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Lecture

Working with General Practitioners

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Psychiatrists and general practitioners have found new ways of working together in the last ten years, but there have also been separate activities which could develop into rivalry. These opportunities and dangers are the central theme of this paper. Ways are considered in which the psychiatry of general practice differs from the experience of psychiatrists. Forms of help are suggested which general practitioners need from psychiatrists, whether in clinical practice or education.

The psychiatry of general practice

Almost all general practitioners in this country now accept that psychiatry is part of their work, as Robertson has confirmed for the neighbourhood of Aberdeen (Robertson, 1979). If they did not, psychiatrists would be overwhelmed and would see many patients whose problems did not need their expertise or lay in some other field altogether. This is what happens in countries where the protective shield of general practice is weak.

Table I, modified from Goldberg & Huxley (1980), indicates in a numerical way the place of general practice and primary medical care in relation to psychiatric needs on the one hand and to specialist provision on the other. It shows how large a load is carried by general practitioners, but also shows the discrepancy between the problems which are recognised ('conspicuous morbidity') and the much larger number which might or might not benefit from recognition ('total morbidity').*

It would be misleading to discuss the ways in which the psychiatry of general practice or primary care differs from the experience of psychiatrists without first saying that the similarities far outweigh them. For example, the demographic and social characteristics of our psychiatric clienteles resemble each other very closely (Goldberg *et al*, 1976; Weissman & Myers, 1978; Henderson, 1981; Weyerer *et al*, 1982; Dilling and Weyerer, 1984).

The differences are in the severity of the cases overall, in the frequency with which different sorts of problems are encountered, in the way they are presented, and in the methods used to deal with them.

*There is evidence, however, that general practitioners prescribe as if more of the problems they see had a psychiatric component than their formal diagnoses suggest (Williams, 1978; Harris *et al*, 1981).

General practitioners meet all the severe disturbances, but not every day. They meet severe depression more often than schizophrenia or severe dementia. The majority of symptoms and disorders are of moderate or slight degree; nevertheless, they are consistently more serious than those experienced by people who do not come to the doctor (Ingham & Miller, 1982).

Anxiety and depression predominate over all other symptoms or disorders. 'Depressive disorder' is diagnosed today by general practitioners as frequently as 'anxiety state' (the latter being diagnosed at least twice as often as depressive disorder in 1958) (Logan & Cushion, 1958; Office of Population and Censuses and Surveys, 1974; Royal College of General Practitioners *et al*, 1986). The distinction between 'psychosis' and 'neurosis' is seldom helpful. The extent to which the symptoms do or do not seem to relate to present or past circumstances, relationships and reactions is of central importance.

General practitioners are probably consulted more frequently than psychiatrists about problems which are close to, or part of, the ordinary life of most people. Their work inevitably takes in reactions of thought, feeling, and behaviour which cannot be considered to be disease or illness. For example, anyone realising or even wrongly suspecting that he had developed cancer would be likely to feel anxious or depressed. People bereaved of wife or husband would be unusual or abnormal if they did not grieve. General practitioners deal every day with such threats and losses – problems in living – usually about family, work, or money, in varying degrees of severity. These differences in the severity and relative frequency of different types of problems are reflected in Table II, based on a study of London general practitioners (Shepherd *et al*, 1966; 1981).

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TABLE I
The pathway to psychiatric care

	The community	*Primary medical care*		*Specialist psychiatric services*	
	Psychiatric morbidity in random community samples	Total psychiatric morbidity, primary care	Conspicuous psychiatric morbidity	Total psychiatric patients	Psychiatric in-patients only
1-year period prevalence median estimates: per 1000 persons at risk per year	250 →	230 →	140 →	17 →	6

Modified from Goldberg & Huxley (1980).

