*Brit. J. Psychiat.* (1969), 115, 1163–74

# Psychiatric Referral from a General Practice

By PHILIP HOPKINS and BRIAN COOPER

## Introduction

Referrals for psychiatric specialist treatment under the National Health Service have increased steadily in numbers, until the annual rate for new patients in England and Wales now stands at over 200,000 (Ministry of Health, 1965). The trend has led some critical observers to conclude that, in the words of one of their number, "Partly because it has oversold itself, psychiatry has become oversubscribed" (Kessel, 1963). This is a serious charge, but in the absence of proper evaluative studies it must be judged non proven.

The aim of the present study was to examine and evaluate the results of psychiatric referral by one general practitioner over a period of five years. One of the authors (P.H.) has been engaged in single-handed practice in Hampstead for the past twenty years, has maintained a special interest in psychiatric problems throughout that time, and was for a number of years attached as a clinical assistant to two local psychiatric departments.

Clearly, one cannot generalize from the experience of a single practitioner. In this instance, the structure of the patient population largely reflects the features of an area distinguished by high mobility, an above-average proportion of middle-class professional people, of foreign-born residents and of single-person households (General Register Office, 1963).

Despite these limitations, the findings were thought to be of more than immediately local interest. In recent years, a number of reports have stressed the need for improved psychiatric training of the general practitioner (W.H.O., 1963; Royal College of General Practitioners, 1967; Report of Royal Commission on Medical Education, 1968) and for his increasing participation in area psychiatric services (Medical Services Review Committee, 1962). The present study examines the case of one family doctor who has had considerable experience of hospital and community psychiatry, and whose situation in North West London provides access to a much wider range of psychiatric services than is available to most general practitioners. The question may thus be posed: given these optimal conditions, what are the prospects for an effective system of psychiatric referral?

## Design and Method

The opportunity for this investigation arose because for some years a file copy has been kept of every letter to a hospital consultant. In consequence, it proved a simple matter to list all psychiatric referrals made during the period 1961 to 1965 inclusive. Furthermore, the practice lends itself to research of this kind in that every consultation is recorded routinely, a day-book is kept of all patient attendances, and there is an up-to-date age-sex register.

An index card was made out for each referral to a psychiatrist during the relevant period. A short postal questionnaire was then dispatched to the consultant to whom each patient had been referred, together with a letter which explained the purpose of the inquiry. The questionnaire covered a number of points, including the psychiatric diagnosis or formulation, the dates of the patient's first and last attendances, the total number of attendances resulting from the key referral, the main lines of treatment or disposal and the patient's psychiatric condition when he was last seen. In addition, supplementary inquiries were made in a number of cases to elicit the details of subsequent in-patient admissions or referrals to other medical agencies.

The information thus gathered was collated with that drawn from the practice medical records and from the practitioner's knowledge of his patients. In this way, a composite picture was built up of the referral and treatment process in each case. For all patients still in the practice at the time of the inquiry, the clinical



https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

notes were abstracted up to the end of 1966, so as to give a follow-up of not less than one year from the key referral. For those who had left, no systematic follow-up was possible beyond the termination of psychiatric treatment, and the assessment of outcome was then based solely on the patient's clinical condition at that time. Hence, most of the findings are concerned with the short-term outcome of referral, rather than with the long-term outcome of the patients' illnesses.

A number of statistics pertaining to the practice population were available for computing rates and as a basis for demographic comparisons. First, censuses based on the age-sex register had been carried out in 1961 and 1963, and again at the end of 1965, so that it was possible to estimate the average number in each age and sex group who had been at risk throughout the survey period. Secondly, the practice had been among those included in a large survey of psychiatric illness in general practice (Shepherd *et al.*, 1966). As a result, the medical and social characteristics of a one in eight sample of the adult patient population in 1961–1962 had been recorded in some detail. Finally, a survey of hospital referrals from the practice had been undertaken some twelve years earlier (Hopkins, 1956), so that comparable data were known for the period 1951–1953.

## Results

### *The Questionnaire Response*

Over the five-year period of the survey, a total of 141 referrals had been made in respect of 124 patients, of whom 11 had been referred on two or more occasions. No questionnaire was sent in 11 instances where the outcome of referral was obvious from perusal of the case-notes, mostly because the patient had failed to keep his initial appointment. Questionnaires were dispatched in all the remaining 130 instances and, after reminder letters to a proportion, all the consultant psychiatrists completed and returned their copies. Of 14 supplementary inquiries, only two remained unanswered when the inquiry was closed in mid-1967. The response rate, therefore, was virtually 100 per cent.

