Should Community Psychiatrists be Specialists?

A report on specialist status from the Working Party of the Social and Community Psychiatry Section

Since the establishment of the Social and Community Section of the College, it has been apparent that differences exist in the viewpoints of its members on such questions as the role of the psychiatrist in the general community, how services are to be evaluated, what are the functional limits of psychiatry in the population and whether 'community psychiatry' is a unitary concept (and if so, whether it implies a generally accepted pattern of services, such as that proposed in 1975 in *Better Services for the Mentally Ill*).

The 1977 Symposium

To help towards clarification of these issues, a symposium was held at the Ciba Foundation in 1977; its proceedings were not published, but a summary was prepared by Dr John Corbett, and appeared in the *Bulletin*. Amongst the points made were (by Professor Wing) that discussions were too often about secondary issues of service processes, rather than primary aims of removing morbidity; that every mental health service should be responsible (to a population), comprehensive and integrated; and that every service agency should have a combination of diagnostic, therapeutic, rehabilitative and preventive functions. Since World War II the 'institutional psychiatry' model (though this only ever applied to a minority of selected people) had been challenged by an alternative, in which the functions were geographically dispersed throughout the population, but remained administratively integrated. At the same time, psychiatrists and allied professional staff were extending their interests from psychosis to a variety of less severe psychiatric disorders, though still seeing only about 5 per cent of people with identified psychiatric morbidity in the population. Once this process began, though, the problem immediately arose of where it was to stop; Caplan's model gave priority to consultative work by psychiatrists with other professionals and with lay volunteers, who in turn would intervene in personal crises of members of the public. It was assumed—without firm evidence—that this would both prevent the development of severe mental illness and provide 'positive mental health'. However, it was not apparent how treatment resources were also to be found for those suffering from acute psychiatric illness or from chronic disabilities.

Although official policy in the UK since the late 1950s had favoured a primarily non-institutional model (or 'secondary community care'), up to the time of this symposium, mental hospitals were still dealing with three-quarters of all psychiatric admissions, particularly those which were therapeutically less rewarding. Dr Bennett pointed out that 'community psychiatry' had become synonymous here with a national plan, whereby treatment functions were transferred to the DGH, and then operated in partnership with extramural facilities, mainly provided by social services. However, the plan did not initially take account of the problem of 'new long-stay' patients, or appreciate the extent of psychogeriatric demands. Staff establishments and training in the NHS were still related to the institutional model, and did not acknowledge the need to serve a district population through a variety of facilities; an exception to this was the development of psychiatric community nursing.

Particular attention was drawn to the handling of emergency situations, since most psychiatric admissions occur as a result of these, yet the vast majority of emergency episodes can be managed without admitting the person concerned. The need for comparative evaluation was stressed, e.g. of a hospital-based emergency clinic as against a domiciliary crisis intervention service, though providing either of these would require much more staff than would a conventional service. The Community Mental Health Centre model, as developed in the USA, was not thought to be highly relevant to this country. As far as GPs were concerned, a survey of them in Norfolk had given disappointing results in terms of their understanding of community psychiatry or of appropriate utilization of its services. On the other hand, the value of psychiatrists devoting part of their time to work in GP health centres seemed to be confirmed by a five-year project of the Tavistock Clinic; though this would need to be compared in other areas. Patients suffering from chronic or recurrent psychoses, and requiring long-term medication or social measures, involve problems particularly of organization, management and continuously updated information; these are in addition to purely clinical measures. However, the clinician in psychiatry, especially if he has a commitment to a community, may have no alternative but to accept responsibility for these extra-clinical aspects of himself, because of the special qualities of the medical role.

Another problem in relation to district services is the place of such sub-specialties as mental retardation, psychogeriatrics, psychotherapy, forensic psychiatry and alcoholism. Quite apart from the constraints of resources, slowness of recruitment and training means that full-time consultants in these highly specialized services can only be available generally at a regional or sub-regional level. In districts, general psychiatrists may have to have a particular interest in one or more of these special problems, obtaining help from the full-time expert in certain cases only. This focusing on the relationship of general to special work in psychiatry led on to consideration of the question of whether

or not 'community psychiatry' was one of those specialisms. However, it was agreed that there could be no single, stereotyped model of community psychiatric services, and that comparative evaluation of the alternative models was most necessary to find those elements which were most effective.

