THE GENERAL PRACTITIONER, THE PSYCHIATRIST AND THE BURDEN OF MENTAL HEALTH CARE

David Goldberg & Kevin Gournay
Institute of Psychiatry, London
ABSTRACT

We argue the case for a radical re-appraisal of the mental health work undertaken by both primary care and community mental health (CMH) teams. The present system produces a pattern of care that is haphazard and inadequate. As effective treatments become available for disorders with high prevalence and low spontaneous remission rates, it is incumbent on policy makers to consider what changes need to be introduced in order to bring effective treatment to the greatest number of patients. We argue that a patient needs to be treated by the CMH team if he or she requires a skill not available in the primary care team.

We wish to see community psychiatric nurses (CPNs) carrying out less supportive work and more cognitive behavioural and other active treatment programmes with those patients who can benefit from them: to bring this about we argue for the creation of generic mental health workers who would carry out supportive work. We propose radical changes to the functioning of CMH teams to bring them more closely into line with primary care teams. These changes include alterations to the way in which catchment areas for CMH teams are at present organised.

Within primary care, we argue for a link worker from the CMH team to work with those patients cared for jointly by the CMH team and the primary care team, and for this worker to act as a skills diffuser to spread mental health skills to practice nurses and other members of the primary care team. The CMH team should work collaboratively with primary care staff in providing training in those forms of psychological therapy known to be effective. We argue for a great expansion in the numbers of practice nurses, and for them to be trained in mental health skills. Existing counsellors should be re-trained in cognitive behavioural skills. The work of helping those who require only supportive care could be shared with the voluntary sector. Computerised self treatments are thought likely to play a progressively greater part in providing future care.
Administrative and medical logic alike...suggest that the cardinal requirement for the improvement of the mental health services is not a large expansion of psychiatric agencies, but rather a strengthening of the family doctor in his therapeutic role

Michael Shepherd, 1966

Shepherd and his colleagues wrote those words over 30 years ago influenced by epidemiological findings, and more recent data gives one no reason to revise their prescription. However, both primary care and mental health services have been changed a great deal in that time, and perhaps the time has come to consider the future of the two services in the light of these changes.

The Workforce: 1 General Practitioners and psychiatrists

In 1966 there were far fewer psychiatrists and general practitioners, and many more hospital beds than there are now. It is possible that there will still be a further reduction in hospital beds, but in some areas closures have gone too far, so that there are unacceptable waiting times for admission, and bed occupancy is well over 100%. The move to the community has been associated with a great increase in the numbers of psychiatrists employed by the NHS in England: there are now 3.5 psychiatrists for every one employed in 1966. There has been a slower rise in the number of GPs, with 1.36 now for each one employed in 1966. In 1970, 21% of GPs worked single handed, and only 5% were in groups of 6 or more; by 1990 only 11% were single handed, and 21% were in groups of 6 or more. However, the number of GPs far outstrips the number of psychiatrists, so that today there are still 12 times as many GPs as psychiatrists. These numbers impose necessary limits on best working relationships between the two specialities (see Table 1).

The present status quo.

The closure of mental hospital and the down-sizing of district general hospitals have thrown a far greater burden onto primary care, and primary care teams have undergone a dramatic expansion to cope with these added
tasks. Health information and the promotion of good health have been added to the tasks of the general practitioner, and a modern health centre undertakes many functions that would previously have taken place in hospitals.

<table>
<thead>
<tr>
<th>Changes with time; England</th>
<th>1966</th>
<th>1990</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of available psychiatric beds</td>
<td>133,000</td>
<td>55,000</td>
<td>39,000</td>
</tr>
<tr>
<td>Number of psychiatrists (Adult mental illness)</td>
<td>606*</td>
<td>1,840</td>
<td>2,120</td>
</tr>
<tr>
<td>Number of general practitioners</td>
<td>19,500</td>
<td>25,662</td>
<td>26,567</td>
</tr>
<tr>
<td>Ratio of psychiatrists to GPs</td>
<td>1: 32.2</td>
<td>1: 13.9</td>
<td>1: 12.5</td>
</tr>
</tbody>
</table>

Table 1: Changes with time in the numbers of psychiatric beds, psychiatrists and general practitioners in England; source: Department of Health statistics division, and the Royal College of Psychiatrists, 1997. * = includes forensic psychiatrists and psychotherapists

The care of patients with chronic mental disabilities in the community imposes a far greater burden on both primary care and community mental health teams, since the latter neither have the economies of scale that the old chronic wards offered, nor the relative safety to the general public that used to be taken for granted with the former model. The task of the key-worker caring for such a patient in the community is both demanding and time-consuming, and patients also demand care from the primary care team. The pressure to manage mental health care on ever-reducing budgets have caused mental health services to confine their attention to those with severe psychotic and organic illnesses, leaving the task of common mental disorders to the primary care team.

