
What a general practitioner can expect from a consultant psychiatrist

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Psychiatry is a subject which interests some people and repels others

(Watts & Watts, 1994)

There are many similarities in the experience and approach of general practitioners (GPs) and psychiatrists. GPs may spend some time in psychiatric posts before settling down as principals in their own practice, while some psychiatrists are members of both their own College and the Royal College of General Practitioners. Although there is great potential benefit for patients in this symbiotic relationship, GPs and psychiatrists work in different settings that require different techniques and time-scales. The professional work of both specialities has been profoundly affected by the National Health Service (NHS) reorganisation of the early 1990s. GPs have developed new relationships not only with psychiatric colleagues, but also with professionals of other disciplines such as psychologists, social workers and counsellors.

Short consultation times in general practice make classical mental state examination impracticable. The usual approach is problem solving and this may at times focus too narrowly on concrete solutions such as prescription of psychotropic drugs. The psychiatric workload in general practice has increased because of demographic changes; particularly, increased numbers of elderly people with dementia and depression. Also, many more GPs are now involved in caring for HIV-positive patients and patients with AIDS, and encounter the psychological problems related to substance abuse.

The general practice setting

The GP works daily in the front line of the NHS; probably 98% of the whole population makes use of

general practices. Personal and continuing care is provided to patients of all ages, with most practices providing same-day service for any problem that the patient describes as urgent. Except in the inner cities, most GPs live in the same community as their patients, knowing first-hand about local issues affecting patients and often caring for families over three generations (Pereira Gray, 1994). As many as 42% of patients are continuously registered with their GPs for over 20 years or since birth (Ritchie *et al*, 1981). About 10% of all consultations take place at home; home visiting remains important, especially for the elderly. Patients over the age of 75 years have seven contacts per year, on average, with one-half of those taking place in the home.

General practice is the point of first contact for patients. Much of what we know about the psychiatric work of GPs comes from psychiatric research, notably that of Michael Shepherd and his colleagues at the Institute of Psychiatry (Shepherd *et al*, 1966). Large numbers of patients, especially women, turn to their GPs for help with important psychological problems. Between one-fifth and one-quarter of the workload of the average GP involves dealing with mental health problems.

Doctors in general practice vary in their ability to diagnose and to manage psychiatric problems, but all face problems of limited consulting time and the tendency of many patients to present the physical rather than the emotional symptoms of their psychological distress. This 'somatisation' is common (Wright, 1990) and may explain much of the underdiagnosis of psychiatric disorder, particularly in patients who are depressed. This is especially so for patients who also have significant chronic physical illness. It is therefore logical and important for GPs to be proficient in the diagnosis and treatment of both the physical and emotional problems presented by their patients.

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Liaising with general practitioners and sharing care

While specialist services see only a small proportion of the people with psychological problems, the consultant psychiatrist has a key role in supporting the work of GPs both directly, by advising on individual patients, and by contributing to continuing education and the development and auditing of primary care services. Particularly appreciated by GPs is personal contact with a consultant psychiatric colleague, either face-to-face or by telephone. This discussion often uncovers the 'hidden agenda' of the GP's problem with his or her patient, which can be difficult to detail adequately in a letter.

The traditional relationship

Formerly, primary and secondary psychiatric care for patients were clearly separated, with communication being almost exclusively between the doctors, usually by the referral letter, and seldom involving other members of the primary or secondary care teams. Doctors met during domiciliary consultations but the practice of joint visits has now almost disappeared (Sutherby *et al*, 1992). Both GPs and psychiatrists have found problems with the traditional relationship (see Box 1); poor communication has caused particular difficulty (Pullen & Yellowlees, 1985). Problems for GPs have included the geographical distance to the hospital, differences in philosophy of care, and conflicts caused by the hierarchical specialist-generalist relationship (Horder, 1988). General practitioners have complained of long waiting lists and lack of clarity about management, with too few in-patients discharged back to primary care. Primary care teams often feel that they have insufficient facilities for direct referral to specialists and too little contact with other mental health professionals, although there may not be any clear understanding within primary care of their respective roles. On the other hand, concern has been expressed that the primary care team should be strengthened in its role rather than de-skilled by too-easy referral.