Community psychiatry as a specialist job

Two years later, the Executive Committee of the Social and Community Section considered the possible need to establish consultant posts in which at least half the sessions would be devoted to community psychiatry, the rest of the time being for general work. The reasons for considering this need were that:

(a) Although social and community psychiatry are regarded as integral parts of general psychiatry in the UK, it has to be acknowledged that these aspects are not adequately taught in most specialist training programmes, and that many doctors appointed as consultants have not had adequate experience of them. Many existing consultants lack the knowledge to deal with the complex communications between health and social services, or to guide their clients through bureaucratic networks to obtain needed services.

(b) Community physicians have the responsibility of liaison between mental health and social services, but their training contains little psychiatric input, and it is widely felt by clinicians that this co-ordination does not work well. There are many problems which may result partly from community physicians' lack of experience, and it is likely that one of a group of consultant psychiatrists who had special training and responsibility could overcome some of these difficulties.

(c) Other liaison and training work needs to be done with the primary care team (particularly community nurses) and within social services, particularly as most social workers now have no mental health training. A specialist consultant should be in a better position to do this than most general clinicians.

(d) In relation to the social needs of clients, a consultant who had detailed knowledge of the activities of social services and related organizations (e.g. housing associations) should be better able to give help.

(e) There is considerable unevenness of provision of community services in different parts of the country, and a specialist consultant could devote detailed attention to the deficiencies in his district, as well as to finding ways in which these might be met. Sometimes, these services can more easily be provided under a medical label, or through medical initiative.

(f) Most clinicians are able to do little in the way of activities which could have a function of primary prevention. A community psychiatrist could devote some of his time to, e.g. bereavement counselling, assisting both families and staff in the care of the dying, crisis intervention, liaison with Samaritans. In all these activities, training of volunteers and lower level professionals would be encouraged. A community psychiatrist could take the initiative in developing innovatory services, using local volunteers and resources.

(g) There are many research opportunities in social and community psychiatry which at present are not being exploited, but which could be if consultants with this special interest were available.

Psychiatric responsibility and training

A Working Party was set up to consider the question, with Dr Hugh Freeman as convener. However, a number of fundamental issues were then thrown up, relating particularly to the boundaries of psychiatric responsibility, the nature of psychiatric training, and the extent to which general consultants were *not* community psychiatrists. Before any model was selected for possible application generally, its effectiveness would have to be evaluated, and the costs fully assessed. In its discussions, the Working Party received information about a number of services which have emphasized community orientation—Lewisham, Dingleton, Napsbury, Craigmillar and the RAF particularly.

DHSS policy envisages the gradual development everywhere of a *comprehensive* community-based mental health service. As this occurs, and more facilities become available outside hospitals, the emphasis of the practice of most psychiatrists should change to include more extramural work. The consultant is seen as working in a geographical area and as being part of the community services there, so that if there were also a specialist community psychiatrist, responsibility for patients' needs might be divided between two clinicians and their teams. (However, this problem may arise, to some extent, with any sub-specialty.)

It became clear that training was a fundamental aspect of the discussions; quite apart from any need to train specialist 'community psychiatrists', the College already recognized that extramural experience was an essential part of general higher psychiatric training, though it was not clear that this necessarily affected the attitudes of trainees. Enquiries showed that in Edinburgh,there was a Fellowship in Community Psychiatry as senior registrar level, but its degree of responsibility was perhaps more appropriate to a consultant. At Bradford, a registrar post had been established in community psychiatry, with no in-patient responsibilities; six sessions are divided between two day hospitals, two spent at Leeds University, one at the Social Services area office and one on research or a relevant special interest. At Lewisham, a supernumerary registrar from Bexley Hospital is attached to the community service, but not senior registrars. Dr Brough commented that current training does not include conveying knowledge on how the system of services works, yet the strength of psychiatry, compared with other disciplines, rests in its ability to move into their territory, and up or down their hierarchies.