TABLE II
Distribution of the main psychiatric categories: comparison of the present survey with hospital statistics

Category	*Present survey: %*	*Maudsley hospital out-patients, 1956–1958: %*	*Mental hospital first admissions, England and Wales, 1957: %*
Psychoses	4.2	24.5	72.3
Neuroses	63.4	43.6	18.1
Character disorders	3.9	23.2	5.0
Miscellaneous	28.5	8.9	4.6
Total	100.0	100.0	100.0
Total number of cases	2049	6752	48 266

From Shepherd *et al* (1981)

Patients consulting general practitioners are more likely to do so with some apparently physical complaint, whether as a manifestation of mental disturbance or as something coincidental, yet not separable (Shepherd *et al*, 1981; Katon, 1982; Wilson *et al*, 1983). This is a particular hurdle for doctors starting in practice – how to explain this situation and to convince patients who are reluctant or unable to accept the real origin of their trouble.

General practitioners can use their frequent contacts with patients to recognise changes in behaviour or consultation habits (Widmer & Cadoret, 1979). Unusually frequent consultation about a child may indicate hidden trouble in a parent or in the parental relationships.

It is a common experience to be faced with people bringing multiple problems – often a mixture of physical, psychological and social – especially older patients. This happens frequently when a doctor has been in practice for a long time. To disentangle what matters most out of the confusion is the doctor's first and most essential task.

How do general practitioners respond to these problems? With great variability; variations in openness to, and acceptance of, psychiatric problems, in skills and knowledge, in decisions about when to intervene and in types of intervention. They show, for example, a ninefold variation in their capacity to recognise a psychiatric problem (Shepherd *et al*, 1981), and a tenfold variation in the level of prescription of psychotropic drugs (Birmingham Research Unit, 1980). In referrals, similarly, Robertson's (1979) study in and around Aberdeen shows rates varying from 0 to 70 per 10 000 population, with a mean of 30. Rural doctors refer less often than do urban doctors; older doctors more often than do younger; single-handed ones more often than do doctors in group practice.

Many studies by exceptional individuals throw light on what general practitioners can do in this field. I quote only those by C. A. H. Watts from Leicestershire, about depressive disorders in a mining village (Watts, 1966); and by E. J. R. Primrose (who died tragically young) in an epidemiological survey of a village in north Scotland (Primrose, 1962). The important studies of Shepherd (Shepherd *et al*, 1966) and of Goldberg (Goldberg & Huxley, 1980) are more representative, examining the practice of a sizeable group of doctors. The only studies to compare the ways in which psychiatrists and general practitioners treat patients come from the USA (Patrick *et al*, 1978; Regier *et al*, 1982). There are, however, papers such as that by Johnson (1981) about inadequate prescribing and compliance in the treatment of depression, the critical nature of which points to likely differences – indeed, to lost opportunities.

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In summary, the worthwhile opportunities for interested and well-trained general practitioners in this part of medicine differ little from those of psychiatrists – opportunities to detect disturbances, to define problems and to respond with basic psychotherapy, medication or social interventions. They cannot, of course offer asylum or electroconvulsive therapy; few work with groups; but they do have chances to prevent (Royal College of General Practitioners, 1984).

Working together?

I have now come to my main theme – opportunities and dangers at the interface between psychiatry and general practice. Four topics will be discussed: psychiatrists working in general practice settings; psychiatric nurses working outside hospitals; community psychiatrists; and community mental-health centres. All four topics are about the extension of the psychiatric service into the field where general practitioners have always worked.

Psychiatrists in general practices

In 1964 I met in Prague Dr Wunschowa, a psychiatrist who had been visiting health centres and polyclinics for several years (Horder, 1964), and in 1965 my group practice invited Dr Alexis Brook, who had already been working with another practice (Brook, 1967). Similar experiments had started independently in Belfast (Lyons, 1969) and Winchester (Gibson *et al*, 1966). These I believe to be the origin of a trend which now involves at least one in five psychiatrists in England and Wales (Strathdee & Williams, 1983).

Dr Brook visited our practice every month, acting as a consultant by seeing two or three selected patients at our request; these were usually patients whom we were already looking after ourselves. So our question to him was: "Are we doing the best possible for this person?" The answer might be: "Yes, nothing else could be offered elsewhere", or "here are some suggestions". It was rare for the answer to be: "Best to refer". There was usually a consultation with the patient's GP after Dr Brook had seen the patient alone. There would then be a discussion with most of the doctors and other team-members, either about the patients seen on that day or about a more general topic. We gained many useful insights over a period of years. Other patterns were tried at intervals.

