MENTAL HEALTH REVIEW TRIBUNAL
MEDICAL MEMBER'S PRE-HEARING EXAMINATION

NAME OF PATIENT: HOSPITAL:
AGE: RMO: WARD: SECTION:

Underline what is applicable in checklist below:

1. PATIENT SUFFERING FROM: mental disorder – specify: schizophrenia, paranoid schizophrenia, unipolar affective disorder, unipolar hypomania, manic-depressive psychosis (bipolar), psychopathic disorder, mental impairment, severe mental impairment, other (specify) _____

2. CURRENT STATE OF ILLNESS: acutely ill/improving/recovered.

3. PATIENT'S AWARENESS OF ILLNESS: insight/no insight.

4. DRUG TREATMENT:

Medication	*Specify if appropriate*	*Dose*
Antipsychotics	_____	low/normal/high
Antidepressants	_____	low/normal/high
Antiepileptics	_____	low/normal/high
Other	_____	

Likely duration of drug treatment: days/weeks/months
Patient's experience of side effects: none/slight/serious
Patient's compliance with drug treatment: willing/unwilling

5. OTHER THERAPIES: electroplexy, behaviour modification, occupational, industrial, other (specify) _____

6. ASSESSMENT OF DANGEROUSNESS: past history, injuring others/self-injury, potentially dangerous situation(s) (specify) —

7. IF PATIENT LEAVES HOSPITAL:
Residence: own home, with family, lodgings, hostel, other _____
Patient's acceptance of support in community: willing/unwilling
Patient's attendance at outpatient clinic and/or day centre: willing/unwilling
Resources: employment, unemployed, benefits

Re-organisation of CPN Services in our District

DEAR SIRS

Talking to medical colleagues I picked up the (learned) helplessness, and sometimes consequent apathy, in situations when local Unit Managers have been aggressive in their interpretations of community care. I thought you would be interested to hear what my colleagues and I have achieved through cohesiveness and constructive assertiveness.

During the early 1980s our District had three CPNs working from the hospital. In early 1985, almost overnight, the energetic Community Psychiatric Nursing Officer moved all the CPNs into 'the community' without consultation with the Consultants and circularised the services of the re-organised service to general practitioners, Social Services etc. In addition, individual CPNs circularised GPs about the specialised service they were offering. By this time, CPN numbers had expanded to 18.

Despite protestations from Consultants about falling levels of care for chronic psychotic, elderly, and other groups of severely ill patients, the CPN services continued to be managed with this form of nursing management. After a series of meetings with Unit Managers, our District General Manager intervened and instructed the other Managers that, for a trial period of 12 months, the CPNs in our District would be divided so that half of them would be "dedicated to Consultants". Arrangements were to be made to evaluate services.

Our interpretation of community care is that it is not synonymous with primary care but has both primary and specialist care elements. As such, the CPNs attached to Consultants have been designated Specialist Team CPNs and work as part of the Consultant-led multidisciplinary team working with patients in the community, supporting them while in hospital and liaising with general practitioners. The primary care CPNs are presumbly functioning in the same ways as before.

When this was effected on 1 April 1989, the GPs had apparently not been informed and this may partly account for the hostility we have encountered. We hope that this will resolve when the general practitioners are advised of the nature and reasons for the current changes in practice. We have also been told of vehement opposition received from the Community Nursing Association at London and the Preston based MIND.

As for the evaluation . . . that remains to be seen.

T. RAJAMANICKAM

The Lamont Clinic,
Burnley General Hospital
Burnley, Lancashire

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