Psychiatric services in primary care: specialized or not?

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SUMMARY. We compare referrals made to a psychiatric service by two comparable general practices. One practice made its referrals through conventional channels; the other referred patients to a multi-professional team who saw patients at a clinic held on the practice premises. The members of the team and the general practitioners in the second practice also met regularly to discuss matters of mutual interest. More patients were referred by this method, which also made greater use of the multiple disciplines involved in psychiatric care.

Patients referred through conventional channels were more likely to have had previous contact with the psychiatric service, were more likely to be admitted to hospital and spent 70 per cent more time as inpatients.

These results confirm the findings of other workers in demonstrating that there are tangible benefits in a multidisciplinary specialist team working in primary care.

Introduction

CHANGES in public attitudes to mental illness and in government policies on the provision of health care, combined with improvement in the range and efficacy of treatment, have led to an increasing amount of 'traditional' mental illness being treated outside hospital. At the same time there has been a greater tendency for emotional and interpersonal problems to be seen as falling within the area of health care. Studies such as that of Shepherd and colleagues (1966) have shown that, in any year, up to 15 per cent of the population go to their general practitioner with a condition which is largely or entirely psychiatric in origin. These conditions range from clear-cut syndromes to ill-defined states of emotional upset, and from long-standing illnesses to transient episodes.

Given the vague boundary between minor psychiatric illness and the normal range of human emotional experience, most general practitioners handle most psychiatric illnesses themselves (Brook and Cooper, 1975). Cooper and colleagues (1969) showed that a high proportion of problems labelled as psychiatric were chronic or recurrent. Shepherd and colleagues (1966) found that in only 50 per cent of cases of chronic psychiatric illness was it possible to confirm that the general practitioners had recognized important causal or precipitant factors. Johnson (1973) was critical of the way depressive disorder was treated in the community, and Buchan and Richardson (1973) have shown the relatively short time set aside by general practitioners to interview, diagnose and treat depressive illness. But it is equally true that specialists in psychiatry, whose experience is culled largely from hospital-based clinics and inpatient units, are not necessarily able to apply their clinical experience to patients within the community (Shepherd *et al.*, 1966).

As Brook and Cooper point out, there is no simple formula for improving the primary care given to patients suffering from emotional disorders. Local factors such as the geographical distribution of primary and secondary care centres, the level of staffing of different health care professions and the attitudes and beliefs of individual workers play a crucial part in the integration of primary and secondary care.

Some of the shortcomings which have been identified can be overcome by developing specialist skills in the primary care setting. Corser and Ryce (1977) have reported on the value of community-based psychiatric nurses and of general practitioners with a part-time specialty interest in psychiatry. McAllister and Philip (1975) have reported on clinical psychologists with a specific remit to work with a primary care team.

Within West Lothian District (population 130,000)

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there are a number of small towns each served by a group practice. As these towns are geographically separate, there is a more marked demarcation than in larger urban areas and each practice serves a discrete area with little overlap of primary care population.

Psychiatric services to West Lothian District are based at Bangour Village Hospital. Most self-poisoning episodes in the district are treated at the adjacent Bangour General Hospital and 80 per cent are screened by a psychiatrist. At the time of our study there was a waiting list delay of at most three weeks for outpatients.

In 1975 it became possible for a specialist psychiatric team to conduct clinics in the premises of a group practice serving a small town (population 11,000 approximately) some eight miles from the psychiatric hospital.

In reviewing the team's first two years' work, it was possible to compare all inpatient and outpatient referrals made to the psychiatric service by this group in town A with similar referrals made by the general practitioners in town W. Town W is also some eight miles from the hospital and shows the same characteristics as town A other than having a slightly larger population. Contact between the general practitioners in town W and hospital-based staff has been of the traditional variety.

Aims

There were two aims of the follow-up: first, to find out what kind of patients were referred to the team in town A and how they were managed; second, to see whether the pattern of referral from the general practitioners in town A differed from the pattern in town W.

Methods

The specialist clinic based on the group practice in town A started on 1 July 1975. The present study deals with all referrals to that clinic from that date until the end of June 1977. The team comprised a consultant psychiatrist, a clinical psychologist and a social worker. The work pattern which emerged over the two years was that the psychiatrist held fortnightly clinics, the psychologist attended the practice weekly and the social worker saw patients mainly through home visits. The team met each week to discuss new and current cases and, when at the group practice, an hour was set aside to discuss patients' progress and problems with the general practitioners. This was seen as crucial by practitioners and specialists alike. Urgent referrals were dealt with at the hospital if required. Such referrals were always discussed subsequently with primary care colleagues.

