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Development of a Rural Community Psychiatric Service Based in a Hospital for Mental Diseases

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THE background, development and operation of psychiatric community services have already been described in detail.[1-14, 16-27]

During the late 1950's and in particular during the early 1960's the admission rate to the Hospital for Mental Diseases, Selkirk, Manitoba, showed a marked upward trend. It was concluded that a regular psychiatric consultation service was needed in the community.

In August 1961, a community psychiatric clinic was started in Selkirk. In January 1962, a second clinic was opened in Beausejour, which is located about 20 miles east of Selkirk. In 1963 a clinic was started in Gimli, and in 1966 in Stonewall and Pinawa.

The Selkirk and Beausejour clinics serve a rural area in southern Manitoba resembling a trapezium with 30 to 60 miles on each side and with a population of between 30 and 40 thousand.

The clinics are located in the local general hospitals and they share facilities with the local health units.

In the beginning, clinics were held weekly in Beausejour and twice weekly in Selkirk. At present, consultants visit the Beausejour clinic twice weekly and the Selkirk clinic almost daily. Patients are of both sexes and of all ages, and belong mainly to the lower income level of the population. Most of them are referred by family physicians; others are examined at the request of the health units, social agencies, relatives and friends. The number of self-referrals has increased. Patients are not charged for the psychiatric and ancillary services which they receive. Indigent patients are supplied with medications free of charge from the mental hospital dispensary.

In the beginning, there was one psychiatrist for the clinics; now two members of the medical staff of the Hospital for Mental Diseases, Selkirk, serve in the community clinics on a part-time basis in addition to their hospital duties. The psychiatrists act as consultants only. Following the initial interview of 60 to 90 minutes, patients are generally seen again at three to five consecutive sessions before they are referred back to the family physician. Psychotherapy is usually crisis-oriented and brief. Drug therapy has proved to be a valuable adjunct to psychotherapy.

A complete case history is written on every new patient and, with the patient's permission, a summary including the diagnosis and recommendations is mailed to the referring doctor. Copies of follow-up notes and the final report conclude the clinical and consultant function of the community psychiatrist, who is careful to express himself in understandable language. A mimeographed paper on phrenotropic drugs has been distributed among the physicians and the public health nurses.[15]

Only in the Selkirk area can emergency services be rendered effectively on the same day. Urgent cases are seen on the same day or on the following day. For other patients, regular appointments are made one or two weeks in advance. There has been no waiting list.

The initial reaction of the nursing personnel in the local general hospitals to the presence of psychiatric patients varied between rejection and over-acceptance. However, as experience showed that psychiatric patients usually were well behaved and that their condition improved, the nurses became eager to do their best. Spontaneous case discussions between the consultant and the attending physicians promoted mutual understanding and improved the care given to the psychiatric patients. Electroconvulsive therapy was introduced at the Selkirk General Hospital in 1963. Under the guidance of the community psychiatrist and only in his presence, two physicians administered this treatment to their psychiatric patients.

The community psychiatrist made several home visits at the request of the family physician. The physically handicapped and the very suspicious could thus be assessed in their home environment.

The community psychiatrist uses selectively the services of the mental hospital psychologist. He only rarely requests the assistance of the social worker because it is often through the efforts of public health nurses that newly discovered patients are referred, and they report regularly to the community psychiatrist and the family physicians on their follow-up of patients. The psychiatrist holds regular case conferences to aid the public health nurses in their work.

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TABLE I.—DIAGNOSES OF PATIENTS SEEN AT THE SELKIRK AND BEAUSEJOUR COMMUNITY CLINICS

	Aug. to Dec. 1961	*1962*	*1963*	*1964*	*Jan. to June 1965*
No. of patients	*20*	*92*	*186*	*248*	*194*
Schizophrenia	4	11	27	22	31
Manic-depressive psychosis	0	2	4	4	5
Involutional depression	0	6	16	16	12
Psychotic depression	0	0	1	0	3
Schizo-affective psychosis	0	2	4	6	5
Toxic psychosis	1	0	3	1	0
Paranoid state	0	1	0	0	1
Cerebral arteriosclerosis with psychosis	2	9	14	16	16
Senile psychosis	2	2	1	0	4
Organic psychosis (syphilis)	0	0	0	0	1
Total number of psychotics	9	33	70	65	78
Psychoneuroses	6	22	44	78	54
Personality disorders	1	9	12	20	9
Alcoholism	0	7	10	10	8
Epilepsy	1	3	4	5	5
Mental deficiency	3	6	13	24	12
Adjustment reaction of childhood	0	4	7	15	7
Adjustment reaction of adolescence	0	8	26	31	21
Total number of non-psychotics	11	59	116	183	116

Only a small minority of patients have needed treatment at the Hospital for Mental Diseases in Selkirk. The community psychiatrist treats these patients in the mental hospital and keeps the family physician informed, thereby maintaining the principle of continued care.