Liaison psychiatry

Over the past few decades there have been rapid changes in general practice and psychiatry. Single-handed general practice is now relatively rare. The primary health care team has evolved and, in the

Box 1. Perceived problems with traditional care

Geographical remoteness of mental hospitals
 Poor communication
 Lack of clarity about management
 Little to offer patients with chronic neuroses and personality disorders
 Long waiting lists, problems with urgent referrals
 Too little contact with other mental health professionals (community psychiatric nurses, psychologists)
 Too few patients discharged back to general practice care

larger health centres, sessional attachment of other professionals including nurses, psychologists and counsellors is common. Psychiatrists are able to offer a growing range of treatments including behavioural, cognitive, family and marital therapies in addition to improved drug treatments. Psychiatrists have responded to these changes by devolving some of their work from hospital settings and offering consultation facilities in primary care. This has been largely pragmatic and due to individual activity rather than following any specific theory. One-half of all Scottish psychiatrists and a somewhat lower proportion in England and Wales work in this way (Pullen & Yellowlees, 1988). The clinics are organised in different ways and the 'shifted out-patient' model of psychiatric consultation is popular. Here the psychiatrist sees patients in the local surgery to provide crisis intervention, assessment and short-term treatment. Some GPs prefer an assessment to be made jointly, with treatment being integrated between primary and secondary care teams.

Many GPs, including myself, have found benefit from these arrangements including increased professional satisfaction. Some of the advantages from better communication are listed in Box 2.

Shared care

The report of the Joint Royal College Working Group on Shared Care (Royal College of Psychiatrists and Royal College of General Practitioners, 1993) provides a useful consensus in several areas. The consensus covers the psychiatric consultation in general practice, the shared care of elderly patients with mental illness, patients with depression, chronic psychoses and individuals with learning difficulties.

Box 2. Some benefits from consultation clinics in primary care

Mutual support

Contain clinical problems, if they cannot be solved
Relieve pressure of 'heartsink' patients
Discuss handling of difficult consultations
More fruitful direct telephone contacts
Better crisis intervention

Better use of the referral system

Make best use of the time of both professionals
Share information on availability of resources
Discuss appropriateness of referrals and shared care arrangements
Make clear who is ultimately responsible for the patient

Education

Pupil-teacher relationship not appropriate but the psychiatrist's way of conceptualising problems is helpful
Developing a more systematic approach to psychological problems
Problems can be mutually educative

Recommendations include the consensus view that catchment areas for psychiatric services should be based on general practice populations, rather than administrative boundaries, and that psychiatric teams should be linked with primary care services. Closer integration of training and continuing medical education for both psychiatrists and GPs is recommended, as is the joint audit of the care of mentally ill people.

A recent report of an NHS Scottish Working Group on Mental Illness (1996) reviewed the roles and responsibilities of psychiatry and of general practice for patients in the community. It recommends a locally coordinated approach to the delivery of community care by primary care teams and GPs. Mental illness services are asked:

to clarify for the primary care team the framework and resources that may reasonably be provided by the community mental health team in order to provide effective care in the community.

Referral to a psychiatrist

Referring doctors are less concerned with whether something is wrong than to know exactly what the

problem is and how to deal with it. The selection of cases for referral is strongly influenced by non-clinical factors such as social problems, unsocial behaviour and pressure from the patient or relatives. Men, young people and the unmarried are more often referred. The very groups at risk of developing chronic conditions, such as women and the elderly, are less likely to be referred for specialist care. Goldberg & Jackson (1992) consider the referral rate too low, attributing this partly to stigma and partly because GPs consider that the psychiatric service offers treatments with little relevance to the problems of patients in primary care.

There is a great need for discussion and negotiation between psychiatrists and GPs locally to ensure appropriate referral in the interests of optimal patient care coupled with the best use of increasingly scarce resources. GPs make more referrals at the patient's behest or because they require assistance with management than because of diagnostic uncertainty, although much depends on the skill and interest of the individual practitioner. Daily practice involves listening to patient's tales of their world and misfortunes. Many of their emotional problems fall short of frank mental disorder and can be managed in less specialised ways. There are also dangers in labelling people with entrenched social and psychological problems as mentally ill. Referring patients with uncomplicated grief may increase the patient's sense of abandonment and resentment and thus be counterproductive (King, 1992).

Most GPs are disappointed with psychiatric treatments for patients with personality or character disorders, who can be very difficult to manage. Although such treatments are in their infancy, many psychiatrists provide long-term, low-key support that is invaluable to the GP. As many of these patients have comorbidity such as mood disorders, substance abuse or sexual difficulties, referral for psychiatric assessment may be particularly pertinent.

In addition to the traditional out-patient consultation many GPs appreciate 'one-off' assessment in emergency situations, and advice on patients not seen directly by the psychiatrist.

Communication between general practitioners and psychiatrists

The quality of care that patients receive is dependent on the quality of the communication between GPs and psychiatrists. Clearly, the

information that psychiatrists require from GPs is different from the information GPs require from psychiatrists. Most formal communication is by letter but telephone contacts are also important as are the impromptu discussions that have become more common as psychiatrists set up consulting sessions in GP's surgeries and health centres.