At Napsbury Hospital, registrars on two of the three

teams go out with consultants on crisis visits and, after about three months, undertake visits themselves with a senior social worker. However, those attached to the third team do not get community experience, but are linked with the DGH unit at Watford. In the Worcester service, special efforts are made in training to avoid 'institutionalization'; the senior registrar and an experienced clinical assistant carry out domiciliary visits and supervise patients in hostels and group homes. Registrars and SHOs accompany the consultant on visits, and may then undertake follow-up visits themselves with a community psychiatric nurse (CPN). At Dingleton Hospital, which is not part of a rotational scheme, much training occurs from working as a member of a pair with an experienced social worker or nurse. In Tameside, a senior registrar rotates for a year from the teaching centre and is attached to the community mental health centre. However, where an innovative and a conventional service are operating alongside each other, there could be particular problems for trainees.

Professor Brandon reported that both he and a lecturer have designated sessions for educational and consultative work with social workers, community nurses, health visitors and a special NSPCC unit at Leicester. He has proposed that a consultant post should be divided so as to provide three sessions each of community work for three consultants whose main duties are with the elderly.

So far as community medicine is concerned, it was reported that following the present reorganization of the NHS, there are likely to be only two community physicians per district, and nearly all of these are to be 'general' in function. However, there is clearly a need for a specifically epidemiological input into psychiatric services, which is unlikely to come from existing general psychiatrists. Possibly this need could be supplied at Regional level.

The Working Party considered the proposition that about six posts might be established in community psychiatry, on an experimental basis; some consultants at present in post might be interested in them, in which case their sessions would have to be replaced. It would be best to test out the model in different types of communities, e.g. a decaying inner city area, a scattered rural community, etc. A special training programme would be required, perhaps consisting of some initial didactic teaching, with subsequent return periods, in which the participants' experience could be shared and evaluated. Evaluation would have to be on a rigorous basis, to see if it was possible to demonstrate better use of resources, with reduction in morbidity and disability among the population served as a result of the new post. However, the Working Party were concerned that this could possibly lead to other consultants feeling that community psychiatry was not their concern.

The 1981 Symposium

To allow fuller discussion of the issues raised, a second symposium was held at the Ciba Foundation in September 1981.

The dangers of a two-tier system within psychiatric services were pointed out, and it was suggested that one of the functions of a community psychiatrist might be an alertness to changes affecting the chronically disabled, and exerting pressure within services on their behalf. However, rehabilitation seems to be in decline, perhaps because of national economic circumstances. Financial resources are still strongly bound to mental hospitals (95 per cent spent on in-patient care) and greater flexibility should be possible in their use; it might be useful to hold a special local meeting, each time a manifest failure of psychiatric care occurred, to see if resources could be rearranged to take account of that problem.

Crisis intervention

The question of crisis intervention services was prominent. Dr Parkes described the arrangement in Tower Hamlets, where families can be seen during the day, though a psychiatrist is not necessarily in the visiting team. The initial interview takes about one and a half hours; one-third of clients receive five to six sessions of family therapy, one-third are referred to other care-givers, and one-tenth are admitted. All members of the crisis team meet weekly. Dr Pullen described the service in north-west Edinburgh, where GPs who request an admission are offered instead a home visit by a trainee psychiatrist with a charge nurse or social worker. The visiting team focus on current problems; as a result of this arrangement, it became possible to close an admission ward, but this resulted in loss of nursing staff, and conflicts developed between intramural and extramural nurses. Dr Pullen had investigated the claims made for crisis intervention services in the USA and found them to be unsubstantiated.

Dr Pariente described the Napsbury service, which covers half the Borough of Barnet; it is available on a 24-hour basis, and does 2,500 visits per annum. The aim is to identify psychosocial transitions that lead to referrals, involving other family members and neighbours in the process. Increasing numbers of clients are attracted, and most cases are managed without admission, resulting in the closure of 160 beds in the hospital. However, travel costs are high and hours of work lengthy, causing strain on the staff involved; admission rates are now at about the national average.

Dr Jones described the Dingleton service, where crisis intervention is associated with a continued therapeutic community approach within the hospital. Each area psychiatric team is available in working hours only, but the limited number of other calls are seen by hospital on-call staff. Most GPs in the area are visited monthly. The ideology that admission is to be avoided at all costs has been modified, but under-65 admissions are 36 per cent below the Scottish average.

