A Psychiatric Emergency Clinic

J. M. A. SMITHIES, Senior Registrar, Moorgreen Hospital, West End, Southampton; formerly Registrar, Department of Psychiatry, Royal South Hants Hospital, Southampton

Provision for dealing effectively with psychiatric emergencies has never been more important than now, with the current increasing emphasis on community care. There follows a description of the psychiatric emergency clinic in Southampton and the changes in its organisation and practice which have taken place over the last few years. It is hoped that this will stimulate discussion on the best methods of providing emergency psychiatric care.

Emergency clinics have been in operation in some centres for a number of years, e.g. in Edinburgh, Lewisham,[1,2] Camberwell[3] and Southampton. Although variously organised, they have the common purpose of providing a recognisable structure for dealing with emergency psychiatric work, which of its nature is unpredictable in both timing and quantity.

The Southampton Psychiatric emergency clinic has been in operation since 1978, when the DGH unit in the Royal South Hants Hospital was opened. Previously psychiatric care had been provided in a mental hospital which, because of its distant siting in the countryside, was not called upon to provide a walk-in emergency psychiatric service. The new DGH unit, on the other hand, was situated in the heart of the inner city. This move from distant mental hospital to locally based DGH unit, coupled with the move to community care, has been paralleled in many parts of the country and seems likely to lead to an increase in demand for emergency services.

The Southampton DGH unit is the base for psychiatric services for all those aged 16–65 in the city of Southampton and surrounding areas—a population of 200,000. The unit is a purpose-built five-storey building opposite the main Royal South Hants Hospital on a rather congested site in the inner city, a stone's throw from Southampton's notorious red light area. The unit contains four 25-bed wards. Three of these serve the three catchment areas into which Southampton is divided and the fourth is a rehabilitation/medium stay ward.

The rehabilitation ward has always been rather different from the acute admission wards in that it tends to deal very effectively itself with crises occurring in ex-rehabilitation patients. This is doubtless because such patients are likely to be well known to at least some of the ward staff.

The DGH also contains two day hospitals, one more psychotherapeutically oriented and the other for long term patients in the community. The emergency clinic, when it existed as a separate entity, was accommodated in the first of these day hospitals, where the nursing staff received special training in crisis counselling work. From 9 a.m. until 5.00 p.m. Monday to Friday it offered a walk-in service to all, including self-referrals, regardless of catchment area. It was separate from the Accident and Emergency Department which was situated in the Southampton General Hospital three miles away. Out-of-hours emergencies would be seen by the duty psychiatrist on a domiciliary basis or at the place of referral, e.g. the Accident and Emergency Department, or would be admitted straight to the wards.

It was for some years staffed by nurses who saw the cases and dealt with about half without calling on a doctor. For the other half they asked for a medical opinion. This arrangement required nurses specially trained and always available, junior doctors on a rota with an unpredictable workload, rooms set aside for emergency clinic use, special forms and secretarial assistance. If patients needed further psychiatric assessment or treatment they were referred to the appropriate sector team. A follow-up service was not formally provided by the emergency clinic, though in effect such a service was obtained by self-referred repeat attenders.

Since its inception the emergency clinic has been vulnerable. It has periodically been criticised because of its expense. The service has been restricted on a number of occasions because of temporary staff shortages; in December 1983 nurses were permanently withdrawn from the emergency clinic for this reason. From then on all cases were seen and assessed by the SHO/registrar on duty.

A typical year's workload of the clinic can be ascertained from emergency clinic records and the Southampton Psychiatric Case Register.[4] Each attendance at the emergency clinic is recorded on a standard form which notes personal and clinical details and a summary of action taken.

In the year 1 December 1982 to 30 November 1983 there were 717 attendances caused by 552 people. Five hundred and fifty-two (77%) were first attendances (i.e. first attendance in this particular year); 165 (23%) were second or subsequent attendances. The Central sector had the highest number and rate of attendances and the highest number of repeat attendances. This is the sector which includes the inner city. One hundred and seventy patients (24%) were admitted in the 24 hours after emergency clinic attendance. The proportion of first contact referrals was highest from GPs while, overall, self-referral was the largest category. Thirty referrals were made by medical practitioners other than GPs, mostly cases of self-poisoning for psychiatric assessment. Twenty-one referrals were from the Accident and Emergency Department of the Southampton General Hospital, six from the Royal South Hants Hospital and one each from a psychosexual clinic, the University Health Centre and a Day Centre.

