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Long-Term Attendance in the Psychiatric Outpatient Department for Non-Psychotic Illness

JOHN C. POMEROY and BRUCE RICKETTS

A comparison was made of initial assessment, treatment, and pattern of care of two groups of non-psychotic patients, referred to a Central London psychiatric outpatient department. The patients, none of whom had been in recent psychiatric treatment, were differentiated into those receiving short-term care (less than one year) and those having long-term care (greater than one year). Chronic psychiatric disorders predominated in both groups. It was also common to have physical illness and contact with other hospital departments. Short-term care consisted of very brief contact for 70% of patients, and psychiatrists seemed unable to engage these referrals in treatment. Long-term attendance was associated with acutely ill young, or chronically ill older patients, more active initial intervention, and referral within the same hospital group. Follow-up revealed that long-term patients reported little symptomatic improvement, experienced considerable disruption in course of care, made increased demands on all aspects of psychiatric service, and often proved to have personality disturbance and social problems that were not perceived on initial contact. Types of intervention and their effects on other hospital departments were examined.

The major focus of psychiatric treatment in Britain until 50 years ago was on the severely disturbed, usually psychotic, patients in mental hospitals. Since then there has been increasing involvement in community and outpatient psychiatric services. This has been accompanied by an awareness of the high level of psychiatric disturbance in the community, particularly for non-psychotic disorders (Shepherd *et al*, 1981). With the advent of the National Health Service, there has been a reduction in the number of mental hospital beds, and psychiatric care is intended to become part of other acute care services in the district general hospital. Although full psychiatric services have opened in many district general hospitals in the last 15 years, there are reports of even well resourced areas failing to achieve these goals (Brough & Watson, 1977).

The latter observation, in association with concern about the quality of psychiatric care to the community (Brook & Cooper, 1975) has led to studies of placing professionals, including psychiatrists (Brook, 1978), psychologists (Johnston, 1978) and social workers (Shepherd *et al*, 1981) in general practice clinics, and, in one case, the establishment of an independent multi-professional mental health advice centre in a London district (Brough *et al*, 1983). Although these types of service are interesting and innovative, they seem unlikely to be replicated universally and are contrary to the established concept of primary care referral to hospital-based specialty care, when required, that makes psychiatry comparable to other medical specialties.

In reviewing the literature of referral from the community to the hospital psychiatric clinic, it is apparent that social pressure or lack of treatment response are more likely causes of referral than diagnostic criteria or demographic factors (Kaeser & Cooper, 1971; Mowbray *et al*, 1961; Rawnsley & Loudon, 1962). The primary care physician has a bias against referring individuals with non-psychotic disorders which may be based on evidence of poor continuity of care and failure to deal with neurotic disorders (Shepherd *et al*, 1981; Hopkins & Cooper, 1969). There is evidence that short-term intervention, even for chronic disorders, is common in psychiatric clinics (Cooper, 1965; Kaeser & Cooper, 1971), but chronic neurosis is also reported to be increasingly burdensome on psychiatric outpatient services (Gillies & Egert, 1973).

We therefore decided to study the treatment of non-psychotic patients in the outpatient clinic of a purpose-built district general hospital psychiatric unit in North West London. The unit had manpower along the recommended guidelines of the Department of Health (1975) and for this area represented the major community psychiatric resource. Since the major criticism of psychiatric care

centered on the continuity of treatment, we planned to compare long-term and short-term treatment of non-psychotic patients to assess the justification for previous criticisms, as well as the reasons for and development of long-term care.

Long-term care, although arbitrarily defined as contact with the clinic of greater than one year with at least nine months of continuous care, represented a period of time in which previous studies would suggest few patients are maintained in the clinic. Patients were also selected to be relatively naive to psychiatric care so that the initial intervention represented the first detailed approach to their treatment needs.

