(a) the need to involve student social workers and qualified staff in the discussion of other social workers cases rather than the discussion being between one social worker and the authors
(b) the need for some teaching, perhaps in a seminar form, on psychiatric topics or topics on the interface between psychiatry and social work.

We are planning to feed back to the entire social work team the conclusions of the review and hope that by running a few seminars that we will increase further the social workers' knowledge and make them more aware of mental health problems and of our role in assisting the social workers in dealing with these problems themselves.

**Is the liaison service achieving appropriate goals?**

Mitchell[1] listed six purposes of liaison work. Substituting the word social worker for the word general practitioner gives the following principles:

(a) to help the social worker identify psychiatric morbidity
(b) to assist the social worker to deal directly with as many cases as are within his/her capability.
(c) to help define at what point a referral to specialised psychiatric services is appropriate and to clarify the purposes of the referral
(d) for the psychiatrist to undertake assessment of patients and to initiate joint care
(e) to share the burden of chronically disabled, demanding and dependent patients
(f) to explore the limits of the social worker/client and the social worker/psychiatrist relationship in the detection, diagnosis and management of mental health problems.

We feel that our liaison service is fulfilling all these six objectives and we hope that the further modifications to our service will have continued mutual benefits for the psychiatrist, the social workers and above all those with mental health problems.

Our conclusion has been that this liaison service has met a real need, and has proved a useful innovation without adding greatly to our workload.

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# Community psychiatric nurses in primary care: consumer survey

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There has been a dramatic increase in the numbers of community psychiatic nurses (CPNs) in the last decade; in the period 1980–1985 the number grew from 1667 to 2758, an overall increase of 65%.[1] Traditionally, CPNs were based within psychiatric institutions. However, in the period 1980–1985 there was growth from 8% to 16.2% in the population of CPNs based in health care centres or General Practitioner (GP) surgeries.[2] Some of the functions of CPNs is also changing, developing away from involvement with chronic psychiatric patients towards patients with minor disorders. CPNs have also argued that work in the community and in GP surgeries is synonymous with primary prevention.[3]

The developments within the CPN service has been accompanied both by an increasing awareness of their professional status and, in some instances, by an increase in identity confusion. Brewer,[4] for example, argued that there was no function which social workers performed which CPNs could not do as well or better, but others have pointed out the confusion which the blurring of roles can cause.[5] There have been calls from within CPN ranks for more involvement in the psychotherapies and for

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TABLE I
*Consumer response to questionnaire survey*

| | Question | Response Yes (%) | No (%) | No response |
|---|---|---|---|---|
| (1) | When your doctor suggested that you talk to a nurse about your problems, had you expected this? | 12 (20.7%) | 44 (75.9%) | 2 (3.4%) |
| (2) | Did you think it was likely to be helpful? | 36 (62.1%) | 20 (34.5%) | 2 (3.4%) |
| (3) | After talking to the nurse, had your feelings about talking to a nurse changed? | 22 (37.9%) | 31 (53.4%) | 5 (8.6%) |
| (4) | Did you feel the nurse was someone who could help with your problems? | 41 (70.7%) | 11 (19.0%) | 6 (10.3%) |
| (5) | Did you find the time spent with the nurse helpful? | 44 (75.9%) | 11 (19.0%) | 3 (5.1%) |
| (6) | Did you find the nurse easy to talk to? | 55 (94.9%) | 1 (1.7%) | 2 (3.4%) |
| (7) | Did you find the nurse interested in your problems? | 55 (94.9%) | 1 (1.7%) | 2 (3.4%) |
| (8) | Did you feel that the nurse understood your problems? | 44 (75.9%) | 11 (19.0%) | 3 (5.1%) |
| (9) | Did you feel the nurse was someone you could trust or confide in? | 52 (89.8%) | 3 (5.1%) | 3 (5.1%) |
| (10) | Would you have been prepared to travel to another clinic to see the nurse? | 22 (37.9%) | 33 (56.9%) | 3 (5.2%) |
| (11) | Would you have rather seen the nurse in your own home? | 20 (34.5%) | 34 (58.6%) | 4 (6.9%) |
| (12) | If your doctor was able to spend more time with you, would you have preferred that to seeing the nurse? | 19 (32.8%) | 32 (55.2%) | 7 (12.0%) |
| (13) | If there was a psychiatrist visiting your doctor's surgery, would you have preferred seeing the psychiatrist rather than the nurse? | 19 (32.8%) | 30 (51.7%) | 9 (15.5%) |
| (14) | Would you have preferred your doctor to refer you to a specialist in a hospital clinic | 9 (15.5%) | 43 (74.1%) | 6 (10.4%) |

specialism within the profession, although some have suggested that specialism may not lead to any extra benefits for the patients.[6]

In the midst of these changes, the effectiveness or appropriateness of CPN interventions have been little studied. Paykel *et al*'s[7] study stands alone in the field. They randomly allocated 71 neurotic patients requiring follow-up, either to routine follow-up in out-patients or to supportive home visiting from CPNs. They found that there was no difference between both models of care on symptomatic recovery, social adjustment, or family burden. Indeed, the patients preferred the CPN follow-up to routine out-patient follow-up. They concluded that in the care of neurotic patients, CPNs were a valuable alternative mode of providing after care.

