and university clinicians could be built into the system. For a start, the doctors' and dentists' review body could well be asked to include university medical staff in its remit: that would leave the government in no doubt of their worth. Then the review could establish, say, whether university clinicians should be seconded to the NHS, employed by the NHS—a solution opposed by medical teachers, or paid a clinical supplement by the NHS. Another possibility might be for the DHSS to transfer funds centrally to the Department of Education and Science to cover clinical duties carried out by university staff. Again, in this era of devolution health authorities and medical schools could be given a free hand to arrange local solutions. There is also the thorny question of private practice by academic staff, an activity governed by a variety of arrangements at different universities. But whatever practical solutions are proposed two principles must remain: university medical staff should continue to provide clinical services for the NHS, and they should be rewarded for these on the same basis as their clinical colleagues. The "honorary injustice" now being annually meted out to medical teachers must not continue.

1 Dickinson CJ. Stagnation and despair in medical research. *Br Med J* 1985;**290**:337-8.
2 University Hospitals Association and National Association of Health Authorities. *A survey of academic medical staffing changes in the clinical medical schools and (university) clinical faculties in England and Wales 1981 to 1984*. London: UHA and NAHA, 1985.
3 Anonymous. Pay set back for clinical academic staff. *Br Med J* 1985;**291**:1218.
4 National Board for Prices and Incomes. *Standing reference on the pay of university teachers in Great Britain*. First report No 98. London: HMSO, 1968. (Cmnd 3866.)
5 Anonymous. Review body proposes 6·3%. Government delays award until 1 June. *Br Med J* 1985;**290**:1836.
6 Anonymous. The week. *Br Med J* 1979;ii:1159.

Regular Review

Chronic mental disorders in general practice

GREG WILKINSON, IAN FALLOON, BISWAJIT SEN

In contrast with the many publications on minor psychiatric morbidity in general practice very little attention has been paid to chronic mental disorder.[1] Such neglect is all the more surprising in view of the growing movement towards community care for the mentally ill.[2,3] Plainly we need more information on the balance between specialist and primary care in meeting the needs of the chronically mentally ill in the future[4]—especially as the general practitioner is now seen to play a central part in the provision of comprehensive health services.

Extent of the disorders

In their classic study Shepherd *et al* found that in general practice about 14% of patients consulted their doctor at least once in a 12 month period for a condition diagnosed as largely or entirely psychiatric in nature.[5] Just over half these patients had chronic conditions, defined as those continuously present for at least one year or recurring with sufficient frequency to cause continuous disability or to require continuous prophylactic treatment. These findings have been confirmed, in general, by subsequent work. In an important recent study in the United States about 30% of patients in primary care were found to have a diagnosis of mental disorder, and five sixths of these disorders had a duration of over one year.[6] Taken together the two studies agree that about 8% of patients seen in primary care suffer from chronic mental disorders with some degree of functional impairment.

Within this heterogeneous group of disorders affective disorders have the highest overall rates of occurrence, but psychotic, anxiety, and personality disorders contribute the greatest proportion of severe disability.[6] Such chronic mental disorder is also positively associated with other forms of chronic ill health and a range of social disabilities.[5]

The burden of care

Much of the burden of medical care for patients with chronic mental disorders falls, inevitably, on the general practitioner. Its extent is not easy to measure. For example, Parkes *et al* studied patients with schizophrenia discharged from London mental hospitals and found that more than 70% saw their general practitioner at least once in the following year (over half were seen more than five times)—whereas under 60% attended a psychiatric outpatient clinic (over half of these were seen fewer than five times).[7] They concluded that: "While mental hospitals and outpatient clinics were responsible for initiating most of the treatment required for maintaining the patients' health, it was the general practitioners who played the major part in dealing with the crises and relapses that occurred in over half the cases."

A similar pattern emerged from a recent survey of the care of chronically mentally ill patients in north Buckinghamshire. In the course of a year patients consulted general practitioners more than twice as often as they consulted mental health services, and general practitioners had three times as many emergency consultations. Over a quarter of all the patients' consultations were for non-psychiatric complaints. The bulk of specialised mental health services were provided by community psychiatric nurses, and care by the psychiatrist was limited to fewer than 10% of the overall patient contacts with medical services.

These findings fit in well with the observation by Shepherd

et al that most patients with identified mental disorder are dealt with by the practitioners themselves.[5] They are also in line with Hassall and Stilwell's findings on support by family doctors for patients on a psychiatric case register.[8] Patients on the register (who had various psychiatric diagnoses) consulted their general practitioners just over twice as often as matched control patients. Contact with the psychiatric services did not reduce the psychiatric patients' demand for their general practitioners' time.