### *The Practice Referral Rates*

Of the 141 referrals, 13 related to individuals who had been private patients at the time. For the remaining 128, it was possible to compute rates based on the National Health Service list. Over the survey period, the registered patient population had risen from 2,106 to 2,240. By taking the mean of these figures as the average number at risk, an annual psychiatric referral rate of 118 per 10,000 population was obtained.

Since 13 of the referrals for registered patients had been made privately, the rate for referral of registered patients under the Health Service was somewhat lower: to be precise, 106 per 10,000 population. Finally, taking the registered patients of 15 and over, the adult referral rate was 127 per 10,000 population, a figure perhaps more directly comparable with other published findings.

Although few statistics are available for comparison, these rates are almost certainly well above average. Rawnsley and Loudon (1962) estimated the national rate for 1958 as 44 per 10,000, while a survey of metropolitan practices (Shepherd *et al.*, 1966) yielded a rate for adults of 71 per 10,000.

No significant trend in the referral rates was found over the five years of the survey. Comparison with the earlier study of the same practice, however, suggested a decrease over the years, the average rate for 1951–1955 being 160 per 10,000. The difference could be accounted for by a decline in the number of domiciliary consultations, from 26 in 1951–1953 to five in 1961–1965.

### *Demographic and Clinical Features of the Patient Sample*

1. *Sex.* Of the 128 referrals from the registered population, 57 were for male patients and 71 for female, corresponding to a sex ratio of 4 : 5. This approximate parity conforms with most psychiatric out-patient statistics. Since in this practice, as in most, the proportion of women consulting with psychiatric symptoms is twice that of men (Shepherd *et al.*, 1966), it appears that the latter are relatively more often referred for specialist treatment.

2. *Age.* The age distribution showed a marked trend for young adult patients to be referred

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

more readily than those in the older groups.* Figure 1 shows a marked contrast with the age rates for psychiatric morbidity in a sample of adult patients consulting in one year. In other words, the observed distribution of referrals could not be ascribed to a raised prevalence of psychiatric disorder among young patients.

A special feature of psychiatric referral in this practice is the low rate for children. Referral to Child Guidance Clinics accounts for about one-seventh of the national psychiatric out-patient figures (Ministry of Health, 1965). In the present sample there were only four child referrals, two of them private. The finding reflects a deliberate policy, for the practitioner concerned regards most psychiatric disorders of childhood as expressions of family disturbance, and as a rule concentrates on treatment of the parents.

3. *Marital status.* The distribution by marital status was notable chiefly for a preponderance of single persons, who comprised two-thirds of the total. This finding was not wholly explained by the associated age bias. Thus, among patients of 30 and over, 21 out of 49 in the referral sample were single, compared with 13 out of 56 in the random sample of consulting patients ($\chi^2 = 4{\cdot}61$; d.f. $= 1$; $p < {\cdot}05$). It seems probable, therefore, that single persons were referred more frequently than others, irrespective of age.

4. *Diagnosis.* The relevance of diagnosis to subsequent medical action can scarcely be doubted. Comparison with the earlier referral study of the same practice suggests that over the years substantially the same types of case were referred in the same proportions, a point illustrated by Table I. Here the only discernible trend is for an increase in the diagnosis of depression at the expense of other categories of neurosis, a feature which has been remarked in hospital out-patient statistics for the same period (Hare, 1965).

In spite of these consistent findings, the psychiatric diagnosis proved singularly unhelpful in classifying the causes of referral. True, most psychotic patients in the practice had been referred at some time, if only because of the attendant risks and problems of management. They comprised, however, only a fraction of the case-load: of the present series, 17 (14 per cent.) were judged in retrospect to have been suffering from psychotic illnesses. In respect of the remaining large majority, diagnosis appeared to have been of secondary importance in the decision to refer.

There were two obvious reasons why this should be so. First, the problems of treatment and management leading directly to referral often cut across the diagnostic groupings. For example, of four patients referred for advice

* Using the age-groups shown in Figure 1, this trend was found to be highly significant. $\chi^2$ for trend $= 38{\cdot}42$; $p < {\cdot}001$.