The aim of our study was to investigate the consumer view on their experience of CPNs in GP surgeries. The study was possible because CPNs in Central Birmingham had provided a service to GP surgeries in one of the electoral wards for at least five years. The study had ethical approval from the Research Ethical Committee of Central Birmingham Health Authority and formed part of a larger investigation into the provision of psychiatric service by CPNs in primary care settings.

## The study

Ninety-two patients seen at the request of GPs by two CPNs providing a service to GP surgeries in Hall Green, over the six month period January to June 1987, were sent questionnaires. Fifty-eight (63%) completed the questionnaire and six (6.5%) were untraceable or had moved away. The respondents comprised 43 (74.1%) females and 15 (25.9%) males. The replies are set out in Table I.

## Comments

The majority of respondents were female. The preponderance of females in the workload of CPNs in primary care settings has been commented upon by other workers.[8-10] The majority of respondents had not expected their GPs to suggest that they talk to CPNs about their problems, but appear to have had enough faith in GPs to believe that it was likely to be helpful. On the whole, the patients were satisfied with their interaction with and experience of CPNs. However, only a third would have been prepared to travel to another clinic to see the CPN. This was perhaps a subtle reflection on the importance which they attributed to the contact. It was surprising that only a third would have preferred to see the CPN in their own homes. It was also surprising that over 50% of the patients did not wish to talk to their GPs even if the GPs had the time to listen; but it was perhaps understandable that the majority would not have wanted to talk to a psychiatrist had one been there. In addition, only a minority would have preferred to be referred to a specialist in a hospital clinic.

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Some of the comments of the patients provided much needed insight into the value and problems attached to the presence of CPNs in primary care settings. Most patients gave positive comments such as "It was encouraging to know that the doctor was concerned about my emotional wellbeing enough to refer me to someone who listened to my problems"; "Seeing the nurse at a familiar place made me more at ease. If a hospital or clinic had been suggested, I would not have gone"; "The advent of CPNs is a good idea to reduce the workload on doctors and psychiatrists"; "The nurse was sympathetic and kind, speaking to a psychiatrist can be intimidating".

A few others who were not entirely pleased pointed out some of the potential difficulties; for example one said: "when my doctor suggested I have a chat with a community nurse I was willing to do so, to see if it would help in any way, but I didn't realise I was seeing a psychiatric nurse, that was never explained to me"; another raised the important issue of medical confidentiality and access to medical notes: "the doctor quite understood the problem, he did what he could. I accepted an appointment with the nurse on the principle that some suggestion to resolve the problem might turn up. I was amazed to find the the nurse having a good read of my medical notes. I was of the opinion (and still am) that only my GP (or a consultant whom I elect to see) had the right to read my medical records". It must be stated that this was an isolated comment and perhaps is not representative of the views of the majority of patients.

In their study, Paykel *et al*[7] demonstrated that patients were more satisfied with CPN follow-up compared with conventional psychiatrist follow-up in the out-patient department. Nurses were rated as significantly more easy to talk to, interested, pleasant, relaxing, caring and better at the job than psychiatrists. Our own findings point in the same direction, and confirm that, on the whole, patients welcome CPNs in primary care and are satisfied with their interaction with CPNs. We conclude from this that there is a place for CPNs in the primary care setting, but believe that there are some fundamental problems which demand attention. CPNs have themselves identified the need for better training because many feel inadequate in their roles.[11] Moreover, others have demonstrated that socio-demographic characteristics may determine which patients are referred to CPNs. Brooker & Simmons[12] put the case very well: "The concern remains that the formation of formal health centre/GP attachments may be at the expense of the most socially deprived group". It is notable that in our district the electoral ward with the most well developed CPN/GP surgery attachment is also one of the more affluent wards.

In our view the debate should now shift from whether CPNs should be based in primary care settings to who should fund CPNs who are so based. In Central Birmingham CPNs based in GP surgeries are funded out of District allocation to the Mental Health Unit. It could be argued that if GPs find CPNs useful in primary care settings (the evidence is that they do relieve the burden on GPs, health visitors, and district nurses[13]) those CPNs who chose to work from such bases should be funded by the Family Practitioner's Committee. The question of clinical accountability and legal culpability have not been directly addressed either by GPs, psychiatrists or CPNs. It is necessary to formulate clear guidelines to CPNs working in primary care settings as to their proper roles, limitations, and responsibility. The current situation is unsatisfactory in that regard.

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