Many patients with chronic mental disorders, however, do not come to the attention of either general practitioners or psychiatrists. Johnstone *et al* followed up a cohort of patients with schizophrenia discharged from a mental hospital.[9] After an interval of five to nine years severe emotional, social, and financial difficulties were still commonplace; and 27% of the sample had no contact with medical or social services, a further 14% saw only community nurses, and 24% saw only their general practitioners.

In the study by Parkes *et al* over the course of a year 27% of the sample had no contact with their general practitioners and 42% had no contact with the psychiatric outpatient clinic[7]; and Hassall and Stilwell found that, though 96% of patients on the case register and 95% of controls had contact with their family doctor during the two year study period, nearly half of the patients on the psychiatric case register had no contact with psychiatric services in this time.[8]

Management objectives

Speaking at a conference on mental health planning at the Royal College of Physicians of London in March 1985 from the perspective of general practice, Ben Essex listed the main management objectives: the identification of all patients with chronic mental disorder in the practice population; the assessment of their needs and the needs of their relatives; the early recognition of relapse; the provision of cost effective care, responsive to patients' changing needs; the reduction of stress in the patient and family; the education of patients, relatives, and voluntary carers in the long term treatment plan, in association with members of the primary care team; the establishment of communications among all concerned in the patient's care; the continuous evaluation of the effectiveness of care provided; and prevention of disability, self injury, stress, institutionalisation in the community, relapse, therapeutic non-compliance, and the breakdown of family and social supports. These objectives might be promoted by the wider use of general practice case registers and by care being shared with hospital specialists.

Improving treatment

Drugs apart (they need a separate article), what are the current options for improving the treatment of patients with chronic mental disorders in general practice? Most general practitioners will probably want to work in consultation with the specialist mental health services. These are currently in a state of review,[10,11] one important factor being the many psychiatrists who are now working directly in primary care settings.[12] The three crucial elements in these developments are: psychiatrist and general practitioner liaison-consultation attachment schemes; the therapeutic role of community nurses and social workers; and the family based management of psychiatric disorder.

Tyrer has recently argued that psychiatric clinics in general practice "offer a way of achieving better community psychiatry without any need for increased resources."[13] Few other models of liaison-consultation have been the subject of such systematic evaluation.[14] Tyrer found that the patients seen in these clinics encompassed the entire range of psychiatric disorders.[13] A "significant proportion" had chronic mental disorders, and almost half were still attending the clinic at the end of two years. Patients sometimes saw the community nurse and sometimes other members of the primary care team, including health visitors and district nurses. The patients apparently preferred such clinics to hospital clinics because of the ease of access and the relative absence of stigma. Comparison of the frequency of contacts with the psychiatric services for patients from practices with and without such clinics showed a 20% fall in the number of admissions to psychiatric hospital, an increase in the number of outpatients seen, and a fall in the number of new referrals.[15]

Two randomised controlled clinical trials have shown clinical and economic benefits from community nursing for neurotic patients. In one study neurotic patients requiring follow up (mean total life time psychiatric treatment received about 40 months) were assigned to receive either routine psychiatric care as outpatients or supportive home visiting from community psychiatric nurses.[16] No differences were found between the two types of service in their effect on symptoms, social adjustment, or family burden at up to 18 months of follow up. Community psychiatric nursing reduced outpatient contacts with psychiatrists and other staff; more patients were discharged, and there was a small increase in contacts with general practitioners for prescribing. In the other investigation neurotic patients with mainly phobic and obsessive compulsive disorders (mean duration seven years) did better up to one year after receiving behavioural psychotherapy from a nurse therapist than routine treatment from a general practitioner.[17] As before, patients preferred being treated in the primary care setting.

Shepherd *et al* have given an account of a social worker attached to a primary care team in the management of chronic neurotic illness in the community.[18] They could not pinpoint specific factors to account for the benefits and concluded: "The likeliest explanation would appear to be that the social worker's personal activities supplement the resources which she mobilises and facilitate a more positive approach by the general practitioner towards the social orbit of morbidity."

A recent study looked at women suffering from acute or acute on chronic depression who were randomly allocated to routine treatment by their doctor or referral to an attached social worker.[19] Sixty per cent of both groups were clinically improved at six month follow up: however, women assessed initially as suffering from acute on chronic depression with substantial marital difficulties were found to benefit from social work intervention. These patients could be distinguished from the others by their high degree of motivation, the initial severity of their problems, and by the amount of practical help provided by the social workers.

Family management of chronic mental disorder

Falloon *et al* compared family treatment at home with clinic based individual supportive care in the community management of schizophrenia in patients taking neuroleptic medication.[20,21] The family treatment approach was intended to help the patient and his family reduce stress by improving

their understanding of the illness and also helping them solve problems. After nine months the results showed that this approach had proved better in reducing the clinical, social, and family morbidity associated with schizophrenia. Moreover, patients treated in the family averaged far fewer days in hospital and fewer emergency consultations than the comparison group. These benefits were maintained over a 24 month period of community aftercare—which cost substantially less than clinic based individual supportive management.

