The relationship between primary care and psychiatry: an opportunity for change

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SUMMARY. The past two decades have seen the development of a symbiotic relationship between primary care and psychiatric services. The changes which have taken place, however, have been piecemeal and variable in their extent. With some exceptions, they have followed an empirical route, and have come about largely because individual practitioners intuitively felt that they yielded positive results or attractive patterns of working. For the most part, they have not followed the elaboration of a specific theory and although a great deal of subsequent research has been carried out in order to analyse their benefits and limitations, routine practice has been slow to change. The recent reorganization of the health service has yet to exert an appreciable effect on the relationship between the two disciplines. Owing to the newly developing structures and patterns of care, future change is inevitable and brings with it both opportunities and dangers. This paper sets out some of the arguments in favour of a new contract between psychiatry and primary care based on an equal partnership.

Keywords: psychiatric services; general practitioner–psychiatrist relationship; inter-agency cooperation; health service provision.

Origins of liaison between psychiatry and general practice

THE title of Strathdee and Williams[1] seminal work on this subject, 'The silent growth of a new service', underlines the unplanned way in which many developments have taken place. The growth of a silent service appeared to surprise many,[2] but for a number of years before that, various articles had been published describing the benefits of close working relationships between psychiatric and primary care teams.[3-5] Historically, there has been cross-fertilization and many general practitioners have spent part of their careers in psychiatry[6] before settling down to life as principals. Similarly, many psychiatrists have dual membership of the royal colleges. There is, however, an impression that much of the traffic in the liaison itself is one way. The bulk of published papers have psychiatrists as their authors, and some of the less enthusiastic responses on paper have come from general practice.[7] The reasons for this are not clear, but may stem from a reluctance by general practitioners to accept the psychiatrist as expert in the field of emotional ill health

It is clear from the perspective of family medicine that psychiatric input has relatively little to offer to the bulk of psychological therapy in general practice. The techniques used in establishing psychiatric morbidity in a mental state examination are impractical in the comparatively brief contacts at primary care level. They cannot be reasonably condensed or exported in a paper and pencil test, despite the value of such tests for screening purposes.[8] Protocols for the management of psychological ill health in primary care appear to meet with little enthusiasm,[9] and it is likely that this is due to the basic difference in conception and approach of the two disciplines. General practice frequently depends on problem solving, whereas psychiatry relies more heavily on longitudinal interpretations and dynamic formulations. These are in no way contradictory, but it is not possible to relocate the processes from one setting to another without considerable adaptation. For example, the problem-oriented approach was in vogue in psychiatry for a while in North America,[10] but in its purest form tends to be inadequate in psychiatric practice because it can miss large areas of the subject's background, development and phenomenological existence. The psychiatrist using this approach runs the risk of over-simplifying a complex case. As a result, communication with the general practitioner may focus too narrowly on concrete solutions such as prescription of psychotropic drugs, thereby ignoring potentially important psychological interpretation which may be more helpful in family medicine. Conversely, the institution of Balint groups,[11] which use methods common to psychiatry, attracted a great deal of attention in general practice, but it was not long before this, too, came under criticism for its elitism[12] and inappropriateness in primary care.[13] More fundamentally, Sowerby,[14] although accepting the value of the Balint method in improving the doctor–patient relationship, criticized it on the basis of introducing a pseudoscience in place of the real thing.

These two different approaches—problem solving and longitudinal interpretations — have, nonetheless, complimented one another and are perfectly appropriate in the correct setting. General practice may have felt that it was being pushed to accept something that was unsuitable and therefore has, at times, rejected the approaches from psychiatry, particularly when dressed in the guise of teacher-expert. In 1983, Lesser went so far as to suggest that an attachment in psychiatry for general practice vocational trainees was no longer appropriate, as the experience was likely to be sterile and have little relevance to the needs of general practice.[13] More recently, it has been suggested that the marriage between psychiatry and general practice is over,[7] and that there are new relationships with workers in other disciplines such as psychologists,[15] social workers[16] and the all-embracing category of 'counsellors'.[17] The marriage, however, refuses to dissolve, and this may well result from the positive experiences of the progeny which come in many forms. A recent example from Scandinavia[18] shows that when psychiatrists and general practitioners work together in identifying and treating depression, they may be able to reduce the level of suicide. Increasingly, the lines of professional demarcation are becoming less clear. Primary care is assuming responsibilities for the welfare of chronically mentally ill patients in the community,[19] in addition to treating the bulk of psychological disorder presenting in general practice settings.[20] There is some concern, however, that this involvement of primary care in mental health services is not always productive[21] and could be improved for the benefit of the patient. There has also been a considerable expansion in the numbers of community psychiatric nurses and psychologists,[2] some of whom are located in primary care, while others continue

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to work in mental health teams. Their role is not well defined and the confusion which results can sometimes leave both mental health and primary care teams feeling that a valuable but poorly understood resource is being wasted. Health visitors and practice nurses are also increasingly involved in the identification and treatment of mental health problems, but their training is minimal and their function equally unclear.

