

# Psychiatric out-patient services: origins and future

Helen Killaspy

**Abstract** Psychiatric out-patient services originated in the early-20th century to enable triage of new referrals to the asylum in order to differentiate between treatable and untreatable cases. They evolved to provide community follow-up of patients discharged from hospital and assessment of those newly referred to psychiatric services. Non-attendance at out-patient appointments represents an enormous waste of clinical and administrative resources and has potentially serious clinical implications for those who are most psychiatrically unwell. The place of out-patient clinics in modern community mental health services is explored with reference to the reasons for, and clinical and cost implications of, missed appointments. An alternative model is described that incorporates recent UK government guidance on the roles and implementation of community mental health teams, liaison with primary care and new roles for consultant psychiatrists.

Psychiatric out-patient services have recently come under close scrutiny. Until April 2005, non-attendance rates at first appointments were one of the performance indicators used by the Commission for Healthcare Improvement (now the Health Care Commission) in awarding 'star ratings' to National Health Service (NHS) trusts for service efficiency. This attention has allowed some creative thinking about the role of the out-patient clinic in modern mental health services. To understand why out-patient services have been such a mainstay of mental health services, it is important to understand a little about their origins.

## History and development of the out-patient model

The first mention of any form of psychiatric out-patient service in the UK can be traced back to the 18th century, when Edward Tyson, a physician at the Bethlem Hospital in London, convinced the hospital Governors of the benefits of apothecary prescriptions to discharged patients to prevent relapse:

'patients who have been Cured of their Lunacies ... in Bethlem being poore and not able to procure themselves a little necessary Physick at the Spring and the fall of the years for want thereof many ... have relapsed ... and become Patients again' (Bethlem Hospital Committee Records, 1718, quoted in Andrews *et al.*, 1997).

As with many service developments, the establishment of psychiatric out-patient clinics evolved as a response to service pressures. One major factor was the difference in admission criteria between registered hospitals and asylums. The latter were considered a last resort: after the parish doctor declared a person insane, the individual was placed on a compulsory reception order by a local magistrate under the Lunacy Act 1890 and taken to the asylum, where the medical officer classified them as 'curable' or 'incurable' (Hunter & MacAlpine, 1974). In contrast, registered hospitals such as the Bethlem stopped admitting parish patients in 1857, and from the late-19th century the Bethlem prided itself on being one of the pioneers of uncertified cases. By 1900, only 3% of Bethlem patients were certified, compared with 97% of the asylum population (Andrews *et al.*, 1997).

In 1917, John Porter-Phillips, Physician Superintendent of the Bethlem, suggested the need to develop an out-patient service to encourage early detection of psychiatric illnesses. This was seen as progressive policy, in keeping with the growing interest in psychoanalysis and psychological treatments for those returning from the First World War and it was hoped that it would allow

'early diagnosis of abnormal nervous and mental retardation leading to a complete eradication of the causative factor in mental illness' (Bethlem Hospital Annual Report, 1917).

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The first specialist psychiatric out-patient department in the UK subsequently opened in 1918 in Lambeth Road, London, as the Hospital for Nervous Diseases. It was so named in order to encourage attendance, since any overt association with the Bethlem was acknowledged to be stigmatising for patients. It was initially considered successful and was widely acclaimed but, owing to financial problems, it was closed in 1927 'having failed to attract suitable cases' (Bethlem Hospital Governors' Report, 1927). Its optimistic aims had not been achieved, since most patients who attended had been previously treated and were not easily cured.

However, as a result of the exponential rise in the asylum population, the Mental Treatment Act 1930 extended the voluntary admission procedure to asylums and encouraged some form of out-patient service to assess patients for their suitability for voluntary treatment prior to admission. In 1925 there were 25 psychiatric out-patient departments in the UK and by 1935 this figure had increased to 162 (Andrews *et al*, 1997).

The social and political climate of the following decades and the introduction of phenothiazine drugs fuelled dramatic changes in mental health service provision, with the closure of the asylums and the relocation of services to district general hospitals within the newly established National Health Service.