Over the same two-year period the service offered to the general practice in town W was of the usual pattern: general practitioners requested appointments or inpatient treatment for their patients by letter or telephone, and patients were seen at hospital outpatient clinics by the consultant psychiatrist and his junior medical staff. Psychological and social work services were available to these psychiatrists but there was no identified team such as that which served practice A.

The data

The information presented in this paper refers to people as well as to episodes. From the case notes it was possible to find out about the patients' age, sex, civil status, whether they were in employment and whether there had been any previous contact with the local psychiatric service. A note was made of the main diagnosis or clinical problem as set out by the specialist in his discharge letter or summary to the general practitioner. The outcome of the referral, whether the patient appeared or not, whether he or she was offered treatment as an inpatient or outpatient and the degree of involvement by psychiatrist, clinical psychologist or social worker were all recorded.

We applied tests of significance to our findings and the results of these are available from the authors. However, we decided to omit them from our published results as our study was primarily descriptive and was based on a relatively small number of patients. We felt that statistical tests would be inappropriate in these circumstances.

Results

Table 1 shows the number of people who were referred as outpatients from the two practices at some time during the two-year period. No differences appeared in relation to sex, age or employment status. Thirty-three per cent from practice A and 50 per cent from practice W had had previous psychiatric contact, but more people from practice A were first-time referrals

Table 1. Characteristics of patients referred during 1975-77 (percentages are given in brackets).

	Practice A	Practice W
Size of population (practice list)	11,191	12,154
Number of patients referred	72	54
Sex		
M	29 *(40)*	26 *(48)*
F	43 *(60)*	28 *(52)*
Age		
60-69	3 *(4)*	3 *(6)*
50-59	12 *(17)*	8 *(15)*
40-49	17 *(23)*	11 *(20)*
30-39	30 *(42)*	23 *(43)*
20-29	10 *(14)*	9 *(16)*
Employed		
M	21 *(72)*	21 *(81)*
F	10 *(23)*	9 *(32)*
Previous psychiatric contact		
No	48 *(67)*	27 *(50)*
Yes	24 *(33)*	27 *(50)*

Table 2. Main diagnosis or problem.

Diagnosis/problem	Practice A n	(per cent)	Practice W n	(per cent)
Psychosis	5	*(7)*	1	*(2)*
Depression	10	*(14)*	8	*(15)*
Neurosis	23	*(32)*	13	*(24)*
Interpersonal/ marital problems	16	*(22)*	14	*(26)*
Social problems	1	*(1)*	0	*(0)*
Alcohol problems	11	*(15)*	9	*(17)*
Sexual problems	3	*(4)*	3	*(5)*
Did not attend	3	*(4)*	6	*(11)*
Total	72	*(99)**	54	*(100)*

*Percentage does not add up to 100 due to rounding.

Table 4. Duration of admission.

	Practice A	Practice W
Total days in hospital	339	587
Average length of stay at each admission	34	23
Average number of days as inpatient	38	36
Diagnostic categories of those 28 days or longer:		
Psychosis*	4	-
Alcoholism/personality disorder	2	9

*3 presenting for first time for treatment.

Table 2 shows the diagnostic categories. No differences were apparent except that during this period three people from practice A presented with a major functional psychosis for the first time.

Table 3 shows admissions. Six from practice A and 12 from practice W chose to be admitted following outpatient contact. Other admissions were emergency direct admissions either direct from the practices or from a casualty department.

Table 4 shows how long the patients spent in hospital. Practice W used substantially more inpatient days, but the average length of stay for each admission was longer for patients from practice A. The average number of days as an inpatient — one, two or more admissions during the two-year period — was the same for both practices. When diagnostic categories were compared, of those who spent 28 days or longer in the hospital admission unit, four from practice A had a major psychosis, three of them presenting for the first time. There were no patients with a major psychosis presenting for inpatient treatment from practice W; all of those admitted from this practice for more than a month were diagnosed as being alcoholic or having a personality disorder.

Table 5 analyses outpatient referrals. Seventy-two people had a total of 78 contacts from practice A and 54 had 63 contacts from practice W. In those instances where there was a single consultation, either the current treatment was supported and the patient was referred back to the practitioner, perhaps with additional suggestions, or alternative treatment was refused or unavailable.