Why has this trend spread? Clearly because both parties value it. Psychiatrists have opportunities to see a wider range of patients and problems at an earlier stage. GPs can provide more useful information and collaborative strategies can be planned. The GP's capacity to deal with psychiatric problems is enhanced. The patients can receive specialist help in a familiar, unthreatening, convenient surrounding. Communication between the three people concerned, and perhaps with a relative too, is easier and much quicker.

It has spread despite the fact that time has to be found for it. Tyrer *et al* (1984) found that it meant an additional one-and-a-half sessions per week for the psychiatrist, but claimed that the reduction in admissions to hospital compensated for this.

There are different ways of working within this general trend. The method adopted by Dr Brook in my old practice of seven doctors and a large team – consultation followed mainly by return to GP care – is not the one in most common use. The majority of psychiatrists undertake treatment themselves, whether short-term or longer, after an assessment which may or may not involve the GP. This may amount to little more than 'shifting outpatients' to a local place familiar to patients; it wastes some of the potential advantages. A third pattern is also to be found whereby the psychiatrist sees other members of the primary care team as well as the GP – nurses, health-visitors, with social workers, psychologists or counsellors where these are attached – and even, as in our case, receptionists.

A study of 58 GPs involved in these attachments (Strathdee, 1987) revealed that these doctors preferred consultation with return to GP care (see Table III). They want personal responsibility, but with expert guidance. They may, however, be an unrepresentative sample since a different message emerges from a study at the Maudsley Hospital (Shepherd *et al*, 1981).

TABLE III
General practitioners' opinions of the patterns of working

Working pattern available	*Pattern considered very useful by GPs: %*
Assessment only by psychiatrist. Treatment conducted by GP	79
Assessment and short-term treatment by psychiatrist	78
Assessment and long-term treatment shared by psychiatrist and GP	53
Long-term clinical responsibility undertaken by psychiatrist	41
Advice on non-referred patients	59
Crisis intervention	79
Total no. of attachments	58

From Strathdee (1987)

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It is difficult to predict the extent to which this trend for psychiatrists to work in a primary-care setting will continue to grow. There are limiting influences. The psychiatric hospital is still there and requires the presence of its doctors. Travelling to small centres is a waste of valuable time, especially if there is no real contact with their team. Despite the value attributed so far by all concerned, there is no paper which attempts to show the balance of costs and benefits, compared with traditional out-patient care.

I see this as a most important development which has implications for the rest of medicine as a means of binding primary and secondary care together. It combines the complementary strengths of generalists and specialists to the maximum advantage of patients. It will go on developing if all concerned ensure that they meet each other regularly and if proper administrative arrangements are made by the general practitioners.

Community psychiatric nurses

My own practice has benefited for years from the part-time presence in our health centre of community psychiatric nurses. They seem to manage successfully the relationship both with the primary-care team and with the psychiatric hospital. Nationwide, however, it is obvious that the problem of accountability is not resolved. Psychiatrists report that some community psychiatric nurses are assuming an inappropriate degree of responsibility for decisions about treatment and that some GPs are encouraging this. Yet papers such as those of Marks (1985) and of Paykel *et al* (1982) show how valuable community psychiatric nurses can be. They are especially valuable as supporters for those patients who have long-term, recurrent or resistant problems; they are the most obvious professionals to fill the proposed role of 'keyworker' (National Unit for Psychiatric Research and Development, 1988.)

I have recently questioned a small number of general practitioners from very different parts of the UK. There is no doubt that they value the work of community psychiatric nurses – but much more so where psychiatrists and nursing-administrators have adopted a generous, imaginative policy which allows them to feel that their main base is primary care. This encourages them to develop their potential, so that they are no longer people who 'just give injections to schizophrenics'. Where GPs are only allowed to refer patients to these nurses through a psychiatrist, they do not value their work to the same extent and an important opportunity for working together has been lost. Clearly there are successful and unsuccessful ways of exerting control. These will need to be studied by those now being appointed as community psychiatrists.

