

General practitioners' use of community psychiatric nursing services: a preliminary survey

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SUMMARY. A questionnaire on general practitioners' use of community psychiatric nursing services was sent to a random sample of 100 general practitioners in two contrasting areas, Croydon and Cambridgeshire. General adult services were widely available though used less often by Cambridgeshire general practitioners than Croydon doctors. Apart from services for the elderly, specialist services were uncommon. Over a third of doctors reported that their adult services were based in a psychiatric hospital. Less than a quarter of general practitioners had access to primary care based nurses. The pattern of responses demonstrates the wide variety of ways in which general practitioners relate to community psychiatric nurses, even where the psychiatric nursing services are long-established. There remains a need for more consistent and coherent policies about the ways in which community psychiatric nurses are employed in primary care.

Introduction

COMMUNITY psychiatric nursing is one of the largest growth areas in mental health services. Historically community psychiatric nurses have been based in psychiatric hospitals and have offered services to patients referred to them mainly by psychiatrists. More recently, there has been a trend towards their closer involvement with primary care and to the acceptance of direct referrals from general practitioners. In 1981, only 27% of community psychiatric nursing services retained psychiatrist-only referral systems while over half had their main bases outside psychiatric hospitals.¹ By 1985 there had been a 20% decrease in the use of hospital settings as main work bases; over 9% more community psychiatric nurses were based in general practice, with the rest being found in other community centres.²

The issue of where community psychiatric nursing services should best be based is contentious. Although some research suggests no differences in intervention styles between hospital based and primary care based teams,³ the tendency for community psychiatric nurses to have their clinical base in general practice settings has led to concern that patients with chronic mental illness will take second place to those with minor affective disorders.⁴ However, location of services does seem to influence the major sources of referrals to the service.² Thus, in the south east Thames region (where the services are most likely to be based in primary care settings), community psychiatric nurses were found to receive the fewest referrals from psychiatrists (41.5%); conversely, psychiatric nurses in Scotland had the highest rate of referrals from psychiatrists (81.9%) and were also most commonly based in psychiatric hospitals.

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There is probably wide variation in the service demands made of community psychiatric nurses by general practitioners, but there has been relatively little investigation of the reasons for this. Locally-based surveys of general practitioners' use of and attitudes towards community psychiatric nurses are likely to provide valuable information for service planning, especially if they include general practitioners who do not make use of such services and who are excluded from referral based studies.

This preliminary survey is based on data from two contrasting health districts: Croydon, where the community psychiatric nursing service originated in 1954, and Cambridgeshire. The paper presents a descriptive account of the views of general practitioners about the community psychiatric nursing services provided in these areas.

Method

Using family practitioner committee lists, a random sample of 50 general practitioners was selected from each of the two areas. A four-page structured questionnaire was sent to each general practitioner with a reply-paid envelope. Topics covered included the general practitioner's experience of working with community psychiatric nurses, the nature of the service provided, and the number of patients referred to the service in the previous 12 months. General practitioners were also asked to provide details of their most recent referral to a community psychiatric nurse and to give their views on the future role of community psychiatric nurses in general practice. The covering letter emphasized that replies were wanted to the relevant sections of the questionnaire even from those general practitioners who did not work with community psychiatric nurses. A second questionnaire was sent out to non-respondents after a month and those who did not respond to this were contacted by telephone.

Results

Sample characteristics

A response rate of 81% was obtained (39 general practitioners in Croydon and 42 in Cambridgeshire). Around a quarter of those who responded were female. The doctors' ages ranged from 28-67 years, with a mean of 47 years. The Cambridgeshire doctors tended to have been longer in practice (mean 15 years) than the Croydon doctors (mean 12 years). The mean number of general practitioners per practice was four. Croydon doctors were more likely to be single-handed (10%) than those from Cambridgeshire (5%).

Availability of services

Table 1 shows that the majority of general practitioners reported that there was a general adult community psychiatric nursing service available for their patients. Only one of the Croydon general practitioners was unaware of such a service as against one fifth of those in Cambridgeshire, which is reflected in the proportions reporting that they made use of the general adult service — 92% of Croydon doctors compared with 62% in Cambridgeshire. Specialist community psychiatric nursing services were less commonly reported and their availability varied between the two areas.

Table 1. Availability of community psychiatric nursing services for general practitioners' patients.

