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LETTERS TO EDITOR

Delusional dish syndromes

Sir, – I read with interest your May 1992 article (1) discussing three cases of "Delusional dish syndrome". I would like to add another case which involved delusions surrounding such a satellite-receiving antenna dish.

The patient was a 32 year old Caucasian female with a long history of paranoid schizophrenia and the attendant social sequelae. Next door, the neighbors had recently installed a satellite dish at their rural home, and the patient had stopped taking her neuroleptic medication several months before this time. She was convinced that Donald Duck, the popular Disney character, was deeply in love with her and had so informed her via the satellite connection. She began to have visual hallucinations of the irascible waterfowl, and her family became alarmed as her behaviour and attitude toward the satellite dish deteriorated. She began to spend hours hovering around it, and when she disrobed and climbed into it, masturbating (while believing that she was in fact consummating her marriage to the fictional Disney duck), the police were called and she was involuntarily committed to a state hospital, where her delusional thinking and hallucinations gradually improved on fluphenazine which was tapered to an eventual maintenance dosage of 1-2 mg/day.

The patient eventually enjoyed considerable insight into her illness, which remained in complete remission on fluphenazine, but she tended (neurotically) to avoid proximity to satellite dishes. However, she has been able to discuss this aberrant behaviour and sees the humour in it. There are definite clues as to the dynamic underpinnings involved both in her original decision to stop the medication and in why she incorporated the powerfully symbolic medium of the satellite dish connection into her system of delusional belief. I am sure, as you have intimated, that deluded individuals will increasingly focus their energies on these and other commonplace technologies.

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Irish Journal of Psychological Medicine 1992; 9: 134-135

Primary care liaison psychiatry:- selected consultation and periodic group discussion model - evaluation of a pilot scheme.

Sir, – Since Shepherd (1) investigated psychiatric illness in general practices in London in 1966, there has been a growing awareness of the need to evaluate liaison psychiatry in general practice. We designed a general practice liaison psychiatry service, using selected out-patient consultation and periodic group discussion between GPs and psychiatrists. The aims of this pilot project were to evaluate this service in terms of patient care, the GP/psychiatrist relationship, the attitudes of patients to psychiatric referral and cost-effectivenss. Our four - month pilot study illustrated some of the difficulties encountered in setting up and running such a service. Our experience holds useful lessons for similar future services.

The service ran from August 1989 to December 1989. Two registrars in psychiatry were available for a total of six hours per week. Consultation requests were made by the GP contacting the community base. Each GP filled out a consultation request form containing information regarding the patient and the GP's diagnosis. The psychiatrists were blind to the GP's diagnosis prior to interviewing the patient, in order to avoid bias. Following the interview with the patient (which took place in the GP's surgery) each GP received a verbal and a written report on the patient. The GP's and the psychiatrist's diagnoses were compared.

Only patients over 18 who were attending Cluain Mhuire Family Centre were eligible for inclusion in the study.

Periodic group discussion took place at the inauguration of the scheme and at the end of the four - month period. At the end of this period each GP was sent a feedback questionnaire on the scheme.

