A Psychiatric Clinic in General Practice

A description and comparison with an out-patient clinic

SALLY M. BROWNING, Lecturer in Mental Health, University Department of Mental Health, 41 St Michael's Hill, Bristol (correspondence); MICHAEL F. FORD, Senior Registrar in Psychiatry, Graylingwell Hospital, Chichester (formerly Registrar in Psychiatry, Glenside Hospital, Bristol); CAIT A. GODDARD, Registrar in Psychiatry, Glenside Hospital, Bristol, and ALEXANDER C. BROWN, Consultant Senior Lecturer, Department of Mental Health, University of Bristol

Only a minority suffering from mental illness are treated by the specialist psychiatric service. The majority of psychiatrically ill patients seen in general practice suffer from minor neuroses, personality disorders and situational reactions and can be appropriately treated by the primary care team. However, a significant degree of morbidity, some of it severe, fails to be identified in general practice and the identification and treatment of psychiatric disorder varies according to the GP's interest and attitudes.

Patterns of referral to specialist services are influenced by factors other than the nature and severity of the disorder and communication between patients, GPs and psychiatric out-patient departments can prove unsatisfactory.

The use of counselling rather than prescription of minor tranquillisers has been encouraged as an effective treatment of minor neurotic disorder and situational reactions in general practice, and this may be facilitated by ease of access to psychiatric advice.

The development of health centres has provided specialists with the opportunity to undertake clinical services outside the hospital setting. The advantages to the patient have been described as follows: "Therapy is adapted to his needs. He can meet the specialist in familiar surroundings, introduced by his own doctor. There is no waiting, and he is not subject to the pressure of the out-patient clinic".[1] Health centres also offer the opportunity of liaison between psychiatrists and the primary care team. That this has proved popular to many psychiatrists is demonstrated by the fact that about one in five senior psychiatrists are now participating in GP liaison schemes.

The advantages of this development to patients and their relatives, psychiatrists and members of the primary care team has been reviewed by Mitchell.[2] Among reservations expressed are a fear that psychiatrists may take over the legitimate role of the GP, or may neglect more seriously ill and psychotic patients treated in the hospital service, or may be overwhelmed by the increased demand created.

Tyrer et al,[3] however, emphasised that the psychiatrist's role should be to buttress the GP's position as the cornerstone of community care, the description proposed by the WHO.[4] Tyrer also claims that psychiatric clinics in general practice can help establish continuity of care and increase re-referral of many chronic psychiatric patients without requiring an increase in personnel or resources.[5] Such continuity would go some way to answering criticism summarised by Kathleen Jones: "So many of our hospitals run as closed systems—the patient dematerialising when he leaves."[6]

We report our experience from a psychiatric clinic in an inner city health centre over its first 18 months of operation.

The Health Centre

The *health centre* was established in 1973. It holds three practices with a total of eight GPs and one trainee. Approximately 15,000 patients are registered with the centre. It also provides a base for health visiting, district nursing and a range of medical and ancillary services. A community psychiatric nurse is allocated to the area but has only limited contact with this health centre. There is no attached social work service.

The *area* served by the health centre is in the inner city and is notable for its high level of social deprivation, high level of alcohol-associated problems and for the high rate of psychiatric admission, particularly compulsory admission under section 2 of the Mental Health Act 1983.

The *psychiatric clinic* was initiated in early 1983 by a consultant with previous experience of liaison in general practice (ACB). One, and later two sessions per week were provided. At each session one member of the psychiatric team (consultant, senior registrar or registrar) was available to see patients and discuss cases. Letters were written to GPs regarding each patient seen (clinic letters). Copies of these provided a record for the visiting psychiatrists.

While referrals could be made by the psychiatrist to services available at the psychiatric hospital base, other members of the multidisciplinary team were not available at this clinic.

The study

A retrospective study of patients seen at the health centre using clinic letters and the GPs' notes was made covering an 18 month period from June 1983 to December 1984. Demographic data, referral, history of previous psychiatric contact, diagnosis, and treatment were noted for all those seen.

A similar clinic is held at another health centre about a mile away at the other end of the inner city area.

Non-attenders were also investigated by reference to the GPs' notes for demographic data, past contact with psychiatric services, reasons for referral and outcome.