About 25% of referrals from 'other agencies' were

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alcoholics referred by S. Dismas and the Hampshire Council on Alcoholism, the two bodies in Southampton offering a non-residential support service to alcoholics.

Of the attendances 3% had no psychiatric abnormality and 2% were in a 'not known' category. Of the remainder, 95% had an ICD9 psychiatric diagnosis, of whom only 8% had a diagnosis of personality disorder and therefore were unlikely to benefit from psychiatric intervention.

Seven hundred and seventeen attendances in one year represented about three per day, excluding week-ends, when the emergency clinic was closed. One in four were judged to need immediate admission; 29% had schizophrenic, paranoid or affective psychoses and 17% had alcohol-related disorders. Only 5% had no psychiatric abnormality or were in an 'unknown' diagnostic category.

Clearly an emergency service was needed and used. However, the question continued to be asked whether the service was better provided by an emergency clinic, or whether a sector-based emergency service would be preferable. This question became more urgent towards the end of 1984 when nurses ceased to be involved in the clinic in a screening role so that all cases were being seen by junior doctors.

With the clinic system, attenders judged to be in need of further psychiatric care were referred on to the sector-based service. The doctor seeing the patient did not continue to be involved unless coincidentally working in the appropriate sector team, which often resulted in time-wasting repetition of assessment procedures which were done in the emergency clinic and again in the sector service. Furthermore, any therapeutically useful rapport built up between patient and emergency doctor was wasted.

It began to be suggested that sector teams could organise their emergency workload themselves, with considerable saving of resources. This would eliminate the emergency clinic at a stroke and might also lead to better continuity of care, and a reduction in repeat emergency attendance. The smaller scale of the emergency service might also facilitate closer links with sector GPs and other agencies in the sector whose comment might be valuable in adapting the service to meet needs.

Worries were expressed that if the sectors took on their own emergencies, this would put a disproportionate load on to the central area. In Southampton the central area has a higher morbidity because of a noticeably higher concentration of patients with schizophrenia or alcoholism: the usual pattern for the inner city. However, it was hoped that the smaller population in the central area would mean that there would be little difference between the numbers of emergency attendances from the three sectors.

In early 1985 the emergency service was altered so that, having registered at a reception area, patients were directed to the appropriate sector team base. It seemed likely that devolving the care of emergencies to the sector teams would save resources without a reduction in the quality of care.

However, there have been teething problems with this new arrangement, which has been in operation for just over a year. It was hoped that patients would arrive having seen their GP and having been referred by him, preferably with a letter. In practice, self-referrals continued to present themselves. The number of attendances in the last year has been 712, i.e. no different from the 1982–3 figure. After checking in at reception the patient is directed to the appropriate sector inpatient ward, where the emergency attenders have no waiting area separate from the in-patients and are seen in a ward interview room. There are problems of lack of space, of emergency clinic attenders being adversely affected by in-patients and vice versa, and of misunderstandings where patients, having arrived on the ward, assume they are automatically to be admitted.

Emergency attenders are usually seen by the ward SHO or registrar, as the nursing staff are in most cases untrained in crisis work and therefore lack the confidence to provide an initial screening service. This results in the junior doctors having a constantly unpredictable workload, never knowing when emergency attenders will interrupt the timetable of work they have set themselves with regard to the in-patients.

Despite these problems, the rate of admission after emergency attendance has dropped from 24% to 14%, perhaps reflecting better management when repeat attenders are seen by the sector team which knows them.

Plans for the future are to re-establish a crisis counselling training service for nurses and to improve premises. Training used to be provided for nurses working in the day hospital when the emergency clinic was situated there. It is hoped that, with adequate training, nurses will feel confident enough to provide a screening service for emergencies, as formerly. There is widespread agreement that the siting of the emergency services on the in-patient wards is unsatisfactory. Fortunately, some accommodation in the Department of Psychiatry will be released soon when a new out-patient block is opened on the Royal South Hants Hospital site. It is hoped then that the emergency service will remain sector-based while occupying premises away from the wards. However, there could be increased costs involved if ward nursing establishments have to be increased to allow nursing staff to man the emergency clinic. Thus it seems that an effective emergency service in present conditions of psychiatric practice cannot be run on the cheap. It may however prove cost-effective in the long run to have an adequate emergency service separately provided for rather than attempting to absorb this work into the busy and unpredictable routine of an acute psychiatric admission ward.

