Attitudes to community psychiatry among urban and rural general practitioners

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SUMMARY. General practitioners' requirements for community psychiatric services may differ according to the area in which they practise. A questionnaire survey of general practitioners' attitudes to community psychiatric services is reported from three contrasting areas: an inner city urban area, a new town and a rural area. General practitioners in all areas wanted more consultation with psychiatrists, and 53–68% wanted regular psychiatric outpatient clinics in their surgeries. There was enthusiasm for community psychiatric nurses and for help with psychotherapy. In the rural area general practitioners favoured surgery based psychiatric outpatient clinics and arranging emergency hospital admissions themselves; in urban areas domiciliary visits from psychiatrists to help with emergencies were favoured. These results appear to reflect the greater geographical distance between primary and hospital based secondary care in rural as opposed to urban areas.

Overall, general practitioners wanted more support from community psychiatric services in carrying out their primary therapeutic role especially in rural areas far from hospital-based psychiatric services.

Keywords: community psychiatric services; doctors' attitude; interprofessional relations.

Introduction

ONE in five patients consulting general practitioners have a primary psychiatric disorder;[1] most (95%) are treated by the primary health care team and never see a psychiatrist.[2] The debate about the resettlement of former mental hospital inpatients has overshadowed developments in another aspect of community psychiatry, that of providing greater access to acute psychiatric services for both general practitioners and their patients. Easier access allows more support for general practitioners in their therapeutic role, and earlier intervention for patients, with an emphasis on prevention, may prevent the development of long term illness and consequent stigma.[3,4]

In recent years there has been an increasing trend for psychiatrists to do part of their work in general practice settings[5] using a variety of strategies including shifting outpatient clinics to general practice, and providing a 'liaison-attachment' and consultation service to the whole primary care team.[6] The models of service preferred by general practitioners may depend on the type of population they serve, their own clinical practice, their previous experience of the service, and their attitudes to psychiatry, psychiatrists and mentally ill people.[1] Urban and rural populations may also differ in the type of psychiatric morbidity they display.[7,8]

There is evidence that use of medical services is directly related to their geographical distance from the population served, and this may affect the tendency to refer from primary to secondary care.[9,10] It is likely that general practitioners practising in rural areas may be readier than their urban counterparts to accept psychiatrists visiting general practice to see their patients. Rural general practitioners may expect a different pattern of service provision from that available in an urban setting.

This paper describes a self report questionnaire survey of general practitioners' attitudes to current and possible future community psychiatric services in three different areas of the north east Thames region, Hackney, Harlow and Uttlesford. Hackney is an inner city borough with an ethnically diverse population of 190 000 (1981 census). Many single handed general practitioners work in a setting of much social disadvantage; unemployment is high (13% in December 1989, Department of Employment) and many people live in overcrowded housing (council waiting list of over 8000, London Borough of Hackney). The population and its general practitioners are situated close to the hospitals providing psychiatric services. Harlow is a well established and geographically circumscribed new town, 35 miles north east of London whose population (79 521, 1981 census) is largely employed in skilled manual work and is served by group practices of general practitioners based in purpose built health centres. Uttlesford is a rural district (population 66 000, 1981 census) with three moderately sized towns, Saffron Walden (population 14 000), Dunmow (population 5700), Stansted (population 5400) and a number of widely scattered villages and hamlets. In the countryside there is a heterogeneous population including an indigenous farming community and a more recent influx of commuters to London.

In all three areas general practitioners are usually in contact with one or two psychiatrists for their adult patients because catchment areas are divided into sectors. For patients involved in long term rehabilitation they might be in contact with an additional consultant. However, in parts of Uttlesford general practitioners might be in contact with two consultants based in either Harlow or Cambridge, because of catchment area boundaries.

At the time of the study most general practitioners in Uttlesford worked in group practices of two or three partners with a practice list size ranging between 2807 and 8404 patients. In Harlow most general practitioners worked in large group practices with as many as nine partners, with a few practices having three partners, with list sizes ranging between 1590 and 17 208 patients. In Hackney approximately 15% of doctors worked as single handed practitioners with individual list sizes between 1200 and 3500 patients and overall practice list sizes of up to 10 000 patients. Community psychiatric services in Uttlesford comprised two newly appointed community psychiatric nurses and a regular visit by a psychiatrist to a clinic in Saffron Walden with availability for domiciliary visits. In Harlow, a community psychiatric

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nurse was allotted to each health centre, although with staff shortages at the time, one nurse might be working at two health centres or more. There was 24 hour access to consultants for domiciliary visits, and an active day hospital. In Hackney, both community psychiatric nurses and community support workers were available, as well as a day hospital, emergency clinic and ready access to domiciliary visits by consultants.

