

Module C (local events such as case conferences) in 16 (23%). Fewer experienced difficulty in meeting the requirements for the other modules. Of those not registered many ($n=14$, 42%) intend to, but some ($n=9$, 27%) are unsure.

Almost all consultants ($n=102$, 94%) and higher trainees ($n=30$, 97%) felt that the adoption of more effective care based on evidence was a desirable goal. Fewer, however, thought it was attainable: 72 consultants (67%) and 23 higher trainees (74%).

Comment

The practice of psychiatry in an evidence-based way, using the best available external evidence, is considered desirable by almost all consultants and higher psychiatric trainees in the West of Scotland, and most think it an attainable goal. However, older influences on decision-making including tradition and deference still play a part, and those responding may tend to adopt evidence-based practice more than others. There is a desire to improve skills in evidence-based psychiatry. Though we still value texts and journals, newer technology is, mostly, available, and this study indicates Continuing Professional Development is gaining acceptance. The West of Scotland is moving towards a more evidence-based practice of psychiatry.

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Liaison-consultation meetings in general practice

An audiotape analysis

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Aims and method Audio-recordings were made over a period of six months of liaison-consultation meetings between general practitioners and a community mental health team in the Scottish Borders to show general trends in length of discussion and information exchange.

Results Meetings were predominantly supportive, with high levels of shared information, but little educational content. Some trends in discussion time are shown.

Clinical implications Audio-recording could form the basis for reviewing the function of liaison-consultation meetings.

While written communication between psychiatrists and general practitioners (GPs) has been studied extensively (Williams & Wallace, 1974; Kessel, 1984; Pullen & Yellowlees, 1985), little attention has been paid to verbal communication. This may reflect the lack of regular verbal communication between primary and secondary care and perhaps the relative ease with which letters may be studied.

The different models of verbal communication in psychiatry include formal lectures and seminars, telephone conversations, and face-to-face contact (King & Pullen, 1994). The latter can be subdivided into that occurring in different settings: outreach clinics in general practices with informal, unplanned discussions; regular liaison-consultation meetings with individual practices; and educational meetings with GPs.

Dingleton Hospital serves the scattered rural population of the Scottish Borders (population 105 000) and has well-developed community mental health teams (CMHTs). Regular liaison-consultation meetings with GPs have taken place for three decades having been developed by Maxwell Jones (Millard, 1996) as an extension of the principles of open communication and social learning that were the cornerstone of the Dingleton therapeutic community. Similar meetings initiated in West London by Burns (a former registrar at Dingleton) were studied by Midgley *et al* (1996). They found that 90% of discussion time was devoted to clinical matters, with 54% related to patients with psychotic illnesses.

This paper presents the results of a study to replicate their findings. The content of liaison-consultation meetings held with the four general practices covered by one CMHT operating in central Borders was analysed. In addition, the results have been used to facilitate a review, with each of the practices, of the role and functioning of these meetings.

The study

Over a period of six months, audio-recordings were made of regular liaison-consultation meetings between the GPs and the CMHT. The team consisted of a consultant, senior house officer, two community psychiatric nurses (CPNs) and an occupational therapist. The four rural practices involved were non-fundholding, computerised, small, group practices with a total population of 22 500. During the study period one three-partner practice subdivided, recordings continuing only at the two-partner practice. Meetings took place at the practices, and occurred at approximately six-weekly intervals. A computerised print-out of the CMHT's current caseload was taken to meetings to aid recall and

provide structure. Meetings lasted from 30–90 minutes.

The analysis of the audiotapes recorded the following: the name of each patient discussed; duration of the discussion; information given by GP or member of the CMHT; joint decision-making; and any educational discussion. All ratings were carried out by the same investigator (RT). The gender, age, length of contact with the CMHT and diagnosis (ICD-9 until February 1996, ICD-10 from April 1996) were obtained for each patient from the computerised case register.

Diagnoses were divided into five broad categories: (1) schizophrenia and manic depressive psychosis; (2) depressive disorders and dysthymia; (3) neuroses, including anxiety and adjustment disorders, phobias, obsessional disorders, somatisation disorders, stress reactions and emotional instability; (4) alcohol and drug related problems; and (5) other (including eating disorders, conduct disorders, personality disorder, self-poisoning, problems in relationships and organic brain disease).

Findings

Each patient was discussed only once per meeting. The percentage of the total time spent discussing patients within each category is shown in Fig. 1.

Not all the patients on the caseload of the CMHT from any one practice were necessarily discussed at every meeting. The mean time per patient discussed was 111 seconds (s.d.=124). The mean time per patient for each diagnostic category is shown in Fig. 2. Standard deviations show substantial variation in each category.

These data are skewed by a discussion, at one of the meetings, of a 17-year-old woman with a diagnosis of borderline personality disorder: she was discussed for 1065 seconds. The patient's behaviour had caused great concern and, while this discussion involved exchange of information, no decisions were taken, and it appeared to be an airing of frustrations and mutual support in a difficult and intractable case.

GPs shared information during 67% of patient discussions, and the CMHT in 81%. There was a trend for mean length of discussion to reduce with increased length of contact with the CMHT, but this trend was not statistically significant (see Fig. 3).