TABLE I

*Comparison of Two Series of Referred Patients by Diagnostic Group, 1951–1953 and 1961–1965*

| Diagnostic group | 1951–1953 | 1961–1965 |
|---|---|---|
| | % | % |
| Schizophrenia | 8 | 8 |
| Depression | 23 | 38 |
| Anxiety state | 10 | 9 |
| Neurosis, other or mixed | 28 | 20 |
| Sexual problems | 7 | 6 |
| Psychosomatic disorders | 8 | 7 |
| Childhood and adolescent disorders | 5 | 3 |
| Other | 11 | 9 |
| Total | 100 | 100 |
| No. of patients | 60 | 117 |

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

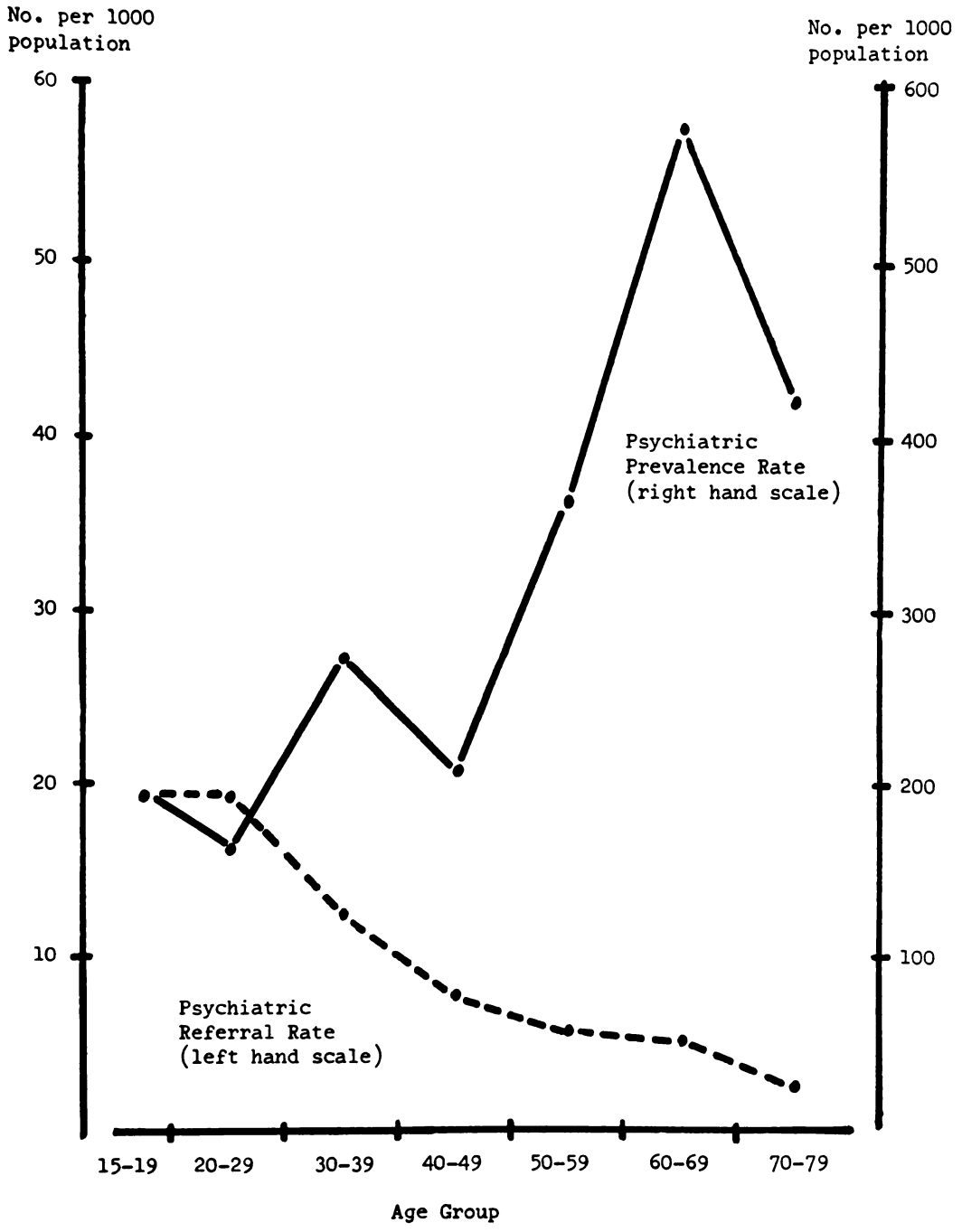



FIG. 1.—Age Distribution of Psychiatric Patients 1961–62 and Psychiatric Referrals 1961–65. (Rates based on population at risk 1961.)

