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The relationship between a community psychiatric rehabilitation team and local GPs

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As mental health professionals move increasingly towards providing community-based services, a good working relationship with general practitioners becomes central to patient care. This relationship depends on good liaison and communication as well as shared goals. This study examines the relationship between a community psychiatric rehabilitation team (CPRT) and GPs by means of a postal questionnaire to local principals in general practice. Although the awareness of the service was less than optimum, clear indications were made of ways of improving communication. The GPs overwhelmingly supported the priorities of the CPRT in the care of those with major mental illness.

Over the past 30 years the role of the psychiatric hospital in the care of those with long-standing mental health problems has declined, to be replaced by systems of community care (Thornicroft & Bebbington, 1989). This has not only involved establishing alternative residential facilities but has also required provision for a range of support needs for people with multiple disabilities and disadvantages.

As psychiatrists and psychiatric nurses move increasingly into the local community, they may find their roles and responsibilities overlapping with other community based professionals, in particular general practitioners (Kendrick *et al*, 1991). There is therefore a need for community based psychiatric services to ensure good liaison and communication with other professionals, as well as the development of shared aims and understanding (Bennet, 1989). The clinical role of the GP in providing primary medical care for the long-term mentally ill has been recognised (House of Commons Social Services Committee, 1985). They are the most consistent point of contact with the caring professions for people who frequently drift in and out of psychiatric care.

This paper examines the relationship between a community-based psychiatric rehabilitation team and local GPs.

https://doi.org/10.1192/pb.19.4.219 Published online by Cambridge University Press

The community psychiatric rehabilitation team (CPRT)

North Tyneside Health District has a population of approximately 150,000 and covers Wallsend, North Shields, Tynemouth and Whitley Bay. It is a mixed urban area to the north east of Newcastle upon Tyne. It includes the seaside resort of Whitley Bay, where a considerable number of people with long-standing mental health problems have been successfully resettled in the supported landlady scheme since the 1970s (Wilson, 1973); Tynemouth: a largely residential suburban town; Wallsend and North Shields; both previously dependent upon local industries, now in decline, and with areas of recognised socioeconomic deprivation such as the Meadow Well Estate.

The North Tyneside Community Psychiatric Rehabilitation Team (CPRT) is relatively new, and part of a developing network of community mental health resources in North Tyneside. It is a multidisciplinary team set up in 1990/1 as part of the devolution of psychiatric rehabilitation from St George's Hospital, Morpeth (some 20 miles away) to the local community. It is unique among other local services in having a specific commitment to long term support and rehabilitation of people with major mental illness.

The CPRT is jointly funded and staffed by the health authority and the local authority social services. At the time of the study the members of the team were one manager, two social workers, two community psychiatric nurses, one clinical psychologist, one assistant psychologist (research), one occupational therapist, and one senior registrar (four sessions).

The aims of the study were

(a) to establish the level of awareness of the team among local GPs,
(b) to explore methods of improving communication between the CPRT and local GPs, and
(c) to establish whether the aims and work of the CPRT were viewed as being valuable by the GPs.

The study

A postal questionnaire was sent to all principals in general practice in North Tyneside Health District. Questions were asked on practice size and type, as well as the number of years in practice and psychiatric experience of individual GPs. The questionnaire went on to ask about previous use of the CPRT and other psychiatric service and sought GPs' views on how communication could be improved. Finally, opinions were sought on the relative importance and usefulness of elements of the CPRT's work.

Findings

Ninety questionnaires were sent. Two GPs were absent on long-term leave. Of the remaining 88 available, 60 replies were received (68% response rate). Responses were representative of all geographical areas and of different practice sizes (ranging from single-handed practices to seven partners in health centres). Experience in general practice ranged from one to 46 years; 43% had had a least six months experience in psychiatry.

Levels of awareness of CPRT

The GPs were questioned on their previous use of the CPRT: 11 had referred patients within the previous 12 months. Eighteen stated they knew little or nothing about the CPRT: four were unsure of its role within the network of mental health services, two assumed referrals would be done by the acute services and four commented on a lack of co-ordination of

Table 1. Rating of GPs of effectiveness of four methods of improving communication from 1: most effective to 4: least effective

	Most effective (1)			Least effective (4)	
	1	2	3	4	No. of replies
Initial notification of key-worker and regular summary	43	9	4	0	60
Increased informal contact	11	33	9	3	56*
Liaison sessions with individual CPRT member	3	11	30	12	56*
Regular formal review meetings	0	5	13	38	56*

*Four respondents indicated only one method as 'most effective'

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Table 2. Assessment by GPs of the importance of individual elements of service provided by CPRT. (Results as number of GPs agreeing with statement)

