Abstract
At first glance the term “primary care psychiatry”, might indeed be perceived as a contradiction in terms. The word “psychiatry” for many may provoke images of someone lying on a couch spilling out their problems to a pensive specialist doctor, or of a towering, grand building with locked doors to keep the patients in and the public safe. In reality, mental health is on such a wide spectrum one may not realize you are sitting near to several people suffering mental health problems. Rising numbers of people suffering from mental ill health cannot all be accommodated by the service of scarce consultants and so many increasingly rely on the GP to provide for their mental health needs. This essay aims to show how primary care has an important role in caring for patients with psychiatric problems, and how the term “Primary care psychiatry” might not be as big a contradiction as first thought. It outlines how psychiatry has developed and how patients with mental health problems are currently treated. It goes on to challenge the premise in the title by arguing that psychiatry can and should be treated in primary care and that this can be achieved through better use of the “four Cs”,

Introduction
In this essay I challenge the premise in the title by arguing that psychiatry can and should be treated in primary care and that this can be achieved through better use of the “four Cs”, Primary care offers most people their first contact with the NHS and provides a gateway to the more specialist services it provides. With one in four people(1) suffering mental health problems, and with over 90 per cent of patients in the health service interacting with primary care services, there is no doubt a generous number will have psychiatric needs. Why should General Practitioners worry about people with mental health problems; surely they can just refer them on to specialists? However, with fewer people choosing psychiatry as a career(2) it is important that those who can be dealt with in primary care receive the appropriate care. People with mental health difficulties often have lower self-esteem and hence lower self-efficacy; they are more inclined to adopt poor life choices and usually feel less able to adopt lifestyle changes(3). This can cause people to present with not only even poorer mental health but with declining physical health, creating a bigger problem for the GP to deal with. However seeing a psychiatrist is still often regarded as a secondary or tertiary level service, requiring physicians with very
specialist knowledge, and it can initially be hard to see how psychiatry can be provided by physicians in primary care.

Psychiatrists are concerned with the diagnosis and treatment and prevention of mental health problems. During an appointment a psychiatrist will generally assess physical health to rule out any conditions which may be causing problems. They then use their skills to ask in depth questions about patients’ life and thoughts and how these are affecting the way they live(4). GPs are responsible for looking after patients in the community with a wide variety of conditions ranging from physical, psychological and social problems. Under the new Health and Social Care act they are increasingly responsible for how the budget for healthcare is spent as part of their role in clinical commissioning groups(5). With psychotherapy appointments often lasting in excess of 45 minutes and GPs allocated 10 minutes to assess and deal with patients’ problems it would seem impossible for psychiatry to be dealt with in primary care. But is there something that can be done to help narrow these differences between the two specialties and can GPs help prevent mental health crises in patients by detecting problems early? With the abolition of primary care trusts in 2013, GPs are increasingly liable for providing and commissioning the correct level of mental health services in their area, which means they will need to take a more proactive approach to assessing patients in need of secondary level care.

**Treatment through history**

Through history at the treatment of people with mental disorders it is clear that “Primary care psychiatry” has not always been standard practice.. The years between the world wars saw an increasing unease around the presence of asylums and the segregation this caused between the sane and the insane. Doctors became more aware that there was a spectrum of mental disorders with some mild cases warranting treatment out of a hospital setting. These borderline cases led the way in prompting a move from institutional care to a more personalized approach. Hospitals began to “unlock their doors” in the 1940s giving way to a new wave of antipsychiatry in the 1960s where patients and psychiatrists lived together. The minister for health decided that hospitalizing large numbers of the population for psychiatric problems was not cost affective. In fact he spoke of how mental health care was not properly funded at all and progress in community care would not be made until this was rectified (6). With the progress in pharmacological treatment for mental disorders, large mental hospitals were not required to provide long term care for patients; acute care
could be given in local hospitals. This then provided further energy to the debate on treating mental health patients in the community and out-patient settings. Larger mental hospitals continued to close with only the most severe and antisocial cases requiring inpatient treatment in the current era.

**Psychiatry, the current situation and the future.**
The important question now is *should* primary care psychiatry be a contradiction in terms? With the percentage of the population diagnosed with common mental health disorders up by 2.1 per cent between 1993 and 2007 (7) there is a clear need for primary care settings to be able to provide appropriate care for such patients in order to prevent crises occurring, leading to a need for more intensive treatment. Not only does this potentially prevent a traumatic admission to a psychiatric hospital but provides clear economic benefit. The national average daily cost for a stay on an acute psychiatric bed is £295, with eating disorder beds costing on average £426 per day in 2009. This can be contrasted with the average outpatient attendance cost of £136 per visit.(8)

Looking to the future, there is growing evidence that neuroscience will play a big role in the treatment of mental health disorders. These treatments often involve use of specialised equipment, not found in a GP surgery. Repetitive transcranial magnetic stimulation has been found to have a beneficial effect in reducing the symptoms involved with anorexia nervosa (9) and deep brain stimulation has been found to be effective in treating treatment-resistant depression (10). These findings hold exciting prospects for curing mental health disorders but with the research often still in early stages we must focus on how best to provide for patients with mental health problems with our current understanding and resources.