Referral letters and psychiatrists' replies

Pullen & Yellowlees (1985) have listed the main information needed by the psychiatrist to be included in the GP's referral letter, and Blaney & Pullen (1989) have investigated the preferred format of referral letters.

Information needed by the psychiatrist

- (1) The reason for referral.
- (2) Is the psychiatrist asked for an opinion and advice only, to provide joint care or to take over completely?
- (3) The main symptoms or problems.
- (4) The GP's working diagnosis.
- (5) The past psychiatric history, if any.
- (6) The family history.
- (7) The medication prescribed so far by the GP.

It is clearly important that the GP provides all the relevant information that cannot be obtained directly from the patient, or information that the patient may not volunteer.

The information most needed by the general practitioner

- (1) The psychiatrist's provisional diagnosis.
- (2) Explanation of the patient's condition including what the patient has been told.
- (3) Assessment of suicide risk, where this is appropriate.
- (4) Treatment recommended or arranged.
- (5) Follow-up arrangements, if any.
- (6) Prognosis, if possible.

In the past few years there have been very rapid changes in psychiatric treatments and in the arrangements for delivery of care to patients with mental health problems. New 'community mental health teams' have appeared and 'case management' has become a technical term. GPs are faced with a variety of health care providers and now have direct contact with mental health professionals, such as psychologists and other therapists, previously accessed through the consultant psychiatric service. Referring GPs may welcome

more detailed information on what the psychiatrist is offering or advising. This is particularly so if there is a question of psychotherapy, cognitive-behavioural therapy, other psychological therapies or, especially, counselling.

Prasher *et al* (1992), studying communication between GPs and psychiatrists, found that GPs prefer letters from psychiatrists that are one page in length and have only two or three subheadings, but psychiatrists appear to prefer to write longer letters which follow the Institute of Psychiatry guidelines. Psychiatrists' letters varied from a minimum of A4 length to a maximum of three sides of A4. The average length was one and three-quarter sides of A4 paper, with 50% of letters containing subheadings. Disappointingly, prognosis was infrequently discussed in these psychiatrists' letters, although it is understandable that the psychiatrists may have been reluctant to give a prognosis after only one interview with the patient. Of the recommendations contained in the psychiatrists' letters, 75% were followed fully. Clearly, it is the content of the psychiatrist's letter that is important rather than primarily its length. A personal reply from the consultant specifically answering the points raised in the referral letter is much appreciated.

When a patient has been discharged from in-patient care it is vital for the GP to receive basic information quickly. This must include accurate details of drugs prescribed and when a particular drug should be stopped, if it is meant to be short-term. It is particularly irritating to have a patient, or a relative, arrive at the surgery and the GP to have no knowledge of the discharge and no information on the drugs which should be prescribed. Such situations also dent the patient's confidence in his or her medical advisers. When a discharge report eventually arrives it is more important that it is informative than comprehensive. A lengthy photocopy of the ward notes is of little immediate value to the GP, especially if there is no personalised letter.

General practitioner attitudes to community psychiatry and the community mental health team

Changing relationships

Ferguson & Varnam (1994) draw attention to the spontaneous but piecemeal development of a symbiotic relationship between many GPs and psychiatrists over the past two decades. The recent reforms of the NHS have accelerated change. The separation of purchaser and provider functions is

now having a notable effect on the relationship between the two disciplines. Fund-holding practices are able to have a strong influence on the nature of the specialist services delivered to their patients. Also, GPs have developed new relationships with other mental health professionals such as psychologists and community psychiatric nurses (CPNs). Referral to experienced counsellors or social work agencies may be considered a useful alternative to traditional approaches.

The new community mental health teams

New community mental health teams have been based in primary care, sometimes in close liaison with GPs (Burns *et al*, 1993a,b). However, some GPs are unclear about the roles of mental health professionals working in the teams and how the existence of these teams affects the traditional relationship between GP and psychiatrist. Confusion can also arise for GPs between the practice-based primary health care team, in which there may work a psychologist, counsellor or CPN, and the similarly named service run exclusively by mental health professionals. Speaking or writing simply of 'the team' can thus be confusing for a mixed audience.

Of particular concern for GPs is knowing which member of the community mental health team has responsibility for their patient at any particular time. GPs need to know about what is happening to their patients and who is seeing them. If the patient has been referred to a consultant leader of a team, a reply is expected from that individual. It may make good clinical sense for the patient to be followed-up or treated by another member of the community mental health team but this must be explicit, particularly if the consultant has not arranged to review the patient personally.