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

about termination of pregnancy, one was mentally subnormal, another schizophrenic, the third a married woman with acute anxiety and depression, and the fourth a single girl who was considered largely on social grounds. The six patients referred because of excessive drinking or drug dependence likewise fell into a number of diagnostic categories.

Secondly, the groups set forth in Table I were of dubious reliability. Since no standard classification had been employed, it was difficult to establish this point, but a rough check was made by sub-dividing the diagnostic formulations as follows:

Psychosis (including schizophrenia, mania and organic states);
Depression (all types);
Anxiety State;
Neuroses, other (including obsessional, phobic and hysterical states);
Character Disorder;
Miscellaneous (including psychosomatic and psycho-sexual disorders).

On this basis, the practitioner's and psychiatrists' diagnoses were concordant in 53 cases (57 per cent.). There was a consistent tendency for the former to specify the illness-episode and the latter the underlying personality structure. Thus, character disorder was cited as the primary or secondary diagnosis in only 15 per cent. of cases by the family doctor, but in 41 per cent. by the psychiatrists.

These findings were not unexpected, since poor concordance between consultant psychiatrists has been reported from a number of out-patient studies (Kreitman *et al.*, 1961; Kidd and Mackie, 1967). In the present series, lack of diagnostic agreement seemed to have exercised little influence on medical disposal. Most of the patients had been accepted for treatment, while the concordance for those referred back after the initial consultation was no lower than for the remainder.

5. *Duration and course of the illness.* Accurate assessment of the duration of illness was precluded by the retrospective nature of the enquiry. It was possible, however, to separate illnesses of recent onset from chronic conditions, using as the divisor an approximate duration of one year. The rates for previous psychiatric referral lent some support to this division, being only 9 per cent. for the new cases, compared with 45 per cent. for the chronic.

When the course of the illness was also taken into consideration, three broad sub-groups could be distinguished. New illnesses accounted for 19 per cent. of the referrals, and a further 21 per cent. were "acute on chronic" cases; i.e., patients with chronic disorders where referral had been preceded by some form of crisis, exacerbation or marked increase in morbidity. The remaining 60 per cent. were "chronic unchanged" cases, whose condition had undergone no pronounced change in the weeks before referral.

6. *Treatment prior to referral.* Almost without exception, those patients with chronic disorders had been prescribed a variety of psychotropic drugs by the general practitioner and his predecessors, with at best temporary alleviation. Only seven of the registered patients had received systematic psychotherapy from the practitioner before being referred. In the majority, one or more long exploratory interviews had served to uncover the nature of the psychiatric problem and to distinguish the need for psychiatric care. Thus the bulk of patients could not be characterized as "failed psychotherapy" cases at the time of referral.

7. *Psychiatric state at referral.* Taking as criterion the patient's clinical condition at the time of referral, the following sub-groups could be differentiated:

A. patients with severe acute clinical symptoms, disturbance of behaviour and/or impairment of function giving rise to serious social difficulties (24 per cent.);

B. new patients who had recently been discharged from in-patient care, or who had been under psychiatric supervision before joining the practice, and were thought to need continuing out-patient support and maintenance of their drug therapy (6 per cent.);

C. all other patients (70 per cent.).

Because of the small numbers involved, the first two groups will be considered together. The joint group comprised mainly patients suffering

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

from acute conditions, nearly half of them psychotic, together with a minority whose unstable equilibrium was thought to depend upon long-term psychiatric support. Related social disturbances were common. Over half the members were known to have had previous acute episodes and to have been under psychiatric treatment in the past. For this group of patients referral was classed as *prescriptive*; that is, the indications were clear-cut and entailed some degree of urgency.

The third and largest group, in contrast, consisted chiefly of patients with chronic neuroses or personality disorders. Their social behaviour for the most part was superficially normal, and few had shown any recent marked change in behaviour or symptoms. While retrospective analysis was difficult, it appeared that the bulk of these patients had been referred because of failure to respond to medication and simple psychotherapy, and because they were considered to need more professional time than the family doctor could well spare. Referrals for this group of patients were classed as *elective*, in the sense that in seeking specialist aid the general practitioner had exercised an open choice.

*Types of Referral*

To some extent these broad sub-divisions were related to the choice of psychiatric consultant and clinic. In terms of the main types of psychiatric setting concerned, the distribution of referrals for registered patients was as follows: teaching hospital departments 9, general hospital departments 40, psychiatric hospitals 17, psychotherapy clinic 49, and private consultations 13. In Table II the nature of this distribution is shown for the two main types of referral.