Community psychiatrists

The role of community psychiatrists is so new that it is unlikely yet to be clear to every GP. They may be seen as helpful, particularly in dealing with seriously disturbed or disabled patients previously segregated in hospital; or they may be seen as specialist intruders into the field of primary care. GP reaction to them as newcomers will depend on how they introduce themselves and how they maintain relationships afterwards. The process is time-consuming, frustrating sometimes, but worthwhile. The passage of information, without ever meeting, is merely minimal collaboration.

Community mental health centres

These are few and experimental in the UK and are, like casualty departments, an alternative route to secondary care – an exception therefore to the general system. They too may be seen by GPs either as helpers or intruders, but most GPs accept that some people do have problems which they cannot take to a doctor who is familiar to them or to their family; adolescents are the obvious example. Even so, it is important to seek the patient's agreement at least for information of attendance to be sent to the general practitioner. Both in the USA and in this country, so far, these centres have proved attractive to the worried well, but of limited success in caring for seriously ill people (Boardman & Bouras, 1988).

To recapitulate – community psychiatric nurses, community psychiatrists and community mental health centres are discussed in this paper, however briefly, for one important reason. Like many other GPs, I feel anxious about the risk of fragmentation inherent in these alternative routes to specialist psychiatric care, risks of responsibility falling between different people, of contradictory advice to patients, and of hostility between professionals. Such things happen very easily. Obviously there are special problems and special patients for whom normal arrangements do not work – or who will not use them. But one of the strengths of our system lies in the co-ordination and continuity provided by most GPs and by the life-long record contained in GP case-notes. How far can we afford to encourage alternative routes? Even if the Royal Colleges of Nursing, Psychiatry, and General Practice have considered these problems, co-operation will need to be encouraged and watched continuously at local

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level. GPs accept that patients should have a variety of 'keyworkers' and that they themselves should not try to do everything, but others involved with patients need to be aware of the GP's legal responsibility for care – the only means through which all care is made universally available.

What general practitioners need and want from psychiatrists

That GPs vary in their attitudes and skills is obvious. Psychiatrists vary too. For the psychiatrist as consultant there is one dominating requirement: 'Know your GP'. There are always at least two clients to consider – the patient and the GP.

This is why it is so essential to meet face to face and why some of the forms of working together discussed here seem so promising. By contrast, it is sad that domiciliary visits are not always attended by GPs and used as occasions for meeting in consultation – at least in most of the country (Dowie, 1983).

Our patients, through the increasing voice of the organisations which represent them, criticise us for the way in which we communicate with them. We do not listen enough – to their own beliefs about their experience of illness, to their fears and expectations (Becker, 1974; Cartwright & Anderson, 1981; NOP survey, 1982; Tuckett *et al*, 1985). We often fail to use patients' own language or to explain enough. We do not take them into the process of deciding what should be done.

These criticisms have an obvious bearing on our ability to detect psychiatric illness. Goldberg has been explicit in showing the extent to which we miss psychiatric disturbance in patients, especially in the presence of physical symptoms. Lack of skills in communication and interview are partly responsible for this failure, and Goldberg has demonstrated that video feedback of interviews with patients can increase accuracy (Davenport *et al*, 1987). The use of this technique is now increasing at all stages of medical education.

Does detection matter? Do patients whose disturbances is missed by GPs lose any advantage? The papers of Johnstone & Goldberg (1976), of Ashcroft *et al* (1987), and of Thomson *et al* (1982) show that the use of antidepressant drugs by GPs does make a difference to the severity and duration, providing the dose is sufficient. The study of Catalan *et al* (1984) shows that the outcome is not influenced when symptoms of anxiety are treated with anxiolytic drugs – whatever their capacity to provide temporary relief. Marks (1985) has shown how community psychiatric nurses can achieve results with behaviour therapy for phobic patients. These are all well-controlled studies. The importance of GPs recognising suicidal intent scarcely needs emphasising; early enough referral to the psychiatrist depends, in the UK , on the GP's capacity to detect and assess. Methods to demonstrate that brief psychotherapy and counselling make a difference have great difficulties to overcome; the balance of evidence does favour the widespread belief in this approach, the simplest elements of which enter almost inevitably into every consultation (Cawley, 1970; Brodaty & Andrews, 1983; Porter, 1984; Martin, 1985; Thomas, 1987).