**Why move to a primary care approach to psychiatry?**
With the spending on depression expected to increase by almost one-third by 2026, in an ever cost-conscious society, it is important that savings for both the economy and the patient are found. (11) Early intervention, over one year for those suffering psychotic episodes has been estimated at around £9422 compared to the cost of standard care of £14,394. This saving was mainly due to the need for fewer patients requiring inpatient care.(12) Moreover, fewer inpatient stays means fewer patients experience the trauma of leaving their home. The cost of an average GP consultation is about £36 for a 12 minute consultation(13) and with many common mental health conditions manageable in primary care, the economic benefits of spotting these early is further supported.
Preventing inpatient stays also improves attendance at follow up clinics. For a number of reasons people who had previously been hospitalised were less likely to attend follow up appointments(14). With 90 per cent of the follow up clinic population suffering severe or enduring mental health conditions, yet the majority of new referrals having common mental health disorders, there is an obvious need for GPs and primary care professionals to recognise and manage severe mental health disorders before they reach a point were admission is required. This will potentially improve attendance rates at outpatient clinics, the outcome for the patient and should inevitably save money.

Another growing problem in the UK is the rising rate of dementia; the number of sufferers is expected to increase by at least 200,000 by 2021.(15) Diagnosis in primary care of the 1 per cent of cases of treatable dementia would result in a saving of £143 420(15), by preventing referrals to secondary care. Cases like these need to be screened during GP consultations. It is estimated that 50 per cent of those presenting with dementia symptoms do not get an initial screen(15).

With the severity of mental health problems inevitably rising with the length of time left undiagnosed there is increased pressure on GPs to be aware of warning signs for disorders which patients may be reluctant to talk about, for example eating disorders. Failure to spot this illness can lead to not only a decline in mental health but also poor physical health. With conditions such as these being very complex to treat, by providing GPs with guidelines on what questions to ask, we can potentially prevent unnecessary suffering. A leading research centre for eating disorders produced comprehensive guidance for GPs on how to approach a consultation with someone with an eating disorder.(16) Such guidance could help keep patients in primary care as the last section focuses on when to refer a patient to secondary care (Figure one).
Primary care psychiatry, four Cs can help patients with mental illness

Mental illness has such a broad spectrum. So how can we equip GPs to recognise those for which psychiatrists train for years to be able to recognise and treat? But, is it ethical to allow people to be treated in primary care rather than referring them to a more specialist doctor? With regards to the ethics of the treatment, this really goes back to the primary question of the training GPs get in mental health problems. If GPs are adequately trained in the management of psychiatric disorders and they are fully aware of the services available in the local community then there is no reason why it would be unethical.

To avoid being in breach of the four principles, autonomy, beneficence, non-maleficence and justice, GPs must have the knowledge to spot early signs of mental health disorders, as well as promoting good mental health strategies. By being able to impart information on the conditions to patients we automatically give them some autonomy to think about their next step in treatment, e.g. self-help, community care or more intensive treatment. If we let inadequately trained GPs treat people with mental ill health, we may potentially cause more harm than good. With one third of people with severe mental illness being seen solely in primary care, it is vital that GPs are fully aware of how to manage these illnesses. (17) In order to address these issues, I propose we learn how to integrate the “four Cs” into daily practice:

- **Curriculum**
In order to be able to diagnose and treat patients with mental illness in primary care we need to ensure primary care can facilitate the level of care they need. The answer to equipping GPs sufficiently lies in medical schools and the attitudes ingrained into students about psychiatry. Although the stigma around mental illness is being broken down, many medical students still see psychiatry as a “wishy washy” science. With up to 42 per cent of people declining psychiatry as a vocation before even entering medical school,(18) it is doubtful if they will pay much attention to any psychiatric teaching they receive in medical school. A study of medical students concerning their attitudes to psychiatry before and after an attachment in a psychiatric ward, revealed a doubling in the percentage of students who would consider psychiatry as a career after placement on a psychiatric rotation. Attitudes to psychiatry as a whole also improved, including their views on the types of patients seen in the psychiatric setting. The type of attachment was also important, for example those who took on health assistant roles such as observing patients in restraint came away with a more negative role of psychiatry.(18)

Often psychiatric placements occur in the latter years of medical school and by this stage students have often a vague idea of the area of medicine they want to enter. Leaving psychiatric placements to this late stage could therefore have a negative effect on the number of people entering psychiatry or generally taking an interest in psychiatry if they enter General Practice. Perhaps having earlier exposure to psychiatry in medical school would help to spark an interest in the subject among medical students. Even if they chose to enter General Practice, they would have a broader understanding of the mental health system and the treatments available. Strengthening this prior knowledge, with publications such as “A General Practitioner’s Guide to Eating Disorders” (16), should see patients getting more appropriate treatment.