Psychiatry began to become accepted as a medical specialty and the model adopted for the organisation of services was the same as for other hospital disciplines, namely in-patient wards and out-patient clinics. Gradually, community psychiatric nurses were added to out-patient services, relocating into community bases outside of the hospital and eventually evolving into multi-disciplinary community mental health teams (CMHTs), integrated with colleagues in social services (Department of Health, 2002). The National Service Framework for Mental Health (Department of Health, 1999a) outlined the development of further specialist community mental health services, such as assertive outreach teams, crisis resolution and early intervention services, which have now been implemented nationally (Department of Health, 2004). Out-patient services have therefore been somewhat usurped by other community service provision and there is therefore a need to reflect on whether they still have a place within modern mental health services.

## Use of out-patient services

In 1995 the National Audit Office estimated that around 40 million out-patient consultations were

booked per year in England and Wales and that 12% of out-patients failed to attend their appointments in 1993–1994 (National Audit Office, 1995). At the time, the cost of each missed appointment was estimated at around £50, giving a total waste of £240 million per year. The rates of out-patient non-attendance at psychiatric clinics have consistently been found to be greater than in most other hospital specialties, ranging from 20% to 57% (Baekland & Lundwall, 1975). National 'league tables' published by the Commission for Healthcare Improvement (<http://www.chi.nhs.uk/Ratings/home.asp>) for 2003–2004 showed that the non-attendance rate at first psychiatric out-patient appointments reported by all 83 mental health trusts in England ranged from 7.5% to 40.1%, with a national average of 18%. The cost of this wasted medical and clerical time and associated overheads will have increased well above £50 per appointment.

A number of studies (Johnson, 1973; Morgan, 1989; Killaspy *et al*, 2000) have shown that the majority of new referrals to psychiatric out-patient clinics have a diagnosis of a common mental disorder such as depression or anxiety. In contrast, the majority of follow-up patients (who make up around 90% of the clinic population) have diagnoses of severe and enduring mental health problems such as schizophrenia, schizoaffective disorder and bipolar affective disorder (Killaspy *et al*, 2000). This suggests that individuals with severe mental illness do not generally access out-patient services by direct referral from the general practitioner (GP) but are seen as follow-up patients, usually after an in-patient admission. It also suggests that the majority of psychiatrists assess patients with common mental disorders but do not necessarily offer ongoing follow-up appointments to them. This trend appears to be growing (Table 1) and illustrates that the role of out-patient clinics has evolved from its original 'triage for admission' function towards assessment of less severe conditions and follow-up of people with longer-term problems.

## Reasons for non-attendance

Review of the literature identifies a number of factors associated with out-patient non-attendance across medical specialties: younger age; lower socio-economic status; lack of family support; greater waiting time between referral and appointment; poor understanding of the reason for referral; and clerical error (Caldwell *et al*, 1970; Baekland & Lundwall, 1975; Skuse, 1975; Deyo & Inui, 1980; McClade *et al*, 1988; Frankel *et al*, 1989; Koch & Gillis, 1991; Lloyd *et al*, 1993; Verbov, 1992; Potamitis *et al*, 1994). Along with ear, nose and throat and dermatology clinics

**Table 1 Diagnoses of new and follow-up patients at psychiatric clinics**

Diagnosis	New: n = 456 (Johnson, 1973)	New: n = 106 (Morgan, 1989)	New: n = 57 (Killaspy <i>et al</i> , 2000)	Follow-up: n = 167 (Killaspy <i>et al</i> , 2000)
	%	%	%	%
Depression	34	47	53	26
Neurosis	11		21	10
Personality disorder	30	19	5	7
Functional psychosis, bipolar affective disorder	4	17	9	56
Other, including substance misuse	8	13	7	2
Organic disorder	5	0	0	0
No psychiatric problem	8	3	5	0

(McGlade *et al*, 1988), psychiatry has very high non-attendance rates and individuals with a diagnosis of substance misuse or personality disorder are least likely to attend (Baekland & Lundwall, 1975; Smyth *et al*, 1990).

