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# Are people left behind on the care pathway?

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## EDITORIAL

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The author has completed the ICMJE form and declares no conflict of interest.

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## Psychiatric care pathways challenge the general practitioner's patient-centred approach.

The care pathway has arrived in the mental health service. Three general pathways were implemented as of 1 January this year, after some debate [\(1–4\)](#): pathways for assessment and treatment in the mental health service, one for adults and one for children, and a pathway for mental health and addiction. These are based on five objectives: increased service user involvement /satisfaction; continuous and coordinated patient pathways; reduced unnecessary waiting times; parity of access to services in the whole country; and better attention to somatic health and lifestyle [\(5\)](#). These general buzzwords are specified as follows: An assessment plan must be drawn up and implemented within six weeks and the patient must receive a copy. Any rejection of treatment must be explained. A set of 'guidelines for priority setting' provides indicative deadlines for when to commence assessment for different conditions – e.g. one week in cases of bipolar disorder type 1 at an unstable stage.

This type of predictability with respect to assessment and waiting times will involve a raising of quality standards compared to current practice. While the cancer care pathways purely serve as waiting time guarantees, the next phase of mental health care pathways will also include the actual treatment to be provided in respect of some diagnoses. We will have dedicated assessment and treatment pathways for obsessive-compulsive disorders, eating disorders in

children and adolescents, and early psychoses in children and adolescents. To my knowledge it is still a matter for discussion whether more frequent diagnoses such as anxiety and depression should also be included.

From the point of view of a general practitioner (GP) there are several reasons for concern. Mental health complaints and disorders are extremely common amongst the general population, and therefore also amongst the patients of GPs. A Norwegian study based on direct observation found that patients would raise a mental health problem during one of four GP consultations (6). Most of these patients are never referred to the specialist health service – they are assessed and followed up by the GP, just like other patients with common complaints and illnesses. Will the new care pathways mean that referrals become a more frequently considered option by GPs, patients and their relatives? If the patient suffers from anxiety/depression/obsessive-compulsive disorder and there is a care pathway for anxiety/depression/obsessive-compulsive disorder, then why not use it? The degrees of severity as defined in the guidelines leave limitless opportunities to apply discretion (5). In today's entitlement society patients will of course want the best possible treatment. Many GPs already experience a pressure for referrals, not only from patients, but from government departments such as the Labour and Welfare Administration and the Child Welfare Service, where therapy may seem to be the answer to most questions. Even if we envisage a doubling of referral rates – or even an increase by a factor of three or five, GPs will still be dealing with the majority of patients with mental health complaints. For the specialist health service, however, this increase will probably be impossible to handle, especially within the deadlines set by the care pathways.

Will the care pathways lead to a more algorithm-based and less patient-centred general practice? The GP consultation is the only medical service with a focus that is entirely defined by the patient's symptoms, worries and expectations (7). Will the only symptoms of interest be those that fit with the pathway guidelines? It has been claimed that life pains in the widest sense are at the heart of around half the consultations in general practice (8) and that the GP's job, every day, is all about helping people who are suffering and have been hit by crisis to handle their lives. Will this competence have to be scaled down in favour of recognising algorithms? For we can hardly expect a care pathway for the pains of life?

Part of the rationale used to justify the introduction of care pathways is that patients who fall within the same diagnostic category have received dissimilar treatments from the specialist health service. But does this variation represent a problem? Or is it based on the patients' need for differentiated and personalised approaches? Is the psychiatric evidence base sufficiently robust to justify that more diagnoses undergo standardisation of assessment and treatment? Is it possible to say that 'anxiety is anxiety is anxiety'? The health authorities point out in other contexts that personalised, user-centred treatments are desirable. This is sensible, also because we know from treatment research that many different approaches may be equally effective. It is difficult to comprehend how the requirement for increased standardisation can work to achieve this, and how these rather different guidelines can be compatible. What about the patients who do not fit in? Will they be given lower priority?

Strengthened patient rights have not been accompanied by increased resources. We may well fear that the work of the specialist health service is seeing a shift from medical assessment and treatment to demanding, time-consuming administration and increased bureaucracy.

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