In primary care, a greater awareness of the ubiquity of depressive illness, and the greater availability of behavioural and cognitive treatments for
those with other less severe mental disorders have created a demand that general practitioners have had difficulty in satisfying. While general practitioners can take advantage of the full range of psychotropic drugs that are now available, the demand from the public for non-drug treatments and the interventions of alternative medicine impose additional burden on a service that is already hard pressed. This possibly accounts for the fact that even though resources are scarce in primary care, to some extent they are being used to purchase interventions which fail to meet the standards of evidence based medicine.

The possibility of the creation of unified mental health authorities envisaged in the Green Paper “Developing Partnerships in Mental Health” gives the question of the division of responsibility between primary care and the CMH services increased salience.

**Problems with the status quo**

The picture that emerges is of two hard-pressed services that often relate poorly to one another, so that the public does not get full exposure to effective treatments for common disorders, and the care of those with long-standing disorders is less effective than it might be. The distribution of mental health staff in primary care is uneven, and community psychiatric nurses (CPNs) have been withdrawn from primary care to support the work of the specialist community mental health team (CMHT). Within the CMHT, new patients are often allocated to CPNs on the basis of who happens to be on duty on the day a new patient is referred, so that CPNs have patients from many different GPs on their case-loads, and liaison between them and individual GPs is less effective than it might be.

There appear to be three problems with the status quo: there is no uniformity of staffing so that some practices are richly endowed with a range of mental health workers, while the majority have none whatever. This means that many patients are treated by neither service, and this is regrettable. Where the care of those with long-term severe illness is concerned some services are duplicated by both primary and secondary
care, and this is inefficient. Finally, the *standards of mental health care* are very variable between practices.

Although the mental illness services tend to treat the more severe cases of disorder, the greatest number of cases is to be found in the community. Estimates suggest\(^2\) that for every patient seen by the mental illness services, the general practitioner is aware of just over four (annual period prevalence, GPs 10.1%; mental illness services 2.35%). With 12 times as many GPs as psychiatrists, it is evident that psychiatrists cannot shoulder all of this burden, nor would either GPs or the public wish them to do so. Given the distribution of mental disorders, and the availability of trained mental health professionals, it is clear that limits must be imposed upon the work undertaken by the CMH teams. One defensible criterion would be:

\[
\text{A patient needs to be treated by the CMH team if he or she requires a skill not available in the primary care team.}
\]

This is an elastic criterion: the patients captured by it will reflect the efficacy of treatments that are available at a particular time, and the skills available in the primary care team. Although the criterion may appear self-evident, it is seldom acted upon. Many patients at present treated by the CMH team (or by mental health professionals working in primary care settings), could equally be treated by primary care staff, while many who would in fact benefit from specialist treatment do not receive it. This can be because their problems are not identified, because members of the local CMH team have not been trained to deliver the treatment, or because the CMH team is so inundated with referrals that they restrict referrals to the very severe mental illnesses.

**The nature of mental disorders seen in primary care**

It is possible to group the mental disorders that are encountered in general medical settings into four groups, taking into account prevalence, associated disability, response to treatment and likelihood of spontaneous remission.
The first important group are severe mental disorders which are unlikely to remit spontaneously, which are associated with major disability and whose care will usually involve both the primary and the CMH team: these are schizophrenias, organic disorders, bipolar disorder and life threatening cases of eating disorder. These patients have been shown to have grossly elevated SMRs in the years following discharge from hospital. Most of these patients will need at least brief admission to the in-patient unit, and it will usually be desirable to involve the CMH team in their treatment (see Table 2).

The second group are well-defined disorders which are also associated with disability, for which there are effective pharmacological and psychological treatments, and which can usually be managed entirely within primary care. Even when these disorders remit, they are likely to relapse once more, so that they deserve to be both recognised and treated. It is important to note that approximately 20% of the anxious depressives become chronic, and form a group often referred to as “heartsink” patients. It is important that these cases are reviewed from time to time with a member of the CMH team. Other illnesses in this group will occasionally also be referred to the CMH team when they fail to respond to treatment. Drug treatments are often cheaper, and almost always easier for the GP to do - but they are not always acceptable to the patient. The psychological treatments need special staff training if they are to be effective, and they are usually very much more time consuming.