Method

Clinic studied

The clinic was in a purpose-built district general hospital psychiatric unit containing all the psychiatric treatment settings for four consultant teams. The hospital was situated within the area of residence served. In addition to normal medical and social work staffing, two consulting psychotherapists, three full-time clinical psychologists, and two community psychiatric nurses were available on request.

Outpatient referrals were allocated to each team dependent on their place of residence or occasionally by direct referral to an individual consultant. Each team had a new outpatient session per week in which two or three appointment spaces were available. Appointments were made by the receptionist on next available space basis and allocated on the appointment day by the consultant psychiatrist to one of the physicians for evaluation. The consultant would supervise the evaluations of the more junior psychiatrists. Although patients were normally seen by appointment, an emergency clinic was staffed by junior doctors for urgent evaluations. Patients in this clinic could be self-referred or referred from other hospital departments and primary care physicians.

Case selection

The records of current attenders at the psychiatric outpatient clinic were reviewed on three occasions over a nine-month period. From all patients who had first attended the clinic more than one year ago, an index group of new, long term, non-psychotic patients was selected by excluding any who had:

1. A diagnosis of psychotic illness (I.C.D.-9: 290–299).
2. A total period of care of less than nine continuous months.
3. A period of psychiatric care in the preceding ten years.

A control group of patients was selected by returning to the clinic diary for the same team and finding the closest first attender to the index patient's initial appointment who also failed exclusion criteria (1) and (3) above, but did not have an attendance at the same clinic more than one year after initial contact.

Data collection

Demographic, symptom, diagnostic, and treatment data were obtained from the patient's records in the whole hospital group (three general and two specialised (ophthalmology and gynaecology) hospitals), psychiatric and hospital social service. The majority of information was of a factual kind, intended and in retrospect proven, to be easily obtained from proficient history taking and record keeping. There were some exceptions:

a. Diagnoses reported were always those of the treating psychiatrist. The majority used I.C.D.-9 coding but occasionally employed more personal terminology. On these occasions, both workers conferred after reviewing the records and gave a consensus I.C.D.-9 diagnosis. The same principle was used for any changes in diagnosis made by the treating physician over the course of treatment:

b. A separation between acute and chronic psychiatric illness was set at six months of continuous symptomatology, following Kedward's findings (quoted in Shepherd *et al*, 1966) that most new psychiatric illness seen in the community has a recovery period of under six months.

Results

212 individuals were in outpatient treatment for greater than one year, and 60% of them were given a non-psychotic diagnosis; 30 patients fulfilled our criteria for inclusion in the index group. Given our preliminary data, the index group represented one-seventh of all the long-term attenders and one-quarter of those given a non-psychotic diagnosis. Since, by our estimates, the long-term attenders only represented about 10% of all non-psychotic patients seen at the clinic, it is worth considering how representative was our index group.

Their importance is apparent in considering patterns of care. The index group had an average length of care of 26 months and between them totalled 653 outpatient appointments. There were 13 inpatient psychiatric admissions (for nine patients) and 23 emergency clinic attendances (for 14 patients) in the first nine months of treatment of the index group. The control group, which is representative of the majority of non-psychotic referrals to this clinic, show a markedly different pattern of care. The average length of treatment was under two months. Seven patients received treatment lasting between three and nine months, but the majority of patients had between one and three appointments in total. During their course of treatment, two control patients were admitted to the psychiatric inpatient service; only one was seen in the emergency clinic.

Although two control patients returned to the clinic following their initial discharge, 83% of the index patients were discharged or lapsed from the clinic but returned, one-third doing this on more than one occasion. Less than half of the index patients had the consistent care of one psychiatrist.

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In reviewing the case-notes, a record was made of the number of patients who reported significant improvement in, or recovery from their referring symptomatology. Only 20% of the long-term patients reported any changes in their symptomatology, although another one-third were considered by the psychiatrist objectively to show signs of change; 56% of the control patients, who were diagnosed as having psychiatric illness that could respond to treatment (25 patients), reported at least significant change at the time of their last appointment.