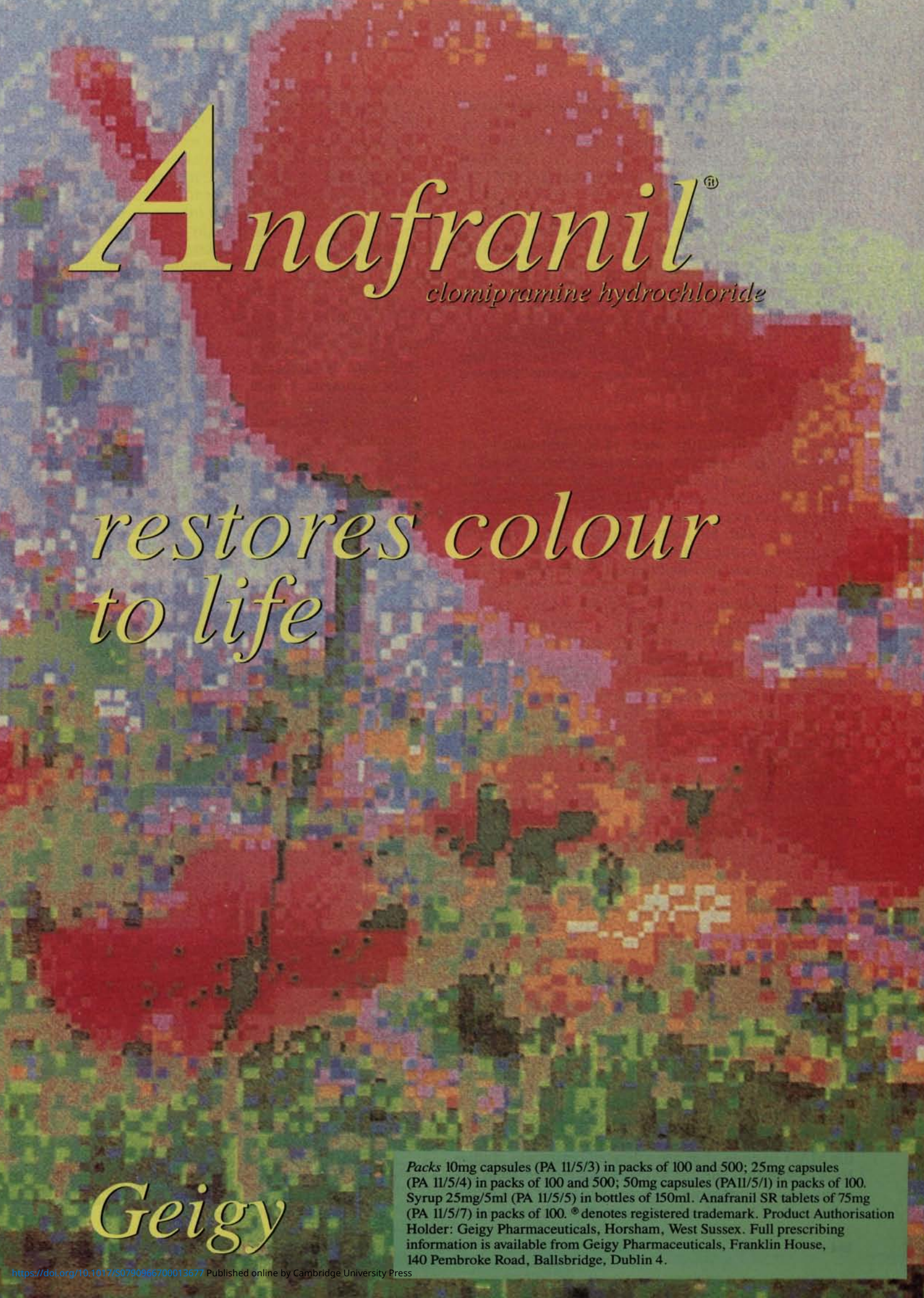
The overall response rate was low. The catchment area has 124 GPs. Of these, 38 (30%) attended the inauguration meeting. There were four consultations requested during the four-month period. 37 GPs replied to the feedback questionnaire. Three GPs attended the group discussion at the end of the four-month period.

Despite the limited uptake of the service, 31 of the 37 GPs who replied to the questionnaire said they would avail of the service in the future, as did the three GPs who attended the four-monthly discussion.

The low response rate to the project raises questions regarding the setting up of such a service, and the factors which may influence its utilisation.

The community base already provides an efficient out-patient psychiatric service for a population of 180,000. Referral to this service does not involve filling out a consultation form or making space available for consultations in the GP's practice as our service did. At the time of the scheme, GPs were busy with an influenza epidemic and were perhaps unable to give their attention to the scheme. The catchment area is relatively "over-doctored" and GPs may be able to provide time to themselves adequately assess and manage patients with psychiatric problems.

The limited utilisation rate of the scheme reveals some aspects of the GP - patient - psychiatrist relationship. Personal visiting by psychiatrists to the GPs' practices might have been a more effective advertising stratgegy than inviting



GPs to the community base for meetings. Furthermore, GPs might have preferred to refer to a consultant psychiatrist than to a trainee.

Current psychiatric practice and psychiatrists' communications with GPs may promote the remoteness of the speciality which GPs may find intimidating. This feeling may be communicated to patients; patients' and GPs attitudes to psychiatry are likely to be mutually interdependent. The most frequently cited reason for GPs not referring appropriate patients to a psychiatrist is the stigma of psychiatric care (2). This reason was cited on 3 of the 4 consultation request forms filled out by GPs.

