Model for the integration of community psychiatry and primary care

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SUMMARY. The work of a community-based psychiatric service in south-east London is described. In the period from 1979 to 1982 1533 clients were seen. A large number of severely disturbed clients were managed at home with the help of family members and local services.

Introduction

PSYCHIATRIC disorders in the community have become increasingly common, with rates of prevalence as high as 250 per 1000 of the population quoted by some authors. Most psychiatric problems are managed by general practitioners, and few are seen by a psychiatrist.[1-3] Most of the psychiatric problems seen by general practitioners appear to be related to adverse life events[4,5] and to be relatively minor in nature. However, such patients represent a major investment both in terms of general practitioners' time and in terms of prescribed medication.[6-8]

In 1973 the World Health Organization recommended that psychiatrists should collaborate more closely with primary care services. In the United Kingdom this has been linked with the development of a variety of community psychiatric services, and with the move towards community care for psychiatrically disabled people. Variation in the type of community services available is partly accounted for by variations in local needs and resources.

This report describes the development of a community psychiatric service in south-east London. Professionals from several disciplines have formed a team that aims to provide both easy access for patients and close links with general practitioner colleagues.

The service

The borough of Lewisham in south-east London has a sociologically mixed population of some 230 500 people. The psychiatric services have been found to be seriously inadequate, being largely provided by a large mental hospital 12 miles from the catchment area. There are no psychiatric beds in the local district hospital and there is no psychiatric emergency service, no psychiatric day hospital and only limited access to hospital outpatient facilities.

In November 1978 a small multiprofessional psychiatric team moved into a vacant house offered to them by the local health authority. This is now known as the Mental Health Advice Centre and serves a catchment area with a population of 82 000, providing a service for people aged between 18 and 64 years. Situated in an ordinary house in a pleasant residential area of the borough, which is easy to reach by public transport, the Centre has neither the appearance nor the associations of a hospital psychiatric clinic. The house has sufficient rooms for offices, group meetings and interviews and is large enough to house a rehabilitation area and a research department.

The multiprofessional psychiatric clinical team has grown to 17 members and now includes psychiatrists, clinical psychologists, community psychiatric nurses, psychotherapists, occupational therapists, social workers, research workers, secretaries and a team manager. Twelve volunteers also help to run the Centre. They assist in the reception of clients and may carry a small individual caseload or participate in work with client groups. A monthly group meeting provides supervision for volunteers engaged in work with clients. Most volunteers are interested lay persons, but some have relevant professional expertise. Such specialized volunteers include a doctor, a social worker, a clinical psychologist and a nurse who work regularly at the Centre without remuneration.

The Centre has developed working links with 72 general practitioners, two social services divisions, local district nurses, health visitors and many organizations.

The walk-in clinic

A professional member of the team is on duty at the Centre every weekday between 09.00 and 13.00 hours to see new referrals. Clients may be referred by general practitioners or other professionals, or may simply walk in. Intake is restricted to people who live in the catchment area. People over 65 or under 17 years of age and those with alcohol or drug-related problems are referred to specialist services elsewhere.

New clients are met by one of the volunteers and are introduced to the professional on duty who then carries out an initial interview, makes an assessment and contacts the client's general practitioner to seek information and to report the visit. A case conference is held at the Centre each week and new cases are discussed. A diagnosis is made by the consultant psychiatrist and a management plan is formulated. One team member becomes the key worker and is given the responsibility of coordinating this plan and of maintaining contact with the client, his general practitioner, and the many other agencies involved. Clients are usually followed up at home, and family members are often involved in the therapeutic process.

The crisis intervention service

Over a period of time it became clear that the walk-in clinic was inaccessible to a number of emergencies. A crisis intervention team was therefore formed to complement and extend the existing services. This team consists of a psychiatrist (G.T.), a senior social worker, and a community psychiatric nurse and is supervised by the consultant psychiatrist (D.I.B.). Work is coordinated by the team's administrative secretary. Referrals are accepted from primary care sources preferably following discussion with the referring agent.

Referrals are accepted by the crisis intervention team on weekdays between 09.00 and 17.00 hours. All patients referred from the catchment area for hospital admission are assessed by the team. Admission to hospital may be avoided when there is evidence that a client may effectively be helped in his own home. The initial assessment is made at the client's home by two members of the team, who then negotiate an interim management plan with the family before leaving. The case is later discussed at a weekly team meeting, when a formal diagnosis

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is made by the consultant psychiatrist,, and a key-worker is given responsibility for the case.

Management is coordinated by the crisis intervention team key-worker. The case may require referral to another part of the service for assessment or treatment — for example, the opinions of the psychologist or occupational therapist — or admission to hospital may be necessary. Medication, if indicated, is prescribed by the client's general practitioner after discussion with the team psychiatrist. Any physical treatments or investigations are also managed by the general practitioner.