	Essential	Important	Useful	Not important	No Reply
Broad-based asessment	34	17	7	1	1
Increasing social contact and reducing isolation	17	33	7	2	1
Monitoring compliance with medication	17	32	10	0	1
Practical help with self care skills and increasing independence	14	33	12	0	1
Providing a named person for liaison and contact	23	24	12	0	1
Support for families and carers	16	31	10	2	1
Helping patients and families cope with symptoms of psychiatric illness	16	27	13	0	4
Regular review of mental state	10	35	13	1	1
Administering depot injection to known patients	18	23	14	2	3
Assessing need for supported accommodation	8	29	21	0	2
Co-ordination of care under the care programme approach	10	21	22	1	6
Advising on appropriate state benefits	6	20	31	2	1

mental health services or expressed general dissatisfaction with mental health services. The mental health resource most used by the GPs was the community psychiatric nursing team with 65% estimating they made referrals monthly or more frequently.

Communication

The question on communication started with a statement that the CPRT wished to improve communication and gave four suggestions of ways of doing this as well as a chance to offer other suggestions. A very clear order of preference emerged (see Table 1) with initial notification to the GP of the key-worker and regular summaries of progress being the most popular option. Informal contact was also seen as effective, but regular formal review meetings to be least effective. Although liaison sessions with an individual team member were not popular overall, a significant minority showed considerable enthusiasm for this approach. Other suggestions were limited but the ideas of patient-held notes with basic information and practice-based CPN/counsellor to assess and refer to specialist mental health teams were put forward.

Assessment of attitude of GPs to aims and work of CPRT

Following discussion with the CPRT, 12 key factors were identified as central to the role of the CPRT in caring for the long-term mentally ill (see Table 2). GPs were asked to grade the importance of each factor in the care of their patients with long-standing mental illness. Overall, more than half of GPs who replied considered all of the factors (with the exception of advice on state benefits) to be not simply useful, but essential or important for their patients.

A broad-based assessment of mental state, social situation and support needs was recognised as the most important factor with 34 GPs (57%) agreeing that this was essential. Factors such as increasing social contact and reducing isolation, practical help with self-care skills, and increasing independence were given priority, along with support to families and carers and helping families and patients cope with the symptoms of psychiatric illness.

Although importance was given also to more medical factors such as monitoring compliance with medication, regular review of the patient's mental state, and administration of depot medication these were not given priority over the above factors which recognise the social support needs of patients and their families.

Other more formal social work roles such as assessing the need for supported accommodation and advising on appropriate state benefits were still seen as important although given less emphasis. Co-ordination of care under the care programme approach

https://doi.org/10.1192/pb.19.4.219 Published online by Cambridge University Press

(CPA) was seen as less than essential, although regarded by the CPRT as an important aspect of their work.

Comment

The CPRT is relatively new and still developing a 'track record' with GPs. The concept of referral to a multidisciplinary team rather than a specific person or department is also new in this context. Despite considerable efforts to inform GPs of the CPRT's existence and role, their awareness of the team was still lower than hoped for. This must in part be due to the small number of patients known to individual GPs who would benefit from the CPRT. In addition, GPs may see referrals to such specialist teams as essentially tertiary, preferring to send patients to the general psychiatrists or generic community psychiatric nurses for assessment. Indeed it may be argued that experienced mental health professionals are better placed to make appropriate referrals to a specialist team. A counter-argument is that a community based team is likely to be more effective if working closely with other professionals involved in an individual's care in the community. The ability of GPs and other professionals to refer directly to the team may improve this relationship. If direct referrals from GPs are to be encouraged, there is a need for repeated contact and good communications. Clearly GPs would appreciate more information on the CPRT's involvement with their patients. To date, feedback would only be given routinely to GPs if they were the referring agent. This needs to be reviewed and could be a simple and effective way of improving awareness and communication.

Formalised co-ordination of community care (such as under the CPA) emphasise improved communications and formal review meetings are a central part of this. GPs, in this study however, do not see this as a practical or desirable method of routine communication. Although liaison sessions with an individual team member may not be possible with every practice immediately, arranging this on a limited basis with practices who showed an interest might well be beneficial and give indicators for future service development.

It is reassuring that the priorities of the CPRT in their care of those with long-standing mental health problems are so strongly supported by GPs. In particular, the need for social, practical and family support, as well as the treatment and monitoring of illness are recognised by both as central, emphasising the need for a multidisciplinary, multi-skilled approach to rehabilitation of the mentally ill in the community.

The relatively low importance attached to the CPRT's role in co-ordination of care under the CPA is disappointing, in view of the emphasis given to the CPA by the government as a means of ensuring the provision of care in the community to the vulnerable mentally ill. However, at the time of the survey the CPA was relatively new and the GPs were perhaps not familiar with it. It would be interesting to see if their view changes with time.

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