

# A survey of links between mental health professionals and general practice in six district health authorities

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**SUMMARY.** *The aim of this study was to obtain an estimate of the extent to which collaborative schemes exist between general practice and mental health professionals and to assess the influence of practice size and district on these schemes. A questionnaire asking about such links was sent to each general practice in six randomly selected health districts in England. The response rate was 75%. Half of the 261 responding practices had a link with a community psychiatric nurse, 21% with a social worker, 17% with a counsellor, 15% with a clinical psychologist and 16% with a psychiatrist. Practices with more general practitioners were significantly more likely to have a link with a counsellor, after allowing for marked differences between the sizes of practices in the different districts. There was a tendency for some practices to have many links, while others had few. This poses questions about the efficiency and equity of collaborative schemes in primary care. Further research is required to investigate the quality of these links and the extent to which they serve the interests of the patient.*

**Keywords:** *interprofessional relations, attachment to GP; community psychiatric services.*

## Introduction

THE view that general practitioners and other professionals need to work together to provide a comprehensive primary care service has been asserted at least since the passing of the 1946 National Health Service act.<sup>1</sup> This act placed a statutory duty on health authorities to develop health centres for use by general practitioners, health visitors, midwives and community nurses. The 1965 doctor's charter encouraged both local authority health centres and group practices.<sup>2</sup> Enthusiasm for teamwork in primary care found expression in widespread support for the attachment of community nurses to general practices, so that by the mid-1970s the new area health authorities were claiming that about 80% of district nurses and health visitors were attached to general practices or liaising with general practitioners.<sup>3</sup> There has also been a gradual trend towards larger group practices, with the proportion of practices with five or more partners trebling between 1970 and 1989.<sup>4</sup> The assumption that bigger is better is challenged, however, by Keeley who argues that the natural conclusion of these trends is the multiprofessional 'polyclinic'.<sup>5</sup> Such clinics could reduce continuity of care<sup>6</sup> and attract resources and staff at the expense of other practices. This would further widen the gap between practices which are high and low investors, posing questions about the equity of primary care provision.

An increasing emphasis has been placed on the primary health care team as the cornerstone of community psychiatry.<sup>7</sup> Models of community mental health care often hinge on strong links between the primary health care team and mental health professionals.<sup>8,9</sup> Studies of joint working in community based mental health care demonstrate that, in practice as well as in theory, primary care workers are linking up with specialist mental health professionals to provide a comprehensive service. One survey conducted in England and Wales found that one in five psychiatrists spent time in a primary care setting<sup>10</sup> and a similar Scottish study found the figure to be over 50%.<sup>11</sup> Between 1980 and 1985 the proportion of community psychiatric nurses working in primary care rose from 8% to 16%.<sup>12</sup> Attachments of social workers to general practice have not been surveyed recently, but the evidence available suggests that the number of attachments rose until the mid-1970s with over half of local authorities reporting at least one social worker in general practice.<sup>13</sup> The number of schemes then declined with the financial cutbacks imposed on local authorities in the 1980s.<sup>14</sup> It has been Department of Health policy since 1977 that general practitioners should have access to a clinical psychology service<sup>15</sup> and between 1977 and 1986 the proportion of clinical psychologists working with general practitioners rose from 14%<sup>16</sup> to 27%.<sup>17</sup> No survey has ascertained the extent to which general practitioners are in contact with counsellors but anecdotal evidence suggests that the number is increasing.<sup>14</sup>

In parallel has been the development of community mental health centres, which are often seen as an alternative to primary care attachments in the provision of a community based mental health service.<sup>18</sup> The number of community mental health centres in the United Kingdom rose rapidly through the 1980s.<sup>19</sup> Concern has been expressed that these centres may treat the 'worried well' rather than the chronically ill.<sup>20</sup>

The new contract for general practitioners provides opportunities for increased collaboration as it removes restrictions on the range and number of staff for whom reimbursement may be obtained under the ancillary staff scheme. It also allows for sessional fees associated with advertised health promotion clinics to be reimbursed.<sup>21</sup> In the light of these changes, the aims of this study were to obtain an estimate of the extent to which collaborative schemes exist between general practice and mental health professionals and to assess the influence of practice size and district on these schemes.

## Method

### Sample

Six district health authorities in England were selected for the study using random number tables. In May/June 1991 postal questionnaires were sent to each general practice in the six districts. Reminders were sent a month later to the practices which had not responded. Practice addresses and information were obtained from the relevant family health services authority. In group practices the questionnaire was addressed to the 'practice administrator' but in single handed practices the addressee was the general practitioner.

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### Questionnaire

The questionnaire elicited whether there was contact between the practice and social workers, community psychiatric nurses, clinical psychologists, psychiatrists and counsellors. Although not necessarily mental health specialists, social workers were included in this survey as their work often has a substantial mental health element. The level of contact could range from no link, through attachment to employment. Practices were also asked about any planned links with these professionals. A definition of counsellor was not given so the results refer to anyone the practice defined as such. It should be borne in mind that practices who employ counsellors or psychologists are required to ensure that they are 'properly qualified', but the issue of definition is far from clear-cut.<sup>22</sup> The questionnaire gave respondents the opportunity to indicate links with mental health workers not specifically mentioned on the questionnaire.