The range of contact during this period shows that 47 per cent of referrals from practice A and 78 per cent from practice W were seen by psychiatrist only. Fifteen per cent from practice A were seen by the psychologist and a social worker only — none from practice W. Finally, 33 per cent from practice A and only 11 per cent from practice W were seen jointly. Overall, 48 per cent from practice A were seen by members of the team, compared with only 11 per cent from the traditional practice.

Discussion

Much psychiatric illness is chronic or recurrent. This is reflected in the overall picture of previous psychiatric contact in the two practices (Table 1) and is in keeping with the nature of psychiatric disorder identified in longitudinal community studies (Cooper *et al.* 1969). The incidence of major psychosis was low, although

Table 3. Inpatient admission during time of study.

	Practice A	Practice W
Total number admitted after outpatient assessment	6	12
Other admissions (direct or from DGH)	3	5
Total number admitted	9	17
Total number of admissions	10	24

Table 5. Outpatient referrals over two-year period.

	Practice A n	(per cent)	Practice W n	(per cent)
Total number of patients referred	72		54	
Total number of outpatient appointments	78		63	
Did not attend	3		6	
Single consultation only	15		13	
Range of specialists seen as outpatient:				
Did not attend	3	*(4)*	6	*(11)*
Psychiatrist only	34	*(47)*	42	*(78)*
Psychologist only	9	*(15)*	—	
Social worker only	2		—	
Psychiatrist + psychologist	7	*(33)*	3	*(11)*
Psychiatrist + social worker	13		3	
Psychologist + social worker	2		—	
All three	2		—	

three new cases of schizophrenia from practice A presented for the first time and required lengthy inpatient assessment.

Although more patients were referred from practice A, where there were closer professional links, those referred from practice W were more likely to have been referred to a psychiatrist on a previous occasion. More of the patients referred in the conventional way were admitted to hospital, and they were more likely to be readmitted and to have a personality disorder. Similar findings have been reported by Fenton and colleagues (1979) and Pullen (1980), and there seems to be no doubt that the presence of domiciliary or community-based support services does lead to a reduction in use of hospital inpatient time.

There was a higher outpatient referral rate from practice A. This reflects the readier availability of other professional colleagues and the opportunities to discuss and decide on a treatment strategy.

No single practitioner, primary care or specialist, or member of the caring professions is able to recognize and manage all the multiple pathology which presents in the community. The specialist team, in establishing itself in a health centre, must not be just geographically more accessible to patients: a vital element must be the interchange between primary and specialist teams in identifying the presenting problems, in devising a management programme and in allocating the necessary time to carry it out. Such an allocation of time makes it possible to discuss ways of coping with emotional behaviour and makes it easier to discuss and decide on specific regimes.

Given the small numbers seen, the variety of diagnostic categories and the multiple problems which presented, it was unlikely that a clear-cut demonstration that a specialist multiprofessional team is clinically more effective would emerge. To a large extent their activities are unquantifiable; they probably reflect the better elements of good domiciliary consultation updated and applied to a multidisciplinary team. Such a service contrasts sharply with many second opinions presently sought within the Health Service, opinions which are often impersonal and do little to foster closer integration between professional colleagues.

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Dementia

Two hundred patients admitted consecutively to the Neuropsychiatric Institute, Sydney, with the provisional diagnosis of dementia were investigated. The diagnosis was confirmed in 164 patients, 16 patients had a chronic organic brain syndrome not characterized by intellectual deterioration and 20 patients had pseudodementing functional illnesses. A potentially reversible cause of the dementia was found in 13 patients: these comprised 11·5 per cent of the demented patients aged 45 to 64 years and 3·8 per cent of the demented patients aged 64 years and older. It is recommended that all patients with a provisional diagnosis of dementia be investigated early in the course of their illness in anticipation of the finding of a reversible dementia or a treatable pseudodementing illness.

Source: Smith, J. S. & Kiloh, L. G. (1981). The investigation of dementia: results in 200 consecutive admissions. *Lancet,* **1**, 824-827.

Visiting in long-stay geriatric wards

A survey of long-stay geriatric and psychogeriatric patients in four East London Area Health Authority hospitals found that only 16 per cent never received any visitors. Forty per cent of the female patients were visited by their children and 12 per cent by the whole family. Only 16 per cent of males were visited by their sons and daughters. The author suggests that it is important for long-stay wards to be easily accessible for visiting.

Source: Gupta, S. (1981). Visiting in long-stay geriatric wards. *Geriatric Medicine,* May, 10.