Further point was given to the dichotomy by an analysis of the practitioner's referral letters. From their content, as a rule, it was not difficult to decide whether the aim of referral had been hospital treatment or a specialist opinion. In a small proportion, the need for in-patient care had been either explicitly stated or strongly implied. Finally, in a relatively large proportion the express content of the referral letters, as well as the choice of consultant, made clear the fact that systematic psychotherapy was the goal. The findings are summarized in Table III.

These sharp differences lent support to the view that there were in fact two distinct categories of referral to be considered. In consequence, the division between prescriptive and elective referrals was taken as the principal axis for analysis of the follow-up results.

*The Outcome of Referral*

In 13 instances, National Health Service patients had been referred privately. This small sub-group showed a preponderance of males (62 per cent.) and consisted almost entirely of elective referrals for chronic conditions. To avoid difficulties of interpretation, it has been excluded from the following tables.

In eight cases (7 per cent.), psychiatric departments had declined, because of their long waiting-lists, to give appointments. One of the

TABLE II

*Type of Psychiatric Setting to which Patients were Referred*

| Type of psychiatric setting | Prescriptive referrals | Elective referrals | All referrals |
|---|---|---|---|
| | % | % | % |
| Teaching Hospital O.P. Depts. .. .. .. | 8 | 7 | 7 |
| General Hospital O.P. Depts. .. .. .. | 58 | 20 | 31 |
| Psychiatric Hospitals .. .. .. .. .. | 21 | 10 | 14 |
| Psychotherapy Clinic .. .. .. .. .. | 10 | 50 | 38 |
| Private Consultations .. .. .. .. .. | 3 | 13 | 10 |
| Total .. .. | 100 | 100 | 100 |
| No. of referrals .. .. .. .. .. | 38 | 90 | 128 |

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

TABLE III

*Type of Specialist Service Expected by the General Practitioner*

| Type of specialist service expected | Prescriptive referrals | Elective referrals | All referrals |
|---|---|---|---|
| | % | % | % |
| In-patient admission | 26 | — | 8 |
| Out-patient treatment: | | | |
| systematic psychotherapy | 8 | 49 | 37 |
| other | 42 | 14 | 22 |
| Specialist opinion and advice | 24 | 37 | 33 |
| Total | 100 | 100 | 100 |
| No. of referrals | 38 | 90 | 128 |

patients concerned had to be admitted to hospital on a statutory order a few weeks later, and three others were accepted for treatment elsewhere.

In a further 13 cases (11 per cent.) the patient failed to keep his initial appointment. Only one of this number was subsequently referred to a psychiatrist. Seven were never seen again by the general practitioner, and eventually either moved away or transferred to other doctors. Of three acutely disturbed patients, one, a schizophrenic woman, was later admitted directly to a mental hospital; a second, also schizophrenic, disappeared from the district and was heard of no more. The third, a severely depressed woman, made a moderate improvement on thymoleptic drugs prescribed by the general practitioner.

The proportion of failed appointments is high, and this finding is not a general feature of specialist referral from the practice. A check on 295 referrals to physicians and surgeons made during 1965 showed that not a single patient had failed his first appointment.

One factor which has been suggested as a cause of the relatively high failure rate for psychiatric out-patient appointments is the length of the waiting lists at many hospitals. In the present study, the waiting time of the patients who failed to attend could not be ascertained, but Table IV shows the pattern for those patients who did attend at least once. The average wait for prescriptive referrals was 11 days, and for elective referrals 43 days, from the date of the general practitioner's letter or telephone call. It can be seen that half the

TABLE IV

*Waiting Time for First Psychiatric Consultation*

| Waiting time | Prescriptive referrals | Elective referrals | All referrals |
|---|---|---|---|
| | % | % | % |
| Less than one week | 55 | 2 | 19 |
| 1–2 weeks | 14 | 7 | 9 |
| 2 weeks–1 month | 10 | 26 | 21 |
| 1–2 months | 21 | 53 | 43 |
| Over 2 months | 0 | 12 | 8 |
| Total | 100 | 100 | 100 |
| No. of referrals | 29 | 58 | 87 |
| Waiting time not known | 4 | 3 | 7 |
| All referrals | 33 | 61 | 94 |



https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

patients had to wait over a month for their appointments.

In 94 cases (82 per cent.) the patient was accepted by the psychiatric department, and kept his first appointment. The immediate outcome of these initial consultations is summarized in Table V below.

