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Trainees' forum

An aspect of community psychiatry training: a senior registrar's experience

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With the closure of large mental hospitals there is increasing emphasis on community psychiatry (Thornicroft & Bebbington, 1989) and a need for experience and training at all grades in this speciality. Some training aspects of an area of community psychiatry as experienced by a senior registrar are detailed.

Description

One of the six core sessions of general psychiatry training at a London teaching hospital was spent developing links with various areas of primary care including a general practice health centre, local social service offices, and a local voluntary sector mental illness hostel. The purpose of the links were multifold: to assess and treat patients; to develop close liaisons; to advertise the full range of psychiatric services; for mutual support; for education in both directions; teaching; and research.

Patients were assessed at a clinic held at the health centre or local hostel using a combination of models described by Brook (1967, 1978). Referrers included general practitioners (GPs), other health centre staff (e.g. practice nurse), social workers and hostel workers.

A monthly meeting was held with the GPs and other health centre staff to discuss referrals already seen, potential referrals, administrative, political, ethical, and educational issues. Unfortunately the community psychiatric nurse was not involved due to other commitments. Attempts to hold a similar meeting with local social services were singularly unsuccessful. Such meetings with the local hostel had recently begun. The consultant community psychiatrist provided weekly supervision for training purposes.

Some advantages and disadvantages of the above approach are described below.

Advantages

(a) The referrals were discussed with the referrer in person, and reasons for referral and expectations clarified. The GP's detailed longitudinal knowledge of the patient and the patient's family provided invaluable information.

(b) Access to detailed general practice case-notes provided valuable information, particularly when it contained letters from several different hospitals, and hence avoided delay in contacting these hospitals for information.

(c) Joint assessments with the GPs were possible. When this was not the case, immediate verbal communication was undertaken enabling the general practitioner to be directly involved in the planning of treatment (Brook, 1978). This was followed by a detailed letter and further discussion at the monthly meeting.

(d) The psychiatrist essentially offered an opinion. The GP continued to manage the patient. This resulted in one psychotropic prescriber and one coordinator for secondary referrals (e.g. to social services) narrowing the risk of poor communication.

(e) The attendance rate was nearly 100% for both new and follow-up patients which is considerably higher than attendance at a hospital based new patient (Baekland & Lundwell, 1975) and follow-up (Shah & Lynch, 1990) clinic. Reasons for this include a shorter trip to the clinic, interview at a familiar and less threatening venue.

(f) The regular monthly meetings fostered good links between primary care and the psychiatric services. Therapeutic success, therapeutic nihilism, and management anxieties were shared, resulting in a feeling of cohesion and teamwork.

(g) Opportunities for teaching both undergraduates and postgraduates were a valuable experience.

(h) As the clinic was away from the hospital constant interruption by the bleep and the telephone were absent. What a relief!

Disdavantages

(a) As the clinic was away from the hospital, whenever the patients needed further

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investigation (e.g. radiology) it was difficult to organise and persuade the patient to accept it.

(b) The administration and secretarial backup was at the hospital and resulted in poor communication between the patient, psychiatrist, and the health centre. Some secretarial backup at the health centre would resolve this.

(c) Some patients felt that the health centre staff were aware that they were seeing a psychiatrist. The close personal contact with the health centre staff and the stigma attached to psychiatry could be a disadvantage.

(d) Once a good relationship was developed with the health centre staff it was difficult to refuse to see patients at short notice, often resulting in unpaid overtime.

(e) Attempts to develop links with the local social service offices were unsuccessful. Despite repeated phone calls, letters, personal visits by both myself and the consultant community psychiatrist, we were unable to establish any clear links. The most obvious reason for this appeared to be shortage of staff.

(f) Close links were established with the local hostel. There were difficulties with patients placed in this hostel from outside the catchment area of the hospital and were being followed up by the original hospital. Input was requested when the patients poorly complied with medication, refused follow-up at the original hospital, when there was poor communications from the original hospital or the hostel staff were dissatisfied with the original hospital's services. As these patients were under another psychiatric team's care, it created ethical and practical difficulties. Resolution of these issues is still under discussion.

Comment

This was a very valuable training experience in an expanding branch of psychiatry. Experience was acquired not only in the field of patient care, but in related areas of administration, politics, education, teaching, research, and greater understanding of colleagues in other disciplines. In my view, the advantages appear to outweigh the disadvantages.

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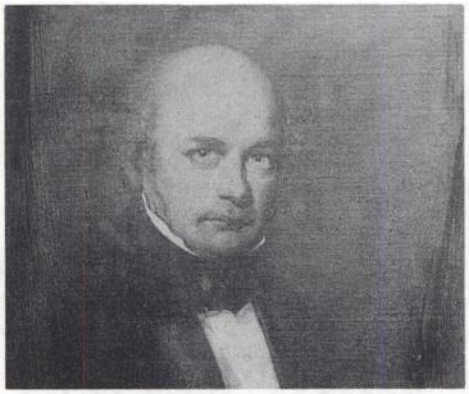

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