

A PSYCHIATRIC SERVICE

AT A COMMUNITY HOSPITAL

DISSERTATION

FOR PART 3 OF THE MASTER OF MEDICINE DEGREE

BY

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OBJECTIVE

The purpose of this dissertation is to evaluate an attempt to use the facilities of a general hospital with minimal psychiatric cover, to deal with acute psychiatric conditions. This is in keeping with current psychiatric opinion in South Africa as expressed by Dr. C.W. Allwood and Dr G.A.D. Hart (11). This dissertation will examine the needs, structure, difficulties and results of the provision of a service dealing with acute psychiatric disorders in a peripheral General Hospital and make suggestions should similar satellite facilities be established at other peripheral hospitals.

Although in principle, the concept of part-time specialist cover at a peripheral general hospital is not new in medical, surgical and gynaecological departments, the previous involvement of private psychiatrists within the teaching department has been in the form of out-patient department sessions only at academic and state psychiatric hospitals as is practiced in Cape Town. This project however allowed for the evaluation of emergency cases with subsequent referral to appropriate treatment centres if needed from a peripheral hospital. A consultation-liason service within the general wards and the opportunity to conduct seminars, lectures and in-house training for all level of professional staff were also encompassed.

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VICTORIA HOSPITAL

Victoria Hospital was built 100 years ago, to meet the health needs of the local population of the southern peninsular suburbs. Over the years the facilities have grown and some departments have been incorporated into the teaching program of G.S.H. However, until the provision of this service, all psychiatric patients were referred to the emergency psychiatric service of Groote Schuur Hospital.

This was often a clumsy and trouble laden process involving ambulance or taxi transport. The patient often being seen only many hours after the initial examination at Victoria Hospital. Collecting collateral information and executing family and marital therapy was often impossible as the accompanying family member or spouse was usually unavailable by the time the patient was finally assessed. All of this placed a considerable burden on the infrastructure of the hospital service, the patient and their relatives.

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More extensive or urgent immediate interventions: such as certification, direct referral to a mental hospital or rapid sedation\neuroleptisation were also difficult to organise. This leads to considerable anxiety and distress amongst the staff at Victoria Hospital and I have experienced this at other hospitals (such as Eben Donques Hospital in Worcester) where I have also worked.

Victoria Hospital caters for all sections of the population, but predominantly the lower socio-economic group. Patients covered by medical aid or private funds are seen by private practitioners. By far the greatest proportion are so-called Coloured, but White, Asian and Black are also seen in the proportion 15: 10 : 1 : 2.. For the vast majority of these, the saving in transport costs, time and the ease of access to the service has lead to increased co-operation, compliance and attendance at follow-up clinics. The average appointment that is not kept is less than 20% at any clinic.

Initially, most of the patients were first-time psychiatric consultations, but as the facility became known more patients who had been previously seen, attended the clinic for follow-up as well as for new problems.

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FACILITIES NEEDED

Initially, I attended to patients in the overnight casualty ward where they would accumulate and be seen the following morning. Names were recorded in a referral book and the location of the patient noted. This allowed for referral from general wards.

As the service grew, the need for an office and formal booking of patients became apparent. This was designed to be accessible to all hospital staff, the object being to encourage them to discuss problem cases as well as any inter-staff or personal difficulties. There was some initial reluctance but even in this delicate area there has been an increase in referrals and currently 20 staff consultations are had each month.

The need for confidential recording of all information was stressed at the outset. A lockable filing cabinet and special folder were obtained and all appropriate confidential material recorded and kept there. An ink stamp "SEEN BY PSYCHIATRIST - NOTES IN CONFIDENTIAL FOLDER" was placed on the patients' folders. Keys for the cabinet are kept by the senior sister in Casualty and by myself.

Out-patients were seen in the Out Patients Department, a clinic room was set aside for this purpose once a week.

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STAFF

Psychiatrist.

