Psychiatrists and General Practitioners

The Working Relationship

The Annual General Meeting of the Royal College of Psychiatrists' Section for Social and Community Psychiatry was held on 20 February 1987 at the Royal College of Physicians. The associated Scientific Meeting was organised jointly by the College and the Royal College of General Practitioners; its focus was the working relationship between psychiatrists and GPs.

The morning session was chaired by Professor Eugene Paykel. In talking about 'Primary Care, Secondary Gain', Professor Paul Freeling examined the secondary gains for GPs and psychiatrists which arose out of working together, and stressed that whatever our motivations, conscious or otherwise, we could justify these secondary gains only if ultimately there was benefit to both doctors and their patients. In the area of mental health which does not involve high technology, human relationships were central and he examined the dimensions of the GP/psychiatrist's relationship using the mnemonic SPEAKING: setting the scene for working together, the participants and their characteristics, the ends of the relationship, the act sequence and how this can be distorted by secondary gains, the key or mood of the relationship, the instruments of communication in the relationship, the norms, or expectations and beliefs of the participants, and the genre or basic style of the interactions within the relationship. Freeling concluded by asking to what extent family doctors were trained to work in this way with psychiatrists, and felt that the traditional values of the second opinion would be lost if the distinction between psychiatrist and family doctor were somehow blurred in a too close and undifferentiated relationship. In discussion, attention was drawn to the importance of consulting with other members of the primary health care team, referral to the clinical psychologists of demanding patients who are difficult to be with (a good example of secondary gain for the referrers!) and the need to confront aggressive patients with limits to their unacceptable behaviour, which should be taken for what it was and not converted into something psychiatric.

In the second paper, 'Training Courses for GPs in Mental Health Skills', Professor David Goldberg contrasted two 10 year periods in his own work of training family doctors for psychiatric work in the context of general practice. In the first decade (the early days of postgraduate training) he was struck by the irrelevance to general practice of much of the content of training schemes, which was corrected in the second decade by the use of video feedback in modifying the doctor's interviewing behaviour. This was vital to the accuracy of what the doctor perceived, of what he used in both diagnostic formulation and treatment planning. GP study days in Manchester are now organised around the use of video of problem-orientated patient interviewing with topic lectures, case conferences and small and large group discussions. Patients giving a positive GHQ score for psychiatric morbidity are used to determine the clinical problem, the patient's motivation in seeking medical help, the patient's capacity for change and the establishment of mutually agreed plans for action.

Emphasis is on awareness of verbal and non-verbal cues, detection of covert psychiatric factors, letting the patient provide the cues to the diagnosis, and the fiscal implications of differing clinical decisions. (Examples of these training videotapes could be obtained from Tavistock Publications.) In discussion, issues of the patient's consent to being videoed, the stage in medical training when this use of video was most relevant, and the content of the psychiatric component of vocational training schemes in general practice were raised.

The final paper of the session, 'Psychiatric Liaison Schemes in Primary Care Settings: the GP Viewpoint' was given by Dr Geraldine Strathdee of the General Practice Research Unit of the Institute of Psychiatry. Dr Strathdee summarised the findings of the 1982 survey undertaken into the different ways in which psychiatrists worked with GPs in primary health care settings, and referred to the follow-up study of GP reactions to the service provided for them. They reported dislike of long-term care of the patient being taken over by the psychiatrists. Rather, they preferred schemes whereby there was help in a crisis and the psychiatrist assisted in assessment, but ongoing care was the responsibility of the GP or where a clear decision on shared care was made. Both psychiatrists and GPs reported advantages of working in this way—better care of patients, better communication between the doctors, easier referrals and clarification of the most appropriate referrals, as well as an increased knowedge of diagnosis and treatment possibilities both for the psychiatrist and GP. Disadvantages related mainly to practical issues of administration, availability of rooms, access to secretarial help, costing and sectorisation disputes. Such schemes required careful evaluation in terms of their own efficiency, but also for their effect on the priority of patients seen and on referrals to available psychiatric out-patient clinics. In discussion, questions were raised as to who should prescribe for the patient—the GP or the psychiatrist, and whether hospital FP(10) could be used for this purpose. There were difficulties in relating to the single-handed GP compared to group practices. There was a danger of the psychiatrist isolating himself from other members of the mental health team. And, just as GPs now had training in psychiatry, was it not now appropriate for psychiatrists to have some experience of general practice?