Studies that have investigated the reasons patients give for non-attendance have found differences between psychiatric and non-psychiatric clinics. Patients who miss appointments at non-psychiatric clinics are more likely to report that they were unwell with symptoms unrelated to the condition for which they were due to attend or that they were away on holiday (Table 2). In contrast, both new and follow-up psychiatric patients' reasons suggest that active symptoms of the illness are a major contributor to non-attendance (e.g. 'too paranoid that day' or 'too depressed to get out of bed'). Reasons given by patients who miss follow-up appointments at psychiatric clinics also appear to be a function of the psychiatric illness itself. For example, lack of insight (e.g. 'no need to attend as not unwell'), apathy ('couldn't be bothered') and reduced organisational skills (e.g. 'forgot' or 'lost appointment card') (Table 3). For those newly referred to a psychiatric clinic, previous out-patient treatment increases the chance of attending (Carpenter *et al*, 1981), but previous psychiatric admission reduces it (Smyth *et al*, 1990). This could be because admission is a negative experience that alienates patients from services or, perhaps a more likely explanation, because those who have required an admission are more unwell and less likely to manage attendance at the out-patient clinic for reasons directly related to their illness, as outlined above. This explanation is supported by the finding that, although some patients cite unhappiness with treatment as their reason for non-attendance, a large study of follow-up psychiatric patients failed to show any difference in satisfaction with treatment or out-patient services between attenders and non-attenders (Killaspy *et al*, 1998).

## Clinical implications of non-attendance

Prospective studies of follow-up patients at psychiatric clinics have demonstrated that non-attenders are more severely unwell, more socially impaired and have a greater chance of admission within 12 months of the missed appointment than attenders (Pang *et al*, 1996; Killaspy *et al*, 2000). Rates of readmission for patients discharged from the in-patient unit who miss their follow-up appointments have been shown to be three times higher than for those who attend (Koch & Gillis, 1991; Nelson *et al*, 2000). One interpretation of these findings is that attendance at the clinic maintains stability of mental health. Alternatively, psychiatrists are perhaps only seeing those who are well enough to attend.

In contrast, some groups of patients may become particularly difficult to discharge from the clinic. For example, Pomeroy & Ricketts (1985) found an overrepresentation of people with a diagnosis of personality disorder among long-term out-patient attenders. This may, of course, have been because the individuals found this form of regular contact helpful and containing. However, in recent years, specialist interventions such as dialectic behavioural therapy (Linehan *et al*, 1991) and partial hospitalisation (Bateman & Fonagy, 1999) for people with cluster B personality disorders have been shown to be effective and may promote a more encouraging longer-term prognosis for this client group than years of out-patient review.

## Encouraging attendance

The evidence in support of prompts aimed at encouraging attendance at first appointments have been summarised in a Cochrane review (Reda & Makhoul, 2001). The authors concluded that written

**Table 2** Reasons that patients give for missing appointments at non-psychiatric and psychiatric clinics

Reason for missing appointment	Non-psychiatric clinics			Psychiatric clinics		
	Dermatology, UK: n = 100 (Verbov, 1992) %	Ophthalmology, UK: n = 224 (Potamitis et al, 1994) %	General medical, UK: n = 162 (Frankel et al, 1989) %	New + follow-up patients, USA: n = 101 (Sparr et al, 1993) %	Follow-up patients, Hong Kong: n = 56 (Pang et al, 1996) %	New patients, USA: n = 103 (Carpenter et al, 1981) %
Physical illness unrelated to presenting complaint	28	22	9	6		
Feeling better	6	8	12		40	28
Away on holiday	5		28			
Forgot	9	18		25		
Unable to take time off work	10	3	12			
Time to appointment too long						12
Appointment not received	6	15				
Appointment altered by clinic			9	5		
Appointment cancelled by clinic		8				
Lost appointment card	3					
Mistook appointment time or date	5			9		
Other commitment	10	4		6	5	6
Family reason	8	1		1		
Transport problem	2	7		4		2
Could not remember reason	4			22	20	
Overslept				7		
Too worried about appointment		3				3
Received treatment in another clinic					10	25
Admitted to in-patient unit				1		14
Went to casualty						2
Stigma of psychiatric treatment					5	
Moved away					7	
Unhappy with treatment					13	

prompts (such as 'orientation statements', which give an introduction to the clinic and what to expect at the appointment) received 1 or 2 days before the appointment are effective at encouraging new patient

attendance but that telephone prompting is not. This is mainly because those with higher social function are more likely to have a telephone and more likely to attend anyway (Burgoyne *et al*, 1983).

