

Psychiatrists and case management

DEAR SIRs

It is disturbing to find no discussion of case management in the report of the President's Working Group on the Mental Health of the Nation as it seems that much of what has hitherto been the work of psychiatrists is becoming included within its remit.

Descriptions of case management (Oynett & Cambridge, 1991) include the assessment of individuals' personal, social, and environmental needs and strengths; individual service planning and implementation in cooperation with users and carers and whatever range of agencies best meets their needs, monitoring progress or the lack of it, and reviewing outcomes. Both intensive work with individual patients and working with purchasers to ensure that the required services are available are also included in some models of case, or the related care, management (Ryan *et al*, 1991).

A range of professionals is now metamorphosing into case and care managers but curiously this does not seem to include psychiatrists despite such planning, bridging, coordinating, monitoring, and advocacy having been a major part of our traditional role. Relevant also may be the term's origin in the USA where these functions have tended not to be carried out by psychiatrists.

We cannot now claim to be the only suitable case and care managers but neither should we be excluded in the many cases where a psychiatrist is appropriate, and where any other arrangement is likely to lead to either duplication or marginalisation.

I would be interested to hear colleagues' views and experience.

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Reply

DEAR SIRs

There is no specific reference in *Mental Health of the Nation* to case management but there is to the Care Programme Approach. The reason for this is that the Care Programme Approach is advocated in the

Department of Health's paper in 1990 *Caring for People*. In general, case, or better, care management is being developed in social services while the Care Programme Approach with a designated key worker is used in the health service and it is hoped that together they will result in improved practice.

A. C. P. SIMS
Immediate Past President

Inappropriate admissions of the physically ill to a psychiatric hospital

DEAR SIRs

To identify physically ill patients inappropriately referred to a psychiatric hospital and sub-region alcohol unit, all admissions over a six month period were monitored and those subsequently transferred to the local general hospital followed up. Only patients admitted early in the study period were monitored for the full six months, while those admitted later were not followed up beyond that time limit.

Data pertaining to patients transferred to the general hospital within a week were subjected to close scrutiny, as they would appear to represent a group in whom the highest probability exists of psychiatric admission resulting from physical illness. Data were derived from the hospital medical records computer and individual case-notes.

A total of 324 patients were admitted, and 16 of these, or 4.9% of the total, were transferred to the general hospital within the six month period. These transfers occurred for emergency treatment or for medical investigations considered beyond the scope of psychiatric hospital facilities. The transfers represented 17% of all admissions to the old age psychiatry service, 2.5% to the alcohol service, and 4.6% to the adult acute service. Seven of the transfers (2.1% of all admissions, or 44.1% of all transfers) occurred within one week.

The group transferred in the first week of admission differed from patients not transferred in that (a) they were older, median age 76 compared with that of all other admissions, 45; (b) the number of past psychiatric admissions was greater, mean 4.2 compared with 1.9; (c) the sources of referral differed, only 57% referred by a GP, to 86%. It was sobering that four of the seven patients transferred within seven days died at the general hospital within the study period.

There would therefore appear to be physically unwell patients who have 'psychiatric' symptoms elicited by the referring doctor or other agency, and admitted to a psychiatric facility in spite of physical problems, sometimes severe or life-threatening.

The risk of such occurrence could be reduced by careful physical examination which only a doctor is

qualified to carry out. Perhaps this is why, in our group transferred within a week, there was a higher incidence of referral from social workers and other professionals. The number of previous psychiatric admissions and age also seem to increase the risks of inappropriate referral.

Colgan & Philpot (1985), studied the routine use of physical investigations in elderly psychiatric patients and found abnormalities in up to 20%. Tench *et al* (1992), comparing pre and post-mortem diagnoses, found a prevalence of physical disorders in psychogeriatric patients similar to those in elderly patients in general hospital wards.

Inappropriate referrals of the physically ill to psychiatric hospitals is unfortunate and wasteful of resources and even lives. Our study suggests that one in 50, 2% of all admissions, fall into this category, if only those transferred within the first week are counted. With more care, such patients could be admitted at the outset to where they clearly need to be – the general hospital!

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Dial 'M' for 'memory complaints'

DEAR SIRS

A local newspaper in the Mannheim area advertised a telephone hotline offering 'specialist information' on Alzheimer's disease (AD). Questions about patient care, therapy and perhaps recent developments in basic research were expected. The lines were busy for more than three hours and the 'experts' were surprised by the callers' response.

I received 16 calls. Twelve (two men, ten women) callers complained about unspecific and mild memory disturbances and feared developing AD. Their mean age was 55 years (range 49 to 65) and they described mild forgetfulness lasting from a couple of months up to seven years (mean 2.7 years). Eight of these 12 memory complainers had one or more relatives suffering from dementia, in six cases one parent had been affected. Most said that they were

too embarrassed to discuss this problem with their doctors and most were afraid that their genetic risk of developing AD was 50% or higher.

Only four callers (two men, two women) with a mean age of 70 years (range 59 to 83) sought advice on patient management. No caller from the second group had an affected parent. Younger age together with the presence and number of affected relatives permitted the correct prediction of memory complaints in all but one of the cases. Four other 'experts' received a similar number of calls of the same nature (but they had forgotten to take notes).

We conclude that the fear of developing AD is a major concern of many people in late middle age with mild or imagined memory deficits and with relatives suffering from AD or other forms of dementia. There is a need for counselling these memory complainers and to offer information about the estimated relative risk of developing AD in comparison to the general population. It was our impression that popular descriptions of AD in the lay press may stir up fears by sensitising people for minor, benign deficits. O'Brien *et al* (1992) observed that a finding of clinical normality in memory complainers can be replicated at a follow-up examination in most cases, but that memory complainers have to be taken seriously because their risk to develop manifest dementia was slightly higher than in the general population. This underlines the need for diagnostic markers of AD which are reliable in the preclinical or very early stages of illness.

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Reference

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GP fundholding and psychiatric practice

DEAR SIRS

In his Keynote article (*Psychiatric Bulletin*, April 1993, **17**, 193–195), Andrew Sims has brought into focus the siting and nature of the contractual flaw in the GP fundholding scheme. It has been long predicted that the GP fundholding scheme was likely to harm the NHS by distorting priorities and undermining planning (Ford, 1990). However, the serious implications for multidisciplinary psychiatric health care delivery have been underestimated.

The freedom to refer people with psychological and psychiatric problems to individual professionals