Two things seem clear: the problems of how best to run an emergency service cannot be unique to Southampton, and these problems will become more acute across the country as we move increasingly towards community care. It is perhaps time to pool ideas and expertise in this difficult area of psychiatric provision so that better standards of care can be achieved.

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Correspondence

Responding to stigma

DEAR SIRS

The detailed response to my article 'Whatever Happened to Stigma?' (*Bulletin*, January 1986, **10**, 8–9) has shown the concern that many psychiatrists, and others, feel about this topic. King (*Bulletin*, April 1986, **10**, 83) has pointed to the unpredictability and uncertainty attached to psychotic patients, noting the layman's view that such illness is 'not real' and 'weird'. Stafford-Clark (same page), in a generous and constructive letter, has stressed the need for psychiatrists to set an example to their colleagues and to see patients (sufferers) rather than clients (customers). Davidson (*Bulletin*, June 1986, **10**, 155) provided data supporting my own, pointed to the urgent need to ensure appropriate services 'to reduce the build up of negative attitudes', and suggested that the College should be at the forefront of research in this field.

Perhaps the most detailed response was that of Spicker (*Bulletin*, September 1986, **10**, 250–251) who suggested that it was beliefs about behaviour and the users of psychiatric services, rather than the services or status of psychiatry itself, that led to stigma. He quoted American research suggesting that more specific definitions of illness created a focus of rejection. The paradox of a precise science seems to be that a 'cure' is expected. None of which I disagree with, but there still seems to be a need for internal action, within the medical profession. There is no prospect of eradicating the superstitious/irrational basis for stigmatising madness, not least because of the 'sense of personal threat' that the condition involves. But until the image of the psychiatrist—the popular versions of TV, books, the cinema—is co-equal with that of the heart surgeon or trusted GP, any attempt by psychiatrists to change opinion will necessarily backfire.

Snide comments about alienists have been around a long time. Ernest Jones quotes a colleague, 'I suppose they read papers on an improved variety of Chubb lock',[1] from the early 1900s. Vincenti (*Bulletin*, September 1986, **10**, 249) quotes a 1984 article by Fink[2] entitled 'You are the only sane psychiatrist I know'. Given the student attitudes elicited by Davidson and myself, and that they can be changed,[3] this is something that the College should be working on. Not only must they insist on retaining a significant slot in the student curriculum for psychiatry, but the teaching therein should be coherent and forceful. Ideally there should be some infiltration into the general medical teaching, so that the psychological problems of hospitalisation and serious physical illness are considered alongside the obvious physical signs.

Of course, the real need is for post-graduate psychiatric experience to be incorporated into the routine training of any general physician. Most GP rotating training schemes include a psychiatric attachment, to everyone's benefit, but will the guardians of the MRCP grasp such a nettle? That should be one of the College's aims, if, like the American Psychiatric Association (Vincenti, *Bulletin*, September 1986, **10**, 249), they are prepared to regard stigma as a priority issue.

T. H. TURNER

Institute of Psychiatry
London, SE5

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Mental Health Act 1983

DEAR SIRS

As a newly approved member under Section 12(2) of the Mental Health Act (1983) and in response to Dr Aznonye's letter (*Bulletin*, August 1986, **10**, 211), I should like to point out that a sufficient working knowledge of the Mental Health Act is achieved during the course of psychiatric training and for the Membership examinations. In the post-Griffith era, therefore, where we are confronted with limited resources, administrative costs, cost-effectiveness, etc., I should think that the considerable overlap between the above and the oral test suggested by Dr Aznonye would make the latter an expensive and unnecessary exercise. Furthermore, I am sure that passing the Membership examination is an adequate test for the 'experience in the diagnosis and treatment of mental disorders'.

J. S. BAMRAH

Withington Hosital
Manchester