TABLE I

Comparison between index and control groups on demographic and referral data

		Index	Control
Age	Under 20 y.	1	3†
	20–29.9 y.	5	6
	30–39.9 y.	6	11
	40–49.9 y.	4	5
	50–59.9 y.	11	0
	60+ y.	3	5
Sex	Male:Female	15:15	14:16
Marital status	Single	14	10
	Married	11	14
	Widowed/Divorced	5	6
Number in household (other than patient)	0	10	7
	1	9	4
	2	5	6
	3+	6	11
	(N.K.	0	2)
Occupational status	Unemployed	7	6
	Housewife	2	5
	Student	0	2
	Retired	2	0
	Full time employment	19	17
Source of referral	General Practitioner	10	17*
	Hospital Physician	18	11
	Self/other/N.K.	2	2
Treatment from referring doctor	None	12	19**
	Drug Therapy	14	8
	Self-referred/N.K.	4	3
Delay between referral and 1st attendance	None	10	1***
	Under 20 days	6	7
	Over 20 days	13	21
	N.K.	1	1
Duration of symptoms	0–3 months	8	1**
	3–6 months	1	5
	7–12 months	4	3
	>12 months	14	20
	N.K.	3	1
Rank of psychiatrist (seen at initial assessment)	Consultant	14	9
	Senior Registrar	2	6
	Registrar	11	10
	Senior House Officer	1	4
	Clinical Assistant	2	1

(Fisher's Exact Probability *P<0.075 **P<0.05 ***P<0.01 X^2 with Yates correction †P<0.05).

Table I shows the demographic and referral characteristics of the two groups. The index patients were older, with peak morbidity in the 6th decade for the index and 4th decade for the control group. Social isolation had some association with the index group: 83% of the under 40 year-old index patients were single, compared with 50% of the controls and five of the over 50 year-old index patients had never married. Female control patients were three times more often married than index females, and were more often working in the home among larger households. Ethnic origin, predominantly British-born Caucasian, showed no differences between groups.

Comparison of referral characteristics showed that the index patients were more likely to be referred by hospital colleagues, to have a previous trial of psychotropic drug therapy, and report the onset of psychiatric illness at less than three months before referral. Chronic psychiatric illness, however, remained much more common for both groups, and in cross-correlating age and symptom duration, chronicity was significantly more common for over 40 year-old index patients and under 40 year-old control patients. There was also an excess of under 40 year-old acutely ill index patients (X^2 with Yates correction, $P<0.01$).

One differentiating factor, evaluation within 24 hours of referral, proved to be due to a bias in our case selection process. Although this did not affect our major findings, the influence of this group will be discussed later.

Table II shows the diagnosis made on initial evaluation of the patients. The most prevalent diagnoses were depressive and anxiety neurosis. The control group showed a trend for less diagnosis of neurotic disorder and greater evidence of personality disorder, which was significant in considering a triad of hysterical, asthenic, and anti-social personality disorders. The major diagnosis, depressive neurosis, showed age and sex differences. The age differences associated with the peak group moribidities in 4th and 6th decade, but index depressives showed a 1.6:1 female to male ratio, compared with 12:1 for control depressives. The latter were also less likely to be given an additional personality disorder diagnosis. Acute depression (4) only occurred in the index group.

Change in diagnosis refers to re-evaluation that occurred over the course of treatment. This revealed an increased perception of personality disorder (particularly hysterical, asthenic, and anti-social disorders) with some reduction in diagnosis of neurotic illness. On final analysis, half the index but none of the control depressives were thought to have an additional personality disorder. Depressive diagnosis remained most stable for older, male patients. Personality disorder without an additional neurotic diagnosis increased from 0 to 5 in index group and 5 to 7 in controls. This rise in perception of personality disorder was most significant in the young, acutely ill index patients so that by final assessment, 80% of the under 30 year-olds from both groups had such a diagnosis.

