Establishing a District Psychiatric Service without Psychiatric Trainees

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The Report of the Social Services Committee of the House of Commons in 1981 (the 'Short Report') recommended the establishment of consultant posts without the support of trainee medical staff as part of a strategy to correct the situation where too many doctors occupied training posts for the number of consultant posts available.[1] The Royal College of Psychiatrists has endorsed this policy,[2] and the withdrawal of approval for training from an increasing number of hospitals around the country is leading rapidly to a situation where a large number of them need to look at alternative arrangements for providing medical cover. We would like to report the establishment and early development of such an arrangement based in a district general hospital.

Background

Bassetlaw Health District consists of the northern third of Nottinghamshire. Its population of 103,000 is concentrated in the towns of Worksop and Retford with a scattering of villages in the remainder of the district. Prior to October 1984 psychiatric services were provided from Saxondale Hospital, situated 35 miles away in the south of the county. All psychiatric admissions were to that hospital under one consultant supported by a psychiatric trainee on the Nottingham training rotation and by a Senior House Medical Officer. Emergency cover was provided within a two-tiered rota system of five trainees and associate specialists, and one senior registrar with four consultants. The responsible consultant visited the District with the trainee and SHMO to conduct out-patient clinics, domiciliary visits, and to see emergencies and referrals from the hospital services on three half-days a week. The assessment of patients admitted to the Bassetlaw Hospitals after deliberate self-harm attempts was made by a psychiatric social worker based in the district who would refer those considered in need of a psychiatric opinion to the consultant on his visits to the district. This occurred at a rate of approximately one in three of such admissions (i.e., 50–60 per year).

Phase 1 of a new District General Hospital built on the outskirts of Worksop, including a Department of Psychiatry, was scheduled to open at the beginning of 1984. Two 30-bed wards, to provide for acute psychiatric admissions, a day hospital, a treatment suite for the administration of electroconvulsive therapy, and an out-patient area, were to form the base for the establishment of a comprehensive psychiatric service for the district. Two consultant posts in Adult Mental Illness were established. No other medical support below consultant grade was planned.

Development of the Service

A lowering of the regional guidelines for acute psychiatry to 31 beds for the population size meant that only one ward was required. Trent Regional Health Authority agreed with the District Health Authority that the second ward should be for long-stay patients with an initial transfer of 20 patients originating from the district who were resident in Saxondale Hospital.

Difficulties in attracting suitable candidates for the consultant posts delayed opening of the department, and an addition of five clinical assistant sessions to the proposed medical establishment was made. Our appointments to the posts eventually occurred six months after the initial proposed opening date. Additional medical cover was provided on a 24-hour basis, with clinical assistant sessional cover for the inpatient wards (total of 10 sessions) and day hospital (five sessions) and 'out-of-hours' cover (11 sessions) provided by local general practitioners based at a health centre in Worksop. This was provided after negotiations in which, amongst other arguments, we contended that specialists in psychiatry (or any other specialty) could not provide medical cover for primarily physical complaints in ward and day patients to the standard of a vocationally trained general practitioner but that such care should be available. The clinical assistants appointed to work during the day also provide assistance with psychiatric assessment and treatment. Consultant and general practitioner colleagues gave invaluable support and advice to us at this stage when the viability of the service was in considerable doubt, and have continued to do so since.

Recruitment of nursing, paramedical and clinical assistant staff to open the service was successful and the day hospital and acute psychiatric ward opened on 29 October 1984. Recruitment of trained nurses for the second ward was however unsuccessful. This allowed us to revise the original plan for the development of the service. Movement of long-stay patients from Saxondale Hospital into a District General Hospital ward was seen as a retrogressive step for patients who in many cases had participated in rehabilitation programmes in accommodation outside the main hospital block. The lack of any formal psychogeriatric provision was also causing serious distress in the community. The alternative suggested by the Psychiatric Services Group (which advises the hospital's Unit Management Team) was that a psychogeriatric assessment ward (16 beds) be sited in the second ward with spare capacity used for six day places, a long-stay psychogeriatric ward be opened in a vacated surgical ward built in 1976 and provision for other long-stay patients originating from and arising within the district be in three hospital hostels, as described by Goldberg et al,[3]

with a total of 24 beds in spring 1986. The assessment ward would be provided from development finance allocated to the district and the long-stay provision would be predominantly opened and financed by transfer of patients at present in Saxondale Hospital with funding from the Regional Strategic Reserve fund.