Follow-up visits to the client's home usually occur over a period of between one and eight weeks, and visits last between 30 and 90 minutes. This allows time for the client and family to work out how best to manage their difficulties, and how the key-worker may be most useful — practical advice may be needed, contact with local agencies may be necessary and medication may need to be recommended. The anxiety of both client and relatives may necessitate frequent contact by the key-worker, especially during the first week when daily visits are often made.

Research

Information about the social, demographic and clinical characteristics of each client has been collected over the four years that the Centre has been operational in order to assist planning, to evaluate service performance and to provide a factual account of the work undertaken.

The questions examined were:

1. Who were the people using the Centre?
2. What were their problems?
3. Who referred them to the Centre?
4. What was the outcome of consultation?
5. What was the effect on the existing psychiatric services?

Results

A total of 1533 clients were seen at the Mental Health Advice Centre from 1979 to 1982. Of these 1092 were seen by the multiprofessional team and 441 by the crisis intervention team.

Demographic and social characteristics

Data on sex, age, marital status, ethnic origin, social class and present work status were collected. The proportions of men and women seen by both teams were similar, with women outnumbering men by two to one. The clients seen were most commonly aged in their middle thirties. Table 1 shows the marital status of the clients seen by both teams from 1979 to 1982. The largest group seen by both teams was that of married women. The difference between the number of men and women in all four marital status categories seen by both teams was statistically significant — multiprofessional team: chi-square = 18.7, three degrees of freedom, $P<0.001$; crisis intervention team: chi-square = 21.7, three degrees of freedom, $P<0.001$.

Table 2. Work status of the clients seen by both teams from 1979 to 1982, expressed as percentages.

Work status	Multi-professional team (n = 1092)	Crisis intervention team (n = 441)	Total (n = 1533)
Full time	39.5	27.1	36.4
Part time	9.8	4.2	8.5
Unemployed	17.9	26.8	19.9
Sick	7.0	8.1	7.9
Student	3.0	2.0	2.8
Retired	3.4	5.8	4.0
Housewife	19.4	26.0	20.5

Table 3. Previous psychiatric history of the clients seen by both teams from 1979 to 1982, expressed as percentages.

Previous psychiatric history	Multi-professional team (n = 1092)	Crisis intervention team (n = 441)	Total (n = 1533)
Inpatient treatment	19.7	51.4	29.2
Outpatient treatment	18.0	9.2	15.4
GP treatment	24.0	6.5	18.8
None	37.1	32.6	35.7
Other	1.2	0.3	0.9

Ethnic origin. Most of the inhabitants of the borough of Lewisham are Caucasian (85.1%). People of West Indian origin account for 8.5% of the population with other ethnic groups accounting for 6.4%. Interestingly, West Indians made up a larger proportion of those seen by the crisis intervention team (11.3%) than by the multiprofessional team (5.0%).

Present work status. Table 2 shows the work status of clients seen from 1979 to 1982. The multiprofessional team saw a higher proportion of clients in full-time employment than did the crisis intervention team. By contrast, the crisis intervention team saw a much higher percentage of clients who were unemployed or housewives than did the multiprofessional team.

Clinical characteristics

Previous psychiatric history. It can be seen from Table 3 that the proportions of clients with a previous inpatient history was high — 19.7% of clients seen by the multiprofessional team and 51.4% of those seen by the crisis intervention team. However, the multiprofessional team saw a higher proportion of clients with a previous history of outpatient treatment or past psychiatric problems treated by the general practitioner only.

Table 1. Marital status of the clients seen by both teams from 1979 to 1982, expressed as percentages.

	Multiprofessional team			Crisis intervention team		
	Male (n = 371)	Female (n = 721)	Total (n = 1092)	Male (n = 150)	Female (n = 291)	Total (n = 441)
Married	44.4	50.3	48.1	30.3	55.3	46.2
Single	42.1	28.5	33.4	54.5	26.5	36.7
Widowed	0.8	4.8	3.3	4.1	3.6	3.8
Divorced/separated	12.7	16.4	15.2	11.1	14.6	13.3

Table 4. Diagnoses of the clients seen by both teams from 1979 to 1982.