In assessing the treatment interventions, those in the

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TABLE II
Initial psychiatric diagnosis and change in diagnosis over course of treatment

	Index Initial diagnosis	Change in diagnosis	Control Initial diagnosis	Change in diagnosis
Neurosis				
NONE	3	+3	9*	+3
Depressive	16	−4	13	−4
Anxiety	5	+2	7	+1
Phobic	3	−2	1	0
Other	3	+1	0	0
Personality disorder				
NONE	24	−11	20	−1
Hysterical	1	+4	4	−1
Asthenic	2 } 3	+4	4 } 10**	+1
Anti-Social	0	+3	2	+1
Obsessional	0	+2	0	0
Other	3	−2	0	0
Alcohol and/or drug addiction				
Primary disorder	4	+1	4	0
Secondary disorder	1	0	3	+1
Associated social problems				
a. Principal cause of disorder				
—Acute	2	−2	2	+1
—Chronic	0	+3	4	+2
b. Accessory to psychiatric disorder				
—Acute	2	0	3	−1
—Chronic	6	+6	4	+1

(Fisher's Exact Probability *P<0.075 **P<0.05).

index group were significantly more likely to be admitted directly to the inpatient service (five index: two control) or followed-up in the clinic within seven days (seven index: three control). Five control patients were given no further appointment since the psychiatrist felt that their disorders were either unlikely to respond to psychiatric intervention or were not due to psychiatric disturbance.

Other than the individual interaction with the psychiatrist, only two other treatment approaches were recorded—psychotropic drug therapy and social work intervention.

Psychotropic drug therapy

The use of medication is summarized in Table III: 70% of index patients received a prescription on first attendance compared with 47% of controls. The drugs used were mainly minor tranquillisers or anti-depressants. Control patients, unlike index patients, rarely had a combination of both types of drugs and were more likely to have a planned withdrawal of medication. Index patients had a large number of individuals never withdrawn from their treatment, despite their two year average attendance.

The use of anti-depressants differed markedly: 94% of index depressives and 31% of control depressives had a trial of anti-depressants. In reassessing the treatment against final diagnosis, anti-depressants had been used in 11 of the 17 personality disordered index patients but only one of the 11 control patients with this diagnosis. The psychiatrists' own records commented that five of the nine index patients never withdrawn from anti-depressant therapy had disabilities more related to social or personality variables.

Social work intervention

Social problems were noted to be present at the time of initial evaluation in similar proportion for both groups (see Table II), but control patients were more likely to have social problems that were seen as their principal cause of disability. Paradoxically, they were less often referred for social work assistance (seven index and three control patients referred within the first two appointments). Continuing treatment was associated with increased awareness of chronic social problems underlying the patient's psychiatric disturbance and for index patients, this increase was associated with six further social work referrals. Index patients referred to a social worker did not have an associated reduction in psychotropic therapy, whereas the three control patients seen by social workers had their medication reduced or stopped. Referrals tended to be for practical problems such as housing and finance, and less often for emotional issues, such as marital conflict. It was apparent that the problems that were not referred were considered by the psychiatrist to be a consequence of their personality disorder (seven patients) or alcohol abuse (five patients).

Associated physical illness and general hospital treat-

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TABLE III
Use of psychotropic drugs

	All psychotropic drugs		Hypnotic/Tranquillisers		Anti-depressants	
	Index	Control	Index	Control	Index	Control
Ever prescribed	25	18	22	13*	21	4***
Prescribed within first two appointments	24	17	15	12	19	3***
Treatment withdrawn						
Before 4th attendance	4	9*	1	7**	2	2
Never withdrawn	12	9	14	8	9	3

(X^2 with Yates correction *P<0.05 **P<0.01 ***P<0.0001).