It was the aim of this study to compare general practitioners' views of community psychiatric services in these diverse populations with the expectation that their perceived needs for services would differ depending on the characteristics of the population served. The study was carried out between 1988 and early 1990.

Method

The questionnaire used in this study was derived from the literature[1] and refined by consultation with experienced general practitioners belonging to the general practitioner medical advisory committee in Harlow. Using both open and closed questions the questionnaire asked respondents for demographic details, for details about their practice and for their views on community psychiatric services. The names of all general practitioners practising in the three areas were obtained from family practitioner committee lists. The self report questionnaire was sent to all general practitioners in Harlow and Uttlesford with an accompanying letter from the department of psychiatry at the Princess Alexandra Hospital, Harlow and the general practitioner medical advisory committee. Non-respondents were sent a second letter, followed by a further letter and questionnaire. The questionnaire was mailed once to all general practitioners in Hackney with a letter from the community psychiatry research unit at Hackney Hospital.

The categorical variables in the questionnaire were analysed in cross tabulations using chi square statistics to test for statistical significance.

Results

The response rate to the questionnaire was 97.3% in Uttlesford (36/37 doctors), 100% in Harlow (46/46) and 34.5% in Hackney (40/116). Not all respondents answered all the questions. The median date when respondents qualified was similar in all three areas — Uttlesford, 1972; Harlow, 1968; Hackney, 1971. However, there were slightly more women respondents in Harlow (26.1%) than in Hackney (20.0%) and Uttlesford (19.4%). In Harlow nine respondents (19.6%) had postgraduate experience in psychiatry while in Hackney the figure was 27.5% (11 respondents) and in Uttlesford 23.5% (eight respondents).

Psychiatrists in general practice

In all geographical areas general practitioners indicated that they would like closer liaison and consultation with psychiatrists (Table 1). Assessment by psychiatrists in general practice was less popular in Hackney than in the other two areas. Regular outpatient clinics in general practice were most welcomed in rural Uttlesford and in that area respondents were more than twice as likely to prefer their surgery as a base for outpatient clinics than doctors in Hackney or Harlow.

In Uttlesford and Hackney the highest percentage of respondents felt that patients with schizophrenia should be seen by a psychiatrist as well as a general practitioner but patients with alcohol or drug problems were felt to be most important in Harlow (Table 1). There was little difference between the areas with regard to whether general practitioners would like psychiatrists to see patients with depression, neuroses, dementia or a personality disorder.

Table 1. Respondents' views on links between psychiatrists and general practitioners.

	% of respondents answering positively		
	Uttlesford ($n=36$)	Harlow ($n=46$)	Hackney ($n=40$)
Closer liaison/consultation with psychiatrists about outpatients	*88.9*	*87.0*	*84.2*[a]
Psychiatrist to visit general practice for assessments	*74.3*[b]	*71.7*	*62.5*
Psychiatrist to visit general practice regularly for outpatient clinics	*67.6*[c]	*53.3*[d]	*57.5*
Preferred base for psychiatric outpatient clinics:			
Hospital	*33.3*	*43.5*	*32.5*
Surgery	*27.8*	*10.9*	*12.5*
Both	*38.9*	*45.7*	*55.0*
Psychiatrists should be involved in providing care for patients with:[e]			
Schizophrenia	*61.1*	*43.5*	*50.0*
Alcohol/drug problems	*47.2*	*54.3*	*42.5*
Depression	*47.2*	*34.8*	*45.0*
Neuroses	*33.3*	*23.9*	*25.0*
Dementia	*30.6*	*26.1*	*35.0*
Personality disorder	*36.1*	*21.7*	*37.5*

n = total number of respondents. [a] $n = 38$. [b] $n = 35$. [c] $n = 34$. [d] $n = 45$. [e] Respondents could choose more than one group of patients.

Community psychiatric nurses

More respondents in Uttlesford believed they had community psychiatric nurses visiting their practice than in Harlow or Hackney ($\chi^2 = 23.9$, 2 degrees of freedom, $P<0.001$) (Table 2). Almost all respondents preferred direct referral to community psychiatric nurses to referral through a psychiatrist. A similar percentage of respondents in Uttlesford and Hackney would have preferred community psychiatric nurses to be based in their practice rather than in hospital or other settings, but this figure was considerably lower in Harlow ($\chi^2 = 13.5$, 4 df, $P<0.01$). In Uttlesford, general practitioners would most like community psychiatric nurses to see patients with schizophrenia while in

Table 2. Respondents' views on the community psychiatric nurse (CPN) service.