Discussion emphasized that admission may be therapeutic, e.g. for a family with a schizophrenic member.

The need for a 24-hour service was doubted, since most 'crises' are not referred immediately; the most important factor was that clients should know who to contact. Thus, administration of the service is crucial, and there must be a flexibility of response. Any arrangement requiring staff to work regularly outside normal hours requires unusual dedication. Very few psychiatrists have been specifically trained in crises intervention techniques; and even if they were, it might exacerbate the tendency for chronically handicapped patients to become overlooked.

Concerning the GP-psychiatrist relationship, better training of GPs was thought necessary, but might require greater involvement by at least some psychiatrists in primary care. As GPs become more competent in handling psychiatric problems, the patients they do refer become increasingly difficult. Dr Mitchell said that one-third of his clinical time is spent in liaison work with 50 GPs, but in other types of area, e.g. inner cities, the quality of GPs might not be comparable and similar arrangements not possible. In the case of the RAF community service, where its initiation had been followed by a halving of the psychiatric discharge rate from the service and a great reduction in the number of admissions and working days lost through illness, in-service training of the GPs and emphasis on the GPs continued responsibility was thought to be essential. This might be fostered by the hierarchical relationship within the services; on the other hand, the psychiatrists spend much of their time dealing with non-medical managers.

Hospitals and services

In relation to mental hospitals, Dr Hall described the Worcester Development Project and emphasized the 20-year time-scale leading to the scheduled closure of Powick Hospital. Because of this, there had probably been over-provision of day places and insufficient beds for the new long-stay. However, in the SE Thames Region, half the districts still contain no psychiatric facilities and to provide them everywhere would cost over £100m (at 1980 prices).

Dr Fryers, reporting on the Salford case register, emphasized the continued shortening of hospital stay, particularly for schizophrenics, and the new categories of non-institutional care—patients cared for by CPNs and those attending only for injections of depot neuroleptics.

A recent development is the addition of beds (for 'crisis' cases) to some day hospitals, which also acted as the base for a social work team; they would then function more like a mental health centre. On the other hand, the opening of more DGH units could strengthen the medical model, and result in general psychiatrists becoming more hospital-bound.

Amongst examples of innovative services, Dr Brough referred to his own for one sector of Lewisham, with a population of 80,000; there are no in-patient or day facilities in the district. An ordinary house has been converted into a mental health centre for the 15–65 age group, and four multidisciplinary teams operate from it during working hours. Since crisis intervention in patients' homes has been introduced, the number of first admissions has almost halved, but re-admissions remain unchanged. If the area covered by a service is larger than this, sensitivity to local problems and interprofessional relationships becomes more difficult; 71 GPs, 65 social workers and 7 CPNs are involved in this sector. Voluntary funding has been found for evaluation.

Dr Gleisner described the service for a similar population in Tameside, also centred on an old house, jointly funded by the NHS and social services. The team includes some non-professional members, but no nurses, though they visit the centre, where no medication is kept. Admissions to the DGH have become fewer, and are now nearly all psychotics. The role of the psychiatrists here is subject to change.

In Craigmillar, Edinburgh, Dr Greenwood works mainly as an 'enabler' for facilities already existing in the community, but has been instrumental in setting up a day centre with voluntary funds. She sees some clients directly (including a large weekly group), but also acts as a mediator with hospital services; some of the clients would not be regarded as clinical psychiatric cases. Psychiatric training does not prepare a person for this role, and the danger has been emphasized of psychiatrists being drawn into social and political action without appropriate authority or expertise.

Concerning child psychiatry, Dr Wolkind said that though this had begun as a community specialty, it was moving back into hospitals, where psychiatrists gained security and authority, as well as having boundaries established to their responsibility and expertise. Unfortunately, since the interprofessional rivalries of psychologists, social workers and child psychiatrists had eroded the tradition of the multidisciplinary team, the psychiatrist needed the hospital as a support base, but it should be within the catchment area. Strict limits should be set for the demands of in-patient work, but the struggles which occurred at the interface with social services tended to make community work increasingly difficult.