The third group of disorders include somatised presentations of distress, panic disorder with agoraphobia and eating disorder where drugs have a more limited role, but where psychological therapies are available. They are rarely treated within primary care, and only a small proportion of cases are treated by CMH teams. Those presenting somatic problems that are associated with psychological distress and fatigue states are numerous, and are often resistant to the idea that their symptoms are psychologically determined. Spontaneous remission can occur with all of these disorders, but both somatoform disorders and fatigue states can become chronic, and are associated with much disability and high NHS costs. Two other
disorders - panic disorder with agoraphobia and mild eating disorders - are often not presented as problems requiring medical intervention, but effective psychological treatments are available. Yet these disorders could all be managed in primary care, providing that trained staff are available.

The **final group** are those which resolve spontaneously, for which supportive help, rather than a specific mental health skill, is required. Those with transient adjustment disorders are relatively numerous, and are often referred to mental health professional since their distress can be very great at the time of referral. However, care by the CMH team is no better than usual care by the GP\textsuperscript{34,35}.

Table 2: Table (on the following page) showing relative prevalence and efficacy of drug and non-drug treatments in general medical clinics. 
KEY Prevalence Very low <1%; Low 1 - 5%; Moderate 5 - 10%; High >10% (*In parentheses* - usually not seeking care for this)
Efficacy: Good: many RCTs showing effects; Fair: evidence equivocal; Poor: uncontrolled trials only.

We have tried to give up-to-date information in this table, and wherever possible have quoted papers that refer to the sort of patients seen in primary care, rather than the highly selected patients referred to CMH teams. However, it is evident that there is an urgent need for systematic reviews of treatment efficacy, in order to fill the gaps in this table.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Prevalence</th>
<th>Efficacy of drug treatment</th>
<th>Efficacy of non drug Rx</th>
<th>Spontaneous Remission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Schizophrenia group</td>
<td>Low</td>
<td>Good&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Fair&lt;sup&gt;6,7&lt;/sup&gt;</td>
<td>66% recur</td>
</tr>
<tr>
<td>2. Dementia</td>
<td>Low</td>
<td>Suppress some symptoms&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Limited&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Never</td>
</tr>
<tr>
<td>3. Bipolar illness</td>
<td>Low</td>
<td>Good&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Uncertain&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Unlikely</td>
</tr>
<tr>
<td>4. Severe eating disorders</td>
<td>Very Low</td>
<td>Poor&lt;sup&gt;11&lt;/sup&gt;</td>
<td>Fair&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Unlikely</td>
</tr>
<tr>
<td><strong>GROUP 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Anxious depression</td>
<td>High</td>
<td>Good&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Will remit &amp; re-lapse; 20% chronic</td>
</tr>
<tr>
<td>6. Pure depression</td>
<td>Medium</td>
<td>Fair&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;14&lt;/sup&gt;</td>
<td>As above</td>
</tr>
<tr>
<td>7. Generalised anxiety</td>
<td>Medium</td>
<td>Fair&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Less likely to remit</td>
</tr>
<tr>
<td>8. Panic disorder</td>
<td>Low</td>
<td>Good&lt;sup&gt;17,18&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;19&lt;/sup&gt;</td>
<td>12% remit&lt;sup&gt;20&lt;/sup&gt;</td>
</tr>
<tr>
<td>9. Obess. compulsive</td>
<td>Very Low</td>
<td>Good&lt;sup&gt;21&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;22&lt;/sup&gt;</td>
<td>Unlikely</td>
</tr>
<tr>
<td><strong>GROUP 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Phobias</td>
<td>(High)</td>
<td>Poor&lt;sup&gt;23&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;23&lt;/sup&gt;</td>
<td>Unlikely</td>
</tr>
<tr>
<td>11. Somatoform disorder</td>
<td>High</td>
<td>(if depressed)</td>
<td>Fair&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Most 1 ry care cases remit, some chronic</td>
</tr>
<tr>
<td>12. Eating disorders (mild)</td>
<td>(High)</td>
<td>Poor&lt;sup&gt;25&lt;/sup&gt; &lt;20% recover</td>
<td>Fair 45% Recover&lt;sup&gt;26&lt;/sup&gt;</td>
<td>some chronic</td>
</tr>
<tr>
<td>13. Post-traumatic stress disorder</td>
<td>Low</td>
<td>(if depressed)&lt;sup&gt;27&lt;/sup&gt;</td>
<td>Good&lt;sup&gt;23&lt;/sup&gt;</td>
<td>Mild cases remit</td>
</tr>
<tr>
<td>14. Drug &amp; alcohol problems</td>
<td>Medium</td>
<td>Limited uses</td>
<td>Fair&lt;sup&gt;29,30&lt;/sup&gt;</td>
<td>Unusual if severe</td>
</tr>
<tr>
<td>15. Chronic fatigue</td>
<td>Medium</td>
<td>Unclear</td>
<td>Good&lt;sup&gt;31&lt;/sup&gt;</td>
<td>90% don’t fully recover</td>
</tr>
<tr>
<td><strong>GROUP 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Bereavement</td>
<td>(Low)</td>
<td>None</td>
<td>Poor&lt;sup&gt;33&lt;/sup&gt;</td>
<td>Most remit</td>
</tr>
<tr>
<td>16. Adjustment disorder</td>
<td>High</td>
<td>None</td>
<td>None</td>
<td>All remit</td>
</tr>
</tbody>
</table>
The Workforce 2: Mental health professionals and primary care nurses