**Table 3 Reasons given for missing appointments (from Killaspy *et al*, 2000)**

Reason for missing appointment	New patient non-attenders (n=29) n (%)	Follow-up non-attenders (n=74) n (%)
Active symptoms of psychiatric illness	4 (14)	10 (14)
Clerical error	4 (14)	8 (11)
Forgot	3 (11)	20 (27)
Felt better	1 (3)	1 (1)
Afraid of admission	3 (11)	0 (0)
Unhappy with referral	5 (17)	0 (0)
Physical illness	1 (3)	1 (1)
Lost appointment card	1 (3)	3 (4)
Other commitment	3 (11)	6 (8)
Travel problem	0 (0)	3 (4)
Unhappy with treatment	1 (3)	6 (8)
No need to attend as no problem	0 (0)	5 (7)
Poor weather	1 (3)	0 (0)
Couldn't be bothered	1 (3)	5 (7)
Overslept	1 (3)	6 (8)

A meta-analysis of approaches to increase treatment adherence (defined as appointment attendance and taking medication as prescribed) of people with schizophrenia and other severe mental disorders supported two interventions: pre-discharge contact between in-patient services and the community team; and psychoeducation about medication and other treatments (Nosé *et al*, 2003). The first of these approaches could be considered an essential component of good discharge planning within the framework of the care programme approach (CPA; Department of Health, 1990, 1999b). In addition, Standard four of the National Service Framework for Mental Health (Department of Health, 1999a) states that patients discharged from hospital should be reviewed in the community within 7 days. Contact from the community team prior to this initial review would seem highly appropriate (e.g. during the admission and/or at a discharge CPA meeting in the in-patient setting). Various forms of psychoeducation for patients and

their families are recommended in the National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of schizophrenia (National Institute for Clinical Excellence, 2002) and again could be considered essential components of good care planning for people with serious mental illness.

## Out-patient commitment

A statutory system of out-patient commitment is in operation in the USA that involves a

'court-ordered compulsory treatment plan for people with serious mental illnesses who have the capacity to live in the community with available supports, a history that indicates a need for treatment to prevent deterioration in mental state that would predictably result in dangerousness and a mental state that limits or negates their ability to comply with treatment voluntarily' (Kisely *et al*, 2005).

The statute is applicable only to patients being discharged from an in-patient unit and specifically prohibits forced medication in the community but allows for enforced attendance at a mental health facility. At present there is no evidence of any benefit for out-patient commitment over standard care in terms of readmission, taking medication as prescribed, arrests or homelessness. In fact it has been estimated that it would take 238 out-patient commitments to prevent one arrest, 27 to prevent one episode of homelessness and 85 to prevent one readmission (Kisely *et al*, 2005). There is currently no equivalent to out-patient commitment in England but the proposed amendments to the Mental Health Act (1983) may include community treatment orders with similar powers.

## Alternatives to the out-patient clinic

If, on the basis of the evidence presented so far, one accepts that the out-patient clinic may not be the best model within which to review the community treatment and care of people with longer-term mental health problems, the next step is an exploration of feasible alternatives.

Over recent decades there has been increasing interest in the establishment of psychiatric liaison services. Strathdee & Williams (1984) showed that 19% of general adult psychiatrists in England and Wales and 50% of those in Scotland had established primary care liaison clinics since the late 1970s. These services vary from the 'shifted out-patient model', where the psychiatrist sees patients in the GP's surgery for assessment and

short-term management, to longer-term liaison with the primary care team. This approach appears to be more acceptable to some patients than the psychiatric out-patient clinic (Tyrer, 1984) and encourages joint management of people with serious mental illnesses by the GP and psychiatrist (Darling & Tyrer, 1990). This is clearly advantageous, since the quality of communication between primary and secondary care has been shown to be particularly poor for individuals with severe and enduring mental health problems who fail to attend their out-patient appointments (Killaspy *et al*, 1999). The GP's active involvement is also especially relevant for the physical health monitoring of this group, treatment of associated conditions such as diabetes and weight gain, and health promotion such as smoking cessation initiatives. Moreover, cardiovascular risk screening in primary care has been shown to be acceptable to people with serious mental illnesses (Osborn *et al*, 2003).

