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Service innovations: a neuropsychiatry outreach clinic

AIMS AND METHOD
We describe the neuropsychiatry outreach clinic in west Kent and review referrals to the clinic over a 4-year period. By comparing the referral pattern of west Kent with adjacent health authorities we show how an outreach clinic can influence the number of neuropsychiatric referrals.

RESULTS
Referrals from west Kent increased from 87 in the 4-year period prior to the outreach clinic to 255 in the 4-year period that the clinic has been in existence. Forty-nine of these patients were first assessed in the outreach clinic. The number of referrals from east Surrey and east Sussex remained low in the same period.

CLINICAL IMPLICATIONS
An outreach clinic provides access to specialist expertise and increases local awareness of specialist services. Similar outreach clinics in other areas may enhance the clinical care of patients who are currently not being referred to neuropsychiatry.

The desirability of providing health care as close as possible to the patient's home has been repeatedly highlighted. The National Association of Health Authorities and Trusts (NAHAT) emphasises the provision of outreach clinics by specialist staff in primary care (Warner & Riley, 1994). They also recommend moving high technology aspects of medicine to a smaller number of centres. A report from the Royal College of Physicians emphasises the need to strengthen the specialist input to district general hospitals and advocates the provision of an outreach service from specialist centres (Cohen *et al*, 1996). The report points out that this recommendation should not be seen as antithetical to the NAHAT report, but as complementary. Traditionally the term district general hospital has referred to a hospital that provides a broad range of services (secondary care) for the population of a defined district. In recent years the role of the district hospital has been changing and this is partly due to increased collaboration between secondary and tertiary care.

The provision of a specialist outreach clinic in a district general hospital is a good example of collaboration that not only strengthens the links between tertiary and secondary care but also makes more widely available the expertise available at centres of excellence. A collaborative arrangement such as this fits with the so-called 'hub and spoke' model of care. The hub refers to the regional or national centre that provides high technology and specialist expertise. The spoke in this context refers to the district general hospital. The hub and spoke model is seen as an effective way of maintaining local access to services and ensuring the delivery of high quality care (Ham *et al*, 1998).

Neuropsychiatry in the Maudsley

Neuropsychiatry is the sub-speciality that deals with the borderland territory between clinical neurology and clinical psychiatry (Lishman, 1992). There is only a small number of specialist neuropsychiatry centres in the UK. One such centre is in the Maudsley Hospital, London, which has for many years provided a neuropsychiatry service. Referrals are accepted from all over the UK and there are no rigid criteria, although there are guidelines for referrers. Most patients will be referred for one of the following reasons: known or suspected organic disorder that may be leading to psychiatric problems; psychiatric aspects of epilepsy; or investigation of cognitive impairment and psychological problems that may be presenting as neurological symptoms such as somatisation/conversion disorder. There are a range of investigational procedures available to facilitate precise diagnosis and effective treatment. These include waking and sleep electroencephalography (EEG), video/EEG telemetry, computed tomography scanning, structural imaging (magnetic resonance imaging), functional imaging (positron emission tomography and single photon emission tomography) and neuropsychological investigations. The non-epileptic seizure service provides confirmation of clinical diagnosis using video/EEG telemetry and a cognitive–behavioural approach to therapy. The multi-disciplinary team approaches the assessment and treatment of the patient

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in a holistic fashion and can provide this in an out-patient setting or in the 10-bed in-patient Lishman unit in the Maudsley Hospital.

Benefits of an outreach clinic

The benefits of an outreach clinic in a speciality such as neuropsychiatry can be broadly divided into two groups, clinical benefits and training benefits. The presence of a clinic with relatively short waiting times provides patients with the opportunity for a screening assessment by a specialist nearer to their home. This early assessment reduces the potential for delayed diagnosis. The importance of available neuropsychiatric expertise cannot be underestimated because the boundaries between neurology and psychiatry are increasingly difficult to define.

The training benefits are relevant to both senior psychiatrists (as continuing professional development) and to junior trainees. Nicol and Bird (1992) reviewed training in neuropsychiatry and found there were only five senior registrar posts and three academic posts for trainees in the UK in this speciality. Outreach clinics offer opportunities to many trainees outside national or regional centres to learn about the speciality.

The Maidstone outreach clinic

In the past all out-patients referred for a neuropsychiatric assessment to the service were seen in either the Maudsley Hospital or King's College Hospital (the hub). However, the service has been expanded with the use of outreach clinics (the spokes). The first of these clinics was set up in Maidstone District General Hospital 6 years ago. It is run under the aegis of Invicta Community Care NHS Trust and receives referrals from within the West Kent Health Authority, which has a catchment population of about half a million people. The clinic was set up and is still run by a consultant general adult/liaison psychiatrist in Maidstone and a consultant neuropsychiatrist from the Maudsley Hospital. The clinic currently takes place every 3 months with an average of three new referrals per clinic. Most referrals are made to the clinic by consultant psychiatrists in the west Kent area. Investigations can be provided on an out-patient basis although admission to the Lishman unit is sometimes required to allow more comprehensive assessment and this also saves on repeated costly visits to London for investigation.

The study

All referrals to the outreach clinic were reviewed for the 4-year period from June 1996 to June 2000. The reason for referral was determined for each patient and each case was reviewed to ascertain the appropriateness of the referral. The total number of referrals from the West Kent Health Authority to the service for the same 4-year period and the 4-year period prior to the outreach clinic (June 1990 to June 1994) was determined. The number of referrals to the service from three adjacent health authorities was obtained for comparison. East Kent, east Surrey and east Sussex do not have formal links with the Maudsley such as those that exist for west Kent in the form of an outreach clinic.

