*Psychiatric Bulletin* (1993), **17**, 140–141

# Continuity of care in serious mental illness

JOY ABBATI, Principal Clinical Psychologist, Tegfan Day Hospital, Whitchurch Hospital; and GREG OLES, Assistant Psychologist, Department of Clinical Psychology, Whitchurch Hospital, Cardiff CF4 7XB

It has been claimed (Abbati *et al*, 1987) that patients benefit from continuity of professional involvement sustained over a long period. Schizophrenia sufferers in particular find it harder than non-sufferers to articulate their difficulties and concerns, and may adjust poorly to change, only building up trust in professionals over an extended period. In their turn, professionals need time to get to know such individuals and to recognise 'early signs' (Birchwood *et al*, 1989) of possible relapse. Management of potential decompensation involves a knowledge of how the individual has responded to changes in medication in the past and what psychosocial factors may be relevant. Working with such patients refines the clinician's skills in interacting with them, obtaining their compliance with a particular regime, and pre-empting potential problems. Without this background of knowledge and experience, the management of sufferers may be crude with adverse results for the patient.

## *The study*

A senior clinician, Dr C. A. B., was on sick leave for 21 weeks in December 1989. She manages a large intramuscular therapy clinic based in a Day Hospital, and is the main source of professional support – apart from the nurse who gives the injection (not always the same person) – for the patients. Thus an opportunity was presented for ascertaining whether any adverse outcomes occurred as a result of her absence. At least three doctors were involved in covering the clinic during this time. The records of all patients attending the clinic were retrospectively examined for the period of Dr C. A. B.'s absence and for the following six weeks (7 December 1989–7 June 1990) – Period Y. The rationale for including the following six weeks was to accommodate the ongoing effects of the management and medication prescribed during her absence. The equivalent six month period in 1988/89 (Period X) was used as a control with records of the same patients being examined.

One hundred and eighteen (73 male, 45 female) patients were involved in the clinic during both periods.

## *Findings*

### Admissions to hospital

During Period X there were eight admissions involving a total of 238 days hospitalisation. There was a significant increase ($P<0.05$) in admissions for Period Y with a total of 15 involving 458 days.

### Clinic appointments kept

For Period X 796 clinic appointments were kept with Dr C. A. B. alone. This was significantly greater ($P<0.01$) than the total of 283 appointments during Period Y.

A breakdown of the Period Y appointments showed that 157 were kept with other doctors during the first 21 weeks while there were 126 with Dr C. A. B. during the final six weeks.

The average number of appointments was 6.75 per patient in the first period and 2.4 per patient in the second.

### Missed clinic appointments

During Period Y, approximately a third of the number of clinic appointments was given, so the opportunity for missing was also reduced. However, missing an appointment can be an alerting signal that a patient is experiencing problems. Dr C. A. B. is aware of these cases and immediately initiates follow-up in the form of a letter giving a new appointment which, if not responded to, leads to a visit from a community psychiatric nurse.

Missed appointments and follow-ups were reduced in Period Y:

Period X 29 (25)* leading to seven follow-ups
Period Y 5 (5)* leading to one follow-up
(*figures in brackets show number of individuals involved).

In Period X, one follow-up led to admission, while, of the 22 not followed-up, only one was admitted. The single follow-up in Period Y did not result in admission, whereas one of the missed appointments that had not been followed-up did.

**Patients seen early or without appointment**

Sometimes early attendance occurs because a patient has problems. Such requests are taken seriously as they may indicate the onset of relapse.
These frequencies were:

| | |
|---|---|
| Period X | 33 (20)* leading to one admission |
| Period Y | 13 (7)* leading to two admissions |

As frequent attendances in Period X led to only one admission as against two admissions after fewer attendances in period Y, it would seem that this procedure may be an effective means of forestalling admissions. Patients' confidence in the usefulness of early attendance may have been undermined in Period Y when they did not know whom they would see at the clinic.

## *Comment*

The significant increase in admissions for clinic patients during Dr C. A. B.'s absence supported the hypothesis that schizophrenia sufferers whose psychiatric management remained in the hands of an experienced and trusted clinician, who knew them well, were less likely to relapse than when their management was in the hands of unfamiliar doctors. The data regarding missed appointments and early attendance underline the extent to which the experienced clinician was able to respond flexibly to known patterns of behaviour, in a way that was impossible for colleagues unfamiliar with the patients. The great reduction in requests for an early appointment during Period Y suggests that patients may have been less prepared to approach the services when they knew that Dr C. A. B. was not available, although an early appointment might have circumvented a relapse.

Service planners could therefore usefully take into account the beneficial effects of continuity of management when considering maintenance of patients in the community.

## *References*

ABBATI, J., HAILWOOD, R. & TANAGHOW, A. (1987) Family treatment for schizophrenia – the work of S.T.E.P. in Cardiff. *British Journal of Clinical and Social Psychiatry*, **5**, 97–101.

BIRCHWOOD, M., SMITH, J. MACMILLAN, F., HOGG, B. *et al*, (1989) Predicting relapse in schizophrenia: The development and implementation of an early signs monitoring system using patients and families as observers, a preliminary investigation. *Psychological Medicine*, **19**, 649–656.

---

*Psychiatric Bulletin* (1993), **17**, 141–144

# Innovations

## Quality assurance and parasuicides presenting to casualty departments

CHRISTOPHER H. CANTOR, Suicide Research and Prevention Program, Queensland Health, GPO Box 48, Brisbane, Queensland 4001, Australia

In view of concern regarding rising youth suicide rates, suicide being a critical event in increasing emphasis on clinical accountability, I conducted a quality assurance exercise in relation to casualty department assessments of parasuicides. While much has been written in the area of suicide assessment and rating scales, I found nothing adequate for my purpose. Accordingly, I present a format for conducting such an exercise with the aim of providing suggestions as to which clinical assessment items