### Home visits

An obvious alternative to waiting in a clinic for a patient who may not attend is to visit them at their home. Home visits provide useful information about the individual's day-to-day living skills and potential risks secondary to impairments of social function that are not available from an interview in the out-patient clinic. They also provide the opportunity to meet family and carers informally. However, many psychiatrists argue that home visits are inefficient since far more patients can be seen in a clinic in the time it takes to make a single home visit. This clearly holds true only for those who attend their appointments.

Since patients newly referred to the clinic differ from those being seen for follow-up appointments in terms of severity of symptoms and risk of subsequent admission, some judgement has to be made about who requires a home visit. The evidence from prospective studies suggests that a single non-attendance predicts drop out from the clinic (Pang *et al*, 1996; Killaspy *et al*, 2000) and therefore automatically rescheduling a further appointment is pointless and wasteful of resources (Box 1). For people with severe and enduring mental health problems, the first missed appointment (often called the time of first attrition) is an important point at which to intervene to try to reduce the chance of relapse, and a home visit may well be the most appropriate course of action (Box 2).

Another argument pitched against home visiting is that the patient might not be in or might refuse to open the door. In a large prospective study of non-attenders at psychiatric out-patient clinics (Killaspy *et al*, 2000) we found that two-thirds of follow-up

#### Box 1 How to respond to a missed appointment

- If the patient is a new referral and appears from the information available to have a common mental disorder but no history or current evidence of risk, refer back to the GP, copying the letter to the patient
- If the patient has a severe and enduring mental health problem, arrange a home visit with the CMHT
- If there is a history of risk to self or others, action will depend on that history and corroborative information of the current situation, but may include an urgent home visit and/or Mental Health Act assessment
- Do not reschedule a missed appointment unless the patient asks you to

non-attenders agreed to be seen at home. Thus, home visiting had the potential to reduce an overall non-attendance rate in this study from 33% to 22% (or if we take more recent national averages, from 18% to 12%). In addition, a number of participants in this study could not be located. Letters sent to them were returned by the post office as 'unknown at this address' or a visit to the address revealed that the property was obviously uninhabited or boarded up. This was the case for 20% of new patients and 12% of follow-up patients who missed their appointments. In such cases it can be seen that an attempted home visit adds a different kind of useful information for the clinician and GP and prevents further futile written correspondence. Untraceable patients may be more common among transient inner-city populations and, although their mental health needs cannot be met by an out-patient appointment or a home visit, at least their identification prevents further out-patient resources being wastefully directed at them.

### The care programme approach

The CPA (Department of Health, 1999b) provides a framework for coherent care planning for people with severe and enduring mental health problems and, when implemented well, is able to deliver a much more appropriate model for their community care than can the out-patient clinic. Community mental health teams operate within the CPA, and care coordinators use a flexible combination of home visits and appointments at the team base to review their clients. Care coordinators can support and encourage clients to attend CPA meetings at

**Box 2 How to minimise non-attendance**

- Develop primary care liaison services to advise on and triage referrals to secondary mental health services
- Develop a single point of entry for all referrals to secondary mental health services, so that all assessments carried out by CMHT staff
- Send newly referred patients an orientation statement with their first appointment
- Be flexible about the location of the assessment, e.g. the patient's home, CMHT base or GP surgery
- Develop brief intervention protocols to treat patients with time-limited common mental disorders
- Refer the patient back to primary care after treatment has been safely initiated and/or brief therapies have been completed
- The care of patients with more enduring and complex needs should be managed in secondary mental health services by CMHTs through the usual CPA process
- Do not automatically reschedule a missed appointment
- If a patient with severe and enduring mental health problems or a history of risk misses an appointment intervene immediately by arranging a home visit

which their care is reviewed with their psychiatrist and can arrange for these meetings to be held in a location most acceptable to the clients (e.g. at home, at the CMHT base or in the GP surgery). The extra support provided by care coordination and the inclusion of the client's support network in CPA meetings has advantages over out-patient review as it provides corroborative information from different perspectives about the individual's progress. A survey of all mental health trusts in England showed that CPA meetings were better attended than out-patient appointments by this client group (Schneider *et al*, 1999).

In support of this, Catty *et al*'s (2002) systematic review of randomised controlled trials of home-based treatment found that two service components were associated with greater efficacy of home treatment teams when compared with other community services, including out-patient clinics: integration of health and social care responsibilities, and regular home visiting, both of which are consistent components of modern multidisciplinary CMHTs in the UK.

