Psychiatric Bulletin (1989), 13, 605–606

All patients great and small

Psychiatric liaison with general practitioners in the Yorkshire Dales

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Having trained in London and Manchester, I found psychiatry in the Yorkshire Dales a little different. Most senior registrar training is done within cities. Most consultant posts are old posts. Moving into a newly created consultant post with hardly any psychiatric service, miles from any city, was a new challenge with clear benefits professionally and personally. James Heriot, our famous local vet, gives the impression of being self-sufficient and isolated when providing his services. Though the countryside is the same, surely the opposite must be true for developing a mental health service.

Northallerton Health Authority covers part of the area between York and Darlington and the whole of Wensleydale and Swaledale. On taking up the post it was accepted that I would work only within one sector of the Health Authority prior to consultant appointments in the rest of the district. This sector is Wensleydale and some of the Vale of York and includes the market towns of Thirsk, Bedale, Masham, Leyburn and Hawes and all the surrounding villages, i.e. some 50 miles long and 20 miles wide. The population is approximately 32,000 and it was my responsibility to provide consultant services for all adults within this sector excluding the mentally handicapped.

Prior to my appointment as consultant for this sector, services were provided from two neighbouring districts using three consultants. Beds were provided in two different hospitals in York and there was one clinic held weekly in Thirsk. There were two community psychiatric nurses working within the sector, most of their referrals coming from the general practitioners (GPs), and some psychology and occupational therapy input to the sector as well as a Day Unit which was provided by the Health Service but which had no medical input. As a result of these arrangements the most severely mentally ill patients were treated outside the district although an acceptable service for patients with minor neuroses and life crises was being provided within the district. The level of general practice within the sector was generally high and the GPs had, for many years, treated much of their psychiatric population with little help locally. Although there were not many referrals from this sector to the psychiatric service prior to my arrival there was nothing to suggest that there was a lower incidence of mental illness within this scattered rural community.

The task was to develop a service within about three years which would be independent of other districts and include a new District General Hospital Psychiatric Wing at Northallerton. In-patient beds would continue to be provided in York until that time. As well as developing a day hospital service and community mental health teams it was vital that a good consultant out-patient service should develop and that all these developments should be done with sensitivity to the GPs. Indeed the key was the GPs. Almost everyone had them and they were involved with their patients and knew them well. They had spent years dealing with their problems and those of their families and, although welcoming a local consultant, were wary that he would take all the psychiatric problems away from them. It became apparent that the local population did not acknowledge the existence of mental illness. They tended to be excessively tolerant of deviant behaviour and protective within families so that there were long delays before people received treatment. When they did, much of the treatment was done in the hospital outside the district. The GPs had become part of this local sub-culture and naturally partially colluded with it so that referrals were often made late and only when patients became so behaviourally disturbed as to create a social nuisance.

It was therefore decided that all referrals to the mental health services should be through the GPs. This was to reinforce their role, to use their expert knowledge of the families and so as to avoid offending them. By doing this we clearly stated that the mental health services were a secondary health care service. In addition we encouraged all staff to have close relations, not only with the GPs but with the whole of the primary health care team.

In-patient beds remained in York (34 miles from Northallerton) and were my responsibility. My office was in Northallerton and there seemed no reason why an out-patient clinic should be provided there as it was outside the sector. I decided to run clinics only in health centres and GP surgeries. One weekly clinic already existed in Thirsk and having worked out

the population covered by this clinic, extrapolation determined where and how often other clinics were needed during the week. Eventually I started clinics in Hawes, Leyburn and Bedale as well as Thirsk. These are all run on a shifted out-patient model but at each I see the GPs and discuss their patients. The prospect of doing these clinics was welcomed with open arms by most GPs but in one corner of the district they strongly discouraged me. This made me feel that the need there was even greater and eventually the GPs agreed to a three monthly clinic in which I would see patients once, give an opinion but then the GPs would continue with the treatment. I, as a consultant, would just be consulted. This service has now developed into a treatment service and referrals have increased, not only in the clinic but also as emergencies. At another clinic the GPs have declined the offer of formal regular meetings but we do often meet to discuss the patients. The style of all these clinics has been determined largely by the needs of the local GPs with some purely wanting an opinion, others wanting treatment to be provided and a few wanting all the psychiatric care to be taken over. It has proved much easier to fulfil the wishes of the GPs as clarification of the reason for the referral has been possible through our regular clinics. In addition the GPs can receive advice over treatments of patients who are not referred onto the psychiatrist. This also improves the GPs' psychiatric knowledge. It has become clear that GPs whom I meet less often and who are irregular attenders at our meetings are those with the least psychiatric skills.

However many clinics are held there remain large distances for some patients to travel and therefore home visiting has become a major part of the out-patient service. Much of this is done in nursing homes and homes for the elderly. The staff of these homes need to be frequently told of the different roles of the GP and the specialist in the case of their residents.

The GPs could have felt threatened by the development of a new community mental health service impinging on their territory. This has been avoided by restating their role as primary health care doctors and then by close personal contact improving communications over patients, educating them in psychiatry and subsequently encouraging appropriate referrals. As a result of this approach more severely mentally ill people who had not been treated for years are benefiting from appropriate treatment.

There are many problems to providing a community service in a rural area in this way, such as enormous travelling times, being unavailable to deal with emergencies in the hospital and day hospital quickly due to distances, the consultant doing all the administrative work in the clinics and carrying all the notes around. In addition, some people find it unacceptable to sit in the local psychiatric clinic waiting room and prefer to be seen away from their own community. The advantages outweigh these; less distance for patients to travel, better liaison between specialist and GP, increased job satisfaction, less stigmatisation for patients and good training experience for junior doctors. In the end the patients are benefiting by a closer working relationship between the consultant and GP.

Attempts are presently underway to evaluate our changing service but since the White Paper one of the most important tests will be whether the local GPs decide to contract our service. I believe by basing our service so firmly on the importance of the GP we have increased our chances of this enormously.

Psychiatric Bulletin (1989), **13**, 606–608

Liaison psychiatry in Scotland: the present service

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The term 'liaison psychiatry' is becoming increasingly popular. Indeed, the Royal College of Psychiatrists has set up a special interest group, the Liaison Psychiatry Group, which has a growing membership. There appear to be developments in training and in service provision but it is difficult to assess their clinical impact. Ongoing research is required to quantify the actual level of service provided to general hospitals.

This paper outlines the results of a survey of the psychiatric service to general hospitals in Scotland in 1987/88. A questionnaire (available on request from the author) was constructed and sent to every general psychiatric hospital in Scotland.