We also decided to compare our experience in the health centre clinic with a sample of out-patient attenders and so we studied all referrals by the health centre GPs to the main psychiatric out-patient department serving the area over the year prior to the establishment of the health centre clinic. We specifically looked at demographic data, non attendance rates, diagnosis and treatment of this group.

Eighty-seven health centre clinic sessions were held between June 1983 and December 1984. One hundred and fourteen patients were

referred, of whom 98 (86%) were seen. Of those attending, 40 were male, 58 female. Age distribution was from 20 to 70 with a mean age of 39. The patients were of European extraction except for nine West Indian, three Asian and one Mauritian patient.

Nearly half the *referrals* (44) were new patients with no previous psychiatric contact. Twenty-six had a history of admission to a psychiatric hospital. While most referrals came from GPs and trainees (89), two came from the health visitors, three from community psychiatric nurses (CPNs), and four direct from the ward from which the patient had been discharged.

There was a wide variation among GPs in numbers of patients referred; the three highest-referring GPs making an average of 17.7 referrals each, while the three lowest-referring GPs made an average of 7.3 referrals each. Every GP made at least one referral.

Female psychiatrists saw twice as many female patients as males while male psychiatrists saw equal numbers of both sexes. There is a clear suggestion that the gender of the psychiatrist is taken into consideration by the referring GP, consciously or not.

The first column on Table I shows the main *clinical diagnosis* for each patient seen at the health centre over the 18 month period. The second column shows out-patient referrals from the health centre for the year preceding the introduction of the new service.

TABLE I
Clinical diagnosis of attenders at health centre clinic and out-patient department

	Health centre	*Out-patients*
Schizophrenia, paranoid psychosis	12 (12%)	1 (3%)
Affective psychosis	2 (2%)	1 (3%)
Neurosis, personality disorder, adjustment reaction	45 (46%)	25 (70%)
Dementia	1 (1%)	0
Mental handicap	0	1 (3%)
Alcohol and drug dependence	16 (16%)	9 (24%)
Psychosexual problems	6 (6%)	0
No psychiatric disorder	16 (16%)	0
Total	98	37

Of the 14 psychotic patients seen, 10 were referred by their GPs, 3 by CPNs and one from the ward at discharge; 9 had a past history of in-patient care.

The psychiatrists attending worked in different ways which ranged from offering a consultation service to GPs to providing brief psychotherapy. The number of follow-up appointments therefore varied as shown in Table II.

Psychiatrist 1 used a consultation model while the other psychiatrists used a mixed model; psychiatrist 5 saw a number of patients for brief psychotherapy. There was no correlation between the number of follow-up appointments and the age, sex or clinical experience of the psychiatrist. The total number of follow-up appointments was 141 for 98 patients seen.

The main line of treatment for all patients seen is shown in Table III, column 1.

At the end of the study period, 54 patients had been discharged directly from the clinic, nine were still attending, nine had been admitted to the local psychiatric hospital and the remaining 26 referred on: eight to day hospital or day care; two to a psychologist;

TABLE II
Follow-up appointments

Psychiatrist	*Total no. of patients seen*	*Total appointments*	*Mean consultations per patient*
1	27	32	1.2
2	9	23	2.6
3	25	53	2.1
4	20	63	3.2
5	17	68	4.0
Total	98	239	2.4

TABLE III
Treatment of attenders at health centre clinic and at out-patients department

	Health centre	*Out-patients*
Assessment only	30 (31%)	16 (43%)
Counselling/psychotherapy	28 (29%)	10 (27%)
Prescription of antidepressant	12 (12%)	3 (8%)
Prescription of anxiolytics	0	1 (3%)
Prescription of major tranquilliser	10 (10%)	1 (3%)
Methadone withdrawal	0	2 (6%)
Referral to day hospital/day care	6 (6%)	0
Referral to other agency	12 (12%)	4 (11%)
Total	98	37

one to a social worker; nine to a physiotherapist (for relaxation); three to CPNs; one to an addiction group; one was seen by his probation officer and one by a health visitor.

Non-attenders. The group of patients failing to attend a first appointment was investigated using the GPs' notes. Sixteen patients failed to attend—of these, three were only briefly registered with the practice—13 case notes were therefore examined.

Age range, sex ratio and nationalities were similar to attending patients. Eight were new patients; of the five with previous psychiatric histories, two were former in-patients. Eleven referrals were from GPs, one from a casualty officer and, for one, the source was unclear. The most common reasons for referral were problems with relationships, depression and behavioural problems.