**Do we need out-patient services at all?**

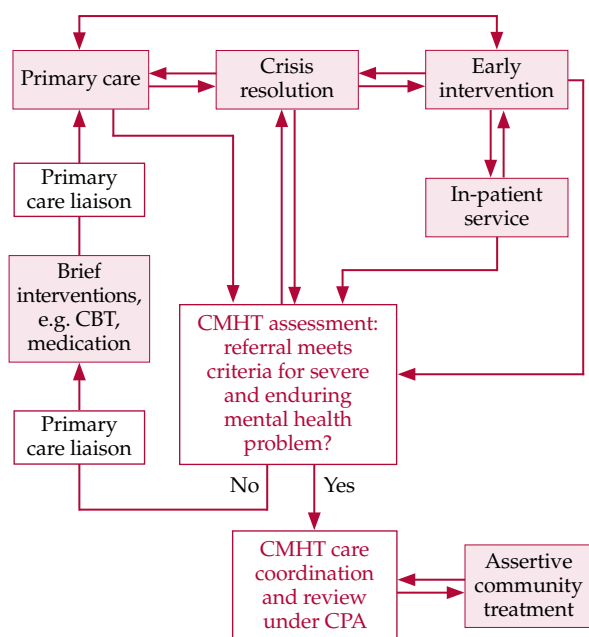
For newly referred individuals who do not meet criteria for care coordination by the CMHT and are not in crisis, the out-patient clinic may provide an appropriate setting for assessment, referral to more appropriate agencies, initial monitoring of response to any medication prescribed and/or brief psychological interventions. Although data in Table 1 suggest that an increasing proportion of newly referred out-patients have common mental disorders, no recent studies have been published that could confirm whether psychiatric out-patient services in the UK are becoming more consultative. Older studies demonstrated a great reluctance on the part of psychiatrists to refer patients back to the GP within 3 months of assessment, irrespective of the severity of their condition (Kaesar & Cooper, 1971; Johnson, 1973). Further exploration of the reasons for this reluctance to consult and discharge is needed since (a) this is in contrast to the consultative role provided by secondary out-patient services in other specialties, (b) it is wasteful of scarce consultant psychiatrist resources, (c) it is clinically illogical for the most qualified member of the multidisciplinary team to treat and review patients whose needs are not complex enough to require management under the CPA, and (d) it is outwith recent guidelines on new roles for consultant psychiatrists (British Medical Association, 2004).

**The central role of the CMHT**

A single point of entry into secondary mental health services may help to discourage parallel systems within community mental health services by routing all assessments through the CMHT. Medical assessment and primary care liaison would be part of this, following which a team decision is made about whether the individual requires ongoing care from the CMHT under the CPA (Fig. 1). Such a system can incorporate in-patient and out-patient referrals and allows some flexibility in the exact nature of primary care liaison and medical input to assessments.

This model, which is described in detail in the policy implementation guide for CMHTs (Department of Health, 2002), helps services to deliver on important aspects of the National Service Framework for Mental Health. For example, Standard two of the latter states that:

'Any service user who contacts their primary health-care team with a common mental health problem should ... be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it' (Department of Health, 1999a: p. 28).



**Fig. 1** The community mental health team (CMHT) as the single point of entry to secondary community mental health services. CBT, cognitive-behavioural therapy; CPA, care programme approach.

The policy implementation guide for CMHTs outlines the need for primary care liaison that includes increased training of the primary care health team to recognise and treat common mental disorders and their increased liaison with secondary mental health services through 'link workers'. The role of the CMHT is clearly detailed as including: advice to primary care health teams; triage of referrals; assessment of referrals; treatment and care for people with time-limited conditions who can benefit from specialist care (such as those with common mental disorders); and longer-term treatment and care of those with more complex and enduring needs (certainly people with psychoses, bipolar affective disorder and severe personality disorder, and possibly also those with common mental disorders whose conditions are not time-limited and who have complex needs). This document suggests that doctors should be involved in the assessment of people with severe mental illness in the majority of cases but that other members of the CMHT should be able to adequately assess those with common mental health problems.