It is clear that the mental health services will need to have a carefully defined role if all the patients who will benefit from treatment are to receive it. There are large numbers of people with treatable disorders who do not at present receive optimal treatment, and it is clear that general practitioners cannot be expected to shoulder the whole burden themselves. We will therefore broaden our manpower enquiry to consider other possible professionals who might contribute to a solution. The figures quoted are from the Department of Health, the relevant Royal Colleges and the Sainsbury Review of “Training for the Mental Health Workforce” 36.

Community Psychiatric Nurses

Although we know that there are 57,000 nurses on the psychiatric register, there are no reliable estimates of how many registered mental nurses work in mental health settings. The numbers of community psychiatric nurses are more accurately known. In 1990 there were approximately 5,000 CPNs in the UK37 and approximately 40% of their workload was devoted to primary care and the management of patients with adjustment disorders and anxiety and depression. A recent RCT35 with this population showed that CPN intervention provided no benefits over routine GP care and an economic analysis from the same work38 showed this intervention to be very costly. Following this the Review of Mental Health Nursing39 recommended that CPNs focus on those with serious and enduring mental illness and since then there has been an increasing focus on those with schizophrenia. However several pieces of work40,41 and a recent survey of CPNs42 indicate that CPNs are still targeting non-psychotic populations in primary care. One of the obvious reasons for this is the continuing use of CPNs by GP fundholders. More positively CPNs are now being trained in family and psychological interventions for schizophrenia in new training programmes such as the Thorn Initiative based at the Institute of Psychiatry and the University of Manchester43. There are indications (Brooker, Personal Communication) that CPN numbers have shown considerable growth, the current estimate being between 8,000 and 10,000 in the UK.
Nurse Behaviour Therapists

The only area of nursing where there are specific data concerning the skills of the workforce, numbers of patients treated, problem categories of these patients and therapeutic approaches used is behaviour nurse therapy. This programme which commenced in 1972 has been tested by randomised controlled trial\(^4^4\) and a 20 year follow up of graduates from the programme has been completed\(^4^5\) with a 25 year follow up currently in progress. We estimate that there are approximately 200 whole time equivalent nurse therapists practising in the UK and we know that each nurse therapist treats about 75 patients a year. Nurse therapists largely work with very specific phobic and obsessional disorders, but over the years their work has gradually increased to include a wider variety of cognitive behavioural interventions which have been shown to be effective in randomised controlled trials. Unfortunately the numbers of nurse therapists in the UK is still small and it is unlikely that the training programmes will be expanded in the foreseeable future because of the current focus on training initiatives with psychotic illness. This workforce can therefore only treat a relatively small number of patients each year (we estimate 15,000 in total across the UK). Therefore there is a substantial argument for suggesting we should train more nurse therapists who in turn could train and supervise more numerous groups of health workers, such as CPNs, practice nurses or lay counsellors.

Clinical psychologists

The British Psychological Society reported that there were 2,070 clinical psychologists in 1992 and that approximately 225 psychologists are accepted for clinical training each year. It is impossible to say how many of the 2,000 or so clinical psychologists are available to provide direct clinical services, as many work in non-clinical areas such as universities and other branches of psychology. Although psychologists have worked in primary care for more than two decades and the Trethowan Report\(^4^6\) suggested that the work of clinical psychologists in taking referrals from GPs should be evaluated, the evidence for efficacy is sparse. While two studies have shown that psychologists were effective when using
behavioural interventions on targetted populations of phobics\textsuperscript{47,48}, other studies of psychologists working in a more generic fashion\textsuperscript{49} show equivocal results and there has, as yet, been no systematic evaluation as suggested by Trethowan. Data from a survey of counsellors in general practice\textsuperscript{50} suggest that there are several hundred whole time equivalent psychologists working in primary care and there is considerable anecdotal evidence of the use of approaches for which there is no randomised controlled trial supporting evidence.