On investigation of follow-up at the end of the study period—three patients eventually saw the psychiatrist, two received further support from the GP, three were referred to other services. Five patients had not been seen again.

Referrals from the three GPs classed as 'high referrers' were compared to referrals from the three GPs classed as 'low referrers'. The 'high referrer' GPs referred proportionally fewer non attenders; 5/53 (9%) to 5/22 (23%).

Comparison with referrals to out-patients clinic

We examined case notes of all patients referred by the GPs at the health centre to the psychiatric out-patient department serving the

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district during the period June 1982–May 1983, i.e. the year prior to the beginning of the health centre clinic.

Forty-four patients were identified: case notes were not available for four, therefore 40 sets of notes were examined. Patient characteristics were compared with the group seen at the health centre. These showed similar sex ratio (15 male, 22 female), and age distribution. Patients were of European extraction except for two West Indians, one Anglo Chinese and two Asians.

Diagnostic categories are shown in Table I, column 2. All referrals were from GPs or trainees. Interestingly, the pattern of relatively high-referrers and low-referrers was reversed when compared to health centre referrals. The three GPs who made most referrals—53/98 (54%) to the psychiatrist in the health centre, referred only 9/40 (22.5%) patients to out-patients, while the three GPs who made least referrals 22/98 (22.4%) to the psychiatrist in the health centre, made relatively many referrals 28/40 (70%) to the out-patients department.

The main line of treatment is shown in Table III, column 2. The total number of follow-up appointments made was 95 for 37 patients (a rate of 2.6 appointments per patient) compared to a follow-up rate of the health centre clinic of 141 appointments for 98 patients (1.4).

At the end of the study period, 21 patients had been discharged from the clinic and one continued attendance. Three patients had been admitted to a psychiatric hospital and ten patients attended day hospital or day care. One had been referred to a psychologist, three to social workers and one to another psychiatrist.

Non-attenders at the out-patients clinic. Of the patients whose notes were examined, only three out of 40 were non-attenders. Even assuming that the four not traced were non-attenders, this is a similar figure (18%) to the non-attendance rate at the health centre (16%) and is lower than the overall non-attendance rate of 25% for all referrals to the outpatient clinic.

Comment

Our first conclusion is that we were providing a different service to a different population when we compare our findings to those of Tyrer. We saw a much higher proportion of new patients and this remained the case throughout the study. The health centre did, however, also provide a convenient site for the follow-up of discharged in-patients living in the vicinity. (This aspect of the service has subsequently been developed with the opening of a depot injection clinic run by CPNs).

Individual GPs showed different rates of referral to out-patient departments and the health centre clinic. Those who made a higher number of referrals within the health centre appeared to select proportionally more patients likely to attend for appointments. The apparently selective referral of more female patients to the female psychiatrists is of interest.

Patients were seen with a range of psychiatric disorders. Proportionally more patients with a diagnosis of psychotic disorders were seen at the health centre clinic than at psychiatric out-patients, referred from the same practice. This was reflected in the treatment offered, prescription of antidepressants and major tranquillisers occurring more frequently in the health centre group (although drug prescription from the GP may have been maintained in some cases). It is of note that at no time was any patient seen at the health centre prescribed a minor tranquilliser by the psychiatrist, even as a short-term measure. The lower proportion of follow-up appointments made at the health centre clinic compared to the out-patient clinic suggests that the clinic was relatively sparing of resources and was not used as a base for counselling at the expense of consultation. With greater ease of communication, it was possible to advise on management while the GP continued to see the patient and to offer to see the patient again on request, without making a further appointment.

In terms of psychiatric resources the clinic described uses two half-day sessions of medical time for a base population of 15,000 in an area known for its high psychiatric morbidity. Assuming a consultant/population ratio of 1:40,000 this approach would imply five to six sessions of medical time for a nominal sector. The present clinic provides useful experience for trainee psychiatrists in addition to fulfilling service function. In a service without any trainees, some of the referrals could be dealt with by social worker, CPN or a trained lay counsellor and the number of follow-up appointments requiring a psychiatrist would be much reduced.

Our comparison of non-attendance rates at the health centre and out-patients reveals similar non-attendance rates. The central situation of the local hospital meant that there was little advantage to the health centre in terms of ease of access, and this factor may be reflected in the higher attendance rates at out-patients for patients from this practice compared to patients from other areas of Bristol.

