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Brief encounters in general practice: liaison in general practice psychiatry clinics

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Liaison psychiatry in general practice has been recognised as an increasingly important part of the development of community psychiatry. Collaborative working between general practitioners (GPs) and psychiatrists has become commonplace in most parts of the country (Strathdee & Williams, 1984). Different models of liaison have been proposed and a variety of advantages claimed for such work (Mitchell, 1985).

However there have been few attempts by psychiatrists to evaluate the content and effect of liaison work within general practice. This study is a first step towards evaluating our own practice. It examines the frequency of personal contact and focus of communication between psychiatrists and primary health care staff in routine clinical work. All contacts occurred in psychiatric clinics held in surgeries and health centres in an inner city area of Nottingham.

The study

All face to face contacts between psychiatrists and primary care staff were recorded and described during one calendar year. Contacts occurred between three psychiatrists, a consultant (PT), senior registrar (CD) and registrar (rotating), and up to 33 GPs and their associated multidisciplinary teams. Meetings between primary care staff and other mental health professionals were not recorded. The contacts occurred during a total of eight clinics held weekly in five health centres and one GP surgery. There were no scheduled meetings between staff during the clinics, which were held in a sectorised catchment area containing a population of 85,000. The clinics had been running for periods ranging from six months to eight years.

Typical contacts occurred unpredictably before, during and after clinics in psychiatrists' interview rooms, GPs' consulting rooms, reception areas, corridors, carparks and lavatories. After every contact the psychiatrist completed a form detailing the contact, including a description of the content and a categorisation of the discussion (Table II). For all contacts concerning specific patients the primary diagnosis made by the ICD-9 classification was recorded.

Findings

During the year 351 contacts took place between the psychiatrists and all primary care workers. Of these, 18 were excluded from analysis because of incomplete data, only four of these being about individual patients. These contacts were generally longer, initiated by primary care staff, and involved general or specifically educational discussion. The remaining contacts were all about specified patients and most of them took place between psychiatrists and GPs (89%). Of these 298 contacts, 174 (58%) were initiated by the psychiatrists. A similar proportion (58%) of the 35 contacts between primary care staff were initiated by psychiatrists; 56 (17%) of the patients discussed were present during the discussion and 210 (74%) were in psychiatric care.

Most contacts were short with 234 (71%) being less than five minutes and very few longer than 15 minutes, although contacts by non-GP primary care staff tended to be longer (Table I). Contacts of less than five minutes were significantly more likely to be about patients in psychiatric care ($\chi^2 = 8.38$, d.f. = 1, $P = < 0{\cdot}05$). GPs initiated fewer short contacts (64%) than the psychiatrists (84%). The range of problems reflected psychiatry in primary care (Tyrer, 1989) with most contacts about female patients (65%). There were similar numbers of contacts about patients with psychotic 123 (37%) and neurotic 114 (34%) disorders.

Details of the nature of the contacts between psychiatrists and GPs are given in Table II. Most, 150 (50%), involved one category of discussion only, with 113 (38%) discussing two categories and 35 (12%) covering three or more. Overall, clarification of the roles of staff was most commonly discussed, particularly in encounters initiated by psychiatrists. Conveying information about a patient was the next most frequently discussed category. As might have been expected, contacts concerning general management and advice were more often initiated by GPs and were longer. Medication was most frequently discussed during contacts initiated by psychiatrists, about patients with neurotic disorders. During contacts about psychotic patients, both advice and

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TABLE I
Duration of contact between psychiatrists and primary care staff

Minutes	*<5*	*5–15*	*15–30*	*>30*	*Total*
Total	234	95	3	1	333
Male	83	36	0	0	119
Female	151	59	3	1	214
Initiated by psychiatrist	145	47	0	0	192
Initiated by GP	79	45	1	0	125
Initiated by other	10	3	2	1	16

TABLE II
Nature of contacts between psychiatrists and GPs

	Total number of responses per category				
	Role of staff	*Information only*	*Management and advice*	*Medication*	*Wider* issues*
Total	142	132	113	60	15
Initiated by:					
psychiatrist	84	74	52	42	7
GP	58	58	61	18	8
Male	47	52	43	20	1
Female	95	80	70	40	14

Contacts involved more than one category in discussion in many instances.
*Wider issues: includes general and educational discussion not referring to specific patients; conveying concern over issues not directly related to a patient's clinical status e.g. family; employment.

information transfer were more common than with other diagnoses.