A third consultant with a special responsibility for psychogeriatrics was appointed in September 1985 and the assessment ward opened in October 1985. The long-stay psychogeriatric ward opened in February 1986, the first hostel in June 1986 and the second hostel is due to open in February 1987.

The relatively limited amount of medical time available and a multidisciplinary philosophy of care has led to an increasing amount of the psychotherapeutic work of the unit being undertaken by the nurses, occupational therapists, social workers and physiotherapists—invaluable in teaching relaxation techniques—who have been attracted to work with the service. Referrals have risen from an average of 16 per month to 43 per month. The vast majority of these are seen initially by one of the consultants. Medical manpower however is still below levels needed for a comprehensive service and this has led to increased referral to the day hospital and community nursing service, early discharge to general practitioners and a reduction in the length and frequency of patient contacts for both out, day and inpatients below desirable levels. A fourth consultant is within the District's plan for consultant expansion.

'Out of hours' cover for 'psychiatric' emergencies has been provided by the consultant staff, with cover for 'physical' emergencies and examinations from the general practice group. Although theoretically the differentiation between such types of emergencies might appear difficult, in practice the system has worked well. Because of the present low level of consultant staffing, the number of hours 'on call' has been onerous, although mitigated by the availability of British Telecom radio-pagers. However the number of telephone calls received over the period from 29 October 1984 to 29 October 1985 was low, averaging 6·54 weekly, and visits from home averaging 2·62 weekly. The number of telephone calls from the ward to the GPs during the same period averaged 1·96 weekly and visits to the ward averaged 1·77 weekly. This would be expected to increase with the development of the service.

Provision was made within the job description of the consultants' posts for sessions to be devoted to research and teaching. Medical students are attached to the unit from Sheffield University for their psychiatric clerkships. Occupational therapy, social work, psychology and nursing students are also attached on an intermittent basis. Research programmes commenced in Nottingham prior to appointment have been continued by consultants.

Use of microcomputers was considered at an early stage and a portable Commodore SX64 purchased with printers. Programs were written to produce patient information sheets and addressograph labels, and to elicit some personal history information from selected patients. Data manipulation with such equipment is necessarily rudimentary and systems providing this and other facilities have been identified but funding has not as yet been made available. A research project using a computer interview to assess patients devised by Carr et al[4] has been initiated.

Discussion

A psychiatric service without psychiatric trainees is described. Clinical assistants provide care for physical complaints and perform physical examinations where required. As trained general practitioners they probably provide for these functions more effectively than can be provided by psychiatric trainees with little or no experience of general practice. This division of labour has been quite successful with nursing and medical staff. There are theoretical objections to such a division as perpetuating the 'mind–body dichotomy' that bedevils the treatment of somatising patients but in practice this has not proved the case. Concern that physical aspects of psychiatric care might be neglected has not become reality.

Clinical assistants have also been used to 'plug gaps' in the psychiatric provision whilst the level of consultant cover is below necessary levels. This has been possible because those who have been recruited have either been Members of the Royal College of Psychiatrists or had extensive experience in psychiatry. The supply of suitable candidates for such posts has been surprisingly good. The establishment of effectively full-time posts using nine session clinical assistants has been criticised and appears contrary to the intention underlying clinical assistant posts that they should be part time. Nevertheless as a temporary solution this has been essential in establishing the service. The permanent solution is, however, provision of consultant cover for all psychiatric care. The minimum level that we anticipate to be necessary to fully provide such cover is five (whole time equivalent) consultants for the 103,000 population. Alongside this, demands on the time and expertise of other professionals is increased. Psychologists, occupational therapists, social workers, community nurses, etc. should receive more appropriate referrals because of the absence of trainees. Adequate secretarial support at Higher Clerical Officer grade is also necessary. The reduction in total psychiatric time available on admission wards can be compensated for by having sufficient nurses employed at charge nurse grade to provide cover on a 24 hour basis (including annual and sick leave).