Only 7% of discussions were specifically educational and, on all occasions except one, occurred only when the consultant was present. Education related primarily to use of medication (especially antidepressants in line with the joint Colleges' consensus statement), but also to use of different services and explanations of different

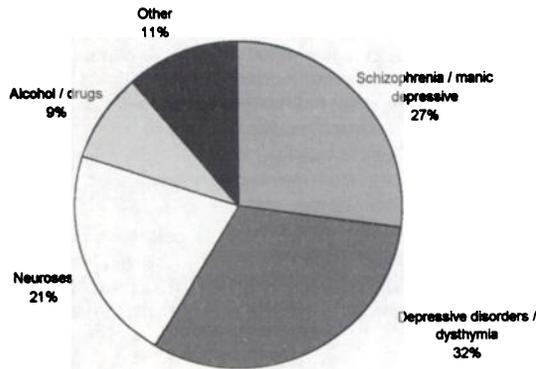


Figure 1. Proportion of the total discussion time per diagnostic category

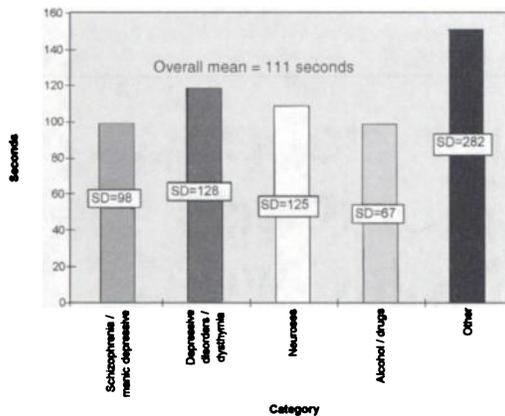


Figure 2. Mean time per patient discussed in each diagnostic category

types of therapy. Joint decisions were taken in only 8% of discussions. Examples of these were: clinical management plans; whether to follow-up patients who defaulted from contact; organisation of joint meetings; referral to other services; the recording of risk assessment; and complex medication decisions.

Comment

The general atmosphere of the meetings was informal and friendly, and it is inevitable that the data cannot demonstrate the mutual support that is one of the most important features.

Depression and dysthymia take the lion's share of discussion time (32%), closely followed by schizophrenia and bipolar affective disorder (27%), then neurotic disorders (21%). This

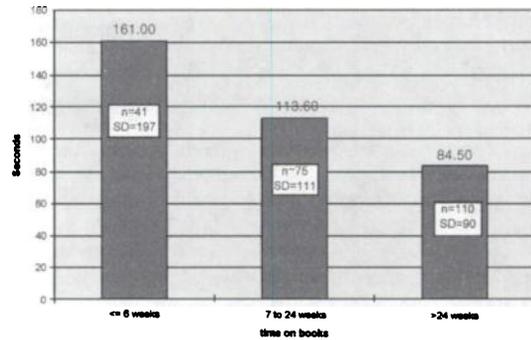


Figure 3. Mean time discussed according to length of time on books

contrasts with the findings of Midgley *et al* (1996), where psychotic patients occupied half the discussion time. It is possible the differences may reflect rural/urban population variations. Almost all discussion time was devoted to clinical matters, with only occasional forays into talk about current issues in the hospital or general practices. As in Midgley *et al*'s study, few service users were discussed who had not yet been seen.

The reduction in discussion time with increased length of contact with the CMHT may be a cause for concern. While new patients might be expected to generate most discussion, people with long-term mental health problems require a structured and coordinated approach from the practice and the CMHT.

Conclusions

Audio-recording is a simple and effective way of measuring and assessing verbal communication. The liaison-consultation meetings were characterised by equal input from GPs and CMHT members, and discussions were more supportive than decision-making. The analysis of the tapes drew attention to the limited educational content of the sessions and the absence of non-medical members of the primary care team. Audio-recording could form the basis for reviewing the functioning of liaison-consultation meetings.

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The outcome of rough sleepers with mental health problems admitted to a psychiatric ward

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Aims and method To describe the outcome of rough sleepers admitted to an acute psychiatric ward; the professional most involved with the person was interviewed.

Results Eleven out of 12 people admitted with a psychosis were accommodated and in touch with mental health services at follow-up (median of 21 months) compared with two out of 10 people, admitted without a psychosis, accommodated and four out of 10 people in touch with mental health services.

Clinical implications Psychiatric admission with good aftercare is worthwhile for rough sleepers with a psychosis, even if it requires involuntary admission.

The plight of rough sleepers has drawn much attention from the media and politicians over the last decade. Those rough sleepers with mental health problems often have particular difficulty in finding appropriate care, especially

in the inner city (Scott, 1993; Williams & Avebury, 1995; Merson, 1996). In the City and East London a specialist health care team has been established with central funding. This team, the East London Homeless Healthcare Team (HHELP) uses people from several disciplines to provide an outreach service, particularly to rough sleepers. Several similar teams have been established nationally (Williams & Avebury, 1995). Such teams sometimes request mental health assessments with a view to admission. What happens to such patients after admission?

The psychiatric team on Strauss Ward, at St Bartholomew's Hospital, works closely with HHELP and the City of London social services department to provide a comprehensive service. Strauss Ward was opened in 1991 and is the first psychiatric ward to be opened in the City of London for several centuries. Its team provide