MEDICAL PRACTICE

Contemporary Themes

Community mental health care: a model based on the primary care team

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British Medical Journal, 1977, 2, 936-938

During the past decade there has been increasing interest in the community care of patients with emotional illness. Shepherd *et al*[1] showed that most consultations for psychiatric or emotional disturbance take place in general practice and few of these are referred to the specialist services. The hospital-based psychiatric services have had to abandon the idea of the hospital as a closed institution and treat patients living at home. Unfortunately, this trend has not been accompanied by closer collaboration between psychiatrists and general practitioners.[2] Psychiatrists, generally, have been unable to influence criteria for referral or modify unrealistic expectations of treatment while most work has suggested that the performance of the general practitioner in diagnosing and treating emotional disorder is far from satisfactory.[3-6] Even if we allow for the fact that most of this work has been done by psychiatrists and that, in our view, this criticism is exaggerated, we must look at ways of improving this position.

The two solutions most commonly suggested are to improve medical education in psychiatry and to encourage more team work, with better collaboration between general practitioners, home nurses, health visitors, and social workers. Nevertheless, we know that not all doctors wish to interest themselves in the emotional problems of their patients,[7] nor are many of them personally equipped to do so, and, in our experience, most attached community nurses and health visitors are not happy caring for patients who are psychologically disturbed. Brook and Cooper[8] recognised and discussed these difficulties and made a plea for closer contact between psychiatrists and general practitioners and for the evaluation of local experimental schemes. We believe our approach in Livingston is such a scheme.

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Craigshill was the first health centre in Livingston New Town and serves a population of about 10 000. As in other new towns this is a young population, 40% being under 15 and less than 10% over 45. Six general practitioners (and for a short time, seven) work from this health centre, each having a five-session appointment as medical assistant or hospital practitioner with the Lothian Health Board in a range of specialties and a list restricted to 1500 patients. The health centre is also the base for a community nursing team of three health visitors, two district nurses, and one midwife.[9] Two practice nurses are also employed directly by the general practitioners.

More recently a clinical psychologist was appointed to the health centre and shortly afterwards a community psychiatric nurse who, although retaining administrative and some clinical links with Bangour Village Hospital, is mainly identified with the health centre. There are regular meetings between the doctors, nurses, and social workers from the area team, and one member of the area team attends the health centre weekly.

Clinical psychiatric team and psychiatric services

The members of the psychiatric team are: a consultant psychiatrist,* who spends one session weekly in the health centre; a general practitioner psychiatrist (post held by CMC until December 1976), who uses two of his specialist sessions weekly in the health centre; and a community psychiatric nurse, spending most of her time at Craigshill, but with some links with Bangour Village Hospital. These

*The post held by Dr J B Rae until his death in April 1976.

members have weekly team meetings, which are also attended by the psychologist fully attached to the health centre and a social worker from the local social work department. As well as contributing to the team the psychologist also accepts referrals, and her first year's work is described elsewhere.[10] Our colleagues in the health centre are free to attend these meetings and contribute to the discussion, but this has happened less often than we would have hoped. In addition the psychiatric nurse and GP psychiatrist meet on several other occasions weekly to discuss patients currently being seen.

Before our clinic started the referral rate to psychiatrists was around 20 patients yearly. This immediately more than doubled and has increased each year: 52 in 1974, 65 in 1975, and 72 in 1976. Initially the consultant psychiatrist was referred more patients than the health centre-based psychiatrist, but this was soon reversed and continued until the death of the consultant psychiatrist early in 1976. From then until the end of 1976 we were able to provide a full range of services without the participation of a hospital-based psychiatrist.

Table I attempts to classify the patients referred to the psychiatrists using a fairly traditional system based on the International Classification of Diseases. A low rate of psychosis is immediately obvious, with a fairly high number of patients with alcohol problems and declared sexual dysfunction. It soon became apparent to us, however, that interpersonal relationship difficulties and socially deviant behaviour, such as alcohol abuse, were more relevant than formal psychiatric illness, making a standard ICD approach to classification extremely difficult. Wing's suggested solution to this difficulty is to use an index of definition of psychiatric disorders, which incorporates cut-off points on the basis of symptoms rated with the present State examination.[11] Our approach has been to use the following standard problem check list with the intention of subsuming a group of problems, if possible, under an ICD diagnosis.

TABLE I—*Classification of 189 patients referred to psychiatrists during 1974-6*

Diagnostic group		Male	Female	Total	
Neurosis	Neurotic depression	4	30	34	57 (30%)
	Anxiety state and phobic anxiety	6	15	21	
	Hysterical reaction	0	1	1	
	Obsessive compulsive neurosis	1	0	1	
Psychosis	Schizophrenia	5	1	6	24 (13%)
	Paranoid psychosis	1	1	2	
	Manic depressive psychosis including endogenous depression	7	9	16	
Organic brain syndrome		3	0	3	(1%)
Personality disorder		9	14	23	(12%)
Alcoholism		28	9	37	(20%)
Declared sex dysfunction		11	21	32	(17%)
No formal diagnosis		6	7	13	(7%)
Total		81	108	189	(100%)

