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Innovations

A combined group and individual long-term out-patient clinic

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Complaints of delays at out-patient clinics are common; a Newham patient's complaint that she had not been kept waiting long enough was correspondingly puzzling but has subsequently proved very fruitful. Her explanation that discussions with other waiting patients and the OPD nurse were often more helpful than the interview with the doctor triggered the development of a clinic designed for fuller participation of patients and staff.

Other important influences were knowledge of a combined group and individual clinic in Ireland (Ward, 1975) and accounts of successful low-key groups for schizophrenic patients, appealingly termed 'Coffee and . . .' psychotherapy, in the USA (Masnik *et al*, 1971; Masnik *et al*, 1980).

Organisation

The new clinic took shape in 1984, within a local day hospital, following the offer of appointments to all long-term attenders at two conventional out-patient departments. A year later the main session moved to a new day hospital which was closer to the homes of most of the patients, although a smaller version continued in the original venue.

At each site, sessions start with a one hour group which a core of five to six patients attend every week; others do so mainly when their injections or individual appointments are due. The resulting fluctuation in numbers – there may be up to 15 in the main centre – has not caused significant problems, perhaps because attenders get to know each other. An informal gathering over tea and biscuits, during which depot injections if due are given in a near-by clinical room follows. Members of staff then see some of the patients individually, usually about 6–10 in all, for their regular appointments, on request, or because they have given rise for concern. Finally, staff review together points that have arisen during the afternoon and arrangements are made for home visits and other interventions; the clinic forms one part of the more extensive long-term care provided by the Newham Rehabilitation Team.

Style and atmosphere

The prolonged interaction between staff and patients during the various components of the clinic produces a sense of cohesion, encompassing even the minority who attend only for injections and/or individual appointments. At each stage patients are involved in the arrangements, which occur in an informal and friendly style.

The group atmosphere is predominantly good-humoured and optimistic, with a great deal of mutual help, but at times some of the pain and despair long-term patients feel emerges clearly. We try to share their experiences and help with problems without the preconception that we know best or hiding behind jargon or technicalities. Patients appreciated a series of presentations given by staff outlining their own backgrounds, training and roles in the belief that personal information should not flow only one way.

Although interventions are more direct than in conventional small groups, they are not confrontational or critical. The CPNs have become adept at unobtrusively passing the conversation around so as to involve all the attenders.

Functions

As might be expected, the combination of a group with individual interviews has proved very useful in monitoring mental status and medication effects. The format also promotes the detection of physical symptoms which may otherwise be overlooked (Honig *et al*, 1989). Attenders are offered regular blood pressure and urine checks and other investigations or referrals made if needed.

Less expected has been the great range of the discussions among patients, almost 90% of whom have schizophrenic illnesses, lasting on average 23 years. As well as practical issues such as welfare benefits, leisure activities and work, emotionally charged matters are frequently included. On several occasions recent bereavements have been discussed with

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appropriate affect and a good deal of support from other group members; textbook emotional blunting or incongruity have been notably missing.

Staff and patients present a number of different strategies for coping with long-term illness and specific symptoms. Even sharing experiences such as auditory hallucinations seems to be beneficial by easing the sense of uniqueness and isolation they produce.

The format also encourages acceptance of medication due to the advice and example of other patients and, unfortunately, on a few occasions because of evident deterioration after insistence on stopping it. On the other hand, continuing group contact seems to have facilitated subsequent resumption: there has been only one admission of a group attender to hospital since 1984.

An additional feature is accessability: medical and nursing trainees can participate without being intrusive; experts, who have included a dietician and a speech therapist, can contribute and also learn about long-term patients' needs; representatives of community agencies may be invited to discuss topics such as training and employment; and videos on health promotion and other subjects can be shown.

Finally, the clinic has had a striking effect in developing social networks among otherwise very isolated people, one of the critical issues for community care. Relationships evolved between individuals of different ages and backgrounds from the beginning, and three years ago, led to the setting up of an evening club for clinic attenders and other long-term patients which has become a source of great pleasure.

Assessment

This style of clinic makes effective use of staff time because of the dovetailing together of its component parts and the contribution of the patients themselves. A total of 45 patients is currently being catered for in the two centres and numbers are continuing to grow as more long-term patients are settling in the community.

The two staff teams now total a consultant, clinical assistant and three CPNs, with additional input from a social worker and a psychologist who has been involved from the outset.

For D.A., the six years of the clinic's operation have proved vastly more satisfying than the dozen preceding years during which he saw similar, in some cases the same patients for conventional out-patient follow-up. Patients had clearly often found it difficult to express themselves and presumably this would have been worse had their doctor changed frequently. The new format ensures continuity irrespective of medical staffing, and the value of the multidisciplinary input has emerged.

However, the most gratifying effect of the new arrangements has been the challenging of pre-existing stereotypes of long-term patients. The extent to which such preconceptions failed to do justice to these individuals' human qualities, illness courses (Cutting *et al*, 1983) and potential for a more satisfying quality of life soon became evident in the new setting and this has greatly widened and sustained interest in catering for their needs. Such experience may be vital in preventing institutional attitudes persisting or redeveloping in community services.

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