Some psychiatrists may worry that providing new community mental health teams will increase the number of patients referred with relatively mild psychiatric disorders at the cost of less time for patients with serious disorders. GPs may in turn be concerned that diversion of resources in this way may weaken emergency service response, which may already be far from ideal. Similarly, at a time of drastic reduction in the number of in-patient beds, there is widespread anxiety that the best achievable community services can never be comprehensive. There is a bedrock of seriously ill patients who will always need asylum and in-patient care.

The experience of Jackson *et al* (1993) in south Manchester suggests that many more patients with depression may be referred to the new community mental health teams, as well as more patients with long-term illness. Provision of a new community mental health team based in primary care resulted

in an increase, by a factor of four, in the rate of the new referrals with depressive illness and also an increase in the referral of patients with psychotic illnesses, almost all of whom had active psychotic symptoms on referral. This suggests that the team was extending the availability of specialist care to patients in the community with severe mental illness who would previously not have received care from mental health services.

Although the referral rate for minor and neurotic illness will inevitably increase, it must be remembered that patients with neurotic disorder and personality problems occupy a substantial proportion of the GP's consulting time, so that the ready availability of specialist advice and help in the management of these patients should eventually be cost-effective. Jackson *et al* (1993) also found that the new service based in primary care saw more women than the traditional service, suggesting that the availability of such a team has reduced the barrier to care for distressed women. Interestingly, no difference in the use of in-patient facilities in the index and control populations was found.

Many GPs would welcome closer working relationships with CPNs, as much for their skills in non-drug therapy for depressed patients as for their expertise in administering neuroleptics and following-up patients with schizophrenia. There does not appear, however, to be a consensus on how their workloads are defined or how their work is supervised or monitored (Strathdee, 1990). Although GPs may see CPNs as useful therapists for depressed patients, the evidence to date, from a large randomised controlled trial, is that they are ineffective and very expensive in this role (Gournay & Brooking, 1994).

Out-of-hours service and crisis intervention

Most GPs are prepared to manage even quite difficult patients with long-term severe mental illness, provided that emergency assistance can be provided promptly and preferably on a 24-hour basis. Direct telephone contact with the consultant psychiatrist is not always easy and it is not uncommon for GPs to find fault with the emergency services. GPs appreciate knowing the preferred method of contact for the primary care team and who can arrange an emergency admission when it is warranted. What arrangements, for example, should be made by both the primary and secondary teams for the acute crisis that invariably presents on Friday afternoons, when everybody appears to be going away for the weekend?

A recent development that will make good lines of communication even more important is that of GP cooperatives to handle out-of-hours calls. Instead

of individual GPs covering frequently for their own and perhaps their partner's patients, they may work intensively, covering relatively large patient populations for a relatively short time. The number of both GPs and mental health professionals involved may therefore be large, making personal contact about a patient more difficult to achieve.

Attitudes of GPs to community psychiatry

The attitudes of English GPs to developments in community psychiatry were assessed by Stansfeld (1991). GPs were asked how community psychiatric services should be developed in a questionnaire survey that received an impressive 100% response. A closer working relationship was favoured by GPs, with 87% wanting closer liaison with psychiatrists about out-patients and 72% wanting psychiatrists to visit general practice to carry out 'one-off' assessments. For psychiatric assessments, 56% would prefer an assessment with short-term rather than long-term psychiatric follow-up (22%). CPNs were popular, with 94% of GPs preferring direct access to CPNs rather than access through a psychiatrist. All GPs who did not have access to a CPN wanted access; CPNs were expected to see patients with depression as well as those with schizophrenia or problems related to alcohol or drug-taking.

The psychiatrist's role in education

The rapid changes in both psychiatry and general practice since the 1960s have been reflected in changing needs in education both for trainee registrars and for experienced practitioners. Didactic lectures by specialists are now much less favoured than seminars to share knowledge and clinical experience. Much use is made of small group work in both registrar training and continuing education for experienced principals. Particular interest is often expressed in discussing issues in management or in arranging an assessment or therapy by the most appropriate member of the mental health team. All GP respondents to a survey in Harlow (Stansfeld, 1991) said they would attend periodic seminars on community psychiatry. Seminars were later set up locally and were well attended.

Formerly, GPs had few options available to treat patients with psychological problems other than a limited number of drugs or referral to the hospital-based specialist. The one occasion for face-to-face contact and learning was the domiciliary visit, although these visits were necessarily infrequent.

Psychiatry now has a growing range of treatment possibilities such as improved psychopharmacology and behavioural and cognitive therapy, together with family, marital and other psychotherapeutic interventions.