Radiological examinations and electroencephalograms are carried out at the Selkirk Mental Hospital.

FINDINGS FROM AUGUST 1961 TO JUNE 1965

In the Selkirk and Beausejour community clinics, from August 1961 to June 1965 inclusive, 750 patients were seen. In addition, 510 relatives and friends were interviewed during the same period. The number of patients and relatives attending the clinics increased steadily. The majority of the patients had psychiatric disorders of a minor nature, but the number of patients with psychoses was relatively high (Table I).

Over the period of the study there was a substantial increase in the number of children and adolescents examined. A comparison between the number of children seen at the Selkirk Child Guidance Clinic in the mental hospital and at the Selkirk Psychiatric Community Clinic indicates that the former service is gradually being supplanted by the Selkirk Psychiatric Community Clinic. The Beausejour Psychiatric Community Services offer facilities for adults, adolescents and children.

TABLE II.—NUMBER OF INTERVIEWS PER PATIENT IN THE COMMUNITY CLINICS

	Aug. to Dec. 1961	*1962*	*1963*	*1964*	*Jan. to June 1965*
Total number of patients	20	92	186	248	194
Interviews per patient	1.5	4.4	4.4	5.2	3.8
Total interviews	30	405	826	1,310	749

The number of interviews given to each patient increased gradually up to 1964. The slight decrease registered during the period January-June 1965 may have been caused by the additional increase in the total patient load (Table II).

Patients exhibiting major functional disorders (psychoses) were usually followed up for a longer period of time than those presenting minor psychiatric disturbances. The group of patients with personality disorders had fewer interviews per patient than the psychotics and neurotics. Possibly the former group had less motivation for therapy (Table III). Psychoneurotics attending supportive-interpretative sessions had the greatest number of interviews per patient, with an average of over 7.5.

TABLE IV.—ELDERLY PATIENTS WITH ORGANIC PSYCHOSIS RECEIVING SUPPORTIVE PSYCHOTHERAPY

	Patients	*Interviews*	*Interviews per patient*	*Mental Hospital Admissions*
Aug. to Dec. 1961	4	7	1.7	0
1962	11	60	5.4	0
1963	15	45	3.0	0
1964	16	46	2.8	2
Jan. to June 1965	20	51	2.5	1

Elderly patients requiring environmental manipulation and drug therapy seemed to need very few interviews. The low admission rate to the local mental hospital of the patients exam-

TABLE III.—NUMBER, INTERVIEWS AND INTERVIEW-PATIENT RATIOS IN PATIENTS WITH FUNCTIONAL PSYCHOSES AND PSYCHONEUROSES AT THE SELKIRK AND BEAUSEJOUR COMMUNITY CLINICS

	Functional psychoses			*Psychoneuroses*			*Personality disorder group*		
	Patients	*Interviews*	*Interviews per patient*	*Patients*	*Interviews*	*Interviews per patient*	*Patients*	*Interviews*	*Interviews per patient*
Aug. to Dec. 1961	4	10	2.5	6	29	4.8	1	3	3.0
1962	22	141	6.4	22	133	6.0	9	31	3.4
1963	52	298	5.7	44	170	3.8	12	56	4.6
1964	48	567	11.8	78	298	3.8	20	91	4.5
Jan. to June 1965	57	424	7.4	54	267	4.9	9	36	4.0

TABLE V.—PATIENTS ON ATARACTIC AND ANTIDEPRESSANT DRUGS

	Total number of patients		*On ataractics*		*On antidepressants*		*On ataractics and antidepressants*	
	Adults	*Children and adolescents*	*Adults*	*Children and adolescents*	*Adults*	*Children and adolescents*	*Adults*	*Children and adolescents*
Aug. to Dec. 1961	18	2	11	0	1	0	1	0
1962	80	12	75	7	9	0	9	0
1963	153	33	123	25	32	0	21	0
1964	194	54	177	9	20	0	32	0
Jan. to June 1965	166	28	150	18	38	0	70	0

ined at the clinics demonstrates how well psychiatric ailments of the aged can be dealt with in the community (Table IV).