Consultations were brief and were mostly in the nature of evaluation and screening rather than intensive therapy. In "Reflections on Psychiatry in the General Hospital setting", Sanders (4), notes that, "for psychiatry to be successfully integrated into the general hospital, the psychiatrist must function within the medical model, and his mode of practice must be consistent with general-hospital caretaking". A good knowledge of organic disorders is therefore also important. Further, it is also important that the psychiatrist has an extensive knowledge of referral facilities in the area, and having trained in Cape Town, I found this knowledge invaluable. Direct referral to the correct agent has established credibility with these units and helped in making referral a smooth and efficient procedure.

Medical Officers

Most of the referrals came from the medical officers in the casualty department, the majority of whom are newly graduated and their up-to-date knowledge of psychiatric disorders resulted mostly in appropriate referrals. Also they were usually happy to accept the patient back for follow-up treatment. This also applies to the interns who have rotated through the unit.

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Both the full-time and part-time medical specialists of the hospital were initially reluctant to make use of the service, but there has been a steady increase in consultations in the hospital wards, both medical, surgical and paediatric.

Nursing Staff.

There was some resistance from the nursing staff while they acclimatised to the new service. Possibly, they feared extra work as a result of the new clinics but this soon changed when the benefits of the service were perceived. An important part of the assessment of any patient has included the written observations and responses of the nursing staff contributed to clinical decisions which left them feeling a part of the unit.

A most important aspect has included the management of the aggressive and difficult patient. In-patient training of casualty officers and nursing staff as well as the porters has helped to ensure the safety of staff, patients and equipment.

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Consultation.

This was possibly the most important aspect of the service provided. As quantity time was unavailable, the quality of the interview is of the utmost essence. Both the patient, referring doctor and the interviewer should feel that essential issues have been addressed and that appropriate interventions have been made.

Although I have been trained in a detailed clinical style of history taking, I had to modify this considerably to manage the workload, concentrating on the presenting problem, the duration of the problem and any precipitating factors. It is important to ascertain whether there has been any past psychiatric contact as this can indicate appropriate re-referral to an agency that has already dealt with the patient.

This approach has been successful and few patients have been refused or re-routed. It must, however be clearly explained to the medical and nursing staff that the ability to assess patients in 20 to 30 minutes is a skill that comes with considerable experience and should not be attempted by inexperienced staff.

The ability to refer efficiently depends on the co-operation of the referral agencies. Regular communication however has ensured the smooth flow of patients from Victoria Hospital to other units.

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Treatment.

As in all of psychiatry, the first contact with the patient can be a significant therapeutic intervention in itself. This was facilitated in this unit by maintaining punctuality, friendliness, respect for the patient and an empathic attitude.

The backbone of therapy was the use of psychotropic medications rather than psychotherapy or environmental manipulation. Brief supportive psychotherapy in appropriate cases, and the use of the Social Work Services at the hospital at times was also valuable.

Once a diagnosis has been made, the appropriate referral or treatment is implemented. Further in-patient treatment or referral to a specialised unit is arranged by the nursing staff after telephonic or written referral has been done by myself. Either ambulance, hospital or private transport is arranged.

Co-operation between the pharmacies of Victoria and Groote Schuur Hospitals is important since medication not normally stocked, but on code, need sometimes to be made available. Usually however depot preparations and standard anti-depressants, major tranquillisers and benzodiazepines have proved adequate.

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Results and Discussion.

The combination of facilities, staff and patients, as described above has resulted in the provision of a service which has supplemented the existing service at G.S.H. and V.H. Psychiatric patients are now efficiently evaluated and given emergency treatment before being referred on. The following Table gives an indication of the different disorders seen on average during a month.

Without a Psychiatric service at Victoria Hospital, it is likely that all the suicide attempts, psychotic patients and the children referred to us would have been sent to psychiatry casualty at GSH, as a matter of urgency. A good proportion of the depressed, anxious and other patients would have been referred to casualty or psychiatric OPD at GSH. This could account for nearly 100 patients per month.

Figures from K4, GSH, from 1986 to 1989, show a decrease of 1000 patients a year during the time of establishing the unit, which could be explained by the fact that they were seen at Victoria Hospital. Other factors, such as an increase in psychiatrists and psychologists in private practice could influence these figures at Ward K4, but as most of the patients are not private patients this is unlikely to be a significant factor.

