

General practitioner involvement in a group home

Tony Kendrick

This paper describes the experience of a general practitioner employed to provide physical care to 12 highly dependent residents of a group home. In the first year after their discharge from hospital the residents required a mean of 15 contacts each, 90% of which occurred during regular twice-weekly visits to the home. Previously unmet needs for physical care were identified on screening, including visual, dental and footcare problems which were usually correctable. Smoking and obesity were common and resistant to intervention. Shared care policies are described which were developed together with the nursing staff and visiting mental health professionals.

Many long-term mentally ill people now live in staffed group homes in the community. General practitioners (GPs) should ideally provide their primary medical care. However, there are potential problems to be overcome.

First, a GP who takes on all of the residents of a group home faces a significant workload. The long-term mentally ill suffer increased cardiovascular and respiratory problems (Allebeck, 1989) and are often demanding of a GP's time. Horder (1990) surveyed three staffed hostels in north London. Two of the three had difficulty finding practices willing to take on the residents, who were subsequently registered with a number of different GPs. In these two homes visiting psychiatrists provided some care for physical problems. Despite this, the residents made frequent demands on their GPs, with consultation rates two to three times higher than average.

The second potential problem is poor communication between the hostel staff and the practice. Horder found that staff had concerns about medical cover, particularly out-of-hours, and wanted clear policies to cover psychiatric and physical emergencies as well as minor physical problems. Having separate records for psychiatric and physical care was a potential source of confusion and duplication of effort. The GP notes were usually kept at the practice and were not available to the psychiatrist, or to other GPs who might be called out-of-hours. She suggested each resident should have a record kept in the home, available to all staff.

Allen (1992) interviewed hostel staff in Gloucester, and the GPs who looked after their residents. The staff felt the GPs could improve the accuracy of their prescribing and be more welcoming to the residents. The staff wanted meetings with GPs, receptionists and practice nurses to discuss roles and expectations. The GPs wanted long-life drug charts in the homes, with prescriptions ordered regularly rather than on an ad-hoc basis. They also welcomed the idea of meetings with staff.

Horder recommended that all the residents of a group home should be registered with a single GP, in order to develop consistent management policies together with the staff. She suggested that extra remuneration might be provided for such work, which is additional to the general medical services covered by capitation fees and other allowances.

I am the GP for 12 residents of a high-dependency group home in my practice area. The residents present many behavioural problems and have spent many years in and out of psychiatric hospitals. Previous attempts to discharge them had failed, including in some cases placements in less well staffed community homes. The home has qualified mental health nursing staff on duty 24 hours a day plus visiting psychiatrists, a psychologist, social worker, and occupational therapist. I accept the registration of all the residents and provide general medical services. My partners cover my absence in the usual way. In addition to this, I am employed as a clinical assistant for a number of extra duties, including developing policies for shared care with the specialist team.

This paper describes the GP workload in the first 12 months of the life of the home, after the residents were discharged from hospital in early 1993; the residents' physical needs, including unmet needs revealed by screening; and shared care policies which have been developed.

The study

To measure workload, I examined the residents' GP case-notes and extracted data on the

frequency and nature of their GP contacts in the 12 months after their discharge from hospital.

To assess needs for physical care, I screened the residents within the first two months after hospital discharge, with a standardised medical assessment including a full physical examination, urinalysis, full blood count, thyroid function test and chest x-ray. Other tests were performed if they were indicated.

Management policies were developed with the staff both informally, as problems arose, and more formally in the weekly multidisciplinary team meetings. The areas covered were incorporated into a contract between the practice and the community unit managers.

Findings

Workload

The average annual consultation rate was 15.3 (range 4–46), compared to an average rate of 2.9 (range 0–18) among a random sample of 100 adults in our practice. Most of the residents could not be relied upon to get themselves to the surgery (two miles away, with no easy public transport) and over 90% of the contacts took place during my regular twice-weekly visits to the home. There were eight out-of-hours visits in the 12 months.

Physical problems

Nine of the 12 residents smoked, in each case more than 20 cigarettes per day. Attempts to persuade them to stop, including offering nicotine replacement therapy, were universally unsuccessful. Four were obese (defined as a body weight more than 10% over desired weight) which seemed at least in part to be due to the side-effects of neuroleptic and antidepressant medication, which could not be stopped safely. Six residents had neglected foot problems requiring chiropody, which significantly improved the mobility of two. Four were found to have reduced visual acuity, one of whom had not previously been provided with spectacles. Six were found to be in need of dental treatment.

Table 1 shows that a high proportion of the other physical problems found were either previously unrecognised or in need of further treatment. It also shows some of the difficulties encountered in providing care.

Shared care

The following areas were addressed:

Division of responsibility between GP and psychiatric staff. An experienced psychiatrist visited the home three times a week. In addition, during the

day the local psychiatric unit staff were available for any psychiatric emergencies. Out-of-hours, the duty GP was called initially, for psychiatric as well as physical problems. The local in-patient psychiatric unit agreed to admit patients urgently who could not be managed in the home.

The ordering, storage and administration of drugs. The psychiatric staff remained responsible for the prescription of psychotropic drugs, while I prescribed for physical problems. Regular repeat prescriptions were provided in synchronised two-monthly batches of FP10s. In addition I wrote up the drugs on the home's prescription charts.

