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Attitudes to developments in community psychiatry among general practitioners

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As general practitioners (GPs) are clinically responsible for the majority of recognised psychiatric morbidity in the community, they have an important role to play in deciding the shape of new community psychiatric services. This paper reports the results of a self-completion postal questionnaire survey of Harlow GPs' views on how community psychiatric services should be developed. Harlow is a mature new town (population 79,521: 1981 census) north east of London, served by a typical DGH department of psychiatry with in-patient wards and a day hospital, outreach services being provided largely by community psychiatric nurses (CPNs). GPs work in group practices in purpose-built health centres.

The study

A 32-item self-report questionnaire for adult psychiatric patients was devised from the previous literature and refined by consultation with three experienced local GPs. All 46 Harlow GPs received the postal questionnaire with an explanatory letter from the Department of Psychiatry and the General Practice Medical Advisory Committee. Results were fed back to a local departmental liaison meeting with GPs and also through interviews with four group practices. A further short self-report questionnaire was developed to clarify areas of ambiguity and was completed by the same GPs except one who had retired and one who had moved.

Findings

The response rate was 100%. There were 34 male and 12 female GPs; 20% had postgraduate experience in psychiatry. In summary, the findings were that 87% of GPs wanted closer liaison with psychiatrists about out-patients, and 72% wanted psychiatrists to visit general practice to carry out 'one-off' assessments. Only 52% would like psychiatrists to see out-patients in general practice; 57% would prefer this liaison by telephone, rather than face-to-face contact in the surgery (28%) or by letter (26%). For psychiatric assessments, 56% would prefer an assessment with short-term psychiatric follow-up, as opposed to long-term psychiatric follow-up (22%); 35% would like a 'one-off' assessment of emergencies and only 26% would like advice about patients not seen directly by a psychiatrist.

GPs would like 46% of adult psychiatric out-patients to be seen in both hospital and general practice, 44% in hospital only and 11% in general practice only. There is a preference for alcohol/drug problems (54%), schizophrenia (44%) and depression (35%) to be seen by psychiatrists in general practice. On the other hand, CPNs are expected to see neuroses and depression (74%) as much as schizophrenia (65%) and alcohol/drug problems (72%).

CPNs were popular: 50% of GPs had CPNs working in their practice and 50% would like closer liaison with CPNs. All GPs without access to a CPN wanted access and 94% wanted direct access to CPNs rather than through a psychiatrist. Thus 52% would like CPNs based in general practice, 24% in hospital and 24% in mixed settings. (Direct access to CPNs was available for GPs.)

In-patient and out-patient psychiatric services were perceived as 'useful' or 'sometimes useful' except for the emergency psychiatric services which 24% of GPs felt were 'not useful'. There was a preference for either seeing emergencies at home themselves and arranging hospital admission (50%) or for a domiciliary visit carried out by the consultant and GP (35%). Urgent out-patient, or CPN domiciliary visits were not preferred. A crisis intervention team, comprising a psychiatrist and community psychiatric nurse to assess emergencies at home was felt to be a useful innovation by 91%. It was felt that this should be an 'out of hours' service (46%), seeing emergencies probably requiring hospital admission (65%) and preferably patients new to the psychiatric services (59%). GPs would also like a community psychiatric team to provide services for anxiety management, counselling and psychotherapy. There was interest in further education and all GPs said they would attend periodic seminars on community psychiatry. On the whole, 61% were dissatisfied with current community psychiatric services for adult patients in Harlow and only 32% were satisfied, while 6% had no feelings either way.

Comment

As GPs look after most of the psychiatric morbidity in the community and because of the increasingly contractual relationship between GPs and the secondary tier of care, those planning community services should listen to GPs' views on how those services should be provided.

General practitioners are dissatisfied with current community services in psychiatry and would like to see new developments. GPs want more liaison with psychiatrists but do not approve of psychiatrists shifting out-patients to their surgeries completely. Although most psychiatric morbidity seen by GPs is anxiety and depression, they discriminate in the use of the psychiatrist in general practice, suggesting that psychiatrists see the more serious disabling and worrying conditions such as alcohol/drug problems, schizophrenia and depression. This has also been found in established primary care psychiatric clinics seeing a significant proportion of patients with psychosis (Brown *et al*, 1988). It is in keeping with the spirit of the *Caring for People*'s emphasis on concentration of resources on those in greatest need (Secretaries of State for Health, 1989). Nevertheless, GPs would welcome other members of the community psychiatric team, predominantly CPNs, to be involved in providing specialised anxiety management, counselling and psychotherapy. Here there may be some conflict between primary and secondary care on the best use of precious CPN time. This is demonstrated by the overwhelming demand for direct access to these services (Strathdee, 1990). CPNs are recommended as very useful by GPs but there is no consensus over how their work loads are defined or how their work is supervised or monitored.

Harlow GPs are not alone in finding fault with the emergency services (Secretaries of State for Health, 1989), and the overwhelming request for crisis intervention services, also seen in an inner city audit survey of community psychiatry (Strathdee, 1990) highlights this as an area where GPs need more support from the secondary care team. The need for more education and training is echoed in the new GPs' contract, and is a very cost-effective way of using psychiatric resources. These seminars have been set up locally and are well attended.

Such questionnaire surveys are cheap and quick ways of obtaining useful information for planning services, designing general practitioner–hospital service contracts, carrying out audit of existing services and if supplemented by both open and individual meetings to discuss the results can also lead to closer contact between GPs and psychiatrists and a greater understanding of each other's roles.

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Copies of the questionnaire and a fuller report of the findings are available from the author.