TABLE IV
Associated physical disorders and use of general medical services

	Index		Control	
Associated physical illness:		*Referred within hospital*		*Referred within hospital*
None	17	10	18	4
Acute	3		1	
Chronic	4	8	11*	7
Psychosomatic	6*		0	
Length of time from initial contact	9 months before	9 months after	9 months before	9 months after
Contact with non-psychiatric hospital departments				
a. Patients with none or acute physical illness				
Admitted (total admissions)	6 (8)	3 (5)	4 (4)	4 (4)
Outpatient clinic (no. of clinics)	10 (10)	5 (6)	8 (8)	6 (7)
No. of outpatient attendances	25	13	15	24
b. Patients with chronic physical or psychosomatic illness				
Admitted (total admissions)	3 (5)	3 (3)	4 (4)	3 (6)
Outpatient clinic (no. of clinics)	9 (18)	7 (11)	9 (14)	8 (10)
No. of outpatient attendances	54	35	50	21

(Fisher's Exact Probability *P<0.05).

ment is summarised in Table IV. Physical illness was present in 43% of all patients. The majority of these illnesses were chronic and were associated with chronic psychiatric disorder and a diagnosis of personality disorder. The chronic disorders differed between groups in that index patients were more likely to have illnesses considered to be psychosomatic in nature. In the nine months prior to psychiatic referral, general hospital treatment (i.e. non-psychiatric) was provided as an inpatient to just under one-third of all patients and as an outpatient to two-thirds. Intra-hospital referral was more common for patients with chronic physical illness, who were also commonly attending more than one clinic.

Table IV shows a crude method of measuring benefits in psychiatric intervention. For both index and control groups, there was an overall reduction in use of inpatient and outpatient facilities. Multiple clinic use was reduced, but the only advantage in length of psychiatric treatment was seen in patients without chronic illness, which was probably an artifact of referral characteristics. For the chronically ill, no statistical advantage was related to length of treatment, but at least two index patients showed considerable reduction in their use of numerous specialists. Overall, psychiatric intervention could not be related to significant reduction in use of non-psychiatric hospital services, and this aspect of treatment warrants further controlled study for a longer period of time.

In the index group, a bias in our selection process occurred, since one-third were evaluated within 24 hours of referral. This 'emergency group' did not influence the findings of excess referrals within the hospital for index patients, but reduced the higher index rates of consultant evaluation and previous psychotropic drug trials. Emergency attendance was not associated specifically with recent onset of illness, but there was a trend for such patients with recent onset to obtain more prompt evaluations. However, many of the future long-term attenders still waited over three weeks from referral before evalua-

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tion, and we concluded that emergency or rapid intervention was not specifically related to long-term outpatient care. More active initial intervention and increased diagnostic unreliably were seen in the 'emergency group', but not significantly more than other index patients.

Discussion

In today's climate of financial austerity and some controversy about how to use limited resources for treatment of the high levels of minor psychiatric disturbance in the community, it seems important for the psychiatric profession to examine their present approaches. This study was limited, since it was a retrospective case history review and observed the practice of only one outpatient clinic, but the striking similarity to other studies analysing outpatient psychiatric treatment in terms of demography, diagnostic profile, chronicity of illness, and average length of treatment (Mezey & Evans, 1971; Johnson, 1973; Cooper, 1965; Kaeser & Cooper, 1971) suggests that some generalisations can be allowed.

In making comparisons, it should be noted that contrary to other studies, we did not find the slight excess of females with non-psychotic disorders and that location of the clinic (i.e. university department, general hospital, or mental hospital) and overall level of resources have an effect on referral profiles, particularly for non-psychotic disorders (Johnson, 1973; Wing & Fryers, 1976). The clinic we studied is probably above the national mean in level of resources but existed as a general hospital unit with no physical relationship to the university centre. In addition to the above observations, this study viewed the practice of four independent treatment teams. Comparisons between the teams were unremarkable, except that one consultant showed a greater tendency to plan earlier in the course of treatment for long-term intervention and this approach was accompanied by a reduced use of inpatient and emergency services.