The survey of community mental health teams\textsuperscript{41} suggests that psychologists do not see themselves as integral to the work of these services and in several areas of the country psychologists have organised themselves into agencies which are distinctly separated from mainstream mental health services. The Clinical Standards Advisory Group\textsuperscript{40} recognised the shortages of clinical psychologists in services working with the seriously mentally ill, but at the same time it is being increasingly recognised that psychological interventions for psychotic conditions may be helpful\textsuperscript{51,52}.

Psychologists clearly represent a major resource for training in various types of psychological therapy in both primary and secondary care, but it is difficult to see that this potential is being properly exploited.

**Occupational Therapists**

We know that there are a large number of occupational therapists involved in mental health work, but although there were 7,360 occupational therapists registered in 1993, there is no information about how many are involved in mental health care. There is evidence that occupational therapy roles may overlap considerably with those with community psychiatric nurses\textsuperscript{41} and it seems clear that, as a workforce, they have the potential to deliver effective interventions for a range of mental health problems.
Practice Nurses

The numbers of practice nurses in the UK has expanded dramatically. The last reliable estimate was that there were 18,000 posts in 1991. It is likely that the UK may have up to 30,000 practice nurses posts with a whole time equivalent of between 15,000 and 20,000 (Armstrong Personal Communication). There is some evidence to suggest that practice nurses may have a useful role in the detection and management of mental health problems and the Department of Health has just funded a large RCT to explore this possibility further. The Department has also recognised that there are relatively large numbers of practice nurses working with people with mental health problems and the Department of Health and the Royal College of Nursing have already begun to implement programmes to assist practice nurses in increasing their skills in giving depot medication to people with schizophrenia.

The role of practice nurses in the future

Given the relatively large number of practice nurses in the UK and the reality that, de facto they are already working with people with mental health problems, specific training initiatives must be considered. There are already some programmes which have targeted practice nurses who work with the seriously mentally ill, for example, the aforementioned effort to increase practice nurse skills in the giving of depot medication for people with schizophrenia.

With neurotic problems, there are probably four key areas:

1. The detection of mental health problems. A recent study showed that practice nurses detect only 23% of cases of depression and it seems obvious that detection rates could be improved. There is an ongoing study in the Institute of Psychiatry which is examining the training of practice nurses in detection and it seems likely that fairly brief training programmes may be effective.

2. Practice nurses have a valuable role in assisting general practitioners with the management of depression. For example, once an anti-
depressant drug has been prescribed, practice nurses can follow up patient’s progress, perhaps by using simple measures of depression such as the Beck Depression Inventory and by monitoring medication side effects, thus potentially improving compliance.

3. It is highly likely that practice nurses could be trained in the treatment of phobic and obsessional disorders using brief interventions. Most patients with agoraphobic avoidance and obsessive compulsive disorders are known to the GP although because of the shortage of suitably skilled therapists, they are often left without treatment. Given the encouraging results of self help programmes\textsuperscript{57} and the simple nature of exposure therapy, it seems likely the practice nurses could be trained without great expenditure of training effort.

4. They could potentially be trained to provide brief cognitive behavioural techniques for specific populations with depression, although it is clear that this area needs research and development attention.

**Place of the practice nurse in the treatment of psychotic illnesses**

Apart from the giving of depot medication they may have other important roles. For example: it is evident from the increased SMRs that there is a need for screening the population with chronic mental disorders for physical illness. Such plans could be incorporated into the contribution made by primary care staff to the shared care plans for these patients, and could best be devolved to the practice nurses who could carry out screening on a regular basis.

**Nurse training issues**

With the advent of project 2000, basic nurse training has changed dramatically. Some of the difficulties regarding mental health components of training were highlighted in the Mental Health Nursing Review\textsuperscript{39}. These include an insufficient focus on mental health problems in the common foundation part of the programme which is taken by all nurses
including general and paediatric) and the great reduction in the specialist mental health component of nurses studying for the specialist psychiatric qualification. Arguably all nurses (including those who will work in general medical and surgical settings) need much more mental health content in their education and rather than the theoretical inputs they currently receive, there is a strong case for arguing that all nurses should be taught specific skills in detection and management. The loss of the specialist RMN training and the consequent reduction of skills training in the Diploma and Degree programmes which now lead to nurse registration are of considerable concern. Furthermore, because of the emphasis on treatment of the seriously mentally ill as recommended by the mental health nursing review, there is now more emphasis on serious mental illness. This could potentially lead to a situation where skills training in dealing with neurotic disorders is neglected. Similarly, education purchasers are emphasising initiatives such as the Thorn Nurse Programmes for qualified nurses and primary care relevant training such as behaviour nurse therapy is considered a much lesser priority.

