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Letter from . . .

Wensleydale

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One morning last week, I had said goodbye to my family, and as usual went to feed my chickens. They were excited to see me except for one, which was lying on its back with its feet up in the air, motionless and stiff. My medical training helped me diagnose death, and after I recovered from the initial shock, I had to consider the aetiology. Unfortunately, a few days earlier, I had found some tunnelling into the chicken shed and eggs had gone missing. I thought this was most likely to be rats. Can rats kill chickens? I was able to clarify the position later in the day, from a patient who was a poultry farmer, who informed me that rats do not kill chickens, but only baby chicks and that it was common for chickens at the age of nine months to suffer from sudden death.

Northallerton Health Authority covers the North Yorkshire Dales of Wensleydale and Swaledale, together with part of the Vale of York between Darlington and York. It has a few market towns and a District General Hospital where a new psychiatric unit is being built. Most of the consultants within the District General Hospital appear to have some involvement in keeping livestock.

This is being part of the community and is complemented by the doctors' uniform of a green Barbour and green wellingtons in the car boot for those muddy domiciliary visits. Cars are indeed a problem, as a Volvo estate with a labrador in the back is the obvious choice, but for the psychiatrist running a community service one requires accessibility to remote areas in the winter, necessitating a four wheel drive car. Volvo have not built a four wheel drive car; they do not understand the plight of the community psychiatrist in Wensleydale.

Living within the district is part of understanding the culture of the patients, but also as it is such a large district, it is necessary so as to avoid long travelling times to work. This can cause problems for a psychiatrist in a small town, and within my town there are two psychotics who have delusions about me, one of whom believes I am an imposter as he is in fact me. Naturally, when I arrived four years ago, I wanted to be ex-directory without my address being published in the telephone directory. British Telecom succeeded in making a mistake and published my name,

Northallerton Health Authority has far more sheep than people.

address and telephone number in all the telephone directories. After no joy from complaints to British Telecom and Oftel, I had to take legal action and was given compensation in an out of court settlement, which I have been able to use for a house security system.

So is psychiatry different in such a rural setting? At present there are no HIV or drugs problems, but otherwise the diagnostic categories are the same as anywhere else. The delivery of service, however, has to be different to take into account the large area and the attitudes of patients and medical staff.

The district is very large (about 1000 square miles) with very little population (about 115,000 humans – far more sheep). As a result we have had to deliver the service in a different manner to most places. The district is sectorised into three areas for the three adult consultant psychiatrists and their community mental health teams. These teams cover all adult and elderly patients, including those with dementia. We decided against having a specialist consultant for the elderly, since to organise a community service they would have spent so much time in their Volvo, and have had little opportunity to create links with the primary health care team. Indeed, it is the liaison with the general practitioners which is probably the hallmark of the service. As they felt threatened at the development of a mental health service, we endeavoured to

bolster their position and make them feel secure. We developed our service very clearly as a secondary health care service, which could only take referrals through GPs. Within our own service, we then laid down very definite priorities.

The community mental health teams see part of their task as liaising with the primary health care team and, all the consultants meet the GP practices within their sector regularly. Recently, we have been able to write our own service contract from the purchasers and have put in as the first aim of the service that we provide "a support and advice service to all members of the primary health care team . . .".

As two of the consultants cover such a large sector, we thought it would be useful being able to communicate with our staff and GPs while driving. We have, therefore, done a research study on the use of car telephones. The district refused to finance the telephones, so we had to do this ourselves and through private enterprise in order to do the research to convince the health authority of the need. Another difference in the delivery of service is the provision of long-stay beds for people with dementia and for functional mental illness. We planned the latter to be provided in hospital hostels throughout the district in small units, and the former also in small units around the district. It became apparent, however, that they would still not be local to most people (even different villages consider themselves separate to each other never mind different dales) and the problems of staff morale in small isolated units was to be a real problem. Therefore, larger units within the centres of population are now planned, so that at least the staff morale can be kept high, and relatives can visit as public transport tends to go to these areas.

Attitudes towards mental illness within the district are curious. People know very little about it and are not aware of possible treatments, but generally are very good at caring for their own families and community. These attitudes are held also by health care professionals. After four years in post, I am still coming across people who have clearly been psychotic for up to 20 or 30 years with no treatment provided, but these people have been cared for and supported by their community. Sometimes their priorities can be slightly misguided. One of my patients became increasingly strange and ended up sleeping rough in the dales and feeding his cattle on stones. The local community had supported him financially for quite some time, but eventually they decided something must be done – they called in the RSPCA to remove the animals. After this had been completed they then asked the general practitioner to see the patient who called me in.

In order to help change and develop attitudes, all the consultants are very involved with public speaking and meetings, spending a lot of time talking to health care staff, and also recently doing radio 'phone-ins.

Psychiatric training is good at teaching about mental illness, but it tends to be mainly city-orientated psychiatry. I was never taught essential techniques, such as dictating letters while driving and the necessity of keeping wellingtons in the car boot. Maybe rural psychiatry is something really one can only learn from experiencing the situation, and living within the culture.

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Case report

David R. was referred at the age of 18. He had always been a socially awkward child, afflicted by mannerisms, tics and grunts. More recently he had become increasingly absorbed in repetitive rituals, apparently of a compulsive nature, such as tying and untying his shoelaces or moving his trouser zips up and down. Life at home was becoming intolerable for his family as David would lock himself in the bathroom to carry out his lengthy washing and shaving rituals.

Admission to hospital was arranged for the purpose of a behavioural analysis. Among other repetitive rituals the nursing staff reported grunting and swearing as David applied his razor to the same area of his face until the skin became quite sore. Here was the diagnostic clue, of course, to a relatively uncommon neuropsychiatric syndrome presenting as a unique clinical variant: this I have designated the "Tour de la Gillette" Syndrome.

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