Most of the patients who failed to attend a first appointment at the health centre were later seen by another member of the psychiatric team, by the GP or referred to another agency. The reason for referral suggests that some, at least, were perhaps more appropriately referred to a social worker or other agency. The working proximity of psychiatrist and primary care personnel allowed discussion of patients not seen and, in some cases, advice on further management.

Liaison psychiatry in general practice can provide a range of services to a population of both 'new' and 'old' psychiatric patients, complementing the service provided by the primary care team. It offers consultation between psychiatrists and members of the team, leading to ease of contact and access to services and mutual learning, of benefit to ensuing patient care.[2] Individual GPs' referral behaviour may be influenced by such a scheme. While health centre appointments do not necessarily reduce rates of non-attendance, eventual follow-up of most non-attenders can ensure that few patients are 'missed' and advice can be readily given even when the patient has not been seen.

Our model differed in several ways from others described. Different services may adapt to the most pressing needs of the local community and to a complementary role with primary care, in part determined by the GPs. As the WHO working party on psychiatry and primary care state "the crucial question is not how the GP can fit into the mental health service, but rather how the psychiatrist can collaborate most effectively with primary medical care".[4]

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A full list of references is available from Dr Browning on request.

Assessing Patients in their Homes

S. J. JONES, Research Associate, Nottingham Psychiatric Case Register, University Department of Psychiatry, Queen's Medical Centre, Nottingham; R. J. TURNER, Consultant Psychiatrist, South and West Nottingham Mental Health Team and J. E. GRANT, Senior Social Worker, South and West Nottingham Mental Health Team, 19 Regent Street, Nottingham

General adult psychiatric services in Nottingham operate on a sector basis, with clinical teams having responsibility for the psychiatric care of all patients resident in a defined area. Sectors, which are conterminous with two or more social service areas, are not of equal population size, but comprise populations likely to give rise to similar demands for psychiatric services. The Social Services Department responded to the introduction of full sectorisation of hospital services in 1982 by allocating social workers to sector teams where possible, aiding the development of multidisciplinary teams.

The first major development was the establishment of the South and West Nottingham Mental Health Team. In October 1982 a community base was acquired in the city centre, which is also central to the area served by the team. A multidisciplinary team was set up, consisting of two consultant psychiatrists, a senior registrar, two senior house officers, a senior and three social workers, an occupational therapist, two community nurses and a psychologist. In-patient (28 beds) and day care facilities are based in the psychiatric unit of a district general hospital. The team provides a comprehensive general adult psychiatric service to people aged between 16 and 64 who are assessed by other agencies (GPs, probation and social services) as being in need of psychiatric help. There is continued access to specialist services such as alcohol and addiction, forensic and rehabilitation facilities. The team has responsibility for a catchment area population of 94,000.

The organisation of the provision of psychiatric care has markedly changed since the inception of the team. In contrast to conventional practice it was decided that initial assessment of patients should be undertaken in patients' homes, unless there were good reasons not to do so. Unlike first contacts which are made in out-patient clinics, where assessment is carried out solely by medical staff, the team has adopted joint assessment by the two members considered most appropriate based on the referral information. A weekly out-patient review meeting has been instituted in order that all referrals can be discussed by the team as a whole and selection made of team members to undertake specific assessments. Since these first assessments are arranged at times mutually convenient to team members and patients, there is greater flexibility than if they had to take place at regular scheduled out-patient clinics. Urgent referrals are still normally seen on the day of referral.

Following the initial assessment visit, a report is made to the next team meeting and one, or sometimes two, key workers are identified to take responsibility for the agreed programme of care. They are responsible for any follow-up that is considered necessary and will involve other members of the team as appropriate. It is understood that any change of direction in the person's care will be discussed wherever possible with the key worker, in an attempt to provide continuity and consistency. If necessary, follow-up may be continued at home.

The style of working adopted by the team is generally preferred by team members. A survey of both patients referred and their general practitioners was undertaken to ascertain their preferences, particularly concerning the introduction of home visits for initial assessment. Additionally an examination was made of the speed of response to referrals and the extent to which different disciplines undertook both initial assessment and subsequent key worker roles.

Methods

Basic details of all patients referred have been recorded since the inception of the team. These include age, sex, source of referral and the time interval between receipt of referral and assessment. Information about the assessors and place of contact of the initial assessment, together with subsequent key worker, were also available. The figures for