Needs of individual practitioners

In this new environment the educational needs of individual practitioners are much changed and much more varied. GPs can best be supported by help with interview technique and the recognition of early symptoms, signs and life events most likely to contribute to illness (Horder, 1988). When the psychiatrist consults from a large health centre or clinic, some GPs may ask for liaison time to discuss their cases, using traditional psychodynamic approaches. Others may request specific pharmacological advice or assistance in obtaining tertiary services.

Increasingly, the educational role of the psychiatrist in the community is seen as offering support for GPs and the primary health care team: providing training in skills, clear guidelines for management, being available for one-off assessments and continuing advice, and, possibly, making resources available for the GP to use, such as self-help and information materials for patients.

Some issues in community psychiatric care

While much progress has been made in improving the care of patients with mental illness, important questions remain. There are thus abundant opportunities for collaboration between individual clinicians in psychiatry and general practice (Wright, 1991). Some practical questions remain largely unanswered (Wilkinson & Wright, 1994). What are the effects of illness-labelling in general practice? What is the best way to manage patients with a somatic presentation of a psychiatric illness?

We also need to know which groups of patients are most appropriately treated by which speciality and in what setting. Are most people with neurotic illness best seen by counsellors, psychologists, nurse therapists, or other practitioners employed by GPs and working in primary care, rather than by consultant psychiatrists? At present about 90% of all patients with mental health problems are managed in general practice without referral. A substantial increase in referrals would be likely to swamp specialist psychiatric services and would

certainly be an inappropriate use of scarce specialist expertise. Nevertheless, the community care, for example, of patients with depression is less than ideal and many patients who could benefit from treatment are not recognised by the doctor.

Rather than increasing the number of health professionals working in general practices, it may be more appropriate to help GPs to develop brief therapy skills. For example Bashir *et al* (1994) have published a controlled trial showing that minimal intervention by GPs can be effective in assisting withdrawal in chronic users of benzodiazepines.

The influence of primary care in shaping secondary services is likely to increase, especially as a result of the purchaser/provider split and the development of GP fund-holding. General practice provides personal, long-term, low-technology care for patients with mental health problems. Psychiatry has much to offer by helping GPs to apply a more systematic approach to this important aspect of their work. Clinical audit of patient care is essential for both disciplines, particularly at the interface of primary and secondary care where there is scope for fruitful cooperation.

Ideal services offering immediate access to a specialist opinion, personal contact with a senior psychiatrist, the assessment of patients in their own homes when necessary and the provision of a crisis intervention team (Strathdee, 1990) cannot be easy to achieve with finite resources. The essential ingredient in providing optimal patient care is continuing personal contact between the psychiatrist and the GP, not only in clinical work, but also in the organisation of care and in continuing medical education for both specialities.

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Multiple choice questions

- The following are preferred by GPs for continuing medical education on psychiatry:
 - didactic lectures on common disorders
 - seminars on community psychiatry
 - tuition on the use of psychiatric diagnostic classifications
 - training in communication skills and recognition skills
 - depression management.

2. The following are generally true of GP referrals to a psychiatrist:
- women and the elderly are more likely to be referred
 - most referrals are because of diagnostic uncertainty
 - referral is strongly influenced by non-clinical factors such as unsocial behaviour by the patient
 - it is usually beneficial to refer patients with uncomplicated grief for psychotherapy
 - GPs appreciate some relief of the pressure from 'heartsink' patients.
3. GPs urgently need the following information when a patient is discharged from hospital:
- treatment/follow-up arranged
 - an accurate DSM-IV diagnosis
 - what the patient has been told
 - a photocopy of the ward notes
 - prognosis if possible.
4. The Joint College Working Group on shared care recommended:
- community psychiatric services should be based on administrative boundaries
 - management guidelines for eating disorders
 - joint audit of the care of the mentally ill
 - separate continuing education for psychiatrists and GPs
 - attachment of CPNs to practices to treat depressed patients.
5. The following are true:
- 30% of all general practitioner consultations take place in the patient's home
 - liaison psychiatry has flourished largely because detailed pre-defined theoretical models were available
 - GPs would like direct access to CPNs for the treatment of depression
 - a recent, large, randomised, controlled trial concluded that interventions by CPNs with patients with depression, anxiety and non-psychotic problems were both ineffective and very expensive
 - GPs need to know which member of the community mental health team has responsibility for their patient at any particular time.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a F
b T	b F	b F	b F	b F
c F	c T	c T	c T	c T
d T	d F	d F	d F	d T
e T	e T	e T	e F	e T