My own experience as a medical student tends to confirm that our teachers and lecturers have negative attitudes to psychiatry, brushing it off as an easy science compared to anatomy and physiology of the body. This will lead to many students spending less time on reading around psychiatry and doing the basic work to develop adequate knowledge about mental health conditions.

**Collaboration**

As well as getting students interested in mental health, there needs to be an appropriate system for evaluating and treating patients with mental illness in primary care. Perhaps the
answer lies in the “care programme approach” which can be held in GP surgeries. (14)
This approach is based around prompt follow up care of those who have been discharged
from hospital, ensuring they receive the support they need to continue to recover in the
community and avoid readmission. Some primary care teams are already well equipped to
deal with these referrals and also with new cases that may present in a GP consultation.
Some GP practices have link workers(19) who are specialist mental health workers who
can offer support and advice on a topic GPs may not be aware of. These link workers help
assess people with complex care needs rather than wait for a referral to secondary care
and use up scarce consultants’ time. Some patients may inevitably have such severe
mental health needs that referral to secondary or tertiary care will be needed but by having
a link worker in place they can assess each case individually with more time than a GP
can spend on each appointment.

❖ Communication

Good communications between care providers and between the care provider and the
patient are vitally important. In fact some patients’ symptoms are alleviated simply by using
talking therapies like CBT. Sometimes people with mental health needs find it hard to
communicate with a doctor in a private consultation. There is evidence that one way to
help such patients can be to formulate a communication checklist for them to complete
prior to the consultation, ensuring they ask the questions they regard as important and are
therefore better placed to ask for the help they need. (20). Although GPs are generally not
able to provide such in depth therapy, they should at least take note that not all patients
will present with illnesses that require a physical treatment. The link worker may be able to
provide appropriate talking therapies or groups. One study where patients inputted the
ratings of their feelings into a computer system and then discussed them with a clinician as
part of their normal care were found to have a better quality of life score at twelve month
follow up, fewer unmet needs and higher treatment satisfaction compared to a control
group receiving normal treatment.(21) Having a link worker from the community mental
health team, perhaps catering for a number of practices, would provide a bridge between
primary and secondary care as CMHTs also work closely with secondary services.

❖ Charity

A growing number of charities now provide therapy free of charge. Some patients who
present to GPs with minor mental health symptoms might be better to approach such
charities for help. In comparison to other illnesses, many psychiatric conditions do not
require the physical tests such as those for say, asthma or diabetes. Charities are able to provide care of an equal if not better level, also with a lower waiting time. Many charities are set up for particular mental health illnesses, for example Beat for eating disorders(22) or anxiety UK (23) for general anxiety disorders. Such charities provide self-help groups, helplines and even apps for smart phones. People often report only feeling truly understood by people who have suffered or are suffering currently; communicating with others can be truly cathartic and comforting knowing you are not alone, so often a feeling blighting these people’s minds. The presence of these charities has potential to greatly alleviate pressure from the NHS. By forming more official links with the NHS and GPs in particular they could act as a resource, accepting referrals, particularly for those with mild mental health needs. By avoiding the need for these patients to go into secondary care, those with more severe mental health needs can get faster access to the treatment they need, thus preventing a possible crisis in their lives. A document produced by the Irish College of General Practitioners supports this view. It states that primary care practitioners should be available to treat mental health problems and promote mental wellbeing. By promoting wellbeing at the individual level, community level and structural level this will provide help for all of the population including at risk groups and vulnerable people(3). Charities would work through strengthening communities by providing self-help groups and at the structural levels by campaigning to reduce stigma around mental illness.

**Conclusion**

It is a fact that the majority of people with mental health problems are still treated in secondary care and psychiatrists are reluctant to discharge people to primary care (24), hence supporting the argument that primary care psychiatry is a contradiction in terms. But this need not be the case. In order to help primary care psychiatry develop there should be a focus on the “four Cs”

- **Curriculum** which integrates psychiatry earlier into medical school.
- **Collaboration** between primary care, mental health specialists and charity services.
- **Communication** within the healthcare team and between doctors and patients.
- **Charity** to help provide self-help and promote mental health in the community, working to de-stigmatize psychiatry and provide services that complement those provided within the NHS.

Moving further and further away from the institutionalized past of mental illness treatment is an exciting and challenging prospect but one which will benefit society greatly. With the co-operation of the government to support mental health charities, medical schools to
increase teaching on mental health problems and doctors themselves to continually engage with mental health promotion, greater primary care psychiatry is clearly attainable.

1. charity R. [02/08/2013]; Available from: http://www.rethink.org/.


22. BEAT. Get support. [04/08/2013]; Available from: http://www.b-eat.co.uk/get-help/get-support/.


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