The afternoon session, chaired by Dr John Horder consisted of a series of briefer papers directed towards the practical issues raised by psychiatrists and GPs working together.

Dr Ross Mitchell described the five styles or models of attachment liaison schemes: the out-patient model, the selected consultation model, the modified 'Balint' model, the tripartite consultation model and the joint team consultation model. He then introduced his colleague, Dr Ian Wallace, who described the effect on a group partnership of the psychiatrist visiting the medical centre for two hours a month, when GP/patient relationship problems and the problems of patient management were discussed. The confidence gained in sharing doubts about how to respond to difficult patients, resulted in better management and the evolution of clear policies for dealing with mental health issues. The confidence that was built up between GP and psychiatrist allowed them to survive a painful confrontation about responsibility for the care of a particular patient, and allowed them to be more open to looking at their own feelings about each other and the patients; this in turn led to further confidence and acquisition of new skills in coping with unclear clinical situations.

Drs Sandy Brown, John Owen and John Jones described the benefits of an attachment of a psychiatric trainee to a health centre. Dr Brown as consultant had prepared the way initially, and thereafter 11 trainees (both at Registrar and Senior Registrar level) had each spent one session a week in the health centre over a period of six months. Dr Owen had canvassed the views of four other trainees who in addition to himself had worked in this attachment, and all agreed that this had been a popular slot in the training scheme. It gave them experience of working close to the primary health care team. They appreciated the face to face contact and felt that this led to more flexible referral practice. Operating away from the consultant (but under his long-term supervision) allowed them to develop a confidence derived from their autonomy. Dr Jones reminded the meeting that GPs interact with consultants other than psychiatrists, and that although some 90% of the population consult their family doctor, only some 0.5% ultimately see a psychiatrist. Nevertheless, given the relatively small numbers concerned, the health centre staff gave their unqualified support to this attachment, particularly as it reminded the trainee psychiatrists of something well known to GPs, namely the impact on the family of a psychiatric patient, and the need for the doctor to respond to their anxieties.

Professor John Cooper discussed the difficult issues around 'Sectorisation and the Freedom to Refer'. He described what is variously called extra-mural psychiatry, community psychiatry, neighbourhood psychiatry and locality psychiatry. In Nottingham nearly all the psychiatric consultants are involved in GP work through the area catchment scheme whereby clinical teams relate to particular sectors. This results in the restriction of admission of patients from a particular sector to a particular ward. This was necessary for the statutory requirements of compulsory admission under the Mental Health Act. This arrangement benefits psychiatrists through the sharing of the load of difficult and demanding patients. Assessing people at home via the domiciliary consultation scheme involved travel but led to increased professional satisfaction. Against this GPs, although agreeing that the scheme gave them a better service, felt they had to defend their right of freedom to refer to the consultant of choice. However, in practice, no sectorisation scheme can be or ought to be rigidly enforced; some 70 to 80% of patients from a given sector are seen by that sector team, so there is a margin for 'cross-referral'. A difficult issue is whether sectorisation should be based on social services boundaries or upon GP surgeries. Whichever is chosen, the psychiatrist can get to know a particular locality only by going there himself.

Drs Francis Creed and Bernard Marks then asked 'Working together: what really goes on?' Dr Creed described his contact with two health centres in which the shifted out-patient model was used combined with case discussion with the GPs, including joint home visits. Dr Creed expressed doubts about the declared effect of a shift out-patient model on the level of referrals to the psychiatric out-patient department, namely that it reduced the number of referrals, and also reduced the number of subsequent in-patient admissions. The effect of the use of other aspects of the psychiatric service, for example the day hospital, had to be taken into consideration as well. He thought, however, that work in the health centre allowed the psychiatrist to help chronic patients who had dropped out of care. He also challenged the idea that psychiatrists working in primary care saw only minor psychiatric morbidity. Finally, he indicated certain problems: psychiatrists are not invited to health centres where most good could be done; it is difficult for the psychiatrist to advise GPs without some idea of their skills and their priorities: and if more psychiatrists were going to work in this way, they would need training to do so. Dr Marks spoke of the problems of working in deprived inner City areas. If liaison schemes were to work, they should benefit both patients and the primary health care team. There had to be clear referral criteria for selecting patients to be seen by the psychiatrist. He stressed the value of clinical discussion, both for organising patient care and for professional education. There was a need for trust to develop a setting in which sensitive issues could be discussed, not only with the doctors, but also with the other staff of the primary health care team.