Counsellors in general practice

It is difficult to be certain of the number of counsellors employed in general practices across the country. The only basis for making such an estimate is a survey of 1880 GPs. Completed questionnaires were obtained from 82% of a sample which forms approximately 5% of the total number of GPs in England and Wales. 586 counsellors were distributed among 482 of the 1542 practices. Extrapolation of this data would lead to an estimate of about 14,000 counsellors across the country. However the situation is complicated by the fact that at least 3 types of counsellor were defined, i.e. Community psychiatric nurses, practice counsellors and clinical psychologists. Furthermore, it is highly probable that since the time that this survey was carried out, some 5 years ago, that the numbers of counsellors have markedly increased. The results of this survey pointed to several areas of concern, not least the fact that the qualifications of a large number of counsellors were unknown to the general practitioner and that many counsellors seemed to be referred problems which were outside their area of expertise. The study also high-
lighted the idiosyncratic distribution of these workers. One group of authors\textsuperscript{58} reviewed specialist mental health treatment in general practice, including counselling and found that, apart from specific behavioural treatment, the interventions delivered were very difficult to define. King and his colleagues\textsuperscript{59} have reviewed the field, as well as carrying out their own RCT of counselling in primary care, without being able to demonstrate any real achievements of counselling as it is practiced at present. The majority of nurses involved in the RCT of CPNs in primary care\textsuperscript{35} described their interventions as counselling and a process analysis revealed that these nurses were using non-directive approaches which the patients largely viewed as supportive. There are extensive problems in defining what counselling is. No studies have systematically examined how prevalent various forms of counselling are, but it is reasonable to assume that there are several thousands of counsellors employed whose approach is largely non-directive and that there is very little use made of evidence based approaches. For patients whose difficulties are likely to remit anyway, this approach probably does not do much harm. However for patients who have conditions where there are treatments of known efficacy such as medication or cognitive behavioural interventions, this population is being deprived of treatment, while at the same time their GP may believe that they are being provided with adequate intervention. One of the challenges therefore is the retraining of this group of workers with appropriate skills.

**Generic Mental Health Workers**

Several pieces of recent work\textsuperscript{41} suggest that support workers are being increasingly employed in CMHTs to carry out roles which do not require a great deal of training but are nevertheless both important and time consuming. These tasks often involve assisting patients with activities of daily living. At the same time several other studies\textsuperscript{40} have highlighted the deficiencies in training for all groups of mental health professionals in the necessary skills for work with the seriously mentally ill while there is increasing overlap between different professional groups\textsuperscript{42}. There seems to be a need for mental health professionals to be trained with an emphasis on core competencies which are shared as priorities by all professional
education bodies. Although there is a need to retain distinct professional identities, there are strong arguments for the expansion of generic mental health workers to carry out supportive tasks in both Primary and secondary care. Given the tremendous difficulties recruiting and retaining staff to work in mental health services, the training of other work forces needs to be seriously considered. These workers could arguably be recruited from the voluntary sector, the potential of which is underrecognised. We also need to consider the possibility that such individuals should be availed of training hitherto only available to Health and Social work professionals. Such developments have of course been made in many of the services in the USA, and have proven successful if these workers are used as part of an array of provisions.

A NEW MODEL FOR PRIMARY CARE AND CMH TEAMS

Relatively few members of staff have the necessary therapeutic skills to deliver cognitive behavioural treatments; the training task ahead is massive, and will need to be resourced. The only practical solution to this problem appears to involve a radical re-think of the relationship between primary care and the CMH teams. We are entering an era of evidence based medicine, and need to concentrate our resource on providing treatments which are known to work.

Table 3: The four diagnostic groups from table 2, showing the status quo and what we recommend

1. The Mental Health Services

i. Shared Care Plans. Apart from patients under the care of forensic psychiatrists on secure units, no patients would be cared for exclusively by the mental health services. However, they would continue to take responsibility for arranging specialist forms of care for those referred to them, and those with severe mental illnesses would be subject to the Care Programme Approach, with multi-axial assessment and management. Responsibility for the patient’s physical health is likely to fall largely upon the general practitioner, who needs to be alerted to the
increased morbidity due to cardiovascular and respiratory disease\textsuperscript{4}. In each case there would be a shared care plan\textsuperscript{60} setting out the respective responsibilities of the CMH team and the primary care team. Such plans will eventually be computerised, but in the absence of these facilities a written record will suffice. Such shared care plans will identify the key-worker responsible and the consultant, with details of telephone numbers and person to be contacted if the patient needs re-admission. It will include details of diagnosis and dates of last admission, and the reason for it. It will indicate name and dose of any drug, make clear who is responsible for prescribing and checking that the patient is complying. It will propose alternative medication, and alert the GP to likely symptoms of a relapse. Such plans will need to be reviewed at regular intervals, and the date on which this was last done will be indicated. An additional resource is a shared care register\textsuperscript{61} which is a listing of such cases for a particular GP.