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Table 1

	WHITE	NON-WHITE	TOTAL
NEW PATIENTS	32	58	90
REPEATS	91	67	158
STAFF SESSIONS	11	8	19
STAFF	7	5	
SUICIDE ATTEMPTS			
OVER AGE 20 - 11		16	27
UNDER AGE 20 - 2		6	8
DEPRESSION	36	40	76
ANXIETY	22	30	52
PSYCHOSES	1	4	5
CHILDREN	1	4	5
EPILEPSY	5	8	13
ALCOHOL	4	5	9
P/D	8	10	18
OTHER	28	28	56
	118	151	269

During the first 14 months, 120 consultations per month were made. The vast majority were patients seen in casualty or the overnight ward where they had been kept for assessment. At that time, there were proportionately less referrals from the wards but this rate increased.

One of the effects of this service has been that an increasing number of general practitioners and specialists in the area served by the hospital have referred patients for assessment and management. Although this has increased the load, it has shown that there is a need for this service beyond the confines of the hospital itself. Such patients are often assessed in the out-patient clinic where they have been given a booking or seen as emergencies after being screened by the casualty officer.

Discussion

The provision of such a service has both benefits and disadvantages. The benefits include the opportunity to introduce a system without a preconceived structure. This service was "tailor made" to suite the part-time consultant primarily, and secondarily the needs of the hospital and patients. It would, however, be impossible to implement such a service without the back-up of a teaching hospital nearby to handle certain cases and after-hours emergencies.

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Other advantages include the opportunity to use nursing and paramedical staff to their full potential. A competent and responsible psychiatrically trained nursing sister is essential as well as services of a social worker. Medical staff need to assist the general organisation by being able to assess and investigate certain aspects of the patients condition - such as home environment, work conditions and record, investigative procedures, CT Scans, EEG's etc.

A major benefit was the opportunity of bringing psychiatry, and especially consultation-liason psychiatry, to a peripheral hospital. I believe that this has significantly altered the opinions of the staff regarding the role of psychiatry in clinical medicine and increased the awareness of the benefits of referral psychiatry. Seminars have resulted in an improved quality of referral. More appropriate cases, including an increasing number of patients with atypical or subtle symptoms, have been referred. This has led to many misconceptions regarding psychiatric practice being dispelled.

Disadvantages have included a sense of isolation from psychiatric colleagues, but this has been remedied by attempting to maintain regular contact with the psychiatric staff of the G.S.H. There have been times when a more in-depth history would be interesting due to my specific interests, but the nature of the service did not allow this.

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Comparison

In his study of referrals to the psychiatric liaison service at Auckland Hospital, Miles (2) showed the following broad break-down of referrals according to diagnostic groupings as described in the DSM III. This is reflected in Table 2.

It is interesting to note that the prevalence of anxiety and depression when broadly grouped as well as psychotic disorders appear to occur in approximately the same proportion at Victoria Hospital as in Auckland Hospital. The absence of adjustment disorder in table 1 is directly due to the high incidence of socio-economic and domestic upheaval faced by the community served by Victoria Hospital and which implies that almost each patient would qualify as an adjustment disorder with depression/anxiety/psychosis.

It is noted that 1.56% of hospital admissions were referred to psychiatry in Auckland and the figure at Victoria Hospital is 10% or 800 referrals to 8000 admissions, which is in keeping with figures quoted in the literature (0.7 - 13%).

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TABLE 2: DIAGNOSTIC CATEGORIES - PRIMARY DIAGNOSIS

Organic mental disorder	23
Substance use disorder	14
Psychotic disorder	10
Affective disorder	24
Anxiety disorder	4
Somatoform disorder	6
Dissociative disorder	5
Adjustment disorder	27
Psychological factors affecting physical condition	5
Personality disorder	4
Eating disorder	3
Diagnosis deferred	3
No psychiatric diagnosis	7

From liaison psychiatry in a general hospital, S.W. Miles Auckland.

It appears that in the early phase of the establishment of the unit, mostly the severely disturbed patients which were easily identified by casualty and emergency staff were referred. This meant that there was a high incidence initially, of psychotic and severely neurotic patients. The degree of depression was also severe and it was only following in service training to doctors and nurses that the more subtle psychiatric disorders such as milder anxiety and depression as well as child psychiatric cases were referred. This could to a certain extent influence the proportion of different disorders noted in Table 1.

