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Commentary

General psychiatry, still in no-man's land after all these years: commentary, Deahl

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General psychiatry; resources; functionalisation; postgraduate training.

Response

I read with interest Anthony Pelosi's comments about my article and thank him for his compliments. In response to his criticism regarding one of my first patients during my psychiatric training, I agree with his broad point: patients were traditionally 'warehoused' and kept in hospital far too long. However, there is a balance to be struck. I tried to illustrate the contrast between times gone by when it was possible for a patient to remain in hospital as long as was felt necessary; and today, when the patient's feet barely touch the ground before discharge, often with only a nugatory, inadequate or even absent assessment and a 72 h follow-up with an often overstretched crisis team. Beyond that, it is all too often a lottery as to what care or follow-up the hapless patient receives. In the case of my patient, the lengthy admission was clinically justified as the phenomenology was both subtle and unclear, and labelling an 18-year-old with a diagnosis of schizophrenia is not to be entered into lightly. Too often in 2024, diagnosis is based upon tick-box questionnaires or perfunctory meetings with medical staff. Of course, in-patient admission should be as brief as possible. In 1985 there were no community supports that supposedly exist today, so in-patient stays were necessarily longer. Nevertheless, any in-patient admission should serve its purpose, and the job, be it the diagnosis of a newcomer to services, stabilisation of a known patient or treatment and formulation of a care plan, should be done properly, and not 'half-baked' because of bed pressures and the need to admit someone more disturbed from the community. Premature discharge is bad for the patient and causes moral stress and fatigue among staff, and as for any continuity of care …

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Declaration of interest

None.