Ataractic and antidepressant medications were administered to the majority of the patients attending the clinics (Table V).

Owing probably to the early recognition of psychiatric disorders, only a few patients (1 to 3%) required electroconvulsive therapy. Six patients (all female schizophrenics) were treated at the Selkirk General Hospital and six (two female and one male schizophrenics, and two male and one female involutional depressives) at the local mental hospital.

Only 10 to 15% of the community clinic patients were admitted to the local general hospitals either in Selkirk or in Beausejour for an average stay of one to three weeks. Admissions to the local mental hospital from the Selkirk and Beausejour areas were increasingly channelled through the local psychiatric community clinics. About 5% of the clinic patients were admitted to the local mental hospital.

Our experience, in which a mental hospital has been used as a centre for community pyschiatric service, has been encouraging, and it is hoped that this report will stimulate the institution of similar programs elsewhere in Canada.

Summary Experience gained from August 1961 to June 1965 in the use of the Hospital for Mental Diseases, Selkirk, Manitoba, as a centre for community psychiatric services is presented.

These services commenced on a regular basis in 1961 in Selkirk and in 1962 in Beausejour. During the period 1961 to 1965 the number of patients in attendance increased considerably, suggesting that the community psychiatric service was serving a useful purpose.

The main impressions gained from this study are: (1) With the assistance of a psychiatric consultant, family physicians are able to look after their own psychiatric patients. (2) Psychiatric patients can be treated in the local general hospital; under the guidance of a psychiatric consultant, electroconvulsive therapy can be given; only 1 to 3% of the patients examined needed electroconvulsive therapy. (3) Therapy by the psychiatrist was usually brief and crisis-oriented; only about 5% of the patients were admitted to the mental hospital; admissions to the local mental hospital were increasingly channelled through the existing community psychiatric clinics.

Résumé L'hôpital pour malades mentaux de Selkirk (Manitoba) a servi de centre pour l'organisation des services psychiatriques communautaires. L'auteur relate l'expérience aquise dans ce domaine.

Ces services ont commencé à fonctionner régulièrement en 1961 à Selkirk et en 1962 à Beauséjour. Au cours de la période de 1961 à 1965, le nombre de malades venus consulter a augmenté de façon considérable, ce qui porte à croire à l'utilité incontestable du service psychiatrique de la collectivité.

Parmi les principales impressions recueillies citons: (1) Grâce à l'aide du psychiatre consultant, les omnipraticiens ont pu traiter eux-mêmes leurs cas personnels de psychiatrie. (2) Les cas de psychiatrie de la collectivité ont pu être traités dans l'hôpital général de la localité. Sous la surveillance du psychiatre consultant, il a été possible, en certains cas, de pratiquer des électrochocs. Sur l'ensemble des malades, une proportion variant de 1 à 3% seulement ont eu besoin de ce type de traitement. (3) Le traitement psychiatrique a été généralement bref et orienté sur la crise. Environ 5% des malades ont été envoyés vers l'hôpital psychiatrique. Les entrées à l'hôpital mental local provenaient de plus en plus des cliniques psychiatriques existantes dans la région.

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CURRENT PROGRESS

Pediatric Home Care Program:
Review of Two and a Half Years' Experience at The Children's Hospital of Winnipeg

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THE volume of literature on the subject and the organization of national[1] and international home care conferences[2] provides evidence of the increasing interest in home care programs.

There must surely be many well-organized and efficient home care programs functioning throughout the North American continent which have received very little publicity. Although pediatric patients are included in many home care programs, there are far fewer which are organized specifically for children.

One of the earliest pediatric home care programs was instituted in 1954 at St. Mary's Hospital, London.[3, 4] The Department of Pediatrics of Harvard Medical School has provided a program in Family Medicine for pediatric house officers for many years, and although this embraces some home care, the prime object of the program is academic.[5]

Two pediatric home care programs were initiated in Canada in late 1964: one, based at the Montreal Children's Hospital,[6] and the other at the Children's Hospital of Winnipeg.

Since the Children's Hospital program in Winnipeg was started, the staff has consisted of a part-time medical director, a full-time nursing coordinator, and a secretary. The Children's Hospital provides office space and facilities in the area of the hospital designated for paramedical services, and the program is financed by a budget from the Manitoba Hospital Services Commission.

Initially, the objectives of the program were:

(1) The initiation of services which would enable a child with an acute illness to be treated

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