Health service reforms

Although the health service reforms have yet to make an appreciable impact in this area, it is clear that changes are already beginning to occur. The separation of purchaser and provider functions, and the subsequent ability of fundholding practices to influence the nature of the specialist services delivered to their practice is, perhaps, more obvious for areas such as surgery and other medical specialties. Much of the information available on the nature of these developments focuses on the phenomena which are most easily counted, such as referral numbers and contact rates. There is, however, potential for qualitative information gathering which may be of far greater importance, particularly for the interface between psychiatry and primary care.

A recent report highlighted some changes which have followed the introduction of the fundholding initiative. A general practice in Derby is reported to have secured the services of the local consultant psychiatrist to run clinics at the surgery on a private basis.[22] This was deemed to be a success, not least because the psychiatrist was able to see more people per hour in that setting when compared with the routine work of the psychiatric clinic. There is clearly a grave danger of taking an apparent rise in the number of patients seen as evidence of an improved service. In order to draw such a conclusion, it would be necessary to know what conditions were being treated, which treatment modalities were being used, and what specific outcomes were achieved. The increased rate of contact, for example, could reflect the use of a consultant psychiatrist as an expensive counsellor or, alternatively, a return to the high volume supportive treatments based principally on pharmacology. There is also a danger that the remaining part of the multidisciplinary mental health team, especially the inpatient psychiatric service can become further divorced from a constructive involvement with primary care.

Variation in need

Several different liaison models have been debated in the literature during the past few decades.[23,24] The apparent favourite among psychiatrists is the liaison-attachment model, in which psychiatrists visit practices offering advice and consultation to their general practice colleagues. The replacement model, whereby the psychiatric service becomes a primary service, is least favoured by the World Health Organization,[25] partly because there are insufficient resources to repeat that model in every location, and partly because of the danger that it would in time reduce the skills of general practitioners. The so-called shifted outpatient clinic model in its purest form does not really involve liaison at all — the two teams work in the same building but rarely interact with one another in a constructive manner. In reality services develop eclectically, with a mixture of all three of these models. Eclecticism in itself is frequently frowned upon but is likely to arise from the differing needs of practice populations:

There is plenty of evidence to suggest that the more serious mental disorders, such as schizophrenia, are to be found to a greater extent in the deprived inner city areas (Gibbons J, *et al,* psychiatric care in eight register areas, Southamptom Psychiatric Care Register, 1983). General practitioners serving such catchment areas may well prefer elements of the shifted outpatient clinic combined with a consultancy or advisory role for the psychiatrist. More affluent areas may prefer to see a predominance of the liaison-attachment model. Although there is good evidence to believe that general practitioners are not antagonistic towards psychiatric patients,[26] it is clear that some general practitioners are not in a position to deliver a psychologically based treatment programme for a number of different reasons. In those exceptional circumstances, a replacement function may be required. The pattern of interaction, therefore, should be defined and determined by local circumstances and not necessarily by ideology.

New opportunities

Both fundholding and non-fundholding practices have a new opportunity to define their relationship with their local psychiatric service in a way which will provide mutual benefit to both. Fundholders particularly are unlikely to put up with a situation in which they are invited to pay for services for which they have not directly asked and which are run by people with whom they have no contact, as may occur with extended psychiatric teams.[27] They will want to know more about what is happening to their patients and who is seeing them. However, to rely solely on contact rates as a measure of the service delivered, neglects the issue of quality, and could only be attractive to those who favour the total replacement model. It is considerably more difficult to decide what should replace these activity figures, particularly as an ill-defined relationship may be synonymous with no change at all. It is also necessary to recognize that a legitimate contract puts demands on both parties. In addition to the requirements of the general practitioner, there will also be demands from the mental health team. They may wish to influence the nature of the referrals, including the choice of therapist, and the information supplied in order to maximize the effectiveness of their own work. General practitioners have consistently been shown to under-diagnose psychiatric conditions, especially depression.[28] The new relationship should focus on such issues and as a starting point it would be wise to use the recommendations recently prepared by the Royal College of Psychiatrists and the Royal College of General Practitioners on the shared care of patients with mental health problems.[29]

Establishing a new relationship

There are three core elements of the relationship between general practice and psychiatry which need to be taken into account when looking to the future: content, quality and structure.

