A Psychiatric Clinic in General Practice

A description and comparison with an out-patient clinic

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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 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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Health centre</th>
<th>Out-patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia, paranoid psychosis</td>
<td>12 (12%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Affective psychosis</td>
<td>2 (2%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Neurosis, personality disorder,</td>
<td>45 (46%)</td>
<td>25 (70%)</td>
</tr>
<tr>
<td>adjustment reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>1 (1%)</td>
<td>0</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>0</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Alcohol and drug dependence</td>
<td>16 (16%)</td>
<td>9 (24%)</td>
</tr>
<tr>
<td>Psychosocial problems</td>
<td>6 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>No psychiatric disorder</td>
<td>16 (16%)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>37</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Psychiatrist</th>
<th>Total no. of patients seen</th>
<th>Total appointments</th>
<th>Mean consultations per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27</td>
<td>32</td>
<td>1.2</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>23</td>
<td>2.6</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>53</td>
<td>2.1</td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>63</td>
<td>3.2</td>
</tr>
<tr>
<td>5</td>
<td>17</td>
<td>68</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>239</td>
<td>2.4</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Health centre</th>
<th>Out-patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment only</td>
<td></td>
<td>30 (31%)</td>
</tr>
<tr>
<td>Counselling/psychotherapy</td>
<td></td>
<td>28 (29%)</td>
</tr>
<tr>
<td>Prescription of antidepressant</td>
<td>12 (12%)</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>Prescription of anxiolytics</td>
<td>0</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Prescription of major tranquiliser</td>
<td>10 (10%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Methadone withdrawal</td>
<td>0</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Referral to day hospital/day care</td>
<td>6 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>Referral to other agency</td>
<td>12 (12%)</td>
<td>4 (11%)</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>37</td>
</tr>
</tbody>
</table>

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
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 character-
istics 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 find-
ings 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 con-
vienient 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 tranquilisers 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 tranquiliser 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 mor-
bidity. 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 appoint-
ment 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. 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
coordinate most effectively with primary medical care".4
ACKNOWLEDGEMENT

We wish to thank all staff at Charlotte Keel Health Centre for their help.

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4 World Health Organization (1973) Psychiatry and Primary Medical Care. WHO Regional Office for Europe, Copenhagen.


6 Jones, K. (1979) Integration or disintegration in the mental health service. Journal of the Royal Society of Medicine, 72, 640-648.

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

Assessing Patients in their Homes

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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
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