<table>
<thead>
<tr>
<th>Diagnostic Group</th>
<th>The status quo</th>
<th>What we recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td>Care poorly co-ordinated; maybe duplicated; inefficient High SMRs, poor physical care</td>
<td><strong>Shared care</strong> - CMH team involved, family treatment, voluntary agencies involved</td>
</tr>
<tr>
<td>Severe mental disorders</td>
<td>Many cases missed despite effective treatments available</td>
<td><strong>Care within primary care</strong> - not necessarily by GP CMH team only if no response</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td>Many cases missed, patients may not present Sx; drugs work less well than non-drug</td>
<td><strong>Care within primary care</strong> - can be by nurses or retrained counsellors; supervised CMHT</td>
</tr>
<tr>
<td>Mental disorders treatable by drug or non-drug Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td>Need supportive care - transient adjustment disorders may consume much resource</td>
<td></td>
</tr>
<tr>
<td>Mental disorders responding mainly to non-drug Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need passage of time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ii. **Providing training in mental health skills** - Members of the CMH team should take responsibility for diffusing skills throughout the primary care team by providing training courses for nurses, receptionists and other workers engaged in assisting the general
practitioners in the mental health aspects of their work. These training courses can be organised within practices in collaboration with the primary care team, or on the premises of the CMH team or local PG Centre and attended by staff from several local general practices. A practice-based, whole team approach has a great deal to offer in terms of diffusing skills and changing roles within the primary care team, but such training is expensive and requires proper funding. If the arguments in this discussion paper find favour, then regional training centres need to be set up between CMH staff and interested primary care trainers to facilitate this task.

iii. The **CMH team should relate to particular GPs**, rather than to areas on a map where patients live. So, the catchment area will still be an area on a map, but it is the addresses of the GPs surgeries that will determine which GPs are the responsibility of the team. This means that a given GP will relate to a single CMH team. If possible, there should be further specialisation so that key workers on the CMH team are also assigned to particular GPs: ideally, a given GP should work with a particular link worker on the team; while each key-worker should relate to about 2 GPs, and will act as the keyworker for the Care Programme Approach for the patients with severe mental illnesses cared for by those GPs. This link worker will usually be a CPN, and will be responsible for providing family interventions for patients with schizophrenia. (This recommendation would entail major alterations to the way in which CMH teams operate: at present a practice near the edge of a sector may have patients cared for by several different teams, and each GP relates to many different keyworkers).

iv. The **link worker** who works closely with the GP should be trained in **cognitive behavioural skills** needed to manage all the disorders in groups 2 and 3 in Table 2, and should be responsible for helping primary care nurses to acquire these skills and take over as much as possible of this work. At present much of the work carried out by CPNs is supportive therapy, which could be carried out equally well by generic mental health workers. Given the shortage of CPNs in deprived
inner city areas, we envisage a shift in the kinds of work undertaken by CPNs in future, with far more of their time spent administering therapeutic programmes which require detailed training - such as family interventions with schizophrenic patients, and specific cognitive - behavioural skills - and shifting much of the burden of supportive care to the generic mental health workers.

v. The remaining activities of the team are relatively non-controversial. Organising long term supportive care for patients with long term disabilities. Some support activities are better organised at the CMH team than at individual practices: examples of this would be support groups for patients with chronic psychoses; groups to advise, educate and support for carers of patients with schizophrenia; groups for treatment of specific disorders such as victims of sexual abuse or post-traumatic stress disorder. The long term support of those with severe mental disorders will continue to be organised by the CMH team, who will visit patients in their homes or in sheltered accommodation. The team will collaborate with local authorities and voluntary organisations responsible for day care and sheltered employment, and will of course be responsible for running the in-patient unit and will co-ordinate the rehabilitation activities needed by these patients.

