opinion & debate

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The future role of general adult psychiatrists

Peter Kennedy and Hugh Griffiths (2001) have convened a timely debate on the role and responsibilities of consultants in general adult psychiatry. They provide an analysis of difficulties in fulfilling this role, including inappropriate general practitioner (GP) referrals, excessive caseloads and increasing stress leading to premature retirement. They provide the jobbing consultants with two models of out-patient practice, both relative to the community mental health team (CMHT). However, they have not considered the potential effect of change currently underway as summarised below.

- The arrival of Primary CareTrusts who (directly or indirectly) will purchase consultant time and will influence new consultant job plans.
- The new consultant contract that has an element of performance-related pay, which will be influenced by the employer (most likely a Primary CareTrust).
- The emphasis on competencies for each sub-speciality (including general adult psychiatry) by the Royal College of Psychiatrists as part of specialist registrar training.
- An expansion of medical schools with an expectation that consultants will teach more students in the community.
- The imminent arrival of the new Mental Health Act with emphasis on rapid delivery of care plans, risk/benefit assessments and capacity judgements.

Kennedy & Griffiths do not describe views of GPs on the role of consultant adult psychiatrists. GPs deal with over 60% of mental illness in the community, which comprises 25% of routine general practice as described by Craig & Boardman (1998). They refer only a small proportion (around 10%) to secondary psychiatric services, with around 80% of referrals to secondary services originating from GPs. Severe mental illness accounts for a very small percentage of GP workload. The main problems are chronic depression with associated employment difficulties, marital dysfunction and substance misuse issues.

GPs refer on a pragmatic basis, usually considering issues of treatability and risk. Cases of somatisation and mental illness associated with physical disease are usually treated within the confines of primary care. General adult psychiatrists have not taken much interest in this area, although GPs have significant difficulties in dealing with these two groups of patients. In addition, the recent guidance from the National Institute for Clinical Excellence (2002) has advised caution when prescribing conventional antipsychotic drugs in the context of side-effects. These prescribing issues could potentially increase referrals of patients currently stable on conventional antipsychotics.

Many GPs accept the CMHT as being a single point of access to secondary services, as this often delivers a rapid assessment. There is, however, concern about a lack of transparency on competences and supervision arrangements for individual CMHT staff. In general, GPs acknowledge that the consultant has the expertise on prognosis and benefits from particular treatments, which are issues that both patients and carers seek information on – hence the need for a consultant opinion early in the referral process. Accordingly, the consultant also acts as a gatekeeper to CMHT activity.

GPs remain somewhat confused about the role of additional teams in the community, which include crisis resolution, assertive outreach, early intervention, forensic and substance misuse teams, alongside the generic CMHT. Both GPs and consultant adult psychiatrists are wary of 'cherry-picking' by these other services, leaving complex and risky clients to be managed between themselves, particularly when admission is imminent. There is also the additional problem of boundary disputes between general adult, old age and learning disability services.

Alternative options for consultants in adult psychiatry

Liaison–consultation model

This has been used within general hospitals to concentrate on adults of working age similar to those seen in primary care. A liaison service usually commences with a medically-staffed consultation service, progressing to a predominantly nurse-led service, with senior medical staff concentrating on liaison activity involving a combination of joint working and teaching. The liaison psychiatrist has special interests that generate a job plan with specific clinics. Examples of these include epilepsy, diabetes and chronic fatigue clinics.

If an adult psychiatrist wishes to work in primary care using the liaison model, they would have to move entirely into general practice with all consultations and clinics held in primary care and community hospital wards. Non-medical staff would subsequently join, with specific skills in psychosocial intervention involving compliance therapy, problem solving therapy, substance misuse management and cognitive–behavioural therapy. The consultant would jointly undertake management of specific conditions (with specific clinics), for example in

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depression, psychosis and phobias. The consultant would also be expected to have competence in managing patients with somatisation and psychiatric illness in the context of physical disease. The medical responsibility for the patient would remain with the GP as the consultant works in an advisory capacity.

