Psychiatrists in primary care: would general practitioners welcome them?

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SUMMARY. During the spring of 1988 a postal questionnaire was sent to all general practitioners in one health district, enquiring about their present links with psychiatrists and asking for their views on the desirability of psychiatrists visiting their surgeries regularly. At present only a minority of general practitioners have a regular link of this kind but a substantial majority would welcome such an arrangement. The type of link most commonly desired is one in which the general practitioner shares actively in the assessment and treatment of the patient. A degree of ambivalence about the role of other mental health professionals was detected.

Introduction

THE high prevalence of psychiatric morbidity in general practice has been recognized for many years, as has the fact that only a small proportion of patients with psychiatric problems receive attention from specialist services.[1] However, a number of psychiatrists and general practitioners have jointly developed methods of liaison to improve the service offered to patients with psychiatric problems,[2,3] and in 1984 Strathdee[4] showed that 19% of psychiatrists in England and Wales had some regular link with primary care. The psychiatrists found this move away from hospital to be of value in improving the continuity of care and in increasing the involvement of the general practitioner in treatment. Early referral, avoiding hospital admission, and ease of access to background information were also noted as advantages of improved liaison. The general practitioners involved with these links valued them,[5] citing similar advantages to the psychiatrists. They also emphasized their desire for short term specialist intervention which was facilitated in this context. A similar survey in Scotland in 1988[6] showed that more than half the psychiatrists had a link of the kind described by Strathdee. There is evidence that patients too welcome this style of consultation. Tyrer[7] moved his outpatient clinic to general practice and found that patients preferred the ease of access, informality and lack of stigma. Many patients perceived an improved understanding between the general practitioner and the specialist. However, Tyrer found that not all general practitioners welcomed psychiatrists on their premises and some were antagonistic to his initial enquiries.

This study aimed to determine whether the benefits of psychiatrists working in general practice were perceived only by enthusiasts already taking part in successful links, or if such links would be welcomed by general practitioners who do not currently participate in such a service.

Method

The study population consisted of all principals in general practice, listed by the Kent family practitioner committee in 1987 as having practices or large numbers of patients in the south east Kent district health authority.

South east Kent comprises three large towns (Dover, Folkestone and Ashford), together with other small towns and villages and a large rural area, including Romney Marsh, with a scattered population. The coastal strip has a high proportion of elderly residents. Public transport is poor.

The psychiatric service in the district in 1988 included consultant outpatient clinics in the major towns and on the district general hospital site just outside Ashford, an outpatient clinic in the one health centre in the district (in Dover) and clinics in the health authority premises in four small towns. The inpatient facilities were moving from a psychiatric hospital in an adjacent district to south east Kent hospitals. Mental health centres, where a multi-professional team is based and where outpatient work with individuals or groups is carried out, were developing.

Initially, a postal questionnaire was sent to 20 randomly selected doctors. Fifteen replies were received and one obviously ambiguous question was modified as a result. In the spring of 1988 the remaining 115 doctors in the district were each sent a copy of the revised questionnaire. Members of group practices were addressed separately and no attempt was made to ascertain whether partners shared the same perceptions of the service or not. Ten practitioners had died or left the practice and of the remaining 105, 90 (86%) submitted useful replies, although not all the respondents answered every question. The questionnaire asked for demographic details about the doctors and their practices, about current links with psychiatrists and about desired future links. Comments were also invited. The doctors' perceptions of service provision and their preferences for development of the service were considered in relation to the demographic data. There were no obvious correlations and it was decided not to pursue this statistically.

Results

A quarter of the respondents described their practices as urban (24%), a quarter as rural (26%) and the remaining half as mixed (50%). Most of the doctors (78%) had personal lists of 2500 or less, but nine doctors (10%) had 3000 patients or more. Single handed practitioners formed 14% of the total, but most of the doctors (54%) were in groups of three or four. The one health centre in the district is staffed by 10 doctors, subdivided into small groups but this group were not considered separately.

The age range of the respondents was typical of all general practitioners in England (Kent family practitioner committee, 1988, personal communication), but 93% were men. This is representative of all south east Kent general practitioners, where in 1988 90% were men (Kent family practitioner committee), but is considerably higher than the figure of 78% for England as a whole in 1986.

A number of doctors (28%) had undergone postgraduate training in psychiatry and 30% declared a special interest in the subject. Twenty of the 90 doctors (22%) reported a link with a psychiatrist but 78% had no links (Table 1); of the options listed on the questionnaire many ticked more than one type. The commonest method of working was for the psychiatrist to conduct a satellite outpatient clinic in the general practitioner's surgery. Only four doctors were involved in joint assessment of the patient with the psychiatrist. Of the reported links seven were

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Submitted: 19 June 1989; accepted: 2 March 1990.

Table 1. Existing links between psychiatrists and general practitioners in a primary care setting and links that would be welcomed by general practitioners.