	% of respondents answering positively		
	Uttlesford ($n=36$)	Harlow ($n=46$)	Hackney ($n=40$)
CPNs currently visit practice	*83.3*	*50.0*	*27.5*
Prefer direct referral to CPNs	*97.1*[a]	*93.5*	*100.0*[e]
Prefer CPNs to be based in practice	*82.9*[a]	*52.2*	*82.8*[b]
CPNs should see patients with:			
Schizophrenia	*97.2*	*65.2*	*65.0*
Depression/anxiety	*91.7*	*73.9*	*62.5*
Alcohol/drug problems	*83.3*	*71.7*	*62.5*
CPNs should administer domiciliary long term depot neuroleptic injections	*55.6*	*39.1*	*22.5*
CPN service useful	*75.8*[b]	*95.5*[c]	*74.3*[d]

n = total number of respondents. [a] $n = 35$. [b] $n = 29$. [c] $n = 44$. [d] $n = 39$.

Harlow doctors would most like community psychiatric nurses to see patients with depression/anxiety and alcohol/drug problems.

The general practitioners' perception of the role of community psychiatric nurses in a rural area is reflected in the Uttlesford respondents' greater preference for community psychiatric nurses to administer long term depot neuroleptic injections in the patient's home rather than relying on injections given by practice nurses or general practitioners at their surgeries or in hospital outpatient departments or day hospital clinics (χ^2 = 8.8, 2 df, $P<0.05$). The community psychiatric nurse service was rated as significantly more useful in Harlow than in Uttlesford or Hackney (χ^2 = 14.2, 2 df, $P<0.001$).

Psychiatric emergencies

More general practitioners in Uttlesford and Harlow preferred to see psychiatric emergencies themselves and arrange admission than in Hackney (χ^2 = 6.9, 2 df, $P<0.05$) (Table 3). In Hackney general practitioners' first choice was to carry out an urgent domiciliary visit with the consultant psychiatrist present. A crisis intervention team was seen as a useful possible innovation in all areas, particularly in Harlow but less so in Hackney.

Table 3. Respondents' preferences for coping with psychiatric emergencies in the community.

	% of respondents answering positively		
	Uttlesford (*n* = 36)	Harlow (*n* = 46)	Hackney (*n* = 40)
See patient at home themselves and arrange admission	*50.0*	*50.0*	*25.0*
Carry out domiciliary visit with consultant psychiatrist	*27.8*	*34.8*	*40.0*
Crisis intervention team a useful innovation	*86.1*	*91.3*	*75.0*

n = total number of respondents.

Mental health centre

It was felt that a mental health centre would be a useful additional resource in both Harlow 68.2% and Uttlesford 79.4% (this question was not asked in Hackney). It was striking that in Uttlesford a mental health centre was a much more popular base for early intervention, assessment and treatment than a day hospital (45.7% of respondents selected only a mental health centre versus 5.7% only a day hospital; 34.3% selected both a mental health centre and a day hospital, 11.4% selected 'don't know' and 2.9% 'other'), while the opposite was true in Harlow where a day hospital was considerably more accessible (23.3% selected a mental health centre versus 39.5% a day hospital; 27.9% selected both, 7.0% 'don't know' and 2.3% 'other') (χ^2 = 12.7, 4 df, $P<0.05$).

Satisfaction with community services

A similar proportion of respondents in all three areas were dissatisfied with current community services — Uttlesford 65.7%, Harlow 60.9%, Hackney 74.3%. Fewer general practitioners were either 'a little' or 'moderately' satisfied with community services in Uttlesford (20.0%) and Hackney (23.1%) than in Harlow (32.6%).

Among services that general practitioners would like a community team to provide (members of team not specified on questionnaire), sexual problem counselling was felt to be important in all areas (Table 4). Marital therapy was also felt to be important in Uttlesford, while anxiety management and relaxation therapy were felt to be important in Harlow, and bereavement counselling (χ^2 = 8.2, 2 df, $P<0.05$) and brief psychotherapy (short term focused dynamic psychotherapy) in Hackney.

Table 4. Services respondents would like a community team to provide.