This medical arrangement is providing clinically satisfying posts despite the lack of psychiatric trainees, with advantages for patient care. A higher proportion of patients have a closer and more consistent relationship with their psychiatrist. Patients often complain in teaching hospitals of the frequent changes in doctor caused by training rotations; establishing a rapport with successions of doctors might even be a factor in perpetuating some psychiatric disorders. Trainees may feel inhibited about changing management programmes and particularly about discharging patients. They are much less likely to have a full knowledge of the roles of other professionals to whom they can refer patients, likewise their knowledge of the community they

are serving is likely to be much less complete than that of a consultant. Emergency psychiatric cover by consultants also has advantages for the patient as the consultant is more likely to know the individual concerned and is less likely to need to admit a patient for assessment unnecessarily.

Time specified for teaching and research is essential in any consultant post but particularly those without psychiatric trainees. Because this time is not tied to the constraints of providing a postgraduate training programme, it can be used in a more varied way in such posts. The proportionately larger consultant body allows administrative duties to be diluted and special interests to be developed.

Despite the apparent advantages of the system outlined there remains considerable opposition to the development of such posts. Change is threatening and where such changes may appear to be administrative ploys to reduce medical staff in 'peripheral' units with a continued concentration of trainees in the 'centres of excellence', it is not surprising that such resistance occurs. Such peripheral units have spent years building up staffing levels only now to see them threatened. Losing SHOs and registrars challenges ways of working developed over many years often in very adverse conditions. Replacement by consultants is uncertain, firstly because once funds are released by such losses, they become subject to the vagaries of the health service and so can be 'frozen' or swallowed in 'efficiency savings'; secondly, because senior registrars have no training or even contact with such posts at present, even if funds are released there are serious concerns about recruiting to such posts.

It is therefore important that the Department of Health and Social Security accepts that the provision of services without psychiatric trainees is not a cheap option, and that it considers issuing guidelines to Regional Health Authorities directing that funds released by closure of training schemes be used for the provision of replacement consultant or clinical assistant posts. It is also important for the College to review senior registrar training. If these posts are to be encouraged it is essential that senior registrars gain experience in them and are, in so doing, dispersed from their present concentration in the universities. They could then experience the advantages as well as imagining the disadvantages of working in this way.

References

[1] Social Services Committee, House of Commons (1981) *Fourth Report: Medical Education*. London: HMSO.

[2] Rawnsley, K. (1984) The future of the consultant in psychiatry. *Bulletin of Royal College of Psychiatrists*, **8**, 122–123.

[3] Goldberg, D. P., Bridges, K., Cooper, W., Hyde, C. & Wyatt, R. (1985) Douglas House: A new type of hostel ward for chronic psychotic patients. *British Journal of Psychiatry*, **147**, 383–388.

[4] Carr, A. C., Ghosh, A. & Ancill, R. J. (1981) Can a computer take a psychiatric history? *Psychological Medicine*, **13**, 151–158.

Awards

Max Fink, Professor of Psychiatry, School of Medicine, State University of New York at Stony Brook, was awarded the first Meduna medal by the National Institute for Nervous and Mental Diseases of Hungary in Budapest in August 1986 for his contributions to the study and treatment of affective disorder.

The Kinsey Institute for Research in Sex, Gender, and Reproduction will award a prize of $1,000 for a doctoral dissertation, from any academic discipline, accepted by an accredited university between 1 May 1986 and 30 April 1987. The award will be announced in December 1987. The recipient will be invited to visit the Institute and discuss his or her work at a meeting of the Institute's Science Advisory Board. Travel costs will be provided. Further information: Dr June M. Reinisch, Director, Kinsey Institute for Research, Morrison Hall, Third Floor, Indiana University, Bloomington, IN 47405, USA.

New Handbook

MIND (National Association for Mental Health) and RADAR (Royal Association for Disability and Rehabilitation) have produced a new guide to the Disabled Persons (Services, Consultation and Representation) Act 1986 for the use of voluntary organisations. Copies can be obtained from RADAR, 25 Mortimer Street, London W1. Prices: 1 copy 25p, 2 copies 65p, 3 copies 85p, 4 copies £1.10, 5 copies £1.40, 10 copies £3.00, 15 copies £4.15, 20 copies £4.90 and 25 copies £6.10. Further information: William Bingley, MIND (01 637 0741) or Peter Mitchell, RADAR (01 637 5400).

'Changes'

Changes, the psychology and psychotherapy journal which provides a forum for the different disciplines to discuss the ideas involved in helping change take place, is now being published by Lawrence Erlbaum & Associates. In future, subscription enquires should be sent to them at 319 City Road, London EC1V 1LJ.