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Psychogeriatricians and general practitioners: a national survey

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Recent changes in the provision of health and social care in the UK such as the institution of a purchaser/provider system and regular screening of the elderly by GPs are of importance to the relationship between primary health care teams (PHCT) and psychogeriatricians. These changes have clarified the necessity for sensitivity by psychogeriatric services to the needs of GPs and commissioning authorities.

The number of consultant psychogeriatricians has grown rapidly in the past 20 years from a handful in the early 1970s to over 350 in 1991. Psychogeriatrics has a strong community focus and there is a widespread acknowledgement of the need to work effectively with primary health care teams to achieve optimum patient care. This led us to ask the question: what is the present state of contacts between psychogeriatric services and general practitioners and what models of interaction are being used?

A similar question was investigated by Strathdee & Williams (1984) for contacts with general adult psychiatrists. They reported "the silent growth of a new service" with one in five of the psychiatrists surveyed taking part in liaison-attachment schemes with GPs. Their study excluded all psychiatrists who were not "general adult psychiatrists and/or psychotherapists"; it therefore did not give any information about links between GPs and psychogeriatricians. While there have been descriptions of various services and models of service provision (e.g. Hilton & Jolley, 1991; Shulman & Arie, 1991) there do not appear to have been any systematic studies yielding quantitative normative data on the state of liaison between GPs and psychogeriatricians.

This paper therefore reports an attempt to ascertain the level and nature of contacts between psychogeriatric services and PHCTs throughout the UK.

The study

A draft questionnaire was constructed and piloted on the five consultant psychogeriatricians working in the Lewisham and North Southwark area. Suggested changes were incorporated and the final version was sent to the 370 consultant psychiatrists working full time or part time in psychogeriatrics on the database of the section of old age psychiatry of the Royal College of Psychiatrists. Those that had not replied within two months were sent a further copy of the questionnaire.

The questionnaire contained enquiries into the size and nature of their catchment area and sessional commitment to psychogeriatrics. Details of new home assessments in the month prior to receiving the questionnaire, of work carried out in GPs' surgeries and of other contacts with PHCTs were also sought. The period of the study was from April to July 1991.

Findings

Two hundred and eighty-three replies were received from the mailings; 270 completed forms were suitable for analysis and 13 exclusions were made for reasons which included death and secondment to managerial posts. This gave a final response rate of 75.6%.

Ninety-two (36%) respondents described their catchment area as urban, 143 (56%) as mixed and 30 (12%) as rural; (missing data 2%). Two hundred and twenty-five (63%) psychiatrists reported working in psychogeriatrics full-time, 65 (24%) from six to ten sessions and 28 (10%) from one to five sessions; (missing data 3%). The mean number of new home assessments carried out in the month prior to the survey was 17 (median 16, range 0–61). The mean number discussed with the patients's GP prior to assessment was 7 (median 4, range 0–50) and the mean number carried out in the company of the patient's GP was 1 (median 0, range 20).

Sixty-two (23%) psychogeriatricians had regular commitments at GP surgeries. Psychogeriatric team members other than the consultant regularly worked in GPs' surgeries as follows: CPNs 192 (71%), psychologists 49 (17%), social workers 41 (15%), junior doctors 24 (9%) and occupational therapists 23 (9%). Overall, in 197 (73%) psychogeriatric

TABLE I

Cumulative number of liaison-attachment schemes with GPs by year of establishment and nature of work carried out for consultant psychogeriatricians and for other team members

Year of establishment/ nature of service	*Consultants**	*Other team members**
1966	1 (0)	0 (0)
1971	1 (0)	1 (0)
1976	5 (1)	5 (1)
1981	12 (3)	21 (6)
1986	29 (8)	83 (23)
1991	56 (16)	136 (38)
Year of establishment missing	6 (2)	61 (17)
Out-patient clinic	49 (79)	32 (16)
See GP referrals	43 (69)	104 (53)
See referrals from other PHCTM	21 (34)	53 (36)
See patient with GP	15 (24)	45 (23)
See patient with other PHCTM	21 (34)	53 (27)
Discuss patient with GP	49 (79)	180 (91)
Take part in case conferences	14 (23)	49 (25)
Run groups with patients	8 (13)	42 (21)

*For year of establishment figures in brackets are % of all service (n = 357) while for nature of service the figures in brackets are % of those with a liaison scheme (consultant n = 62, other team members n = 197).

services team members other than the consultant regularly worked in GP surgeries. Details of the type of work carried out by consultants and by other team members and the year of establishment of these services are presented in Table I.