### *The psychiatrists' viewpoint*

The report on the consultation meetings with 600 consultant psychiatrists about proposed new roles stated:

'There was almost universal dissatisfaction with out-patient clinics. The doctor is isolated from the team and patients frequently do not attend. Patients may present very differently in the artificial environment, leading to differences with staff who see the patient at home. Patients are brought back routinely so as not to lose touch with them rather than out of necessity' (National Working Group on New Roles for Psychiatrists, 2004: p. 12).

If this is representative of the majority of psychiatrists' views on the out-patient model, then the fact that most mental health trusts in England are still operating out-patient clinics is somewhat surprising. The fact that some psychiatrists are still duplicating the work of other CMHT members through the use of out-patient reviews is even more concerning. This may reflect a simple time lag in the implementation of Department of Health guidelines on the CMHT model, or impediments to this way of working on the part of services in both primary and secondary care. These impediments might include a lack of interest on the part of GPs to become more informed about mental health problems, a resistance to change on the part of psychiatrists reluctant to let go of the familiar out-patient model, lack of confidence in the assessment skills of CMHT staff, a reluctance to give up the only part of the work of a consultant psychiatrist that involves rewarding one-to-one contact with patients, or a lack of confidence in GPs' skills to provide ongoing treatment and care for patients.

### **Coordination and continuity of community mental healthcare**

A sea change is therefore required to modernise out-patient services and bring them into line with an integrated and comprehensive approach to community mental health service provision. This might involve a 'spring clean' of the out-patient clinic to prevent unnecessary and wasteful duplication of patient reviews and ultimately a gradual devolution of the clinic altogether. This would involve a review of all out-patients to decide whether their needs would be better met and led by the care coordination offered by the CMHT, with episodic consultant review at CPA review meetings. For patients who do not meet criteria for CMHT care, a judgement has to be made as to whether their illness could be adequately managed in a primary care setting. Obviously, the development of primary care liaison services would make this option easier.

A sudden discharge of all out-patients to CMHTs and primary care would clearly be inappropriate. Indeed, for patients with histories of self-harm who have required admission, reduction in the amount of



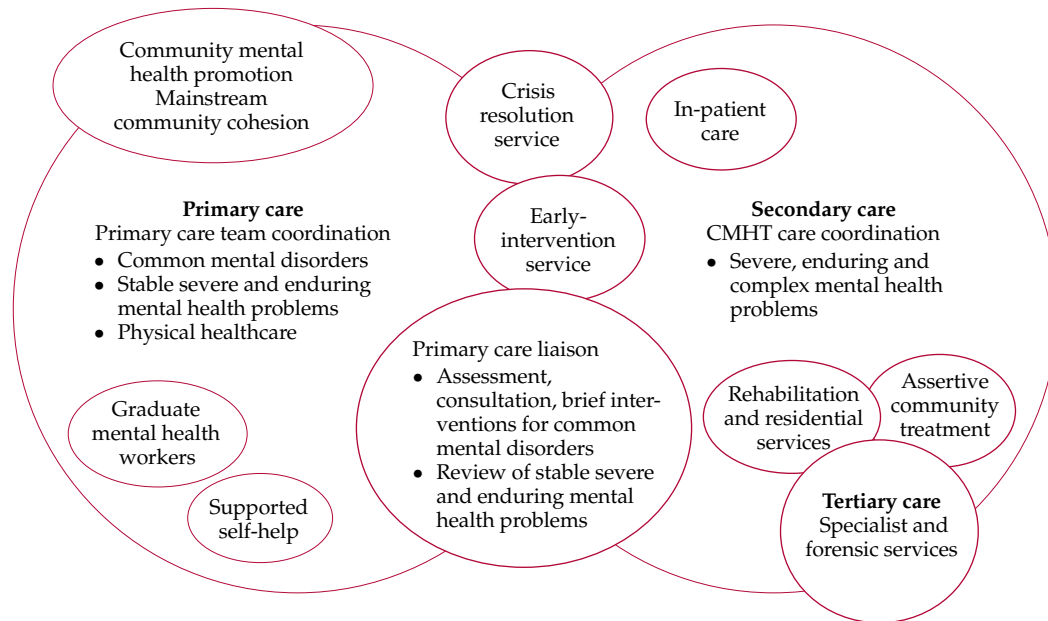


Fig. 2 Community coordination model of mental healthcare.

care offered in the community has been shown to be associated with a greater risk of suicide (Appleby *et al*, 1999). Therefore any reorganisation of out-patient services needs to be undertaken within the context of a well-coordinated strategy supported by service managers and commissioners who can facilitate meaningful links between primary and secondary care services.