Of the 12 patients for whom in-patient care was deemed advisable, all but one were in the prescriptive referral group. Otherwise the differences between the two groups are unremarkable. Twelve patients were referred back to the general practitioner forthwith, but this was less than half the number he had referred expressly for specialist opinion and advice. One may therefore conclude that the bulk of the referrals, including those classed as elective, were accepted by the psychiatrists as legitimate.

Eight patients were directed to various other medical agencies, ranging from the Institute of Psycho-Analysis to the local obstetric department. Twenty-six were put on waiting lists for group, and 13 for individual, psychotherapy. Finally, the remaining 23 were proffered immediate treatment on an out-patient basis with some combination of drugs and supportive techniques.

The number of out-patient attendances which had ensued from each referral could be derived from the completed questionnaire. In-patient follow-up attendances were included in the count, provided they formed part of a continuous spell of specialist care resulting from the key referral. Day Hospital attendances, on the other hand, were not thought to be strictly comparable, and were excluded.

As might be expected, the number of attendances varied widely. At first, there was a rapid loss of patients from treatment, so that of 83 seen at least once, only 32 attended more than three times as out-patients. Thereafter the fall-out diminished sharply: 24 patients were seen at least 10 times, and 6 at least 100 times apiece. The duration of specialist care showed a similar pattern. Just over a third of the patients had terminated treatment within one month of the initial consultation, but 38 were still in treatment after six months and 20 after one year.

The mode of termination of treatment is shown in Table VI. More than one patient in three lapsed either by refusing further treatment or, more usually, by failing appointments. It is notable that most of these lapses occurred among the elective group.

Each patient's psychiatric state at the time of his last interview was rated as Recovered, Relieved or Not Improved, the psychiatrists' ratings being accepted as correct in the absence of strong evidence to the contrary. In general, the practitioner was in agreement with these ratings, although in a small minority he considered the reported improvement to have been only transient. The results are given in Table VII. The percentages shown relate to the patients for whom psychiatric assessments were available, but to lend perspective the numbers of those who could not be rated have been appended.

The over-all picture is disappointing. Of the patients seen at least once, only two-fifths had improved up to the time of assessment. The immediate outcome was clearly better for the

TABLE V

*Disposal Following First Psychiatric Consultation*

| Disposal | Prescriptive referrals | Elective referrals | All referrals |
|---|---|---|---|
| | % | % | % |
| I.P. admission arranged .. .. .. .. | 33 | 2 | 13 |
| Continuing O.P. attendance arranged .. .. | 46 | 77 | 66 |
| Referred to other medical agency .. .. .. | 9 | 8 | 8 |
| Referred back to G.P. .. .. .. .. | 12 | 13 | 13 |
| Total .. .. | 100 | 100 | 100 |
| No. of referrals .. .. .. .. .. | 33 | 61 | 94 |

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

TABLE VI

*Mode of Termination of Psychiatric Treatment*

| Mode of termination | Prescriptive referrals | Elective referrals | All referrals |
|---|---|---|---|
| | % | % | % |
| Patient discharged by psychiatrist .. .. .. | 62 | 35 | 44 |
| Patient refused treatment, or failed to attend .. | 22 | 44 | 37 |
| Patient still in treatment at follow-up .. .. | 16 | 21 | 19 |
| Total .. .. | 100 | 100 | 100 |
| No. of referrals .. .. .. .. .. | 32 | 61 | 93 |
| Not known .. .. .. .. .. .. | 1 | — | 1 |
| All referrals .. .. .. .. .. .. | 33 | 61 | 94 |

TABLE VII

*Psychiatrists' Assessments of Patients' Clinical State at Last Interview*

| Psychiatric Assessment | Prescriptive referrals | Elective referrals | All referrals |
|---|---|---|---|
| | % | % | % |
| Recovered .. .. .. .. .. .. | 6 | 8 | 8 |
| Relieved .. .. .. .. .. .. | 45 | 28 | 34 |
| Not improved .. .. .. .. .. .. | 49 | 64 | 58 |
| Total .. .. | 100 | 100 | 100 |
| No. of referrals .. .. .. .. .. | 31 | 60 | 91 |
| Died while in treatment .. .. .. .. | — | 1 | 1 |
| Clinical state not recorded .. .. .. .. | 2 | — | 2 |
| Referred but not seen .. .. .. .. .. | 4 | 17 | 21 |
| All referrals .. .. .. .. .. .. | 37 | 78 | 115 |

prescriptive than for the elective group, the proportions showing some improvement being 51 per cent. and 36 per cent. respectively. Further scrutiny revealed that the Type A (urgent) referrals had had the best outcome, 58 per cent. being rated as Recovered or Relieved. The short-term outcome appeared to be directly related to the number of attendances recorded: among those who had received only out-patient treatment, the "Not Improved" group contained an excess with not more than three attendances.