Our observations support work previously cited in that non-psychotic patients referred to the psychiatric outpatient clinic are likely to have chronic disorders for which the majority (approximately 70%) will receive treatment lasting under three months. The psychiatrist appears to have difficulty engaging outpatients in treatment, but also finds that approximately one-third of the patients that do stay in the clinic for at least three months become long-term attenders, many of whom place considerable demands on their service, report little symptomatic improvement, and resist attempts to discharge them from the clinic.

It seems obvious that the patient's opinion of psychiatric treatment would affect the length of treatment. For example, nine control patients openly expressed reluctance to attend the clinic initially, although four of them did re-attend at least once. Patient choice was shown by all of the control patients who failed to improve, since they either lapsed from the clinic or refused treatment offered. Two control patients were offered assessment for psychotherapy but failed to follow this up, one of them not returning to the clinic following a successful court appearance assisted by a psychiatric report. More encouragingly, at least half the control patients considered to have treatable psychiatric disturbance did experience benefit from the treatment received.

The characteristics of those patients who were engagable in an intermediate length of treatment and could be discharged from the clinic reporting better health are worth reviewing. Their major disorders were mostly mixed anxiety and depressive neuroses and they were predominantly young married females (often with large families). This social group has commonly been shown to be susceptible to short-lived minor psychiatric disturbances, notably depression (e.g. Brown & Harris, 1978). Of interest to our study is that these patients were mostly treated by junior doctors and although drug therapy was used (mainly minor tranquillisers), the underlying personality and social problems were perceived from the beginning of treatment. These patients had all been referred by general practitioners, and it might be inferred that a good supportive relationship with a primary care physician is an important factor in preventing long-term care.

Three clinical stereotypes emerged among the long-term patients. The first was a group with chronic depressive or anxiety disorders. These patients tended to be an older age-group, with a slight excess of males and some having psychosomatic illness. The second group was mostly younger patients initially diagnosed as having neurotic illness, often acute, but proving to have underlying personality disorder (females were classified as hysterical and males as asthenic). The smallest group was a mixture of anti-social, alcoholic, and drug abusing patients. The latter two groups were the most clinically demanding, and our study suggests that they would be unlikely to be maintained in the clinic if diagnosed correctly on first interview.

In speculating on the process of development of long-term care, our observations suggest that the

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natural history of the psychiatric disorder is not the only or probably the most influential cause for long-term treatment. Five groups of factors emerged—

Referral process

Our observations suggest that patients who have had previous contact with psychiatry or a previous trial of psychotropic drug therapy are more likely to be maintained in the clinic, and this is accentuated if they have been referred within the hospital. All of these factors may mean that familiarity with the type of psychiatric treatment they will receive or with the institution itself helps patients establish themselves in the clinic. The importance of preparing patients for referral to the psychiatric clinic is highlighted by Skuse's (1975) work, showing that new outpatients are often extremely naive to the type and cause of referral and often do not know that the psychiatrist is medically qualified.

Diagnostic variables

On initial evaluation, there were few remarkable differences in diagnosis between the groups. The slightly higher diagnosis of personality disorder in those with brief intervention may reflect feelings of therapeutic poverty for the psychiatrist, or patient personality variables that precluded the potential for forming a therapeutic relationship.

Psychiatric intervention

Even allowing for the index patients seen on an emergency basis, the psychiatrist responds much more positively to those patients who become long-term attenders with higher rates of inpatient admission, early re-assessment, drug therapy, and social work referral. These responses presumably relate to the perceived severity of the disorder and urgency of needs, but do not necessarily explain the continued need for lengthy treatment. However, the psychiatrist's response must impart a belief that there are useful therapeutic interventions and suggest that aspects of the referral process and diagnostic variables influence his approach. Examples of the latter might include a different response to patients referred by hospital colleagues, those thought to be personality disordered, depressed elderly males, or patients with psychosomatic illness. There is some evidence that patient expectation for a certain type of treatment is a factor in developing long-term care. In this study and others (Craig & Huffine, 1976), early prescribing of drugs is important. Use of drug therapy is known to be the major intervention in British psychiatric clinics (Johnson, 1973; Goldberg & Huxley, 1980).