The checklist is divided sequentially into six parts, namely: *Problems of mood and affect*—depressed mood, looks sad and unhappy, cries a lot, feels excessively tired, feelings of guilt, feelings of worthlessness, feelings of hopelessness, feelings of anxiety, feelings of fear, feels unable to cope, feelings of unreality. *Problems of thinking*—confusion, clouding of consciousness, memory difficulty, obsessive thoughts, impaired judgment and insight, thought disorder, delusions, hallucinations, passivity feelings or impulses, paranoid ideas. *Social environment*—employment problems, marital problems, financial problems, recent loss or separation, child caring problems, other family problems. *Behavioural problems*—alcohol abuse, drug abuse, antisocial behaviour, manifest anxiety, compulsive behaviour, danger to self, emotional immaturity, hostile behaviour, poor impulse control, phobic behaviour, poor personal habits, sexual problems, social withdrawal, interpersonal relationship problem. *Physical symptoms*—appetite problem, sleeping problem, other specify. *Incomplete data base.*

Table II shows the commonest problems of 100 consecutive patients referred to the GP psychiatrist, and the commonest problems of 100 patients referred to the psychiatric nurse (all the 1976 referrals to the psychiatric nurse). Of the nurse's patients 82% were female, compared to only 55% of the general practitioner psychiatrist, and the nurse tended to rate rather more problems than the psychiatrist. In both groups of patients depressed mood was, by far, the commonest psychiatric symptom, much commoner than anxiety, and 66% of the patients who had symptoms of anxiety also had symptoms of depression. Symptoms such as impaired judgment and insight, feelings of guilt, and paranoid ideas appear in the psychiatrist's list

TABLE II—*Twenty commonest problems of patients referred to either the GP psychiatrist or the community psychiatric nurse*

Problem	No of patients referred to psychiatrist	No of patients referred to nurse
Marital problems	61	67
Depressed mood	59	67
Sexual problems	38	32
Unable to cope	31	56
Feelings of anxiety	29	52
Sleeping problems	26	91
Alcoholic abuse	24	22
Looks sad and unhappy	23	66
Interpersonal relationship problem	20	20
Employment problems	18	22
Recent loss or separation	16	19
Impaired judgment—insight	14	
Cries a lot	13	45
Feels excessively tired	12	
Phobic behaviour	11	
Memory difficulty	11	13
Feelings of guilt	10	
Feelings of fear	9	
Paranoid ideas	9	
Financial problems	9	42
Appetite problems		69
Feeling of hopelessness		18
Emotional immaturity		32
Social withdrawal		28
Child-caring problems		26
Other family problems		22

TABLE III—*Number of patients referred by practices to either the psychiatrists or to the community psychiatric nurse*

Practice No:	1	2	3	4	5	6	7
No referred to psychiatrists (n = 189)	20	24	19	30	29	57	10
No referred to community psychiatric nurse (n = 100)	7	10	18	19	15	18	13

of most common problems while not in the nurse's, perhaps reflecting the fact that patients with more obvious psychiatric syndromes were referred to the psychiatrist. Of the problems appearing only in the nurse's list, probably the child-caring problems are the most important and have provided a fruitful area of co-operation with the health visitors. Table III shows the referrals from individual practices to the psychiatrists or the nurse during the three-year period. There are interesting differences in the referral rates in that practice 6 has referred many more patients to the psychiatrists, although only slightly more than average to the psychiatric nurse, while practices 1 and 2 have referred rather less than the average number of patients to the nurse. It is worth noting the high referral rate from practice 7, as this practice was not established until early 1976 and had only about 400 patients by the end of 1976.

Although many patients were discussed informally at the weekly meetings, 44% of the patients seen by the psychiatrist were also seen by the community nurse, 12% by the social worker, and 10% by the psychologist. Of the patients referred to the psychiatrists, 16% were admitted to hospital, representing almost half of the hospital admissions from Craigshill Health Centre. While in hospital the day-to-day care of these patients was undertaken by the general practitioner psychiatrist as a member of the appropriate sector team.

Discussion

We have shown that it is possible to organise a community psychiatric service based in a health centre with trained general practitioners and psychiatric nurses actively participating and sharing patient care with skilled persons from other disciplines. Generally, the service seems to have been well received by our professional colleagues in the health centre but, in particular, the health visitors and community nurses have enthusiastically welcomed the support of a psychiatric nurse and, as well as referring and discussing patients with her, have themselves been more confident with emotionally distressed people. Communication is made extremely efficient by daily contact, regular team meetings, and by the common use of A4 casenotes. The attendance rate has been 97%, suggesting that the patients find this system of care convenient and without stigma. We would expect

the tendency for the consultant to be referred relatively fewer patients to continue, allowing him to assume a truly consultant and advisory role in the health centre and possibly more widely in the community.