Also in keeping with the Auckland Hospital study, was a higher incidence of unemployed people referred to psychiatry compared with the general population. No specific investigation has been attempted to ascertain accurate details of unemployment in the Southern Suburbs but it appears that as nearly 70% of the referrals to psychiatry at Victoria Hospital represented unemployed people, this would be significantly higher than the level in the general population.

In their paper, "implementing a consultation-liaison service in a psychiatrically underserved area", Gardner and Flannery (1) share similar experiences to those of the author. They note some of the difficulties in establishing and implementing such services in an underserved area in which there is a scarcity of both registrars in training and an established psychiatric liaison facility.

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They note the importance of the collaboration between a primary-care-orientated medical school and a community general hospital. It would be most pleasing and I believe most beneficial if registrars training could incorporate some time in such a unit so that they may experience the particular challenges found in the unit and procedures described above.

FEBRUARY 1989 AND ONWARDS.

As a result of the growth of the service, I requested that provision of a full-time psychiatric nursing sister be made. Sister M Dor was appointed in February 1989 and has co-ordinated the service since then. She screens the referrals and handles most of the routine uncomplicated patients including admissions and referrals to psychiatric hospitals. She has also promoted the service within the hospital and as a result the number of consultations has increased to more than 400 per month. Two thirds of these are from in-patients in medical or surgical wards. Many of these consultations are to seek advice on how to avoid or minimise psychiatric sequelae following treatment for the medical/surgical condition (eg pre-amputation). This indicates the improved service of the consultation-liason aspect of the service.

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Store et al (3) report on the successful use of a community psychiatric nurse. Their study showed that some patient's attending an accident and emergency department were making heavy use of hospital and community based services and that referral to a community psychiatric nurse was accompanied by a substantial problem in the use of facilities over the period of a year. It is my belief that use of a trained and experienced psychiatric nursing sister in a peripheral hospital such as Victoria Hospital has a similar affect on the facilities available at a teaching hospital such as Groote Schuur Hospital. It has become apparent that the majority of the patient's referred to the unit came from the casualty, emergency room and overnight ward where patient's were seen initially. This accounted for almost half of the referrals to the unit.

What has also become apparent is the need for home visits and consultation with day hospitals in providing a better service to the psychiatrically indigent population. The use of the nursing sister to liaise with the day hospital clinics to avoid splitting by patient's between the day hospital and general hospital department has proved most effective. It has led to a decrease in unnecessary attendants at the unit at Victoria Hospital where patient's are referred on to day hospitals or medication once they are stabilised.

There appears to be an increasing opportunity to do research within the service as there is sufficient material and facilities. It is not envisaged that this service would replicate the service provided at the teaching hospital, but there are some conditions that appear more prevalent in this setting and these could be researched.

CONCLUSION

Without an existing structure, there have been some initial difficulties regarding referral of patients, issues of who should investigate the patient ("our team or theirs"), whether the patient could be kept overnight in the overnight ward or admitted to the ward or transferred to the teaching hospital, and others. By maintaining clear communication with the various referral agencies and with the constant help of the medical superintendent of Victoria Hospital, these difficulties have been quickly resolved.

It has been the concensus of the staff at Victoria Hospital, that the service has worked well and filled a need for improvement and better utilisation of staff and facilities. This is confirmed by the increased rate of referrals and the effect on the patient load at the emergency services of Groote Schuur Hospital. Personal communication with staff at Victoria Hospital likewise confirmed this.

I am unable to quantify the effect of the implementation of the service in financial terms but I believe that it is significant. Presumably approximately 100 patients were transported by Victoria Hospital to Groote Schuur hospital each month, this is a considerable expense which is now being saved. The opportunity to establish a tailor made service has shown that practicality often outweighs theoretical considerations and expertise in managerial skills is essential. There has been considerable responsibility as the only psychiatrist at Victoria Hospital but there has always been excellent support from the staff at GSH.

I am deeply indebted to Dr Loubser and the staff in the Superintendents office as well as Dr Regensberg. They, together with the staff at Victoria Hospital have made the establishment of the service as painless as possible.

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