2. Primary Care

i. General Practitioners

There is still a substantial need for training of general practitioners in mental health skills, both on vocational training schemes and in the continued professional training offered to established practitioners. We need additional training materials, produced jointly by GPs themselves and mental health experts. The general practitioner should have undergone training in re-attribution skills for somatic symptoms, be familiar with management guidelines for those abusing alcohol and drugs in addition to being familiar with management guidelines for the detection and treatment of depression. The responsibility for accurate detection rests largely upon the GP, and so also does the responsibility to refer onwards to other members of the primary care
team. To do this the GP needs to be aware of the special skills available both within his or her own team, and in the specialist mental health team. When a patient’s illness does not require a special skill, the GP should consider those unable to provide specialist care, but well able to provide supportive care. Although GPs would still be able to refer directly to the psychiatrist or clinical psychologist on the CMH team when occasion demanded, as much care as possible would be delivered according to protocols or good practice guidelines within the practice, and the link worker from the CMH team would normally be the person consulted when help was needed.

ii. The practice nurses should have undergone training in the management of common mental disorders, and should assist the practice with this task. It is likely that as much as 50% of their time might eventually to occupied in this way: but such a change would require major shifts in recruitment, and altered arrangements for remuneration of these nurses. Practice nurse have shown themselves to be very good at sticking to treatment protocols (eg those for asthma); many GPs will prefer to confine themselves to diagnosis and onward referral to their own staff.

iii. Health Visitors and District Nurses can also be trained in mental health skills, and will be capable to carry out whichever mental health skills are appropriate to their work.

iv. Existing counsellors need to be re-trained if they are to provide more than supportive help to other primary care staff. There are effective specific skills that they can contribute, although at present many counsellors have not had a suitable training to allow them to undertake this work.

v. Where trained staff are not available, some supportive work can be shared with generic mental health workers, and co-operation with voluntary agencies. Organisations such as Relate, Alcoholics Anonymous and the Depression Alliance can all usefully supplement the work of the primary care team.
vi. As technological progress allows, it is likely that computerised self treatment packages will play a greater part in the treatment of common mental disorders in primary care.

Problems with these proposals

**CMH Teams:**

the first problem is a shortage of CPNs. There are at present not enough CPNs to operate the Care Programme Approach and the Supervision Register in inner city areas; the present proposals would involve more CPNs serving as link-workers than exist in total at present. Work undertaken in primary care would add to the workload of a labour force that is already overstretched. Nor is it practical to plan for all CPNs to be employed as link-workers: it is likely that some will be needed to operate the Supervision Register, while others will be in a managerial role: the proposals would need approximately 50% increase in manpower to bring them about.

The working practices and case-loads within the CMH team have to be completely re-allocated, and there is likely to be staff resistance to these changes.

The catchment area proposals will create problems with social services. However, it would be very much better to improve working relationships with primary care, and put up with the small inconvenience of relating to more than one social service team on occasion.

The task of providing training, setting up good practice guidelines, setting up shared care registers and drawing up shared care plans involves considerable effort.
CMH teams need to contain a repertoire of specific therapeutic skills, and not see their role as being confined to those with severe mental disorders. They need to be able to supervise workers in primary care, and be available to staff in primary care when problems arise. At present we are witnessing a narrowing of focus within many CMH teams: there will be a real training need in putting this right. Increasing the number of training places for nurse behaviour therapists would be one obvious solution.

Primary Care:

GPs will lose their freedom to refer patients to whoever they please, although they will still be free to refer a particular patient to other members of the CMH team, if they believe that their link worker would not be the right person for that particular patient. However - in default of this, the link worker will be consulted.

GPs would no longer be able to refer cases with a good outlook to the CMH team as they often do at present; however, they could refer them to their own practice nurses instead, although it would be necessary to make mental health work re-imbursable.

The size of the training task is formidable, and would require specialised training centres to be set up to diffuse the requisite skills, or trained pairs of GP tutors and nurses to deliver practice based training. One fruitful approach is to train the entire staff of a primary care practice.

Considerable extra expenditure is involved in employing far more practice nurses than exist at present in order to carry out these proposals.
REFERENCES


37 White E (1990) The quinquennial survey of CPNs in the UK. University of Manchester Department of Nursing Monograph


44 Marks IM (1985) Nurse Therapists in Primary Care. RCN Publications: London


Friedli K, King M (1997) Counselling in general practice - a review. Primary Care Psychiatry 2 (4) 205-216


65  Gask L, Lewis B (1994) *Focus on alcohol*. Teaching package for primary care, Postgraduate Medicine Department, University of Manchester


Extra copies of this discussion paper may be obtained from
Mr Paul Clark,
Institute of Psychiatry,
de Crespigny Park,
London SE5 8AF
for £2.95 including post and packing.