Type of link	Number (%) of respondents		
		Preferred links among those with:	
	Present links ($n=20$)	Existing links ($n=20$)	No existing links ($n=70$)
Psychiatrist assessment and treatment of patient	17 *(85)*	10 *(50)*	22 *(31)*
Psychiatrist assessment of patient; joint treatment or by GP	11 *(55)*	12 *(60)*	44 *(63)*
Joint assessment of patient; joint treatment or by GP	4 *(25)*	14 *(70)*	54 *(77)*
Advice on management (patient not seen by psychiatrist)	2 *(10)*	8 *(40)*	31 *(44)*
Other (including education)	15 *(75)*	11 *(55)*	23 *(33)*
Any link	20 *(100)*	17 *(85)*	64 *(91)*

n = total number of respondents.

initiated by psychiatrists and 11 by general practitioners (no information was available for the other two). Of the 20 doctors with existing links, three (15%) did not want to continue with the links. As with the existing arrangements many of the 17 doctors who wanted to develop links further were prepared to consider more than one type of link, but the most popular (70%) was joint assessment of the patient with the psychiatrist (Table 1). The 70 doctors with no links were offered the same options and again the most popular choice (77%) was joint assessment, though many were prepared to consider the alternatives (Table 1); six doctors (9%) did not want to consider a link.

The doctors' type of practice, list size, age and whether they were trained in psychiatry or had a special interest in the subject were not related to the doctors' perceptions of service provision, or with their stated preferences for service development.

When the group with no links were asked why these links had not developed 63% stated that they had not previously considered the idea, and an almost equal proportion cited pressure of their own work (57%) or of psychiatrists' work (60%) as an obstacle. Just over a quarter (27%) mentioned difficulties with accommodation and a few (7%) the small size of their practice. Only two doctors (3%) stated that they had a poor relationship with the psychiatrist to whom they made referrals. The nine doctors who did not wish to continue or commence this method of working cited similar reasons but three gave adequacy of the present service provided by the psychiatrist as a reason and three adequacy of the service provided by non-medical professionals.

Discussion

It appears from this study that about one fifth of the general practitioners in south east Kent have developed some form of link with a psychiatrist who works in their surgeries, but that only a small minority of them participate actively in joint decision-making. The usual pattern of shifted outpatient clinics does not give general practitioners and psychiatrists the chance to influence each other greatly.[8,9] Although there were some differences in the replies of the groups with and without existing links, the results are broadly similar and in both groups the highest degree of interest appears to be in joint assessment. It is not clear how feasible this method of working would be but only one of the doctors who had expressed an interest in developing an existing link, and two of those who would like to establish one raised feasibility as a possible difficulty in their written comments.

This survey shows that the majority of links already made have been initiated by general practitioners, not psychiatrists. This is different from the pattern described by Strathdee[5] and is consistent with a high degree of interest in developing closer links with consultant psychiatrists, extending beyond the ranks of those already involved in such liaison. However, it should be remembered that while the general practitioners in Strathdee's study[5] were a selected group working mostly in health centres, the sample used in this study comprised all the practitioners in the health district, the great majority working in their own surgeries. Unlike the general practitioners in Strathdee's studies,[4,5] few of them had had direct experience of the methods of working which they claimed to favour. Nevertheless the high level of interest does suggest that there has been a change in attitudes and expectations among both general practitioners and psychiatrists since 1971 when Kaeser[8] found that most general practitioners wanted psychiatrists to take over the care of the patients they referred. The reasons for the change have yet to be established. Tyrer[7] suggested that the moving of the clinic to the primary care setting was instrumental in bringing about this expectation, but the present study indicates that there is now an expectation of a collaborative approach even before such moves are made.

There were many appreciative comments about the contributions of individual professionals, particularly psychiatrists and community psychiatric nurses. Other comments however, indicated opposition to the use of non-medical mental health professionals to assess referrals. Gehlhaar[10] found that about 90% of general practitioners had no reservations about trainee psychiatrists making specialist assessments of the elderly ill, but that there was considerable suspicion of the use of non-medical disciplines for this purpose. Horder[3] has described general practitioners' fears that alternative routes of referral to the mental health team may lead to fragmentation of the services. From their comments it would appear that south east Kent general practitioners are concerned that the setting up of multiprofessional mental health teams accepting referrals from non-medical sources could erode the primary care role. The comment that 'Community psychiatry requires much closer working between hospital based staff and the general practitioners' teams' prompts the suggestion that the current involvement of psychiatrists and the mental health team of professionals in community psychiatry needs to be expanded and the role of all staff clarified.

The response rate to this survey and the large number of comments indicate that psychiatric services, which are in a state of change, are of great interest to general practitioners. They want to be involved in the care of their patients and want their views to be considered. The desire among general practitioners for regular face-to-face communication with psychiatrists is great and if this were to happen many of the perceived problems might be solved.

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Acknowledgements

We thank all of the general practitioners who completed the questionnaires, Mrs Barbara Wall for data analysis, Miss F Pickering, Mrs D Smith and Mrs P Brealia for secretarial help, and Professor Michael Shepherd and Dr Geraldine Strathdee for valuable professional advice. The project was supported by a grant from the South East Thames Regional Health Authority Research Committee.

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