In 76 (28%) services GPs made direct referrals to health professionals other than the consultant while in 191 (71%) teams all referrals were channelled through the consultant. Thirty-one (12%) psychogeriatricians reported that they had established formal links with their family health service authority and 105 (39%) had a GP on their elderly mental health planning team. One hundred and eleven (41%) had carried out "market research" into GPs' needs and 47 (17%) had been involved in primary health care screening of the over 75s.

Comment

The most striking findings of this survey were that 71% of psychogeriatric teams had a CPN regularly working in GPs' surgeries, and that 23% of psychogeriatricians themselves ran services there. The consultants' most frequent activities were holding their out-patients clinics in health centres, discussing cases with and seeing patients referred by GPs. Other team members' main activities were discussing cases with GPs and seeing referrals from GPs and other PHCT members. Also of interest were the findings that around 40% of psychogeriatricians had a GP on their elderly mental health planning team and that the same percentage had carried out "market research" on local GPs.

The most commonly reported advantage of links with GPs was improved communication. This was followed by improved management; a chance to educate GPs in the mental health problems of the elderly; ease of access for the patients, decreased crisis referrals; reduced need for admission and a speedier provision of service. The disadvantages most commonly identified were links too time-consuming; increased work load; encouragement of inappropriate referrals and the possibility that a two-tier system might be provided with those GPs not receiving team visits receiving a "second class" service. Comments were however predominantly positive with the most common answer being "no disadvantages".

These results suggest that there are substantial links between psychogeriatric teams and PHCTs. These links appear to have arisen by local initiatives rather than by central planning and to have been increasing steadily over the last 10 years rather than as a reaction to recent changes.

There are increasing opportunities for psychogeriatricians to work in collaboration with PHCTs as teams move out of hospitals and into community settings. By working in these settings and having contact with PHCTs it is likely that the quality of

treatment for elderly people with mental health problems could be improved. This is of particular importance for people with depression or neurosis since these people are often managed by PHCTs with little reference to psychiatric teams.

It seems that the models of consultation currently adopted by psychogeriatric teams are aimed more at increasing patient throughput and reducing admissions rather than at increasing PHCTs' skills. In the long term, education of PHCTs may be a more effective means of improving patient care and of reducing the demand on secondary care services. However, in order to be effective as a source of expertise and education the members of psychogeriatric teams may themselves need training in the broad range of psychiatric morbidity presenting at the primary level, and in effective teaching methods.

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Towards sectorised psychiatric care – what do GPs think?

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The last ten years have seen the development of sectorised psychiatric services across many areas of the country. The characteristic feature of such a service is that a given team is responsible for serving a population base defined either on geographical grounds or by general practice (Tyrer, 1985). However there has been little research on the impact of sectorisation (Tyrer *et al*, 1989).

How do GPs experience the change to a sectorised service? The views of GPs are important in this area as they see most of the mentally ill (Goldberg & Huxley, 1980) and are increasingly buyers of services. The development of a sectorised service in April 1990 in Oxford provided an opportunity to study this question.

The new service is based on the GP populations in the city where 94 GPs working in 28 practices serve a population of 158,000. Pre-sectorisation, the GPs had access to any of the four general adult teams, two based at the Warneford Hospital, and two at Littlemore Hospital. After consultation with the GPs, the city was divided into four sectors, each serving between five and nine city practices. No new resources were available, and there were no other specified community workers apart from the CPN teams. A second stage of development of the service would be to include extra resources; for example, enlarging the sector teams and providing community facilities. Ideally both stages should occur together but with current financial restriction this was not possible.

The study

This study aimed to identify GPs' understanding and apprehension about a sectorised service before its introduction (pre-sectorisation) and monitor the accuracy of the GPs' perceptions after the service had been operating for 12 months and identify new anxieties (post-sectorisation).

Design

The study was based on the responses to two self-report postal questionnaires. These consisted of open ended questions, rating scales and opportunities to provide further comments if wished. The areas covered in the questionnaire included perception of sectorisation, availability of services, who would benefit from the changes and any anxieties GPs wished to raise. A small pilot study was carried out with GPs outside the city who had previous experience of sectorised psychiatric care. This ensured that the questions covered subjects which the GPs would find relevant. The first questionnaire was sent to the GPs in February 1990 (pre-sectorisation questionnaire); and the second was sent in March 1991, 12 months after the changes were introduced (post-sectorisation questionnaire).

Response rate

Sixty-three of the 94 GPs (67% of total) completed questionnaires on each occasion. A further eight