Criticism of GP management of patients is frequently directed at the overuse of drugs, compared with giving time for discussion, for simpler forms of psychotherapy or for environmental modification. If psychotherapy is allowed to include the ability to listen with understanding to a patient's difficulties; dependability; a tolerant attitude towards unusual people and unusual behaviour; and continuity and willingness to take even minor disorders seriously – then many, perhaps most, GPs do offer these things alongside any drug they give. No line seems to me to separate these qualities from what Cawley (1970) refers to as "the supportive and directive psychotherapies used in psychiatric practice", short of analytical techniques.

However, the hurry in GP consultations has been something which worries doctors as it does their patients. Shortage of time was the commonest complaint made to me by doctors when I travelled the country for my College. With a 7-minute mean consultation time the UK compares badly in this respect with other similar countries. Morrell *et al* (1986) have recently compared the ways in which the same doctors behave when subjected to 5-minute and 10-minute appointment booking intervals. One of the benefits recorded for the longer intervals was that more psychiatric problems were recognised and discussed.

Many of us are also worried about abuse of group practice whereby patients move too much from doctor to doctor within a group. There is evidence that this diminishes compliance with treatment (Ettlinger & Freeman, 1981); it probably also diminishes recognition.

These last criticisms must be dealt with by ourselves, but we still need help with interview technique, with the recognition of early symptoms and signs, and with the recognition of the life events most likely to contribute to trouble in adults and children. Recognising them can even lead to some preventive actions, for instance in paying attention to people recently bereaved, to those who have to

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care for elderly demented patients or even in remembering that divorced parents have children; in such instances, earlier imaginative support makes a difference.

I have listed these criticisms because they point to some of the areas in which we need any help that psychiatrists can give. But how? In principle through clinical work, organisation and education. Personal contact is of especial importance in all of them.

In clinical work, GPs value quick support in emergency, prompt case-summaries when patients are discharged and the possibility of case-discussion on the telephone. Pullen & Yellowlees' work in Edinburgh (1985) offers succinct advice about letters and case-summaries. Scottish doctors prefer a one-page letter with two or three subheadings.

In organisation I only want to urge an increase in the attachment of psychiatrists and psychiatric nurses – and also of psychologists and counsellors – wherever a practice signals a welcome.

Concentrating on education, it seems important to add to the needs implicit in the criticisms above by emphasising one fundamental feature which GPs want – younger ones particularly. Above all, in any educational experience, they want any specialist to enter into the clinical problems of general practice – especially problems that are common, worrying, fascinating, and current. This is why this review started by describing differences from psychiatric experience. It is the obvious way to respond to the variations in GPs' competence. It is also, of course, a principle of effective education to start from what the learner already knows and from the problems which are already engaging his attention. Yet it seems hard to achieve. This principle was adopted by Michael and Enid Balint (Balint, 1964) when their GP seminars started 35 years ago. They also used the principle of active learning, which a small group permits, because there is a chance to talk as well as to listen. Each group met regularly for at least two years – thus using the principle of reinforcement. It was not everyone who stayed the course, chiefly because the doctors' values, thinking, feelings and behaviour were a major subject of scrutiny. These seminars focused on the doctor/patient relationship and the clinical cases were not necessarily psychiatric. They encouraged the detection of psychological and social factors in every case, but did not encompass all approaches to psychiatric treatment.

Conclusion

The title of this review was chosen because the territory shared by psychiatrists and GPs has become larger in recent years. GPs have become increasingly aware of psychiatric thinking in the broadest sense; psychiatrists have become increasingly concerned with care outside the hospital where GPs have traditionally worked. Together we have set off a most promising innovation which promotes collaboration and mutual education simultaneously.

Meanwhile the other recent innovations – the emptying of hospitals, the recruitment of community psychiatric nurses, and the appointment of community psychiatrists – seem less clearly oriented. At present they seem as likely to lead to chaos as to co-operation. I believe that the right guidance can be found in a familiar quotation from the World Health Organization's European office:

"The crucial question is not how the general practitioner can fit into the mental-health services but rather how the psychiatrist can collaborate most effectively with primary-care medical services and reinforce the effectiveness of the primary physician as a member of the mental health team" (WHO, 1973).