Despite the increasing number of referrals, we consider that most are appropriate and that agreement on realistic goals with the referring practitioner has been relatively easy. As all the practices, except practice 7, are almost exactly the same size, it is interesting to note the differing referral rates. Practices 1 and 2 are the oldest and most stable practices, with practices 6 and 7 being relatively new with a fairly large number of patients in practice 6 having transferred from other practices. Several studies have shown the increased consultation rate by newly-registered patients, and, although Bain and Philip[12] suggested that psychiatric illness accounted for a substantial proportion of these consultations, the use of the general health questionnaire with newly registered patients, both consulting and non-consulting, did not confirm this.[13] Undoubtedly, too, the characteristics of the practitioners are important, and this would merit further scrutiny.[14]

We have not yet attempted any scientific evaluation of the results of our approach because of the extreme difficulties, but Cooper *et al*[15] have shown that this is possible, albeit in a rather limited way. We hope, however, to obtain the help of the Medical Research Council in at least evaluating the contribution of the community psychiatric nurse, both in traditional settings and based in the primary care team. Although the number of patients with psychosis is relatively small, we find that they can be managed well in this kind of setting but that our main concern has been with families exhibiting marital, sexual, child-caring, and alcohol problems. We have started conjoint marital therapy, often with a co-therapist, but have found selection of couples difficult. Sex therapy and counselling using a Masters and Johnston approach may be a better investment of resources, especially in a general practice setting, and when used at an early stage in the marriage may prevent the development of maladaptive interactions which are more difficult to modify. We find these sexual problems often come to light after childbirth, usually after the first child, and we are currently looking at this group of patients more closely. It may be that this more restricted evaluative approach will be more rewarding than a more global evaluation. It is important, however, to emphasise the unusual age distribution of this new town population and that in a more usual practice problems relating to the elderly would assume more prominence.

Conclusions

Despite some administrative problems, a heavy work load, and some opposition from traditional practitioners very similar to the recent controversy after the Court report,[16] we submit that this concept deserves further evaluation, especially in practices not in new towns. General practitioners interested in psychiatry and psychiatric nurses would, we are sure, welcome the opportunity to develop new skills and would enthusiastically co-operate with professional colleagues in a true community mental health service.

We are grateful to our colleagues, both in Craigshill Health Centre and Bangour Village Hospital, and especially to the late Dr J B Rae, consultant psychiatrist. We would also like to thank Mrs June Forsythe and Mrs Anne Henderson for help in collecting the figures and preparing the manuscript.

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(*Accepted 29 July 1977*)

WORDS The belief that good health depended on the correct balance between various body fluids dates from before Hippocrates (*c* 500 BC) and persisted until the middle of the nineteenth century, when it finally succumbed to the cellular pathology of Rudolf Virchow. These fluids were called HUMOURS (L *umor*). It is quite proper to apply this term to the fluids within the eye, and we use the adjective HUMID for anything wet or damp. The revived term HUMORAL refers to the transmission in body fluids of hormones and biochemical mediators. In ancient times there were thought to be four humours—blood, phlegm, yellow bile, and black bile; and it was the correct balance thereof that was supposed to maintain one's physical and mental wellbeing. If a man was optimistic, self-confident, and sexy it was ascribed to an excess of blood (L *sanguis, -inis*) and he was called SANGUINE. If he was cold and unexcitable he was said to be PHLEGMATIC because of an excess of phlegm (G *phlegma*). If he was easily roused to anger he was said to be CHOLERIC from an excess of yellow bile (G *chole*), and if sad and depressed MELANCHOLIC because of an excess of black bile (G *melan*, black; *chole*, bile). This may have been a clinicopathological observation, for depression commonly occurs with obstructive jaundice, when the bile in the gall bladder is concentrated and blackish.

WORDS Though black bile was associated with melancholy, JAUNDICE was associated with envy (green with envy) and jealousy. (Curiously, *jalousie* means venetian blind in French and German. Shades of Maupassant and Schnitzler!) Yellow, too, meant jealous, but towards the end of the nineteenth century it came to mean cowardly. KIDNEY implied temperament or class (A man of my kidney, *Merry Wives*, iii, 5, 116). BOWELS were the seat of tender and sympathetic emotions (If any bowels and mercies, *Philippians*, ii, 1). GUTS, implying determination in face of difficulties, is of late nineteenth century coinage.

WORDS The viscera were believed to influence emotion, mood, and personality. In the middle ages the LIVER was, for no very obvious reason, thought to be the seat of the passions—that is, emotions in which there is a component of suffering (L *patior*, *passus*, to suffer). Later it was the seat of courage, and a pallid anaemic liver made one cowardly.

> How many cowards . . . who, inward search'd, have livers white as milk. (*Merchant of Venice*, iii, 2, 86.)

> For Andrew, if he were opened, and you find so much blood in his liver as will clog the foot of a flea, I'll eat the rest of the anatomy. (*Twelfth Night*, iii, 2, 67.)

Perhaps Shakespeare had knowledge of some astute clinicopathological observations here, for Andrew Aguecheek says:

> I am a great eater of beef, and I believe that does harm to my wit. (*Twelfth Night*, i, 3, 84.)

Is this hepatic encephalopathy occurring in cirrhosis after a large protein meal, as the late Dr Bill Summerskill suggested?