### Analysis

The results were analysed using *SPSS/PC+* (statistical package for the social sciences, version 3.1) and *EGRET* (epidemiological graphics, estimation and testing package, version 0.19.5), a logistic regression package. Associations between variables were initially tested with the chi square statistic. Logistic regression is a model which allows testing of an association between two variables after allowing for the influence of another variable.<sup>23</sup> In this instance the model was used to test relationships between professional links, district, practice size (number of general practitioners) and whether the practice was based in a health centre.

### Results

The six districts selected were Barnet (75 practices), Chester (31), Hull (58), Maidstone (40), Tower Hamlets (46) and West Birmingham (100). The response rates were Barnet (60 practices, 80.0%), Chester (27, 87.1%), Hull (42, 72.4%), Maidstone (29, 72.5%), Tower Hamlets (33, 71.7%) and West Birmingham (70, 70.0%). Overall, 261 practices responded (response rate 74.6%).

The 89 non-responding practices were only slightly more likely to be single handed (44.9%) than the 261 responding practices (36.0%) and response was not significantly associated with practice size.

### Professional links

Table 1 summarizes the findings concerning the extent of links between responding practices and the professionals listed. None of the respondents indicated that they had links with mental health workers not specifically mentioned on the questionnaire.

Of the responding practices 15.7% reported a link with a psychiatrist. This figure ranged from 8.3% in Barnet to 27.3% in Tower Hamlets. The number of general practitioners in the practice did not seem to be associated with a link with a psychiatrist (Table 1). A link with a social worker was reported by 21.0% of practices.

The percentage of practices reporting links with clinical psychologists and counsellors was 14.9% and 16.9%, respectively. In part, these overall percentages were the result of high figures in one district only, Tower Hamlets and Chester, respectively (Table 1). Excluding Tower Hamlets, the overall percentage of practices reporting a link with a clinical psychologist in the remaining districts was 10.1%. The relationship between the district and links with a clinical psychologist, allowing for differences in practice size, was marked (likelihood ratio statistic ( $G^2$ ), used as chi square statistic = 38.11, 5 degrees of freedom,  $P < 0.01$ ). Of the practices reporting no link with a clinical psychologist 1.8% reported that a link was planned. In the Chester district 44.4% of practices reported a link with a counsellor compared with an overall figure 13.7% for the remaining districts. This was reflected in a significant association between district and links with a counsellor ( $G^2 = 16.59$ , 5 df,  $P < 0.01$ ), even after allowing for differences in practice size ( $G^2 = 12.59$ , 5 df,  $P < 0.05$ ).

Overall, 47.9% of practices reported a link with a community psychiatric nurse. There was an association between district and links with a community psychiatric nurse ( $\chi^2 = 12.27$ , 5 df,  $P < 0.05$ ), with practices in Barnet, Tower Hamlets and West Birmingham less likely to have a link with a community psychiatric nurse than practices in the other three districts. This association was no longer statistically significant at the 5% level, however, when differences in practice size were taken into account.

### Intervariable relationships

The 125 practices reporting a link with a community psychiatric nurse were significantly more likely than the 136 practices

Table 1. Percentage of practices reporting a link with a mental health professional, by district and size of practice.

	% of practices with link with professional				
	Community psychiatric nurse	Social worker	Counsellor	Psychiatrist	Clinical psychologist
<i>All practices (n = 261)</i>					
With link	47.9	21.0	16.9	15.7	14.9
Planned link <sup>a</sup>	1.9	0.4	1.9	0.0	1.9
<i>District</i>					
Barnet (n = 60)	38.3	18.3	15.0	8.3	1.7
Chester (n = 27)	59.3	14.8	44.4	22.2	14.8
Hull (n = 42)	66.7	16.7	11.9	21.4	11.9
Maidstone (n = 29)	55.2	27.6	17.2	13.8	13.8
Tower Hamlets (n = 33)	39.4	15.2	21.2	27.3	48.5
West Birmingham (n = 70)	41.4	28.6	8.6	11.4	12.9
<i>No. of GPs in practice</i>					
1 (n = 94)	42.6	19.1	8.5	16.0	10.6
2 or 3 (n = 99)	44.4	19.2	18.1	14.1	14.1
4+ (n = 68)	60.3	26.5	26.5	17.6	22.1

n = total number of practices in group. <sup>a</sup> Some planned links were in addition to an existing link.