Contacts between psychiatrists and other primary care workers showed a broadly similar pattern. The main differences were that more contacts were concerned with patients with psychotic disorders, a larger proportion involved the patient being present during the contacts, which were longer often involving discussion of complex family and social issues.

Comment

These results show that it is possible for psychiatrists to achieve considerable face to face contact with GPs during the course of clinical work in health centre clinics. Far fewer meetings occurred with non-medical primary care staff. The clinics were well established and capable of functioning without any contact or liaison. The fact that contacts were commonplace and mutually sought suggests contact was valued by both disciplines.

The brevity, number and focused content of contacts is reminiscent of the style of consultation seen in general practice that is, short cross-sectional contacts occurring within a framework of continuing long-term care. It has been suggested that this type of contact familiar to and often preferred by GPs may be less attractive to psychiatrists (Wilson & Wilson, 1985). However, in our work the psychiatrists were initiating more shorter contacts.

Many GPs, possibly a majority, prefer consultation with a pyschiatrist, while maintaining clinical responsibility for their patients, provided advice and support are readily available (Strathdee, 1987). In this study 26% of the contacts were about patients not in psychiatric care. We do not know how many of these patients may have been referred without the opportunity to discuss them, or the knowledge that further advice would be available if required. It seems to us that an important ingredient of such liaison work is the mutual willingness to be readily accessible to face to face contact. However sporadic contacts may be in danger of promoting a spurious sense of understanding. Such a danger may be minimised by being regularly available and building trust through a series of irregular contacts. In this way even short contacts can be rewarding. To take one example,

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during one five minute contact a GP asked about the psychological sequelae of diabetes mellitus. During the discussion he revealed that a diabetic patient of his had recently committed suicide. Subsequently it became clear that the GP had gained a good deal from the contact, particularly reassurance about his own practice, beyond the information ostensibly sought.

As community care extends within psychiatry, both GPs and psychiatrists have an increasingly important role coordinating the resources of psychiatry and primary care. Before starting the study we had established that few contacts were taking place between other mental health staff and the primary care team. We were also surprised to find relatively few contacts between the psychiatrists and non medical primary care staff. While increased liaison by non medical staff may be desirable, it appears that the doctors were acting as the filters and communicators between complex multidisiciplinary teams. The central importance of communicating, who is doing what for whom when, is suggested by the most commonly discussed category being "clarifying the role of staff" followed by "conveying information".

This combination of liaison with routine clinical work in general practice is part of what has been called the "comprehensive collaborative model" of liaison psychiatry in general practice (Tyrer *et al*, 1990). It enables ordinary out-patient clinics to provide more patients with the benefit of specialist psychiatric advice (Creed & Marks, 1989), as well as perhaps enhancing the care of those receiving direct psychiatric care. There is also evidence that patients seen in a primary care setting are more likely to receive all their psychiatric care in this setting and have significantly less need for in-patient services (Tyrer *et al*, 1990). It seems reasonable to conclude that the brief liaisons we have described are both cost effective and useful to both general practitioners and psychiatrists and that this "hybrid vigour" could be extended elsewhere without much difficulty.

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Observations on the management of depot neuroleptic therapy

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For the past three years I have been involved in a study of the effects of depot neuroleptic therapy on the social functioning of chronic schizophrenics with Dr D. A. W. Johnson. Having had to screen the bulk of the depot patients of two Area Health Authorities (South and Central Manchester) in the search for possible study entrants, and then monitor a large group of patients for two years who were under the clinical control of a range of Consultant Units, I have been in a good position to make observations about depot management. These are generalisations and may not apply equally to other psychiatric services, but I suspect they will have some relevance.

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