GPs have always had to practise psychiatry. Some are better at it than others. We know from studies like those of Walton (1966) on medical–student characteristics that this is inevitable, even now that doctors are choosing general practice because they want to do it and not because they have been unable to do something else; but education *can* make some difference. The gradual influence of liaison attachment, whether of psychiatrist, psychologist, counsellor or psychiatric nurse, has the great educational merits of personal contact and reinforcement applied to the active clinical problems which GPs are trying themselves to resolve. These are the three characteristics which emerge as crucial in deciding whether continuing education results in changed behaviour (Horder *et al*, 1986).

In the UK we have seen general practice rediscover its role in a specialised medical world. The present preference of young doctors for this career – inconceivable even 20 years ago – is unique in the world. But it has been achieved partly through emphasising the division between primary and secondary care. This now calls for a new effort in organising shared care, especially for patients with chronic conditions. That is essential if patients are to get the benefit of the marriage betwen expertise on one side, comprehensiveness and continuity on the other. Antenatal care is the only other area of medicine where sharing is so well developed as in the pattern which psychiatrists are now working out in liaison attachment schemes. Together they are an example to the rest of the profession. Many people have contributed to the co-operation I have been describing, but I want to pay tribute to my fellow medical student, Michael Shepherd. He expressed a

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view about the future organisation of psychiatric care which was unpopular 20 years ago and he has attracted a succession of thoughtful workers to epidemiological research of rigorous quality; they are responsible for many of the references in this text.

The interface between psychiatry and general medicine has provided for me the most fascinating and challenging part of general practice. I am deeply grateful to the Royal College of Psychiatrists for inviting me to speak and write and for allowing me to feel that, to some extent, I belong in both fields.

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References

ASHCROFT *et al* (1987) Consensus statement: panic disorder. *British Journal of Psychiatry*, **150**, 557–558.

BALINT, M. (1964) *The Doctor, His Patient and the Illness* (2nd edn). London: Pitman Medical Publishing Co.

BECKER, M. H. (1974) The health belief and sick-role behaviour. *Health Education Monographs*, **2**, 409–419.

BIRMINGHAM RESEARCH UNIT OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS (1980) Second National Morbidity Survey. *Journal of the Royal College of General Practitioners*, **30**, 547–550.

BOARDMAN, A. P. & BOURAS, N. (1988) Mental health advice centre in Lewisham. *Health Trends*, **20**, 59–63.

BRODATY, H. & ANDREWS, G. (1983) Brief psychotherapy in family practice. A controlled prospective intervention trial. *British Journal of Psychiatry*, **143**, 11–19.

BROOK, A. (1967) An experiment in GP/psychiatrist co-operation. *Journal of the Royal College of General Practitoners*, **13**, 127–131.

CARTWRIGHT, A. & ANDERSON, R. (1981) *General Practice Revisited*. London: Tavistock Publications.

CATALAN, J., GATH, G., EDMONDS, G., BOND, A., MARTIN, P. & ENNIS, J. (1984) The effects of non-prescribing of anxiolytics in general practice. 1. Controlled evaluation of psychiatric and social outcome. 2. Factors associated with outcome. *British Journal of Psychiatry*, **144**, 593–610.

CAWLEY, R. (1970) Editorial. Evaluation of psychotherapy. *Psychological Medicine*, **1**, 101–103.

DAVENPORT, S., GOLDBERG, D. & MILLAR, T. (1987) How psychiatric disorders are missed during medical consultations. *The Lancet*, *ii*, 439–440.

DILLING, H. & WEYERER, S. (1984) Prevalence of mental disorders in the small-town-rural region Traunstein (Upper Bavaria). *Acta Psychiatrica Scandinavica*, **69**, 60–79.

DOWIE, R. (1983) Trends in domiciliary consultations. *British Medical Journal*, **286**, 819–822.

ETTLINGER, P. R. A. & FREEMAN, G. K. (1981) General practice compliance study; is it worth being a personal doctor? *British Medical Journal*, **282**, 1192–1194.