without such a link to report a link with a psychiatrist (27.2% versus 5.1%;  $\chi^2 = 22.98$ , 1 df,  $P < 0.001$ ), psychologist (24.0% versus 6.6%;  $\chi^2 = 13.18$ , 1 df,  $P < 0.001$ ), counsellor (24.0% versus 9.6%;  $\chi^2 = 8.21$ , 1 df,  $P < 0.01$ ) or social worker (35.2% versus 7.4%;  $\chi^2 = 28.08$ , 1 df,  $P < 0.01$ ). Similar relationships were found for links with each of the mental health professionals (except counsellor and social worker); if a practice had one link, it was much more likely to have others as well — clinical psychologist and counsellor:  $\chi^2 = 20.51$ , 1 df,  $P < 0.001$ ; psychologist and social worker:  $\chi^2 = 9.18$ , 1 df,  $P < 0.01$ ; psychologist and psychiatrist:  $\chi^2 = 45.85$ , 1 df,  $P < 0.001$ ; counsellor and psychiatrist:  $\chi^2 = 15.62$ , 1 df,  $P < 0.001$ ; social worker and psychiatrist:  $\chi^2 = 50.35$ , 1 df,  $P < 0.001$ .

### Health centres

The 29 practices based in health centres were significantly more likely to have more general practitioners than the 232 practices not based in a health centre (41.4% had four or more doctors versus 23.7%;  $\chi^2 = 8.22$ , 2 df,  $P < 0.05$ ). There was a significant association between reporting a link with a community psychiatric nurse and with a psychiatrist and being based in a health centre (allowing for differences in practice size: link with a community psychiatric nurse  $G^2 = 5.12$ , 1 df,  $P < 0.05$ ; link with a psychiatrist  $G^2 = 7.33$ , 1 df,  $P < 0.01$ ). There was no significant association between being based in a health centre and links with other mental health workers.

### Practice size and district

There was a strong association between the number of general practitioners in the practice and district ( $\chi^2 = 37.36$ , 10 df,  $P < 0.001$ ), with Chester and Maidstone having the highest proportions of practices with four or more general practitioners (40.7% and 51.7%, respectively) and Barnet and West Birmingham the lowest (13.3% and 18.6%, respectively). The more general practitioners in a practice the more likely the practice was to have links with mental health professionals (Table 1), but only the association between a link with a counsellor and the size of practice was statistically significant (allowing for the district effect described above:  $G^2 = 5.29$ , 1 df,  $P < 0.05$ ). The number of professional links per general practitioner, however, was higher in single handed practices (0.97) than in two or three handed practices (0.47) or practices with four or more general practitioners (0.33).

### Discussion

The number of links with clinical psychologists and counsellors, especially in Tower Hamlets and Chester, respectively, highlight the recent growth areas in the care of mentally distressed people in the community. Practices in Chester have been successful in employing counsellors for one or two sessions a week to run 'stress clinics' and in offsetting the cost of this service by claiming back clinic fees through the health promotion initiative in the new general practitioner contract.<sup>21</sup> These clinics have proved popular with patients and have been well attended (Rose D, Cheshire family health services authority, 1991, personal communication). A similar scheme is being set up in Maidstone to develop clinical psychology placements in a number of general practices (Parry S, Maidstone Clinical Psychology Service, 1991, personal communication).

The trend for community psychiatric nurses to work more closely with primary care workers<sup>12,24</sup> seems to be confirmed, although direct comparison with previous studies is problematic because of the specific focus on general practice links in this study. Nonetheless, almost half of the practices in this study reported a link with a community psychiatric nurse and the figure

was fairly high across the heterogeneous districts surveyed.

The fact that 21% of practices reported a link with a social worker demonstrates that social workers have not entirely disappeared from the primary care stage as a result of cutbacks. The recent community care legislation (National Health Service and community care act, 1990) may have some impact on joint working between health and social workers.<sup>25</sup>

The 16% of practices reporting a link with a psychiatrist is comparable with that obtained from a survey in south east Kent in which 22% of general practitioners reported a link with a psychiatrist.<sup>26</sup>

This study has shown that professional links tended to be concentrated in certain practices, with some reporting many links with mental health professionals and others none or few. Innovative practices were clearly more likely to extend to a number of links with mental health professionals rather than assume that one is enough. Some practices were likely to have been more attractive to mental health professionals, because of size, location, facilities or staff. This may explain why community psychiatric nurses and psychiatrists were more likely to have had links with practices based in a health centre, after allowing for practice size. It is probable that contact with one professional encourages links with others; for example, a link with a community psychiatric nurse may lead naturally to contact with a psychiatrist. The question arises whether it is the most effective use of resources for some practices to have links with a counsellor, psychologist and community psychiatric nurse, while other similarly sized practices have none of these links. The patients on the lists of highly collaborative practices may receive a better service (or at least a better range of services) only at the expense of patients at other less accessible or less amenable practices.

Another question is even more important: does interprofessional collaboration necessarily mean a better service for patients? Large, multiprofessional teams may reduce continuity of care.<sup>6</sup> Studies evaluating the effectiveness of the professionals discussed here almost unanimously fail to produce concrete evidence of an improved service, at least in terms of outcome.<sup>14</sup> Improved professional satisfaction and a general feeling that interprofessional collaboration will benefit the patient are not enough.<sup>27</sup> In order to attract resources to develop collaborative schemes in primary mental health care further, an improved service for the patient needs to be more persuasively demonstrated.

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