Findings

There were a total of 49 new referrals to the outreach clinic in Maidstone between June 1994 and June 2000. Table 1 shows the reasons for referral. All 49 referrals were considered to have been appropriate. Table 2 shows the variability in the number of referrals to the service from the four health authorities studied. The past 4 years have seen a large increase in the number of referrals from west Kent (87 to 225) and from east Kent (24 to 191), unlike east Surrey (22 to 42) and east Sussex (28 to 24), where the number of referrals has remained low.

Comment

The reasons for referral were in line with the previously mentioned guidelines. The two most common reasons (investigation of cognitive impairment and investigation for an organic cause of psychiatric illness) accounted for 61% of the referrals. Only 12% of the referrals were for conditions of a purely psychological nature (non-epileptic seizures and abnormal illness behaviour). There are two possible reasons why fewer referrals were made for non-organic problems. First, most referrals were from psychiatrists, which is unlike the usual pattern of referral to the service (referrals come from both neurologists and psychiatrists) and perhaps reflects the incorrect

Table 1. Outreach clinic referrals (June 1996 to June 2000)

Reason for referral	Referrals (n=49)
Investigation of cognitive impairment	19
Investigation for organic cause of affective disorder or psychosis	11
Psychiatric complications of epilepsy	6
Adult attention deficit hyperactivity disorder	3
Non-epileptic seizures	3
Narcolepsy	2
Diagnostic dilemma	2
Abnormal illness behaviour	3

Table 2. Neuropsychiatric referrals to the Maudsley

Health authority	Number of referrals (1990–1994)	Number of referrals (1996–2000)
West Kent Health Authority	87	225
East Kent Health Authority	24	191
East Surrey Health Authority	22	42
East Sussex, Brighton and Hove	28	24

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perception among psychiatrists that neuropsychiatry deals with purely organic problems and treats these problems using only physical treatments. Scheepers *et al* (1995) have noted this previously in their survey of in-patient admissions to the neuropsychiatric service in Bristol. Second, it may be that patients with psychological problems masquerading as physical problems are first referred to a neurologist rather than a psychiatrist. We conclude from this observation that neurologists in west Kent should be made more aware of the neuropsychiatry service, including the outreach clinic, and also that psychiatrists should be informed about the full scope of services that neuropsychiatry can provide.

There were 255 referrals in total from the West Kent Health Authority in the recent 4-year period studied. In a similar period prior to this there were only 87 referrals. The large increase in referrals to the service in the past 4 years has coincided with the outreach clinic's existence. Nineteen per cent of the 225 referrals were first assessed in the outreach clinic (the remaining 81% being seen in the Maudsley Hospital or King's College Hospital, London). This implies that the outreach clinic has not only provided a means of referral to neuropsychiatry but has also served to raise general awareness of the speciality as a resource for patients in west Kent.

This is further highlighted by comparison with the surrounding health authorities. There were only a small number of referrals in both 4-year periods from east Surrey and east Sussex, Brighton and Hove. It may be that they have access to local neuropsychiatric expertise or make referrals to other national centres, but we have no knowledge of this.

The increased use of the service in the west Kent area has occurred as a result of the collaboration between the Maudsley and secondary care services in Maidstone in the form of an outreach clinic. It is likely that a similar arrangement in other areas would have the effect of increasing the use of the service in those areas also. Of interest is the large increase in the number of referrals recently from the East Kent Health Authority despite the absence of an outreach clinic in that area. The high number of referrals from this area can, in part, be explained by the fact that 62 (32%) of the referrals in the past 4 years were made by a consultant neurologist in the area who has a specialist interest in epilepsy.

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Time to abandon the subjective–objective divide?

"We don't see things as they are, we see things as we are" (Anaïs Nin, 1969)

In the mental state examination, a standard method of describing the clinical encounter is to contrast the patient's supposedly 'subjective' account with the doctor's 'objective' description. In this model, the doctor is granted a privileged position: the clinician's perspective is taken to be superior to that of the patient. The doctor's objective approach is considered neutral, scientific and representing the truth of the matter. In contrast, the patient's subjective report is regarded as unreliable, distorted and potentially false. The lowly status of the subjective perspective is further emphasised by the frequent use of the accompanying prefix, merely.

On reflection, this dichotomy is an extraordinary one. It is held that the doctor is an authority on the patient's inner experiences. The doctor knows more about how the patient is thinking and feeling than the patient him-/herself. This belief ignores the preconceptions and prejudices that the clinician brings to the interview. It ignores the impact that the interview has on how the doctor perceives the patient, and how the patient responds. In the physical sciences, it has long been recognised that the observer has an influence on what is being observed. As the physicist, Heisenberg (1958) commented:

> 'Science no longer confronts nature as an objective observer, but sees itself as an actor in this interplay between man and nature. The scientific method of analysing, explaining and classifying has become conscious of its limitations, which arise out of the fact that by its intervention science alters and refashions the object of investigation' (p. 29).

Another physicist, Schrödinger, made the point succinctly: 'the object is affected by our observation. You cannot obtain any knowledge about an object while leaving it strictly isolated' (see Boyd, 2000). If these considerations pertain in the world of modern physics, they surely have even more relevance for the human sciences, whose data is usually taken to be much 'softer'. In fact these concerns have been acknowledged in some areas of psychiatry. In psychoanalysis, the concept of

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