While some of these reasons for the limited uptake of the servide can only be inferred, there is no doubt that the design of the service contributed to the low uptake also. The period of study was very brief - it is likely that such a service requires considerably longer than four months to become integrated into the psychiatric services so that it is widely known of and frequently used.

GPs are unlikely to readily utilise a new service when previously available services are already satisfactory. Indeed, during the period of the study, there was no change in the number of referrals made by GPs to the out-patient department.

The relationship between GPs and psychiatrists may need to be improved before such a liaison service could be fully utilised. A survey of what GPs felt would be appropriate for such a service could result in a more satisfactory service. It may be that an emergency liaison service, with a more flexible referral system would have been perceived by GPs as being more useful. Our service excluded patients already attending Cluain Mhuire; it may therefore have been aimed at a patient population that are not particularly problematic and add little to the burden of the GP.

Hence this pilot project highlights the pitfalls and difficulties of setting up a relatively ambitious service to the community. We feel that it has been a learning experience for us. It is only through such trials that we can design and shape an adequate liaison service. We hope that communication between GPs and psychiatrists can both improve and be improved by such services.

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CONFERENCE REPORT

Symposium on "Medical, Legal and Ethical Psychiatric Perspectives" – Clifden, County Galway. 20-22 March, 1992, sponsored by E. Merck.

Mr. Paul Ranson, specialist in Pharmaceutical/Health Care Law, Reading, UK, dealt with topical aspects of psychiatric research and practice. He stressed that patients consenting to inclusions in clinical trials were entitled to special protection, and investigators must be fully conversant with regulatory and legal provisions governing clinical studies. Sponsoring companies must ensure that investigators have the necessary level of competence and facilities properly to undertake the particular study.

Referring to the vital question of patient compensation and investigator indemnity, Mr. Ranson pointed out that EEC legislation currently under debate would involve a reversal of the present position, with the prescriber having to *disprove* negligence. "Peer approval of a particular course of action was *not* a complete rebuttal."

Dr. P. A. Carney, Galway, reviewed the provisions of the Control of Clinical Trials Bill in the Republic of Ireland and considered the role of Clinical Research Ethics Committees. He stressed that the Bill required all clinical trials to be submitted for prior approval by the National Drugs Advisory Board. It was vital for doctors undertaking clinical trials to be able to demonstrate the appropriate level of competence in clinical research procedures.

Ethics Committees should include legal representatives. Problems could arise with multicentre trials in deciding which Ethics Committee – or possibly Committees – would be most appropriate. Patients informed consent to participation should always be obtained in writing and should be witnessed. Basic information on possible drug reactions should be provided to the patients in a standard format.

Professor R. Daly, Cork, spoke on the subject "Suicide – the Risk Factor". Ayd had made the challenging statement that depression was the world's major public health problem, and Sartorius estimated that there could be one hundred million cases world-wide. Suicide in depressed patients should not be thought of as just a theoretical risk. The prescription of an old tricyclic antidepressant could be seen as offering the patient "a loaded gun". Professor Daly went on briefly to review the basic principles of malpractice law, and he concluded with some considerations of cost versus benefits in relation to antidepressant drug therapy.

Dr. T. Dinan, Dublin, considered advances in antidepressant therapy, dealing with the current perspectives and possible future developments. He placed antidepressants in four main categories:
a) old tricyclics
b) "cleaned up" tricyclics
c) serotonin reuptake inhibitors
d) reversible monoamine oxidase inhibitors.
Regarding the latter, he felt there was still a question of effectiveness when compared with the established antidepressants.

Dr. Dinan pointed out the need for antidepressant drugs with greater efficacy and swifter onset of action. Depression should be viewed as a far more serious disease. More complex paradigms were needed – not just simple concepts that depression was due, for example, to a deficit of serotonin. "For 99% of brain neurones we just don't know what transmitters they use!"

Dr. Dinan went on to develop the hypothesis that depression might stem from stress-induced activation of the hypothalamic pituitary axis and conjectured about the potential antidepressant value of drugs capable of lowering cortisol levels.