### Community coordination

With this in mind, the government's recent encouragement of increased community coordination of all healthcare (Department of Health, 2006) could be used to promote shared coordination and delivery of mental healthcare between primary and secondary services. Secondary community mental health services are already well-developed. Mental health skills within primary care teams will benefit from the introduction of graduate mental health workers, supported self-help programmes, and primary care liaison teams offering specialist advice, assessment and short-term medical and psychological treatments for common mental disorders and review of people with stable longer-term problems managed in primary care (Department of Health, 1999a, 2006). For people with more complex and enduring mental health problems, the CMHT provides longer-term care coordination and referral to other specialist mental health services. Figure 2 shows this as a proposed 'community coordination model' that incorporates the possible demarcation and overlap of

primary and secondary mental health services, with specialist teams such as crisis resolution, primary care liaison and early intervention providing a clear bridge between the two.

### Continuity of care

There is an emphasis throughout the National Service Framework on the importance of continuity of care, a theme supported by the findings of a recent robust Canadian study which showed that greater continuity of care for people with severe mental illness was associated with better community functioning, lower symptom severity and greater service satisfaction (Adair *et al*, 2005).

The model suggested in Fig. 2 promotes continuity throughout the care pathway of referral, assessment and treatment for anyone with a mental health problem, irrespective of severity. Given the limited numbers of psychiatrists currently available in the UK and the difficulties in recruiting into the specialty, this model appears both feasible and necessary.

### A new direction for CMHTs?

There is now good evidence that specialist intensive forms of community treatment for those with severe and enduring mental health problems offer no clinical advantage over care by CMHTs but are more acceptable to 'difficult to engage' clients (Thornicroft *et al*, 1998; UK700 Group, 1999; Killaspy *et al*, 2006). This appears to be associated with specific

components of the assertive community treatment (ACT) model such as the team approach and low case-loads. It is therefore conceivable that, over time, the CMHT could become split into two major areas of expertise: (a) assessment, short-term treatment of common mental disorders and primary care liaison and (b) specialist ACT-style services for people with severe and enduring mental health problems. A complete split into these two areas of expertise would have obvious disadvantages in terms of boundary disputes and overspecialisation of staff, so a model that incorporates rotational placements within different service models might be attractive in terms of staff recruitment and training.

## Conclusions

I have attempted here to outline the origins of the psychiatric out-patient model, to question its relevance to modern community mental health service provision and to suggest a feasible alternative. Accepting that there will always be individual patients who are exceptions to any strategic reform of services, the proposed community coordination model for primary and secondary mental healthcare is capable of providing appropriate assessment and treatment for those who require both short- and longer-term management of their mental health problems. Its implementation would, over time, invalidate the need for a separate consultant-led out-patient service.

## Declaration of interest

None.

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## MCQs

- The psychiatric out-patient model originated from:**
  - a need to triage people before admission to asylums
  - a duplication of other specialties' approaches
  - the recognition that continuity of care could prevent relapse
  - a government initiative.
- Factors associated with missing out-patient appointments include:**
  - female gender
  - family responsibilities
  - lower socio-economic class
  - lower age .
- Factors associated with missing psychiatric out-patient appointments include:**
  - greater severity of psychiatric illness
  - greater social disorganisation
  - dissatisfaction with the out-patient service
  - lack of a telephone.
- Evidence-based alternatives to out-patient clinics include:**
  - home visiting
  - primary care liaison services
  - out-patient commitment
  - CPA review.
- The best response to a missed first appointment by a patient with no history of risk to self or others is:**
  - to send another appointment
  - to telephone the patient
  - a home visit with the CMHT
  - to ask the GP to visit.

### MCQ answers

1	2	3	4	5
a T	a F	a T	a T	a F
b T	b F	b T	b T	b F
c T	c T	c F	c F	c F
d T	d T	d F	d T	d F