Service required	% of respondents		
	Uttlesford (*n* = 36)	Harlow (*n* = 46)	Hackney (*n* = 40)
Marital therapy	*80.6*	*60.9*	*67.5*
Sexual problem counselling	*80.6*	*80.4*	*77.5*
Anxiety management	*77.8*	*82.6*	*75.0*
Brief psychotherapy	*75.0*	*76.1*	*77.5*
Relaxation therapy	*69.4*	*89.1*	*72.5*
Counselling	*63.9*	*71.7*	*70.0*
Bereavement counselling	*47.2*	*54.3*	*77.5*
Social skills training	*44.4*	*56.5*	*52.5*
Assertiveness training	*38.9*	*52.2*	*37.5*
Occupational therapy assessment	*36.1*	*50.0*	*45.0*

n = total number of respondents.

Discussion

This study has demonstrated a desire for closer liaison and consultation with psychiatrists among general practitioners in all three areas. However, the low response rate from general practitioners in Hackney is disappointing and means that the findings and comparisons between Hackney and the other two areas should be treated with caution because of the possible response bias. The reasons for the poor response are not clear but are likely to include the failure to follow up non-respondents. On the other hand, the similarity in the demographic characteristics of general practitioners in all three samples lends validity to comparisons which include the Hackney sample.

The differences in the results from the three areas might be explained by the geographical distance between primary and secondary care in each area. General practitioners in the rural area of Uttlesford, far from the nearest hospital, were keener on psychiatrists visiting their surgeries for patient assessments and regular outpatient clinics than doctors in the other areas. The lower proportion of general practitioners in Hackney who had community psychiatric nurses visiting the practice could again be explained by the closer proximity of the hospital based community psychiatric nurses to the population being served. This would make access to community psychiatric nurses more feasible, and practice based nurses less necessary than in Uttlesford. The same reasons are likely to apply to the respondents' contrasting perceptions of the community psychiatric nurse's role in administering long term depot neuroleptic injections; fewer doctors regarded domiciliary injections as important in Hackney where patients can readily reach the hospital clinic or their general practitioner's surgery. As far as psychiatric emergencies are concerned, the relative ease of access to a psychiatrist in Hackney and the greater difficulty of general practitioners arranging admissions themselves may explain the Hackney general practitioners' greater enthusiasm for consultant psychiatrist domiciliary visits in psychiatric emergencies compared with doctors in Harlow and Uttlesford. In Uttlesford, the greater distances suggest that the more practical procedure is for general practitioners to arrange admissions themselves rather than call out a consultant psychiatrist. There are likely to be other factors, social and economic, which may also contribute to these differences and caution should be exer-

cised in attributing such differences only to geographical distance between the services.

The lower proportion of general practitioners in Hackney who considered a crisis intervention team as a useful innovation compared with Harlow and Uttlesford might be explained by the availability of the emergency clinic at Hackney hospital, but it should be emphasized that a high proportion of respondents in all three areas saw such a service as useful.

Overall, despite the disparate nature of the populations, it is striking how similar the general practitioners' attitudes were in all three areas. They would welcome closer contact with psychiatrists and the majority would like psychiatrists to see patients in their practices. They are also keen for community psychiatric nurses to be based in general practice. More respondents felt psychiatrists should be involved in the care of severely mentally ill patients than those less severely mentally ill but it was also clear that they believed patients with the less severe psychological disorders should receive specialist services. Respondents wanted help and support with counselling and psychotherapy. Members of the community psychiatric team, for example, community psychiatric nurses, social workers, clinical psychologists or counsellors, are well equipped to provide such treatment and primary care is an appropriate setting for this.

The large number of respondents in all three areas who were dissatisfied with community services is disappointing but does reflect a need for the development of effective community services. The need for general practitioners to formulate views on what a community psychiatric team should provide has become more important with the purchaser-provider split in the National Health Service, leading to a greater onus on specialists to provide services that general practitioners regard as necessary and relevant. Many psychiatrists are actively seeking the views of general practitioners and it is in the interest of general practitioners to talk to their local psychiatrists about services. It is clear that general practitioners do not wish psychiatrists to take over the care of psychiatric patients in primary care but do see roles for specific members of the community psychiatric team within the wider orbit of the primary care team.

Future patterns of service will need to be tailored to meet the different requirements of rural and urban areas. A dialogue between general practitioners and their local psychiatrists is a necessary prerequisite for the development of community psychiatry services which are sensitive to local variations in need.

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