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.

References

HILTON, C. & JOLLEY, D. (1991) Meetings between general practitioners and a hospital based trainee psychiatrist: benefits for patient care and doctors' education. *Psychiatric Bulletin*, **15**, 360–361.

SHULMAN, K. & ARIE, T. (1991) UK survey of psychiatric services for the elderly: direction for developing services. *Canadian Journal of Psychiatry*, **36**, 169–175.

STRATHDEE, G. & WILLIAMS, P. (1984) A survey of psychiatrists in primary care: The silent growth of a new service. *Journal of the Royal College of General Practitioners*, **34**, 615–618.

Psychiatric Bulletin (1993), **17**, 594–596

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

replied but did not complete questionnaires each time. This made a response rate of 76% both pre- and post-sectorisation (71 of 94 GPs). Those who replied but did not complete the questionnaires gave a variety of reasons, for example, that they were locums. Forty-seven GPs (50% of total) completed questionnaires on both occasions. In presenting the results, the percentages refer to the total of completed questionnaires (i.e. n = 67 = 100%). However, the results also include findings from the subgroup of 47 GPs who responded to both questionnaires. This allows a more accurate comparison of before and after sectorisation to be made.

Findings

Perception of Sectorisation

The GPs' understanding, pre-sectorisation, was of a consultant-led team in most cases (46% of respondents). GPs predicted that the major effect for them would be a combination of a restriction of choice and expectation of improved communication (57% of respondents). GPs also thought that a limited choice of consultant would be the major effect for patients. Post-sectorisation, a combination of lack of choice and partially improved communication was the main concern for GPs (46% of respondents).

Availability of services

Pre-sectorisation GPs predicted that GP/consultant liaison would improve (60% of respondents) and that they would find it easier to refer directly to CPNs (50% of respondents). Availability of specialist services (e.g. mother and baby work) and local service (e.g. GP based clinics) were expected to remain unchanged. Post-sectorisation, this perception proved to be accurate. GP/consultant liaison was not as good as GPs had predicted but CPN involvement had increased.

The same trends were apparent when the subgroup of 47 GPs answering on both occasions was examined. Thirty-nine of this group reported on contact with CPNs. Pre-sectorisation 21 GPs stated that at most, they would see a CPN only once a year. After sectorisation, this low frequency of contact applied to nine GPs.

Who is to benefit?

Pre-sectorisation, the GPs predicted that the changes would benefit managers and consultants more than GPs and CPNs, with patients being considered least likely to benefit. Seventy-six per cent of respondents predicted benefit for managers and consultants compared with only 28% predicting benefit for patients. Post-sectorisation the order of benefit remained unchanged.

Similar results were found when the subgroup of 47 GPs was examined. Forty of these reported on perceived and actual benefits for patients. Six GPs felt that the change would help patients and still held this view 12 months later. Eighteen GPs felt that patients would benefit and continued to believe this. Seven GPs had expected patients to be helped but found this not to be so. Nine GPs changed their views in favour of patients being helped by sectorisation. Forty-one GPs reported on the effect for managers. Twenty-four had expected managers to benefit and still held this view 12 months later. Only five GPs thought managers would find sectorisation unhelpful and persisted with this belief. Eight GPs had expected managers to be helped but found this not to be so. Four GPs changed their views, believing sectorisation had probably benefited managers.

GPs' anxieties

Anticipated anxieties

GPs anticipated certain difficulties before sectorisation which had also been predicted by the psychiatrists and managers.

(a) Lack of choice. GPs feared that patients with long-standing relationships with a particular team would be required to change teams. Provision for this had been made by stipulating that patients known to the services pre-sectorisation should be transferred gradually to the correct sector team. A worry about lack of choice also applied to new patients. This was not matched in practice by 'out of sector' referrals. In the first 12 months after sectorisation less than 5% of city referrals were out of sector. These referrals were made in the first three months.

(b) Limited resources. This concern was realistic and recognised by all involved.

(c) Special groups. Some groups were recognised as potentially problematic, for example, the large mobile student population, and the homeless who may not be registered with a GP. Some of the homeless have contact with a centrally placed practice which does not require registration beforehand; one sector has taken responsibility for this practice. On a day to day basis, the sector team rotate the responsibility for accepting other non-registered patients who present as emergencies.

Other anxieties

GPs also raised a number of concerns which would have been more difficult to predict.

(a) Would the burden of care in the sectors fall on CPNs rather than be shared across a team?
(b) Were psychiatrists aware of what GPs could offer, for example, practice counsellors?

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(c) GPs emphasised the importance of the different cultures attached to the two hospitals, for example, the strong links between the University and Warneford Hospital.
(d) GPs recognised that teams had special interests. Sectorisation might limit access to these.

Conclusion

It is important to preface any concluding statements by emphasising that although the response rate was 67% on each occasion only 50% of GPs responded both times. Pre- and post-sectorisation comparisons can be made most accurately using this subgroup, but the results may not be representative of all the GPs. Several factors may explain the low response rate. Some GPs had left their practices by the second questionnaire. Others were absent on leave. Some GPs stated that pressures on their time were too great to comply because of the demands of the newly introduced contract. However, most practices were represented by at least one GP who responded on both occasions so that there was no particular sector or part of a sector which was under-represented.

GPs' preconceptions about most aspects of the service changes had been accurate. This applied particularly to the dilemma of achieving better communication at the cost of diminished choice. At follow-up they acknowledged that there had been some changes in the service as evidenced by increased use of CPNs and marginally better communication. However, they felt that the service was still primarily hospital-based. Most of the difficulties GPs predicted had been anticipated in advance. GPs showed no consistent antipathy to sectorisation as indicated by the lack of 'out of sector' referrals. GPs shared the same concern as psychiatrists that a good sectorised service was likely to be expensive to run. In its present early form, the need for clear communication and continued encouragement of GPs remains vital especially in the current provider/purchaser climate.

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References

GOLDBERG, D. & HUXLEY, P. (1980) *Mental Illness in the Community: the pathway to psychiatric care*. London: Tavistock.

TYRER, P. (1985) The hive system: a model for a psychiatric service. *British Journal of Psychiatry*, **146**, 571–575.

—— *et al* (1989) Integrated hospital and community psychiatric services and use of in-patient beds. *British Medical Journal*, **299**, 298–300.