Undiagnosed Personality Disorder

37% of the long-term patients proved to have personality disorder not perceived on initial contact. This increased diagnosis could be due to the psychiatrist's attempts to rationalise the lack of treatment response or an unacceptance of the chronicity of some neurotic illness. Neither of these theories was upheld in the notes, but it is conceivable that in treatment of the neurotic disorder, the underlying personality disturbance is revealed. Tyrer *et al* (1983) have shown that the presence of personality disorder significantly impairs treatment of neurotic conditions, and clinicians often fail to make combined diagnoses. The increased perception of hysterical and asthenic disorders, with their shared characteristics of resourcelessness, dependency, and vulnerability (Tyrer & Alexander, 1979), would suggest long-term support to be a likely consequence, once established in treatment.

Social problems

Over half the long-term patients had significant social problems, of which half of these were not revealed early in treatment. Social factors are not only important in the initiation of minor psychiatric symptomatology, but limited social contact or the personality factors that prevent perception or use of social contacts increase the risk of potential for psychiatric illness (Henderson, 1977; Henderson, 1981). Also, Huxley *et al* (1979) have shown that social circumstance is an independent and more significant factor in predicting the length of minor psychiatric disturbances than most clinical factors.

In assessing the clinical relevance of the study, consideration of the value of long-term treatment must be made. It seems clear that the benefits of treatment cannot be defined by symptom improvement. In fact, the maintenance of possibly unnecessary drug treatment and continuation of symptomatic complaint may be the method by which the patient receives the needed long-term support of the clinic. The value of this type of study might be to circumvent the volatile, demanding early relationship and offer an appropriate period of care, which would hopefully lead to discharge to the care of the primary physician. This study implies that psychiatrists should give greater consideration to potential personality disturbance and social problems which are not initially apparent, not begin drug treatment until time for evaluation and information gathering

from other sources has been allowed, pay more attention to possible social and psychotherapeutic interventions and, for appropriate individuals, discuss the possibility of long-term intervention. It is of note that it was rare for friends or relatives of the patient to be interviewed and uncommon that long-term therapy was considered early in treatment.

Combining our findings with other studies, it is apparent that only limited service for non-psychotic illness is provided by the outpatient clinic to the community. The district general hospital setting may provide better service to the patients of other hospital physicians and more research is needed to learn about this referral process and the benefits of psychiatric intervention to the physically ill.

The ability to function as a referral and treatment centre may be improved by increased contact between the psychiatrist and community physicians, which could help in promoting appropriate referrals and improve the preparation for patients for such referrals. The ability appropriately to discharge patients back to their G.P.'s care can also be improved, and Paykel *et al* (1982) have shown how much smoother such discharges are when using the resources of the community psychiatric nurse.

At this time, we would recommend that studies begin to look at ways to improve the ability for the general hospital psychiatric clinic to function as a community resource that do not necessarily remove the service from the hospital, but make it more accessible to those defined as likely to benefit from its resources. It is also necessary for psychiatrists to accept a relatively small community need for long-term treatment for a sub-group of patients with non-psychotic disorders.

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*John C. Pomeroy, MB, BS, MRCPsych, *Assistant Professor in Child Psychiatry, Health Sciences Center, State University of New York at Stony Brook, Stony Brook, New York 11794, USA*

Bruce Ricketts, MB, BChir, MRCP, MRCPsych, *Consultant Psychiatrist, Royal South Hampshire Hospital, Graham Road, Southampton SO9 4PE*

(This work was completed whilst the authors were Registrar and Senior Registrar respectively at St Mary's Hospital, London W9)

*Correspondence

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