Warner, J. P., King, M., Blizard, R., *et al* (2000) Patient-held shared care records for individuals with mental illness. Randomised controlled evaluation. *British Journal of Psychiatry*, **177**, 319–324.

MCQs

1 The proven benefits of a shared care approach include:
a the opportunity to use the strengths of different healthcare settings
b fewer in-patient admissions
c a pooling of expertise
d reduced consultation rates in primary care
e a smoother patient pathway.

2 The physical health of people with schizophrenia is poorer than that of the general population because:
a people with schizophrenia are more likely to smoke
b people with schizophrenia rarely see a GP
c antipsychotic medication can have significant long-term side-effects
d GPs are less likely to engage in health promotion or prevention with people with schizophrenia than with the general population
e most GPs are unaware of their responsibilities in this area of healthcare.

3 Barriers to shared care include:
a good communication across the primary / secondary care interface
b adequate training in mental health in primary care
c confusion over roles and responsibilities
d negative attitudes towards people with serious mental illness
e lack of understanding of primary / secondary care cultures.

4 The mental health indicators in the new general medical services contract state that:
a the GP practice should have a register of people with serious mental illness regardless of their wish to be included on it
b the practice must review people on the register annually
c the review should include arrangements for coordination with secondary care
d for the majority of patients on lithium, the practice should have a record that serum creatinine and thyroid-stimulating hormone have been checked within the previous 15 months
e the practice nurse is responsible for administering all depot medication.

5 Successful implementation of protocols requires:
a top-down implementation
b restricted local input into development
c appropriate training in how to use protocols
d a commitment to development and implementation across the interface
e patient involvement in their development.

MCQ answers

1	2	3	4	5
a T	a T	a F	a F	a F
b F	b F	b F	b F	b F
c T	c T	c T	c T	c T
d F	d T	d T	d T	d T
e T	e T	e T	e F	e T

Shared care, individual expertise

Invited commentary on... Shared care for people with mental illness

Tom Burns

'Shared care in mental health is now a policy imperative in England and Wales, yet its meaning . . . [is] . . . still open to debate'. Dr Lester's opening line says it all (Lester, 2005, this issue). We're all in favour of it, but none of us is exactly sure what it is. Ambiguity is considered a failing in academic publications and, under pressure from editors, we usually excise the unnecessary and unclear. Politicians, however, often deliberately insert ambiguity, as it allows scope for interpretation. By a simple shift in emphasis, either shared care's achievement can be claimed as a manifesto success or slow progress towards it can be cited to justify further targets.

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Any psychiatrist reading Lester's article will recognise a kindred spirit and be heartened to see such a clear understanding of the needs of people with mental illnesses (in particular, such a recognition of the complex and special needs of the more severely ill among them). Closer working relationships and better communication are in the best interests of the patients, the general practitioners (GPs) and the psychiatrists. So what's in a name? Does it matter that all these issues are subsumed under the rubric of 'shared care'? I think it does.

A common goal that is open to the wide range of interpretations that Lester outlines is just as likely to increase misunderstanding across the primary / secondary care boundary as to reduce it. The very plasticity of the term frustrates our search for those changes in practice that improve collaborative working and are durable, feasible and not critically dependent on individual local initiative. The literature on shared care in mental health is littered with innovations which have made some difference, but few which have generalised or outlived the enthusiasm of their champion. Avoiding the term altogether and disaggregating the components of shared care may take us further.

Improved communication

There is an overwhelming case for improved communication between primary and secondary care in this area. There are well recognised ways of trying to improve liaison between community mental health teams (CMHTs) and GPs (Burns & Bale, 1997), and one approach that seems to be more feasible and productive in the long run is the practice-based liaison meeting. Such liaison (where GPs and CMHTs get to know each other and form realistic expectations of what each has to offer), allied with reasonable local agreements on waiting times for assessment and continuity of care in CMHTs, would answer most of the listed concerns about poor communication.

Patient-held records

Although patient-held records and crisis cards may or may not reduce miscommunication, their purpose is more ambitious. The Warner study (Warner *et al*, 2000) did not demonstrate a sustainable, generalisable improvement, any more than Ben Essex's pioneering work (Essex *et al*, 1990) did in the 1980s. What both shared was an enormous investment of energy to support an innovation that faded away soon after the studies had ended. However, both these studies and the Henderson study of crisis cards (Henderson *et al*, 2004) have a wider significance. They are attempts not only to improve communication, but to explore and alter the power relationship in mental health practice. As such, it is not their immediate failure to generalise or to improve care that is so important but their contribution to a wider conception of the research and service development challenge.

Physical and psychiatric care of serious mental illness

The complementary (not shared) roles of primary and secondary care are most clearly demonstrated in the guidance on the care of serious mental illness cited by Lester. Serious mental illness substantially raises morbidity, and it is proposed that greater vigilance is needed both with regular health checks and in the monitoring of antipsychotics prescribed and administered in primary care. The use of registers and protocols to identify high-risk groups and improve their care is not dependent on shared care. This independence is highlighted by the finding that up to a third of schizophrenia patients received all their care in primary care (Kendrick *et al*, 1994) – following the guidelines is *good* care but not necessarily *shared* care.

Boundaries aren't always bad things

It will be clear that I share Dr Lester's ambition for closer working relationships between CMHTs and primary care teams. However, I have perhaps more faith in systems that have evolved and endured than in systems imposed on what Lester recognises as a sceptical profession. Clearly it is not desirable to have a fragmented system of care requiring patients and GPs to jump through hoops to obtain needed treatments. We want it to be as facilitatory and smooth as possible. On the other hand, there is only so much expertise that any one individual can master. Being a GP is fairly demanding and so is being a psychiatrist – trying to be both is unrealistic.

Boundaries should exist only where they make sense (a somewhat hypocritical comment coming from one whose profession seems engaged in an apparently endless process of subspecialising). Boundaries ensure that practitioners are not required to act outside their competence and they help define for others what we do. Clarity about competences and appropriate divisions of responsibilities usually improve relationships. Our emphasis should be on fostering harmonious collaboration;

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sometimes this will involve shared care, but more often it will simply need better communication and improved understanding of our different skills and tasks.

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