Type of service	Number (%) of respondents reporting service available		
	Croydon (n = 39)	Cambs (n = 42)	Total (n = 81)
General adult	38 (97)	33 (79)	71 (88)
Elderly	16 (41)	25 (60)	41 (51)
Acute/crisis intervention	12 (31)	9 (21)	21 (26)
Drugs/alcohol	9 (23)	12 (29)	21 (26)
Behaviour therapy	7 (18)	8 (19)	15 (19)
Rehabilitation	6 (15)	6 (14)	12 (15)
Children/adolescents	5 (13)	4 (10)	9 (11)
Family therapy	2 (5)	5 (12)	7 (9)

n = total number of respondents.

Main clinical base of services

Table 2 shows that, overall, 37% of general practitioners reported that their psychiatric nursing service was based in a psychiatric hospital and 35% that it was based in a day hospital. Cambridgeshire doctors were more likely to report having a traditional hospital-based service whereas in Croydon the nurses were most commonly based in more community-oriented day hospitals. Less than a quarter of the general practitioners had access to primary care based community psychiatric nurses. A higher proportion of the Croydon general practitioners (72%) reported more than one base location for the service than did their Cambridgeshire counterparts (29%).

Use of general adult services

The mean time that general practitioners reported working with community psychiatric nurses providing a general adult service was four years. Croydon doctors reported having referred nearly twice as many patients over the past year as Cambridgeshire doctors (means of 10 and six patients, respectively).

Table 2. Main clinical base of community psychiatric nursing services according to general practitioners.

Main base of services	Number (%) of respondents		
	Croydon (n = 39)	Cambs (n = 42)	Total (n = 81)
Psychiatric hospital	7 (18)	23 (55)	30 (37)
Day hospital	27 (69)	1 (2)	28 (35)
General practice/health centre	10 (26)	8 (19)	18 (22)
Psychiatric unit (DGH)	2 (5)	6 (14)	8 (10)
Other ^a	0 (—)	5 (12)	5 (6)
Not known	2 (5)	3 (7)	5 (6)
None (no service)	0 (—)	3 (7)	3 (4)

^a Includes geriatric hospital and social services. n = total number of respondents. DGH = district general hospital.

Referral methods

Table 3 shows that telephone contact was the most common referral method, but this was less so where the service was practice-based, presumably because this facilitated face-to-face contact. Nearly all general practitioners reported that they were sometimes in contact with community psychiatric nurses only because the nurses saw some of their patients on behalf of local specialist psychiatric services and not because they initiated contact. However, 84% had referred patients who were not already being seen by a psychiatrist.

Table 3. Methods of general practitioner referral to community psychiatric nurses (CPN).

Method of referral	Number (%) of respondents with:		
	Practice-based service (n = 16)	Other base (n = 46)	Total (n = 62)
By telephone	7 (44)	38 (83)	45 (73)
GP referral letter	9 (56)	18 (39)	27 (44)
Face-to-face contact	11 (69)	12 (26)	23 (37)
Via GP's receptionist	6 (38)	6 (13)	12 (19)
Form specially designed for CPN service	4 (25)	2 (4)	6 (10)
Other ^a	1 (6)	4 (9)	5 (8)

^a Includes regular sessions held in practice, and arranged by others (eg, psychiatrist, social services, community nurse). n = total number of respondents.

Views of community psychiatric nurses' activities

Table 4 shows that long-term treatment or support by community psychiatric nurses was almost universally available. Emergency assessment and short-term treatment were only available to about half the general practitioners and advice about patients to a quarter. Interestingly, 69% of general practitioners with practice-based community psychiatric nurses reported that short-term treatment was undertaken compared with 38% of those with the service in other locations.

Table 4 also shows that the greatest demand from general practitioners was for an emergency service. In addition, 19% of general practitioners would have liked an assessment service from the community psychiatric nurse, with the general practitioner retaining responsibility for conducting treatment. This was more commonly wanted where the service was not practice-based.

Although the majority of general practitioners reported satisfaction with the contribution community psychiatric nurses made to patient care, communication was sometimes a problem, especially in the long term: feedback about initial assessment was generally reported to be more satisfactory than that about outcome. A quarter of the Cambridgeshire general practitioners said they had never had adequate feedback about eventual outcomes from community psychiatric nurses.

Table 4. Activities undertaken by community psychiatric nurses (CPN).