GIBSON, R., FORBES, J. M., STODDART, I. W., COOKE, J. J., JENKINS, W. & MCKEITH, S. A. (1966) Psychiatric care in general practice; an experiment in collaboration. *British Medical Journal*, **1**, 1287–1289.

GOLDBERG, D. & HUXLEY, P. (1980) *Mental Illness in the Community. The Pathway to Psychiatric Care*. London: Tavistock Publications.

GOLDBERG, R. L., HAAS, M. R., EATON, J. S. & GRUBBS, J. H. (1976) Psychiatry and the primary care physician. *Journal of the American Medical Association*, **236**, 944–945.

HARRIS, R., LINN, M. W. & LINN, B. (1981) Psychotropic drugs in the ambulatory care of elderly males. *Medical Care*, **19**, 930–937.

HENDERSON, S. (1981) Social relationships, adversity and neurosis: an analysis of prospective observations. *British Journal of Psychiatry*, **138**, 391–398.

HORDER, J. P. (1964) The general practitioner in Yugoslavia, Czechoslovakia and Israel. Part 2. Psychological medicine. *WHO Fellowship Report* (available at the Royal College of General Practitioners, London).

——, BOSANQUET, N. & STOCKING, B. (1986) Ways of influencing the behaviour of general practitioners. *Journal of the Royal College of General Practitioners*, **36**, 517–521.

INGHAM, J. & MILLER, P. (1982) Consulting with mild symptoms in general practice. *Social Psychiatry*, **17**, 77–88.

JOHNSON, D. A. W. (1981) Depression. Treatment compliance in general practice. *Acta Psychiatrica Scandinavica*, **63** (Suppl. 290), 447–453.

JOHNSTONE, A. & GOLDBERG, D. (1976) Psychiatric screening in general practice. A controlled trial. *The Lancet*, *i*, 605–608.

KATON, W. (1982) Depression: somatic symptoms and medical disorders in primary care. *Comprehensive Psychiatry*, **23**, 274–287.

LOGAN, W. P. D. & CUSHION, A. A. (1958) Morbidity statistics from general practice. *Studies on Medical and Population Subjects* No. 14. London: HMSO.

LYONS, H. A. (1969) Joint psychiatric consultation. *Journal of the Royal College of General Practitioners*, **18**, 125–127.

MARKS, I. (1985) Controlled trial of psychiatric nurse therapists in primary care. *British Medical Journal*, **290**, 1181–1184.

MARTIN, E. (1985) Counselling in general practice. *Journal of the Royal College of Medicine*, **78**, 186–188.

MITCHELL, A. R. K. (1983) Liaison psychiatry in general practice. *British Journal of Hospital Medicine*, **30**, 100–106.

MORRELL, D. C., EVANS, M. E., MORRIS, R. W. & ROLAND, M. O. (1986) The 'five minute' consultation: effect of time constraint on clinical content and patient satisfaction. *British Medical Journal*, **292**, 870–873.

NATIONAL UNIT FOR PSYCHIATRIC RESEARCH AND DEVELOPMENT (1988) The co-ordination of care for people disabled by long-term mental illness. Working group report (to be published).

NOP SURVEY (1982) *The Public's Use of and Attitudes Towards GPs*. London: NOP Market Research Limited.

OFFICE OF POPULATION CENSUSES AND SURVEYS (1974) Morbidity statistics from general practice. Second national study 1970–71. *Studies on Medical and Population Subjects* No. 26. London: HMSO.

PATRICK, D. L., EAGLE, J. & COLEMAN, J. V. (1978) Primary care treatment of emotional problems in an HMO. *Medical Care*, **16**, 47–60.

PAYKEL, E. S., MANGEN, S. P., GRIFFITH, J. H. & BURNS, T. P. (1982) Community psychiatric nursing for neurotic patients: a controlled trial. *British Journal of Psychiatry*, **140**, 573–581.

PORTER, R. (1984) Psychotherapy: physiological measures and intrapsychic events. *Journal of the Royal Society of Medicine*, **79**, 257–261.

PRIMROSE, E. J. R. (1962) *Psychological Illness. A Community Study*. London: Tavistock Publications.