Equipment needed for physical care to be provided in the home. This included a stethoscope, sphygmomanometer, auroscope and ophthalmoscope, scales, urine testing sticks, urine and blood specimen bottles, syringes, needles, swabs and request forms.

General medical records to be kept in the home. Each patient's problems were recorded on a summary card which was placed prominently in the front of the medical record. This is to be replaced annually. The card enables any GP called to the home out-of-hours to grasp quickly the patient's past history and main problems.

Availability to speak to residents' relatives. Relatives were seen at my regular twice-weekly visits to the home, and could telephone me at my surgery at prearranged times.

Comment

This study confirms that providing good quality GP care to a group home can be very time-consuming. It demonstrates some of the advantages of having a single GP primarily responsible for all the residents, and some of the issues which should be addressed in order to share care appropriately. The model of care described, with regular visits by a single GP, is particularly suited to very dependent residents who cannot be relied upon to attend surgery premises, and who need a high level of continuity of care. It is not the only possible model, however. Less dependent residents might be better able to attend surgery, if and when they decide themselves that they need attention, which might help to encourage a more normal and perhaps less institutional existence.

Physical screening of such disabled mentally ill patients seems worthwhile, at least on one occasion after they leave psychiatric hospital. Previous studies of screening long-term mentally ill

Table 1. Physical problems of residents in a high-dependency group home

Age	Sex	Psychiatric diagnosis	Length of most recent hospital stay (years)	Physical problems (* previously unmet)	Repeat prescriptions for physical problems	Difficulties in providing care
38	F	Schizophrenia (Personality disorder)	12	Recurrent bronchitis Urinary incontinence* Hiatus hernia	Antacids	Refused chest X-ray
53	F	Manic-depressive psychosis	19	Epilepsy Hypothyroidism Radical vulvectomy Urinary incontinence* Recurrent cellulitis	Carbamazepine Thyroxine Aperients	Refused vision test Many spurious symptoms
46	M	Brain Injury	28	Epilepsy Spasticity Bleeding haemorrhoids*	Sodium valproate Baclofen Aperients Iron	Very poor memory Self-injures
47	F	Schizophrenia (Personality disorder)	2	Severe constipation* Anaemia* Pleural neurilemmoma* Postmenopausal bleeding*	Aperients Iron	
42	F	Schizophrenia	10	Constipation Ingrowing toenail*	Aperients	Suspicious, guarded
45	M	Schizoaffective disorder (Alcohol abuse)	10	Abnormal liver function*		
63	F	Schizoaffective disorder	20	Recurrent bronchitis Urinary incontinence*	Aperients	Refused to see dentist or optician
37	M	Schizophrenia	9	Otitis externa*	Hydrocortisone ointment	Refused vision test
54	F	Schizophrenia (Anorexia nervosa)	5	Hiatus hernia	Antacids	
39	F	Schizophrenia	4	Ankle deformities (Jumped from window)	Analgesics Aperients	
34	M	Schizophrenia	5		Carbamazepine	Refused to see dentist or optician Convinced he has heart disease. Puts detergent in eyes
42	M	Schizophrenia	9	Epilepsy Conjunctivitis		

patients have also revealed unmet needs for physical care (Brugha *et al*, 1989; Honig *et al*, 1989). However, some problems, particularly smoking and obesity, are not very amenable to intervention.

Providing primary care to a high-dependency group home is a challenging task but one which I have found rewarding and never boring. The difficulties in providing a high level of care to such disabled residents and support to the staff should not be underestimated, and should be recognised by way of remuneration in addition to the usual fees for general medical services.

References

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Tony Kendrick, *General Practitioner, Health Centre, Steppages, Chertsey, Surrey KT16 8HZ and Senior Lecturer, Division of General Practice and Primary Care, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE*

Links between fund-holding general practices and mental health professionals

T. I. R. Mutale

A postal questionnaire was sent to a random sample of 300 fund-holding general practices. Respondents were asked to indicate if they had links with a psychiatrist, community psychiatric nurse or psychologist; 210 (70%) general practitioners returned completed questionnaires. Out of 210 practices 161 (77%) had links with at least one specialist mental health professional. Community psychiatric nurses had links with more practices than psychiatrists or psychologists. Problems with time or space made it difficult for practices to form links.

Patients with psychological disorders make up one fifth to a quarter of the workload of the average general practitioner (Shepherd *et al*, 1966). The recent shift of mental health resources to community-based care has led to a greater need for specialist input at primary care level. Some GPs have responded to this need by establishing links with mental health professionals (Thomas & Corney, 1992). Fund-holding practices, who are direct purchasers in their own right, are in a powerful position to influence such links.

This study set out to determine the extent and quality of links between fund-holding practices and a broad range of specialist mental health professionals. Previous studies have determined links between GPs and mainly one type of profession (Brown & Tower, 1990). Those that have looked at links with a wider range of professionals have not determined the quality of the links found, or made a distinction between child and adult mental health practitioners (Thomas & Corney, 1992). This study remedies both these shortcomings. In addition, it is the first survey to study the impact of fund-holding on working relationships between mental health professionals and GPs.

The study

In May and June 1993, 300 general practices were chosen from a list of first wave and second wave fund-holding practices in the United Kingdom, using a random numbers table. One