It may be argued that these findings reflect the diagnostic nature of the case-material. Although the numbers involved were too small for detailed examination, the analysis of outcome by diagnostic category shown in Table VIII lends some support to this view. At the same time, it does not appear that the relatively unfavourable short-term results can be ascribed to a preponderance of any one diagnostic group.

*Psychiatric State at Follow-up*

Since only 44 of the referred patients (42 per cent.) were still in the practice at follow-up, no clear picture could be formed of the clinical progress of this patient cohort following the termination of specialist treatment. Of the residual number, 10 were well and off all medical treatment, a figure which suggests only limited further improvement. Seventeen patients were being treated by the general practitioner for psychiatric symptoms; 14 were under psychiatric out-patient treatment,

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

TABLE VIII

*Outcome of Psychiatric Referral by Diagnostic Category*

| Psychiatric assessment | Psychoses | Neuroses | Character disorders | Psychosomatic reactions | All categories |
|---|---|---|---|---|---|
| | % | % | % | % | % |
| Recovered .. .. | 10 | 9 | — | 14 | 8 |
| Relieved .. .. | 60 | 33 | 21 | 43 | 34 |
| Not improved .. | 30 | 58 | 79 | 43 | 58 |
| Total .. .. | 100 | 100 | 100 | 100 | 100 |
| No. of referrals .. | 10 | 55 | 19 | 7 | 91 |

and three in institutional care. It is noteworthy that of 7 patients originally classed as new patients 5 were now asymptomatic, compared with only 5 out of 37 originally classed as chronic.

## DISCUSSION

Little is known about the determinants of psychiatric referral. Difficulties of investigation stem partly from a dearth of hospital statistics, partly from the problem of relating such figures as are available to base populations. The present findings conform with those of some other workers (e.g., Hare, 1965; Shepherd *et al.*, 1966) in suggesting that referral rates are high for single persons and for those in the younger age-groups; while relative to the numbers of mentally and emotionally disturbed persons in the community, men are more often referred than women.

The consistently high rates for this practice could be accounted for by a large number of elective referrals, many of them made with a view to psychotherapy. Here the high proportion of professional people and students in the practice population may have been influential, since patients from these groups tend to be selected for psychotherapy, and may indeed exert their own pressures in that direction.

In addition to clinical and demographic factors, the rate of referral is subject to local influences, such as the extent and quality of the specialist services and the family doctor's attitudes towards them. In the present context an important contributory factor was the general practitioner's own active interest in psychiatric problems. Successful experience with psychotherapy for some patients had influenced him to seek the same relief for many more whose treatment he could not hope to undertake. Although he tended to select only the more difficult and intractable cases for specialist attention, the net effect was to increase the total number of patients referred from the practice.

In so far as the study relates to conditions where the local services were good and a high-referral policy obtained, it is of some significance that over a five-year period the results of psychiatric referral were disappointing. A high proportion of patients either failed their initial appointment or lapsed from attendance soon afterwards, in some instances before any formal treatment had begun. At the termination of hospital care, only a minority showed definite improvement.

No conclusions can be reached as to the efficacy of any particular method of treatment, but at an operational level it appeared that the psychiatric services had achieved better results with acute illnesses and psycho-social crises than with the problems of patients in need of long-term treatment and support.

The over-all results of psychiatric referral might thus appear to be more rewarding in practices where either this measure is reserved largely for urgent problems, or a higher proportion of cases of good prognosis are selected. A collaborative study would be of value in establishing this point. The question remains, however, as to what the family doctor can best do to help those patients whose need for treat-

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

ment is none the less real because they do not present urgent problems of management. Such, for example, are many phobic housewives, men with psychogenic impotence, alcoholics not yet socially deteriorated, depressed individuals who have failed to respond to medication and simple psychotherapy. Not infrequently with such patients the general practitioner can foresee the pattern of future crises, but may feel himself powerless to take preventive action. Where specialist referral proves unsuccessful the situation is aggravated, because the patient loses faith and all medical contact may be broken.