ICD-9 code	Diagnosis	Number (%) of clients seen by multiprofessional team		Number (%) of clients seen by crisis intervention team	
295	Schizophrenia	31	*(3.4)*	103	*(26.5)*
296	Affective psychosis	50	*(5.5)*	47	*(12.1)*
300.4	Neurotic depression	107	*(11.7)*	63	*(16.2)*
300	Other neurotic disorders	117	*(12.8)*	24	*(6.2)*
301	Personality disorders	191	*(20.9)*	42	*(10.8)*
309	Adjustment reaction	307	*(33.7)*	71	*(18.3)*
	Other diagnoses	54	*(5.9)*	37	*(9.5)*
	No psychiatric diagnosis	55	*(6.0)*	2	*(0.5)*
	Diagnosis not specified	180	—	52	—
	Total	1092		441	

The percentage of clients with no previous psychiatric history seen by the crisis intervention team fell over four years from 44% to 26%. The percentage of clients with a history of outpatient treatment doubled (8.6% to 16.7%) while the percentage of clients with a previous history of inpatient treatment rose from 45% to 54%. The proportions of clients with a history of previous psychiatric treatment, both inpatient and outpatient, seen by the multiprofessional team remained similar over the four years. These figures reflect the tendency for the clients seen by the crisis intervention team to be more disturbed than those able to attend the walk-in clinic, a growing awareness of the availability of the crisis intervention team among other local services, and the increasing tendency for the crisis intervention team to offer both a selective and consultative service.

Diagnosis. The clients seen by both teams were diagnosed after discussion with the consultant psychiatrist according to the criteria of the ninth revision of the *International classification of diseases* (ICD-9).[9] The figures available for clients seen from 1979 to 1982 are shown in Table 4.

The functional psychoses formed the largest diagnostic category for clients seen by the crisis intervention team — of the patients seen by this team 26.5% received a diagnosis of schizophrenia. In the same period only 3.4% of the clients seen by the multiprofessional team received this diagnosis. The crisis intervention team saw fewer cases of adjustment reaction (18.3%) and personality disorders (10.5%) than did the multiprofessional team (33.7% and 20.9%, respectively) over the same period.

Source of referral

Table 5 gives the source of referral of the clients seen during the four years studied. The majority of referrals came from local general practitioners. The proportion of patients referred to the multiprofessional team by general practitioners decreased slightly over the four years from 82.0% to 71.0%. The number of self-referrals increased from 4.0% to 17.6%. The number of self-referrals to the crisis intervention team was small, reflecting the policy of the team to accept referrals only from other professionals except in exceptional circumstances — for example, if a client was well known or telephoned for advice from outside the area.

The outcome of consultation

Table 6 shows the management of clients seen by both teams. The majority of the clients seen received some form of counselling. However, while 27.1% of the clients seen by the crisis intervention team were admitted to the local psychiatric hospital, only 3.3% of the clients seen by the multiprofessional team required hospitalization. It is also interesting to note that 19.1% of those admitted to hospital had a previous history of inpatient psychiatric treatment.

Table 5. Source of referral of the clients seen by both teams from 1979 to 1982, expressed as percentages.

	Multi-professional team (*n* = 1092)	Crisis intervention team (*n* = 441)
GPs	*72.0*	*85.0*
Self referrals	*13.0*	*2.0*
Social workers	*2.0*	*5.0*
Health visitors	*2.0*	*3.0*
Others	*11.0*	*5.0*

The number of admissions to hospital made by the crisis intervention team fell from 39% of those seen in the first year, to 26% in the fourth year. Of clients with affective psychosis seen by the crisis intervention team, 57% were admitted to hospital, compared with 36% of clients with a diagnosis of schizophrenia. A high proportion of clients with personality disorders (31%) were also admitted to hospital by the crisis intervention team.

Of clients seen by the crisis intervention team, 37% of schizophrenics, 30% of those with affective psychosis and over 50% of clients with personality disorders, neurotic disorders or transient situational disturbance were managed at home.

Table 6. The management of the clients seen by both teams from 1979 to 1982, expressed as percentages.

	Multi-professional team (*n* = 1092)	Crisis intervention team (*n* = 441)	Total (*n* = 1533)
Domiciliary support and treatment	*43.6*	*37.0*	*41.3*
Referred to outpatient departments	*18.0*	*12.4*	*16.5*
Psychotherapy	*14.0*	*4.1*	*11.2*
Referred back to GP	*3.6*	*3.3*	*3.6*
Admitted to hospital	*3.3*	*27.1*	*10.4*
No further action	*7.4*	*5.1*	*6.6*
Other	*10.1*	*11.0*	*10.4*

Discussion

The Mental Health Advice Centre has brought together a team of professionals who are both rapidly and easily accessible to clients and who have been able to provide a comprehensive service of assessment, treatment, rehabilitation and prevention. This paper describes some aspects of the service which was offered in the first four years and the characteristics of the population who used the Centre.

