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Editorial

It's time to talk: rekindling the relationship with primary care†

Roger Banks & Linda Gask

Abstract Healthcare provision in the UK is in a process of continual change. The structures and processes by which people with mental health problems and people with learning disabilities receive support from statutory services have been, and continue to be, subject to many and varied strategic, policy and professional influences. Integrated and collaborative ways of working between generalist ('primary') and specialist ('secondary') care have become eroded over time and yet they may be needed more than ever. In this editorial we encourage a collaborative approach between practitioners in generalist and specialist care in studying and developing three strands of work: policy and strategy; training; and professional behaviour. Above all, we advocate strongly for a renewed and dynamic dialogue between psychiatrists and general practitioners in working together to provide high-quality mental healthcare.

Twenty years ago it was not unusual for psychiatrists in the UK to spend at least some of their time working in a primary care setting (Mitchell, 1985; Pullen & Yellowlees, 1988). A considerable literature developed on ways of working within, and across the interface between, primary (generalist) and specialist care (Gask *et al*, 1997), with clarification of the evidence base for particular ways of working (Bower & Gilbody, 2005). The intervening years, however, have seen a widening rather than a narrowing of the gap between primary care and mental health services. Recent data are difficult to track down but a common perception would be, at least in urban areas, that psychiatrists now rarely visit general practitioner (GP) clinics or meet their GP colleagues. The focus of mental health services on severe and enduring mental health problems over the past decade has seen a shift in GPs' perceptions of the accessibility of psychiatrists for consultation or advice, particularly about the assessment and management of people who do not have a psychotic illness, but who may nevertheless present with a complex mixture of mood disorder, social difficulties, risky behaviour and often comorbid physical health problems (Chew-Graham *et al*, 2007; Cohen, 2008, this issue).

†See pp. 98–105 and 106–108, this issue.

It is not always easy for generalists and specialists to understand each other's view of the world, and a variety of barriers stand in the way of better integration between primary and specialist mental healthcare (Lester *et al*, 2004; Gask, 2005*a*). General practitioners currently work in a system in which they are the first point of access for all comers with every type of health problem; a high-volume, low-intensity provider system with centrally imposed targets for access times set by central government. Psychiatrists who work in crisis teams may also feel something akin to this constant flow of human need through their services, but many of our profession now work in highly specialised teams to which access is increasingly limited by protocols and referral criteria.

With the development of GP commissioning, GPs are being encouraged to play a greater role in determining the overall shape and functioning of mental health provision in the community. If we psychiatrists rarely meet our GP colleagues we never get to explore commonalities and differences in the views and ideas that we each hold about mental health policy, service provision, the world and each other. More important, however, is that patients and service users surely cannot be receiving optimal care in a system that does not encourage better inter-professional communication (Miller *et al*, 2005).

Roger Banks is current Vice-President of the Royal College of Psychiatrists (Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK. Email: rbanks@rcpsych.ac.uk) and Consultant in the Psychiatry of Learning Disability with Conwy and Denbighshire NHS Trust. He is also Honorary Senior Lecturer at the College of Health and Behavioural Sciences, Bangor University. Linda Gask is Professor of Primary Care Psychiatry at the University of Manchester and Honorary Consultant Psychiatrist with Salford Primary Care Trust and Bolton, Salford and Trafford Mental Health Trust.

We think that it is time to question and re-examine mental health policy in the light of the evidence that has accrued over the past two decades about the interface between primary and secondary care. What are the benefits to be gained for the patient, the practitioner, the organisations and the wider health economy through primary care and psychiatry working more closely together? What are the optimal ways of achieving this? Where are the examples of good practice? What research still needs to be conducted to strengthen the evidence and inform the direction of policy?

To follow up these lines of inquiry, we need to work on three different fronts: policy and strategy, training and professional behaviour.

Policy and strategy

The Royal College of Psychiatrists has successfully rekindled the dialogue with primary care through the appointment of a Vice-President (R.B.) with a remit to develop a primary care strategy. Initiatives thus far include liaison with the Royal College of General Practitioners on the accreditation of GPs with a special interest in mental health and work towards the establishment of a joint Special Interest Group in Primary Care Mental Health across both Colleges.

Training

Many psychiatrists in training have only limited opportunities in their posts to learn how to manage anxiety, non-psychotic depression, and obsessive–compulsive and eating disorders. We need to consider how to widen training opportunities for psychiatrists so that we do not lose our traditional broad expertise in the management of all mental health problems, not simply psychotic disorders. We need to do this not only to ensure the well-being of the profession (a narrow work experience is unattractive to recruits), but also to be able to enter into effective dialogue with primary care practitioners about the substantial and pervasive mental health needs of their patients. Consideration of this is, we feel, crucial to the future of general psychiatry. Is it also crucial to the future of mental health services in which primary care will play a stronger and more directive role through such developments as practice-based commissioning and the Improving Access to Psychological Therapies programme, now being piloted in England (www.mhchoice.csip.org.uk/psychological-therapies/psychological-therapies.html).

Better training in mental health in primary care will be the remit of a newly established Joint Educational Advisory Group between the two Colleges.

Professional behaviour: finding new ways of working

The College's Faculty of General Psychiatry will be reviewing the potential for new roles for psychiatrists in working more closely with primary care, taking into account the evidence base that has accumulated. This is not simply to re-create the old, overloaded job of the general psychiatrist, but to develop better models of providing specialist input to primary care (Gask, 2005*b*). Such models appear to fit well with the suggested change in the role of the psychiatrist in New Ways of Working for Psychiatrists (Care Services Improvement Partnership *et al*, 2005).

As psychiatrists, we are well aware of the therapeutic potential of the conversation in achieving change. It's time to restart the dialogue and bridge the gap between psychiatry and primary care.

Declaration of interest

L.G. has received payment from several pharmaceutical companies for lecturing on the topic of mental health problems in primary care.

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