Dr Ian Pullen gave the final paper entitled 'Patterns of Communication between Psychiatrists and GPs.' Having been a GP himself he fully understood the frustrations derived from not having effective communication between GPs and specialists in both directions. He reviewed research into the desirable nature and content of correspondence between them. The psychiatrist wished to be told about medication, presenting symptoms, special background information known to the GP, the reason for referral, and any past psychiatric history. GPs wished to be told the diagnosis, the treatment recommended, arrangements for follow-up and the prognosis. Apart from content, there were questions to be answered about overall length, format and style. Dr Pullen indicated that GPs preferred reports to be no more than two pages, and of a size to fit into the

patient's record envelope. Otherwise, GPs would edit reports by the judicious use of scissors and the wastepaper basket!

There then followed a general discussion in which the following topics were raised:

the place of community mental health centres (in the UK, as opposed to the perjorative experience of this terminology in the USA);
the place of other agencies in primary health care consultation, for example social workers, voluntary agencies and housing departments;
the most effective use of resources, with doubts whether the needs of the chronically ill and the severely acutely ill were best served by such liaisons;
the problem of relating to the single-handed GPs possibly by seeing patients from a number of individual GPs in one central location;
the need to evaluate existing schemes, and to determine the different profiles of patients seen in GP settings, in psychiatric outpatient departments, and in community mental health centres;
a reminder that while GPs see most of the less mentally disordered, psychiatrists in turn see most of the very disturbed;
the independent practitioner status claimed by nurse therapists who want to work directly with GPs who in turn may not welcome this.

Dr John Horder in his closing remarks asked three questions:

(i) Will this style of working spread, and if so what new forms might it take?

(ii) Who will evaluate existing schemes, before there is an explosive 'take-off' in new directions?

(iii) Do psychiatrists appreciate how much they can be valued both as teachers and as supporters when working in GP settings?

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Mental Handicap Nurses—Training in Psychiatric Aspects of Care

Section for the Psychiatry of Mental Handicap

Changing patterns of care for the mentally handicapped are having a profound effect on the roles of all professions concerned—not the least mental handicap nurses. Many will continue their caring role in the community. Others will work as community mental handicap nurses providing domiciliary support to families and local authority services. Those remaining in the hospital service will be increasingly concerned with the care of the psychiatrically ill and behaviourally disturbed, the profoundly and multiply handicapped and the elderly. This has important implications for training nursing staff both at present and in the future.

In the long term the NHS will have a continuing responsibility to provide a service for mentally handicapped people who develop psychiatric illnesses or exhibit severe behavioural problems and certain mentally handicapped offenders. Recent epidemiological studies indicate that between 40% and 50% of mentally handicapped adults and children suffer superadded psychiatric disorder. A specialised service is required because of the unique features attending the occurrence, nature, diagnosis and treatment of psychiatric disorder in mentally handicapped people, organised and staffed by appropriately trained and experienced doctors, nurses and other staff who have a wide knowledge of the general field of mental handicap. Specialised psychiatric units for the mentally handicapped are increasingly being developed within mental handicap services throughout the country.

Nurses working in these services should have a primary training in mental handicap with experience and possibly accreditation in psychiatric nursing. Nurses with a primary qualification in psychiatry and additional training in mental handicap would also be acceptable.

The Section is concerned that these changes in mental handicap nursing practice are not adequately reflected in current nurse training syllabuses at both basic and post-basic levels. Indeed the amount of time devoted to the medical and psychiatric aspects of care of the mentally handicapped has been increasingly eroded over recent years with the result that nurses are inadequately equipped to care for the profoundly and multiply handicapped and those with psychiatric disorder who are forming an increasing proportion of hospital patients.

We recommend:

(1) That the current *basic training* syllabus should include, preferably in the third year, a module of training in psychiatric aspects of care which should include practical experience within a specialist psychiatric unit for the mentally handicapped.

(2) The establishment of *in-service training* courses, including practical experience, in psychiatric aspects of the

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