The results indicate that a considerable proportion of the clients were young married women and that the clients seen by both teams were similar with respect to sex, age and marital status. These findings echo previous studies which have suggested that psychiatric disorders are more common in younger age groups[10,11] and among women[3,12] but differ from studies of community samples which showed higher rates of morbidity among separated and divorced people.[2,13]

Not surprisingly, the clients seen by the crisis intervention group tended to be more disturbed than those seen by the multiprofessional team and were also more likely to be unemployed. The rate of unemployment among the clients seen by the crisis intervention team increased between 1978 and 1982, and was considerably greater than the overall rate in the borough of Lewisham, where unemployment for males rose from 8.6% (3.0% for females) in January 1978 to 15.9% (6.6% for females) in January 1982. People of West Indian origin were also over-represented among the clients seen by the crisis intervention team. These findings agree with other studies which explore the association between social disadvantage and physical illness.[13-17] The relatively high number of females with schizophrenia may reflect cultural and pathoplastic factors influencing the presentation of clients from ethnic minority groups.[17-19]

The crisis intervention team provides a service for severely disturbed clients. The multiprofessional team, by contrast, sees clients with transient situational disturbances or personality disorders, who have had a less formal psychiatric history, and are less likely to require admission to hospital. Interestingly, it is this type of client who most closely resembles the recipients of traditional crisis intervention services as described in most of the available literature.

Many of the clients seen by the crisis intervention team had a significant psychiatric history, particularly of inpatient treatment, and were referred to the team with a further acute episode. This often occurred following loss of contact with follow-up services and discontinuation of medication, emphasizing the need for improvements in this aspect of care.

Although useful, the ICD classification of psychiatric illness has limitations in the context of a community psychiatric service. Psychiatric symptomatology alone often escapes referral for treatment because family and social disturbances are tolerable, and clients who are referred often present a picture in which psychopathological features are set in a context of considerable social and domestic difficulties. A multiaxial classification such as that proposed by Goldberg[20] may have greater relevance both to the management and to the study of psychiatric morbidity in a community setting. A multiaxial approach was characteristic of the most effective home treatment programmes coordinated by both teams at the Centre. Thus the majority of clients seen by both teams received practical support and counselling in addition to more specific, symptom-oriented treatments. Additional help was often received from local social and community services, or volunteers.

Many clients were referred to the crisis intervention team as psychiatric emergencies requiring immediate hospital admission. Almost one-third were admitted to hospital, but efforts were made to avoid this where there was evidence that a client could effectively be helped in his own home.

Factors preventing successful home care included serious risk of suicide or homicide, social isolation, self-neglect, the absence of a person with an existing trusting relationship with the client, or the reluctance of such a person to assist the key-worker with the containment and resolution of the client's difficulties. Counselling and support to the family was a major component of most successful treatment programmes particularly in the case of psychiatric emergencies. The failure of home management programmes was often associated with persistently high levels of anxiety or hostility in a client's family, and a failure of strategies employed to contain these.[21-25]

Since the Centre was opened and the teams have become established the pattern of utilization of different parts of the psychiatric service has changed. The figures presented here suggest a decrease in the number of first admissions to hospital, new referrals to outpatient departments and consultant domiciliary visits. The mean number of first time admissions to hospital per month decreased as the mean number of clients seen by the crisis intervention team increased. No similar relationship was found for those attending the multiprofessional team, or for those who were new referrals to outpatient departments. Furthermore, no relationship was found between the mean number of clients seen by the crisis intervention team per month and those seen by the consultant psychiatrist on domiciliary visits, although requests for domiciliary visits by the consultant psychiatrist were often passed to the crisis intervention team after discussion with the general practitioner, especially when an immediate response was desired.

Local general practitioners formed the major source of referrals to both teams. The number of self-referrals to the multiprofessional team increased over the four years studied, but is expected to remain small, in keeping with the low rate of self-referral to psychiatric emergency clinics noted elsewhere.[11] The changing pattern of referrals by general practitioners to different parts of the service suggests that the availability of the Centre has altered the conventional model for referral as described by Goldberg and Huxley,[2] and has resulted in higher total numbers of referrals than would otherwise have been expected. The model described by Goldberg and Huxley suggests that the majority of patients with psychiatric symptoms are treated by their general practitioners, while the referral of a minority for formal psychiatric treatment is governed by a series of filters. The volume of referrals to the Centre from local general practitioners suggests that the low rates of referral elsewhere may largely be a consequence of the organization and accessibility of the local services rather than any reflection of the incidence of need in a community.

The results presented here suggest that the Mental Health Advice Centre is an innovation in community psychiatry in providing a service to a group of clients who have not previously had access to a specialist service, and who may previously have had unmet needs. In addition, the Centre offers a wider variety of treatment approaches to patients previously treated by a service confined to a more limited range of options. The crisis intervention team has been able to develop a system of community care not only for people 'in crisis' but also for people with acute mental illness.

It is hoped that the Mental Health Advice Centre has made a considerable contribution to the development of a community mental health service in the area, and that further evaluation of the delivery of psychiatric services may help to inform and direct service planning in the future.

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