LETTERS TO THE EDITOR

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The psychiatrist in primary care: let's look before we leap.

Sir – Dr Phelan in her review "The psychiatrist in primary care: let's look before we leap"[1] mentions three models of collaboration between general practitioners and psychiatrists. I would like to draw your attention to a variant as practised in the Scottish Borders over 25 years where 100% of psychiatrists collaborate with GPs.

Dingleton Hospital serves a mostly rural, scattered population of 104,000, there is no "Out-Patient Department" and all referrals go to the multidisciplinary sector team. Patients are seen for the most part in their own homes, preferably with a co-therapist. Only very small numbers are seen in the psychiatric hospital or GP surgery. Liaison takes place at regular meetings between the teams and GPs at the local health centres.

This home assessment and home treatment service has many advantages. There is improved access to care, with Dingleton's failure to attend rate running at about 5%. Patients often perceive it to be less stigmatising to be seen in the privacy of their own homes and patients' transport difficulties in this rural area are also overcome in this way. Home assessment with a co-therapist facilitates a holistic approach with improved opportunities for investigation and intervention in psycho-social and family factors. The GPs have access to the multidisciplinary team on a regular basis, with opportunities for collaboration, education, training and support.

Some of the disadvantages to collaboration models cited in Dr Phelan's article do not apply in the Scottish Borders. Because the system has evolved in this way over a period of time, administration and record keeping is not an issue. Accommodation problems are overcome by seeing people in their homes. Time spent in transit can be kept to a minimum by careful planning of visits. Hand free dictaphones and mobile phones can be used while travelling and time between joint work can be used to review cases.

Although the service at Dingleton has not yet been evaluated in the Scottish Borders, Burns et al[2,3] evaluated the Dingleton model in an urban setting. They found no differences in clinical or social functioning outcome but a substantial reduction in in-patient care and reduced total cost for a home based service. They believe that adequate investment in funding expanded teams able to operate in a truly multidisciplinary manner, would prove cost effective in the medium term.

Thus while appreciating Dr Phelan's caution about widespread introduction of psychiatric services in primary care settings, I would suggest the Dingleton model as one that could be extended to Ireland in both rural and urban areas. Given the Irish system where there are many single-handed GPs it is unlikely to be cost effective for multidiciplinary teams to visit every small practice on a regular basis. However, a negotiated time limited attachment may be applicable.

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References

1. Phelan D. The psychiatrist in primary care: let's look before we leap Ir J Psychol Med 1995: 1: 17-21.
1. Burns T, Beardsmore A, Bhat AV, et al. A controlled trial of home based acute psychiatric services. I: Clinical and social outcome. Br J Psychiatry 1993; 163: 49-543.
2. Burns T, Raferty J, Beardsmore A, et al. A controlled trial of home based acute psychiatric services. II: Treatment patterns and cost. Br J Psychiatry 1993; 163: 55-6.

Author's reply to 'Commentary on *A sceptical reflection on the diagnosis of multiple personality disorder*'

Sir – I am grateful that Dr Putnam, one of North America's most eminent contributors to the multiple personality disorder (MPD) debate, should give me the opportunity to elaborate on my earlier paper in the journal.[1,2] Dr. Putnam begins by noting that multiple personality disorder (MPD) has a long history. So, of course, have demonic possession and exorcism, but these are also chimera.

Mistakenly, he says that I note a continuity between early 17th. century reports and modern cases. This is not the case. Modern cases are quite different. For example, earlier reports describe cases where the number of personalities were relatively few (often "dual personalities") and a reported history of childhood sexual abuse rarely reported.

Putnam says that my paper is in the tradition of prior critiques, perhaps encouraging a yawn, but the reality is that there are few, developed, sceptical critiques of MPD, hardly enough to warrant the categorisation "tradition". A recent and distinguished exception is to be found in North *et al.*[3]

He takes me to task for basing my speculations about the incidence and prevalence of MPD on straw-polls (letters published in the Bulletins of the Royal College of Psychiatrists and the British Psychological Society, circulated to 6000 psychiatrists and psychologists) and correspondence with colleagues. However, by his own admission there are, as yet, no published data to resolve arguments