Content. This refers to the type of work expected by both parties. It defines the clinical profile of patients who should be referred for assessment and management, or those for whom only advice is required. It goes further by defining what these activities will mean in reality. What information should accompany the referral, and be expected when the assessment is completed? We know what information psychiatrists may feel they need[30] in order to arrange an assessment by the most appropriate member of the mental health team but this may not be universally applicable and should be a matter of local agreement. Some general practitioners may ask for liaison time to discuss their cases, while others may request specific pharmacological advice or assistance in obtaining tertiary services.

Quality. This is frequently evaluated by using measures of process, for example, the time taken between assessment and

referral, or receipt of correspondence. Clearly, where there are inordinate delays, such process measures are quite valuable. Equally, the number of patients seen, or contacts made, are indicators of service provision, but cannot stand on their own. Information systems are now available which can define diagnostic groupings, demographic features and social deprivation indices, and these measures need to be incorporated into activity data if they are to have any meaning. In general, however, activity data should be relied upon for its descriptive value rather than as a pure outcome measure. It is far too easy to double the number of contacts and simultaneously reduce the quality of input. Conversely, it is possible to reduce the number of contacts by virtue of more effective liaison, and thereby improve quality of service.

The temptation to use numbers of patients referred as a way of defining quality should be resisted. It presupposes that we already know how to calculate the present quantity of service input, but this clearly is not the case. In time, such issues may be resolved, but as yet the baselines cannot be estimated and would give a spurious impression of performance.

Increasingly, psychiatric audit is yielding new outcome measures (Wing J, health of the nation outcome scales in development, Royal College of Psychiatrists research unit, 1993). The admission rates for particular conditions, uses of electroconvulsive therapy and psychotropic medication, and standardized symptom ratings, are some of the tools which can describe the quality of the service being offered. On a more sensitive note, the unhelpful tendency for the persistence of the expert–pupil interaction between the disciplines could be altered by using the observation skills of the general practitioner to help evaluate the work of the psychiatrist. This has been shown to be a sensitive and helpful way of auditing psychiatric services[31,32] and could become a two-way process.

Structure. How frequently will consultant time be made available and for how long? What will be the method of contact for the primary care team and who can arrange an admission when it is warranted? How much input can be expected from the extended community psychiatric team? Such issues are not simply one way. There may be equal demands from psychiatry for general practice to become more available, and to play an active role in combined care including prescribing. What arrangements, for example, should be made by both teams for the acute crisis which presents on a Friday afternoon, when everybody appears to be going away for the weekend?

There are other aspects to the structural relationship which might warrant exploration particularly in the light of the recent 'Defeat depression' campaign.[33] Despite a plea nearly a decade ago, for appropriate training and accreditation of counsellors in general practice,[34] standards vary and at times it can prove difficult for primary care teams to write informed job descriptions for or monitor progress of attached counsellors. Senior members of the local mental health team may well be able to share their skills in this area so that they can adopt a true consulting role without taking over the job of therapist itself.

It is not suggested that all of this need necessarily be incorporated into a formal service specification. Indeed, that approach is likely to be sterile, and lead to conflict. It is certainly worthwhile committing the process to paper, particularly as personnel may change. It is, however, a prerequisite for a successful partnership that the key practitioners meet and discuss their relationship; it should not be left to a management exercise in which the quality statements become perfunctory ingredients that are never implemented.

Conclusion

The new relationship between primary care and psychiatry which will necessarily follow the reforms of the health service provides an opportunity to clarify the contributions and needs of both parties. Contrary to some speculation, the marriage between the two disciplines is a healthy one which will survive.

Like all relationships, the parties occasionally need to reflect on their roles and adapt to changing expectations. Up to this point, perhaps one of the partners has been keen to play the more dominant role. Primary care may wish to redress the balance a little, so that the partnership of the 1990s becomes a more equal and mature union.

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