From the national viewpoint, Dr Dick said that many district services have poorly developed resources in the community, while there may be no individual there to take on the organizational responsibility of planning, developing and managing community services. Problems may be particularly severe where there are few consultants in a district and they no longer have an attachment to a mental hospital. Up to now, good community services had developed through individual initiatives and through co-operation between the NHS and local authorities; however, they have not yet become institutionalized as a formal part of psychiatric care, and dissemination of information about them is poor. Though it is relatively rare for psychiatrists to work through a variety of extra-hospital agencies, most consultants are probably spending much of their professional time in work outside hospitals. However, this has the result that in-patient work, particularly with the long-stay, is

being left more to nurses, who may be expected to develop an increasingly independent role.

Dr Leff said that while a number of particular services provide models of community psychiatry, these have generally contained individual clinicians with the charisma and determination to establish them. The change which had occurred in social attitudes to the mentally ill started in mental hospitals, where efforts were made to combat the handicaps of the chronically ill. These efforts of tertiary prevention later spread to day hospitals, and then the focus of therapeutic activity moved out into the general community, involving GPs, relatives, etc. Most of the innovative activities described were concerned with primary and secondary prevention, and since a variety of services were flourishing, in different social environments, the experimental posts that had been considered in community psychiatry in fact already existed.

The next steps

The next step was to evaluate these developments scientifically. Preliminary data indicated that the introduction of new services, such as crisis intervention, was generally followed by a fall in first admission rates, whereas re-admissions remained static. This suggested—surprisingly—that such services may be more effective in primary than in secondary prevention. However, it would have to be shown that this reduction in first admissions improved patients' morbidity in the long term; it also makes much less impact on bed usage than reduction in medium-term or long-term admissions.

No general support emerged during the Working Party's discussions for the formal establishment of community psychiatry as a sub-specialty. On the other hand, it was agreed that there is great confusion about the administration of services, leadership of multidisciplinary teams, etc.

Regrettably, psychiatrists in general have not shown impressive management abilities, but the restructuring which accompanies the 1982 reorganization provides new opportunities which ought not to be neglected, e.g. in trying out the proposals of the Nodder Report.

Mental hospital beds are continuing to fall, and are increasingly occupied by psychogeriatric patients, but monitoring and audit of these and other services remain in their infancy. Here, greater use might be made of the data provided by case registers. Though a non-institutional approach has become the conventional wisdom in British psychiatry, its implementation—and particularly how to teach the special qualities of innovative services to trainees—remains problematic. The reliable identification of community methods and arrangements which are of proved value in reducing morbidity is a continuing priority, but disappointingly little progress has been made in that direction up to now.

Should training change?

The question of training emerged as a crucial one for community psychiatry. Dr Dally has suggested that trainees may be led up the garden path, e.g. by the holding out of such vague objectives as preventing delinquency, vandalism or unwanted pregnancies through their intervention in schools; although neurotic and psychosomatic disorders are very common in the general population, many resolve spontaneously while the special skills of psychiatrists do not seem to be more successful for the rest than those of the GPs or other specialists. Psychiatrists must know 'what they are really hoping to achieve and why'.

On the other hand, much present-day specialist training has been described as little more than learning to make diagnoses and prescribe drugs, whereas psychiatric skills should include understanding why people feel as they do and helping them to understand themselves and others. Discussion of adolescent behaviour with a psychiatrist may help teachers, for instance, to cope better with their own professional routines. Recruitment is still a considerable problem in psychiatry, but those doctors who now favour general practice because it is in a non-hospital setting and involves working with the 'whole person' may be more attracted to psychiatry if this includes community work at registrar level, related to a catchment population. Special opportunities might be offered for this, as they are now in child psychiatry, psychogeriatrics, etc.

If British psychiatry is to be generally a community-based discipline, therefore, the training issue must be clearly faced and resolved; psychiatric nursing has already made the decision to emphasize extramural experience. In higher psychiatric training, however, this has not yet been mandatory, and tends to be squeezed out by the demands of in-patient experience. It is recommended that the JCHPT and College Assessors should insist on adequate social and community experience, particularly at senior registrar level.

Lack of concern for the epidemiological aspects of psychiatry amongst clinicians should also be a matter for concern, and senior registrars or consultants should be encouraged to acquire knowledge of these matters, e.g. at part-time or short term courses.