Joint working model

This model has been used in Whitby, North Yorkshire, where the GP, consultant and CMHT work together for patients and carers. Essentially, it is a combination of liaison–consultation and well-organised community psychiatry. The consultant and GP work on a liaison–consultation basis with out-patient clinics in primary care, including a dedicated clinic for new outpatients. Occasional joint consultations are also utilised. The consultant and the CMHT work together through the Care Programme Approach, with meetings incorporated into out-patient clinic slots. Primary care mental health workers who are based in general practice are able to assess referrals, and triage appropriately enables the GP to have early access to a non-medical opinion. The primary care worker can also request second opinions from the consultant as required.

In this model, new referrals are assessed and triaged either by primary care mental health workers, health workers or medical staff, with the CMHT working as a severe mental illness team with an element of protection from unnecessary referrals. The consultant carries a caseload of less than 20 patients, the wait for a new out-patient clinic slot is under 2 weeks and the maximum wait for a follow-up slot is one month. Patients discharged from the ward can usually expect a follow-up within 7 days.

The system relies on over 80% of new out-patient referrals being passed back to the GP, with a care plan agreed with the patient and preferably also the carer. GPs are also expected to share responsibility for managing patients with severe mental illness in the community in areas such as discharge planning, treatment options and risk management. A joint working model is probably more effective in rural areas where GPs have more consistent contact with patients suffering from severe mental illness. The issue of medical responsibility is less distinct compared to the pure liaison model, but this is shared locally between the consultant and the GP – perhaps being easier to achieve for a psychiatrist with outreach clinics in a rural area.

Sub-speciality model

A more radical model would be to split adult consultants into two groups: those working predominantly in psychiatric hospitals and community consultant psychiatrists working predominantly in primary care. The in-patient consultants would have a role in liaising with crisis resolution teams and thereby preventing inappropriate admissions and revolving door activity. The community psychiatrist would predominantly deal with primary care referrals as part of a community mental health team and liaise with learning disabilities, substance abuse, old age and child psychiatry services along with consultants in general medicine/surgery. There would be a 'hand-over' process between in-patient and community psychiatrists of patients who are not at risk of immediate readmission. The in-patient consultant would have a lead role implementing the Mental Health Act 1983, working with tribunals and dealing with capacity issues. They would be expected to look after patients from a number of areas including liaising with forensic and intensive care units. Community psychiatrists would be sectorised hopefully co-terminus, with general practices and social services. This model would also accommodate itinerant and homeless clients who often do not have a GP. This model is already in practice in some inner-city areas (for example, south London), and is being seriously considered in other urban areas.

Conclusions

We have both worked in inner-city areas prior to working within rural areas, such as Whitby and the surrounding North York Moors. We are aware of major changes to the Health Service resulting from increased government funding, with the emphasis on delivering rapid and effective secondary care services within primary care. Therefore, it is imperative that the voice of primary care is heard within all specialities in secondary care. Consequently, traditional working practices and boundaries in secondary care will need reconsideration, possibly involving the models discussed. It is our opinion that Kennedy & Griffiths (2001) have not been radical enough in their analysis, which was based on interviews with a relatively small number of consultants in the north of England.

In rural areas, setting up separate assertive outreach, early intervention and substance abuse teams is, in our opinion, a retrograde step – leading to frustration and disempowerment of CMHT workers and producing difficulty in access. The alternative would be to place workers with these skills within CMHTs. The crisis resolution team would have to be integrated with the in-patient unit, concentrating on preventing inappropriate admissions and breakdown of discharges.

From an educational perspective, it would be easier to train junior doctors and teach medical students if consultants concentrated on either in-patient or community activity. General practitioner trainees would benefit from predominantly community psychiatry training, including experience of adult and elderly CMHTs.

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