Conclusions

There is no established, empirically based, comprehensive and integrated approach to the psychopharmacological, social, and psychological treatment of patients with chronic mental disorders in general practice.[22] We have not yet found how to determine what balance of physical, social, and psychological care is appropriate for specific patients and who should give appropriate care. Care, in this context, is also likely to mean including attention to patients' occupational, educational, and housing needs. This whole subject requires experimental and evaluative investigations.

General practitioners and hospital specialists need to be trained not only to detect patients with chronic mental disorders but also how to organise and provide early and continuing treatment for them and to recognise when specialist psychiatric consultation and referral are likely to be helpful. Undergraduate and postgraduate clinical teachers of general practice and psychiatry have great scope for collaboration in this endeavour, as do the respective royal colleges.

In the future therapeutic management strategies for the care of patients with chronic mental disorders in primary care settings are likely to be based on closer community based therapeutic contact among patients, their families and friends, and their professional helpers; a more direct working relationship between general practitioners and psychiatrists; and closer cooperation between primary care and multidisciplinary specialist psychiatric teams in the community.[23,24] The private and the voluntary health care sectors and self help groups continue to have enormous scope for imaginative contributions.

Changes of the kind outlined have management, manpower, planning, policy, and resource implications; these should be attracting attention in the Department of Health and Social Security.

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1 Wilkinson G. *Mental health practices in primary care settings*. London: Tavistock Publications, 1985.
2 Department of Health and Social Security. *Better services for the mentally ill*. London: HMSO, 1975.
3 Department of Health and Social Security. *Report of a symposium on chronic mental illness*. London: HMSO, 1978.
4 Department of Health and Social Security. *Care in the community. A consultative document on moving resources for care in England*. London: DHSS, 1983.
5 Shepherd M, Cooper B, Brown AC, Kalton G. *Psychiatric illness in general practice*. Oxford: Oxford University Press, 1981.
6 Regier DA, Burke JD, Manderscheid RW, Burns BJ. The chronically mentally ill in primary care. *Psychol Med* 1985;**15**:265-73.
7 Parkes CM, Brown GW, Monck EM. The general practitioner and the schizophrenic patient. *Br Med J* 1962;ii:972-6.
8 Hassall C, Stilwell JA. Family-doctor support for patients on a psychiatric case register. *J R Coll Gen Pract* 1977;**27**:605-8.
9 Johnstone EC, Owens DGC, Gold A, Crow TJ, MacMillan JF. Schizophrenic patients discharged from hospital—a follow up study. *Br J Psychiatry* 1984;**145**:586-90.
10 Wilkinson G. Community care: planning mental health services. *Br Med J* 1985;**290**:1271-3.
11 Tyrer P. The hive system: a model for a psychiatric service. *Br J Psychiatry* 1985;**146**:571-5.
12 Strathdee G, Williams P. A survey of psychiatrists in primary care: the silent growth of a new service. *J R Coll Gen Pract* 1984;**34**:615-8.
13 Tyrer P. Psychiatric clinics in general practice: an extension of community care. *Br J Psychiatry* 1985;**145**:9-14.
14 Mitchell ARK. Liaison psychiatry in general practice. *Br J Hosp Med* 1983;**30**:100-6.
15 Tyrer P, Seivewright N, Wollerton S. General practice psychiatric clinics: impact on psychiatric services. *Br J Psychiatry* 1984;**145**:15-9.
16 Paykel ES, Mangen SP, Griffith JH, Burns TP. Community psychiatric nursing for neurotic patients: a controlled trial. *Br J Psychiatry* 1982;**140**:573-81.
17 Marks I. Controlled trial of psychiatric nurse therapists in primary care. *Br Med J* 1985;**290**:1181-4.
18 Shepherd M, Harwin BG, Depla C, Cairns V. Social work and the primary care of mental disorder. *Psychol Med* 1979;**9**:661-9.
19 Corney RH. The effectiveness of attached social workers in the management of depressd female patients in general practice. *Psychol Med* 1984; monogr suppl 6.
20 Falloon IRH, Boyd IL, McGill CW, Razani J, Moss HB, Gilderman AM. Family management in the prevention of exacerbations of schizophrenia. *N Engl J Med* 1982;**306**:1337-40.
21 Falloon IRH. *Family management of schizophrenia: a study of clinical, social, family, and economic benefits*. Baltimore: Johns Hopkins University Press, 1985.
22 Lennox G. Psychological problems. In: Hasler J, Schofield T, eds. *Continuing care. The management of chronic disease*. Oxford: Oxford University Press, 1984.
23 Anonymous. Teamwork in the community [Editorial]. *Lancet* 1981;ii:403-4.
24 McKechnie AA, Philip AE, Ramage JG. Psychiatric services in primary care: specialised or not? *J R Coll Gen Pract* 1981;**31**:611-4.