

References

1. Goldberg DP, Huxley PJ. Common mental disorders. A biosocial model. London: Routledge, 1992.
2. Strathdee G, Williams P. A survey of psychiatrists in primary care settings: the silent growth of a new service. Br J Psychiatry 1984;34:615-8.
3. Gask L, Sibbald B, Creed F. Evaluating models at the interface between mental health services and primary care. Br J Psychiatry 1997;170:6-11.
4. Jackson G, Gater R, Goldberg D et al. A new community mental health team based in primary care. Br J Psychiatry 1993;162:375-84.
5. Goldberg DP, Jackson G, Gater R et al. The treatment of common mental disorders by a community team based in primary care: a cost effectiveness study. Psychol Med 1996;26:487-92.
6. Hansen V. Psychiatric services within primary care. Acta Psychiatr Scand 1987;76:121-8.
7. Tyrer P, Sievewright N, Wollerton J. General practice psychiatric clinics: impact on psychiatric services. Br J Psychiatry 1984;145:15-9.
8. Lawrence R, Copas J, Coloper P. Community care: does it reduce the need for psychiatric beds? Br J Psychiatry 1990; 159:334-40.
9. Strathdee G, Jenkins R. Purchasing mental health care for primary care. In: Thornicroft G, Strathdee G (eds). Commissioning mental health services. London: HMSO, 1996:71-3.
10. Goldberg DP, Gournay K. The general practitioner, the psychiatrist and the burden of mental health care. Maudsley Discussion Paper No.1. London: Institute of Psychiatry, 1997.
11. Rajagopal S, Goldberg D, Nikolaou V. The current relationship between mental health services and primary care services in England and Wales. Primary Care Psychiatry (in press).
12. Kates N, Craven M, Crustolo A et al. Integrating mental health services within primary care. A Canadian program. Gen Hosp Psychiatry 1997;19:324-32.
13. Katon W, Robinson P, Von Korff M et al. A multifaceted intervention to improve treatment of depression in primary care. Arch Gen Psychiatry 1996;53:924-32.
14. Schulberg H, Block M, Madonia M et al. Treating major depression in primary care practice: 8 month clinical outcomes. Arch Gen Psychiatry 1996;53:913-9.
15. Simon G. The contribution of psychiatrists to management in primary care. In: Tansella M, Thornicroft G (eds). Common mental disorders in primary care. London: Routledge, 1999:105-15.
16. Mohit A. Mental health in Tehran in the context of the national mental health programme of Iran. In: Goldberg D, Thornicroft G (eds). Mental health in our future cities. Maudsley Monograph No 12. Hove: Psychology Press, 1998: 217-38.
17. Gersons B. The competitive relationship between mental health services and family practice. In: Goldberg D, Tantam D (eds). The public health impact of mental disorder. Bern: Hogrefe-Huber, 1990: 214-20.
18. Balestrieri M, Williams P, Wilkinson G. Specialist mental health treatment in general practice: a meta-analysis. Psychol Med 1988;18:711-17.
19. Berardi D, Menchetti M, Dragani A et al. The Bologna primary care liaison service: first year evaluation. Commun Ment Health J 2002;6:439-45.
20. Harding T, Arango M, Baltazar J. Mental disorders in primary care: a study of their frequency and diagnosis in four developing countries. Psychol Med 1980;10:231-41.
21. World Health Organisation. Atlas: country profiles on mental health resources. Geneva: World Health Organisation, 2001.
22. Board on Global Health, Institute of Medicine, Washington. Neurological, psychiatric and developmental disorders: meeting the challenge of the developing world. Washington: Institute of Medicine, 2001.
23. Kilonzo G, Simmons N. Development of mental health services in Tanzania. Soc Sci Med 1998;47:410-28.
24. Wig N, Murthy S, Harding T. A model for rural mental health services. Indian J Psychiatry 1981;23:275-90.
25. Goldberg D, Mubbashar M, Mubbashar S. Development in mental health services - a world view. Int Rev Psychiatry 2000;12:240-8.
26. Wang Q, Gong Y, Niu K. The Yantai model of community care for rural psychiatric patients. Br J Psychiatry 1994; 165(Suppl. 24):107-13.
27. Levav I, Restrepo H, Guerra de Macedo C. The restructuring of psychiatric care in South America. J Publ Health Policy 1994;154:71-85.
28. Iacoponi E, Ramos Lavanjeira R, Mari J. Brazil: a giant wakes up to progress and inequality. In: Appleby L, Araya R (eds). Mental health services in the global village. London: Gaskell, 1991:131-48.
29. Murthy RS. Community mental health in India. In: Murthy RS (ed). Mental health in India. Bangalore: People's Action for Mental Health Press, 2000:150-76.
30. Mubbashar M. Mental health services in rural Pakistan. In: Tansella M, Thornicroft G (eds). Common mental disorders in primary care. London: Routledge, 1999:67-80.
31. Rahman A, Mubbashar M, Gater R et al (1998) Randomised trial of impact of school mental health programme in rural Rawalpindi, Pakistan. Lancet 1998; 352:1022-5.