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Trainees' forum

Community psychiatry – a training experience

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The emphasis of psychiatric care is being moved from the large mental hospitals towards community-orientated care and there seems also to be a need for a shift in the training of psychiatrists to include greater emphasis on the special issues involved in this approach to service provision.

I am writing about my own experience of a community psychiatrists registrar post which I undertook in the Membership year of my training. My concern is to report on a training period rather than to comment on the quality or quantity of service provision. It was a unique experience for several reasons; firstly, I was the first incumbent in the post which has the advantage of having no predecessor to live up to, but also the heavy responsibility of establishing a suitable identity for the post. Secondly, the unusual nature of the area and its services.

Geographical and historical aspects

For various historical reasons, the borough of Dumbarton has previously been under-provided as regards psychiatric services. For administrative purposes, it is divided by the River Leven into two segments, each segment being within the catchment area of a psychiatric hospital which lies outside the boundaries of Dumbarton District. Persons in West Dumbarton (population 43,000) are served by out-patient clinics run by psychiatrists from Argyll and Bute Hospital (72 miles away). The consultant psychiatrist responsible for West Dumbarton lives locally and the majority of his service is based on various out-patient clinics and day hospitals within the district. Apart from a psychogeriatric unit at the local district general hospital, admission beds are provided at the Argyll and Bute Hospital. My attachment was due to this consultant.

Persons in East Dumbarton (population 43,000) are served by out-patient clinics run by psychiatrists from Gartnavel Royal Hospital, Glasgow, (13 miles away) and all admission beds for that sector are provided at Gartnavel Royal Hospital.

There are obvious disadvantages to this system; people living along the road from one another have vastly differing provision of services and access to them. As a result of these anomalies in service provision, the psychiatric services are in a development phase. For me, however, this engendered a feeling of anticipation and the added interest of participating in the early stages of a growing and developing service.

Current service provision

At present there is a 28 bedded psychogeriatric ward in the local DGH and there is a psychogeriatric day hospital with 20 day places. In the last two years a new 24 place day hospital for adults with general psychiatric problems has been opened. The opening of this unit coincided with my appointment as registrar in community psychiatry.

Out-patient clinics are held in local medical centres, the district general hospital and Hartfield Clinic which is the mental health community centre for a multidisciplinary psychiatric team of six community psychiatric nurses, a clinical psychologist, a social worker and secretarial staff. It was also the base for a consultant in child and adolescent psychiatry as well as for my consultant and myself.

My clinical role in the team

As the psychiatric registrar, my work was almost entirely community based with a substantial commitment to out-patient work through clinics based at Hartfield and other health centres. In addition to routine psychiatric referrals, I was involved in liaison work, seeing cases of deliberate self-harm at the DGH and also dealing with psychiatric morbidity arising in the medical and surgical units there.

The Clyde Unit, and adult day hospital, took up three of my sessions in the week. I provided general psychiatric care, was involved with the team of nurses, occupational therapist, clinical psychologist, general practitioner and social worker in assessments, running groups and family work as well as individual work with patients.

I was also involved in regular clinical meetings at the in-patient psychogeriatric unit, the psychogeriatric day hospital and attended a full community

multi-disciplinary team meeting once a week. This meeting was a forum to discuss both clinical matters and also any administrative or staff issues arising. The nature of the service and its entirely community based function made this meeting a crucial factor in the smooth running of the service. The community psychiatric nurses have a large case load themselves which they manage on a relatively independent basis but this meeting provides formal opportunity to keep up-to-date with developing problems, to have discussion and to receive information.

Advantages

A major advantage was the variety of experience on offer – out-patient work, day hospital work, liaison psychiatry, psychogeriatrics, family work. Along with this there was opportunity for various forms of therapeutic intervention in different clinical settings.

The regular contact and close co-operation between workers in different disciplines was an invaluable element in the smooth running of the service. To be working in a setting where daily contacts were more likely to be with colleagues from different disciplines was an experience I found most challenging and rewarding.

The contact with general practitioners was another area I found beneficial, both through contact at clinics held in health centres and also through their involvement with the psychiatric services. They were available to provide much valuable information about patient's home and family backgrounds as well as a broader perspective about many aspects of care.

The close working relationship between consultant and registrar required in such a setting was another advantage. This tended to be a flexible relationship whereby the consultant was available for regular supervision and frequent contact but allowed myself as trainee sufficient autonomy to develop skills and confidence in patient management and in taking clinical responsibility.

During my time in the post I took on several new projects: I began attending local authority social work elderly resource allocation group meetings to provide psychiatric guidance as well as to 'argue the case' for individual patients.

A major development was to move one of my out-patient clinics from the community clinic to a local health centre, Dumbarton Health Centre. I contacted the general practitioners there in advance and met with them prior to commencing. This provided opportunity for further informal meetings and discussion of patients as well as a familiar and convenient setting for patients attending the clinic.

Another area in which I was actively involved was the continuing development of the adult day hospital as it progressed through its early years and gradually developed a satisfactory working identity. As part of this I was involved in setting up an assessment system for new referrals, a relative support group and participated in informal and formal discussions among staff concerning the frustrations and rewards of being involved in the growing phase of such a unit.

Disadvantages

The main disadvantage of this post was a feeling, at times, of isolation from fellow psychiatric colleagues and also a relative lack of access to academic meetings and formal teaching sessions. I was also aware of the fragmentary nature of the job; at times there was not only the familiar feeling of having to be in two places at the same time but also of having no very clear-cut institutional base. This sensation of being spread thinly over a large area can be frustrating if one feels torn as to where to direct one's energy. This seems to invite a decision about whether to concentrate in more depth on some areas, or whether to try and do everything and end up doing nothing adequately. I was also aware of spending a good deal of time in my car moving from place to place and while this provides variety, it does take up time.

Comment

I am aware that as first incumbent in a new post that continues to develop, mine was a unique situation in many ways. Nevertheless, the potential for a valuable learning experience was demonstrated to me, not only because of the variety of case material, but also in a more personal way, with the challenge of developing self-awareness and skills in coping with situations outwith the safer confines of the large mental hospital setting.

Although there may be developments in other parts of the country concerning training in community psychiatry, I hope that by setting down impressions of my particular experience in a training situation, I may stimulate further discussion of the needs and availability of adequate training in this area of psychiatry.