Many psychiatrists are only too well aware of these problems, and suggestions for improvement of the service have not been lacking. Briefly, the courses which have been advocated are as follows:

1. more individual and group psychotherapy should be made available under the National Health Service, and specialists recruited and trained to that end;

2. general practitioners who wish to develop their skills in this form of specialist treatment should be encouraged to do so by the provision of training facilities and extra fees;

3. the out-patient referral system should be supplemented by direct general practitioner-consultant contacts and opportunities for regular case discussions. By this means psychiatrists could advise on the management of many patients without the need for formal referral.

Since it is clear that the first two of these measures would involve additional expenditure, a clear official policy directive is needed as to the extent to which psychotherapy can be provided under the National Health Service. At present there is some confusion on this score, because the service purports to be comprehensive but is not so. The third proposal carries the advantage that it could be implemented to some extent with the present manpower, and at no additional cost.

The respective merits of these different lines of action are at present a matter for debate. There is a strong need for the establishment of local experimental services and their evaluation by means of research programmes.

## Summary

A study was undertaken of the results of psychiatric referral from one metropolitan practice over a five-year period. Information was obtained from the patients' medical records and from the responses to a postal questionnaire sent to all the consultant psychiatrists concerned. The practice referral rate was consistently high (on average, 118 per 10,000 at risk), and some possible reasons are indicated. The clinical and social characteristics of the referral sample are outlined.

The outcome of referral was somewhat disappointing: of 115 patients referred wholly under the National Health Service, 18 per cent. were not seen, 29 per cent. subsequently lapsed from treatment and altogether 57 per cent. were rated unimproved at the end of the spell of hospital care. The results were most favourable for those patients referred because of acute symptoms, social crises or other reasons imparting some degree of urgency; least so for those with chronic problems who had been referred for psychotherapy and long-term readjustment.

A number of suggestions for improvement of the specialist service are briefly outlined, and an experimental approach is advocated.

### Acknowledgments

This enquiry was undertaken during the tenure by one of us (B.C.) of a Senior Lectureship supported by the Mental Health Research Fund. We are indebted to Miss D. Rockett of the Institute of Psychiatry for much of the work of data analysis, and to Mr. G. Kalton of the London School of Economics for helpful criticism. Finally, our thanks are due to all the consultant psychiatrists whose co-operation made the investigation possible.

### References

General Register Office (1963). *Census 1961, England and Wales. County Report.* London: H.M.S.O.

Hare, E. H. (1965). Triennial Statistical Report of the Bethlem Royal Hospital and the Maudsley Hospital, 1961–1963.

Hopkins, P. (1956). "Referrals in general practice." *Brit. med. J.*, **2**, 873.

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press

KESSEL, N. (1963). "Who ought to see a psychiatrist?" *Lancet*, *i*, 1092.

KIDD, C. B., and MACKIE, R. E. (1967). "The psychiatrist factor in case register data interpretation." *Soc. Psychiat.*, **2**, 168.

KREITMAN, N., SAINSBURY, P., MORRISSEY, J., TOWERS, J., and SCRIVENER, J. (1961). "The reliability of psychiatric assessment: an analysis." *J. ment. Sci.*, **107**, 876.

Medical Services Review Committee (1962). A review of the medical services in Great Britain. Social Assay, London.

Ministry of Health (1965). *Annual Report for the Year 1964*. London: H.M.S.O.

RAWNSLEY, K., and LOUDON, J. B. (1962). "Factors influencing the referral of patients to psychiatrists by general practitioners." *Brit. J. prev. soc. Med.*, **16**, 174.

Report of the Royal Commission on Medical Education (1965–1968). Cmnd. 3569. H.M.S.O.

Royal College of General Practitioners (1967). Reports from General Practice, VII: Education in Psychology and Psychiatry.

SHEPHERD, M., COOPER, B., BROWN, A. C., and KALTON, G. W. (1966). *Psychiatric Illness in General Practice*. London: O.U.P.

World Health Organization (1963). Preparation of the Physician for General Practice. Public Health Papers No. 20, Geneva.

Philip Hopkins, M.R.C.S., L.R.C.P., F.R.C.G.P., *General Practitioner, Hampstead, N.W.3*

Brian Cooper, M.D., D.P.M., *Senior Lecturer, Institute of Psychiatry, De Crespigny Park, Denmark Hill, S.E.5*

(*Received 18 July, 1968*)

https://doi.org/10.1192/bjp.115.527.1163 Published online by Cambridge University Press