PULLEN, I., YELLOWLEES, A. J. (1985) Is communication improving between general practitioners and psychiatrists? *British Medical Journal*, **290**, 31–33.

REGIER, D. A., GOLDBERG, I. D., BURNS, B. J., HENKEN, J., HOEPER, E. W. & NUCZ, G. R. (1982) Specialist/generalist division of responsibility for patients with mental disorders. *Archives of General Psychiatry*, **39**, 219–224.

ROBERTSON, N. C. (1979) Variations in referral patterns to the psychiatric services by general practitioners. *Psychological Medicine*, **9**, 355–364.

https://doi.org/10.1192/bjp.153.4.513 Published online by Cambridge University Press

ROLAND, M. O., BARTHOLOMEW, J., COURTENAY, M. J. F., MORRIS, R. W. & MORRELL, D. C. (1986) The 'five-minute' consultation: effect of time constraint on verbal communication. *British Medical Journal*, **292**, 874–876.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1984) Combined reports on prevention. *Reports from General Practice*, 18–21. London: London Royal College of General Practitioners.

ROYAL OFFICE OF POPULATION CENSUSES AND SURVEYS & DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1986) *Morbidity Statistics from General Practice*. Third national study 1981–82. London: HMSO.

SHEPHERD, M., COOPER, B., BROWN, A. C. & KALTON, G. (1966) *Psychiatric Illness in General Practice*. Oxford: Oxford University Press.

——, ——, ——, —— & CLARE, A. (1981) *Psychiatric Illness in General Practice* (2nd edn). Oxford: Oxford University Press.

STRATHDEE, G. (1987) Primary care – psychiatry interaction: a British perspective. *General Hospital Psychiatry*, **9**, 69–77.

——, WILLIAMS, P. (1983) A survey of psychiatrists in primary care: the silent growth of a new service. *Journal of the Royal College of General Practitioners*, **34**, 615–618.

THOMAS, K. B. (1987) General practice consultations: is there a point in being positive? *British Medical Journal*, **294**, 1200–1202.

THOMSON, J., RANKIN, H., ASHCROFT, G. W., YATES, C. M., MCQUEEN, J. K. & CUMMINGS, S. W. (1982) The treatment of depression in general practice: a comparison of L-tryptophan amitryptiline and a combination of L-tryptophan and amitryptiline and placebo. *Psychological Medicine*, **12**, 741–751.

TUCKETT, D., BOULTON, M., OLSON, C. & WILLIAMS, A. (1985) *Meetings Between Experts*. London: Tavistock Publications.

TYRER, P., SEIVEWRIGHT, N. & WOLLERTON, S. (1984) General practice psychiatric clinics. Impact on psychiatric services. *British Journal of Psychiatry*, **145**, 15–19.

WALTON, H. J. & CARSTAIRS, N. (1966) Differences between physically-minded and psychologically-minded medical practitioners. *British Journal of Psychiatry*, **112**, 1097–1102.

WATTS, C. A. H. (1966) *Depressive Disorders in the Community*. Bristol: John Wright & Co.

WEISSMAN, M. M., MYERS, J. K. (1978) Affective disorders in a US urban community. *Archives of General Psychiatry*, **35**, 1304–1311.

WEYERER, S., DILLING, H., KOHL, R. & MARTENS, H. (1982) Social class and mental disorders. A study of the use of medical services. *Social Psychiatry*, **17**, 133–141.

WIDMER, R. B. & CADORET, R. J. (1979) Depression in family practice: changes in pattern of patient visits and complaints during subsequent developing depressions. *Journal of Family Practice*, **9**, 1017–1021.

WILLIAMS, P. (1978) Physical ill-health and psychotropic drug prescription – a review. *Psychological Medicine*, **8**, 683–693.

WILSON, D. R., WIDMER, B., CADORET, J. & JUDIESCH, K. (1983) Somatic symptoms: a major feature of depression in a family practice. *Journal of Affective Disorders*, **5**, 199–207.

WORLD HEALTH ORGANIZATION (1973) *Psychiatry and Primary Medical Care*. Copenhagen: World Health Organization, Regional Office for Europe.

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