Activity	Number (%) of respondents (n = 61)	
	Activity currently available	Would like this activity
Conducting long-term treatment/support	58 (95)	2 (3)
Emergency assessment/treatment	32 (53)	17 (27)
Conducting short-term treatment	29 (47)	7 (11)
Assessing new referrals, but treatment carried out by GP	22 (36)	12 (19)
Participation in case conferences	20 (32)	3 (5)
Advising GP about patients (whom the CPN has not seen)	15 (24)	10 (16)
Advising other members of the team about patient management	12 (19)	10 (16)
Other ^a	4 (7)	6 (10)

^a Includes stress management/relaxation classes, managing drugs, closer liaison and more help with elderly/demented patients. n = total number of respondents.

Recent clinical referrals

General practitioners were asked to give details of the last patient they had referred and this was done by 57. Three-quarters of the patients described were female. A higher proportion of Cambridgeshire patients were elderly (59% aged over 60 years) than Croydon patients (26%), presumably because of the greater availability of a specialist service for the elderly in Cambridgeshire.

The most commonly reported presenting problem was depression (32%), followed by anxiety (14%), senile dementia (14%) and schizophrenia (12%). A third of these patients had problems of recent origin (under a year), while another third had had a problem for more than five years. The proportions did not differ between the two areas. By far the most common reason for referral was for support (46%), followed by requests for assessment (13%).

Table 5 shows that in two-thirds of these referrals the general practitioners were at least reasonably satisfied with the clinical outcome. However, in 16% of cases the outcome was assessed as poor.

Table 5. General practitioners' assessment of clinical outcome of the last patient referred.

Type of service	Number (%) of respondents		
	Croydon (n = 33)	Cambs (n = 24)	Total (n = 57)
Good	10 (30)	9 (38)	19 (33)
Reasonable	12 (36)	6 (25)	18 (32)
Poor	5 (15)	4 (17)	9 (16)
Not known ^a	6 (18)	5 (21)	11 (19)

^a Includes 'too early to say', 'no comment', 'no contact with community psychiatric nurse'. n = total number of respondents.

Discussion

While no nationally relevant extrapolations can be made from such a limited study, the findings are of interest in their own right. The differences between the two areas suggest that larger scale surveys of general practitioners' use of and views about community psychiatric nurses could provide valuable information for regional and national planning of services.

General practitioners' experience of working with community psychiatric nurses varied considerably between these areas, both in terms of type of contact and nature of the service. In both areas the service provided was primarily for patients with chronic mental illness. As one doctor stated:

'Community psychiatric nurses are at present performing a useful role in following patients discharged from specialist psychiatric care, monitoring their progress in the community and alerting the general practitioner when intervention is needed.'

However, several general practitioners maintained that community psychiatric nurse involvement could also be useful in the management of minor psychiatric disorders, for example:

'There are so many social problems causing depression/stress. If these can be dealt with early by myself and the community psychiatric nurse, very few of them need psychiatric referrals.'

The relationship developed between a community psychiatric nurse and a general practitioner is one of the most important factors affecting the number and appropriateness of referrals.⁵⁻⁷ This was identified as a major area of difficulty. According to

one general practitioner:

'At present I do not know names; they do not come to the health centre to introduce themselves. A regular presence, for example, once a month, for person-to-person (that is, nurse-doctor) discussion would vastly improve our relationship.'

Generally the general practitioners welcomed the idea of working with community psychiatric nurses, even when their experience of the service was limited. Over 40% of the respondents made comments indicating the importance of community psychiatric nurses becoming integrated within the primary care team:

'I feel our service needs to change from a very hospital out-patient based scheme to a much more general practice oriented service with far more contact/liason with general practitioners while obviously maintaining strong contacts with the hospital psychiatric firms.'

In particular, several general practitioners commented on the extent to which community psychiatric nurses were able to give more time to patients than they had available themselves. Others mentioned their role in caring for the often immobile elderly. Where general practitioners reported bad experiences, these generally seemed to be associated with communication problems: nevertheless, one general practitioner commented 'responsible community psychiatric nurses can be a helpful compensation for indifferent psychiatrists'.

The national growth of community psychiatric nurse services seems to have been poorly planned and little coordinated. From a general practitioner perspective, there are probably marked local differences in service provision and use. This suggests that current service provision is likely to be both ineffective and inefficient. Since the future of general mental health services is overwhelmingly in primary care settings, it is important that community psychiatric nurse services should increasingly be harmonized with primary care services.

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