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Editorial

Community Psychiatry: Central Policy, Local Implementation

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Mental health services are a key area within *Health of the Nation* targets, and the development of comprehensive mental health services is one of a small number of medium-term priorities for the Health Service (NHS Executive, 1995). This should present an opportunity to develop comprehensive community mental health services in line with national priorities and targets. In practice, the delivery of community mental health services is fragmented and policy is confusing. This editorial presents a framework (Fig. 1) that describes the competing forces currently influencing the delivery of mental health services.

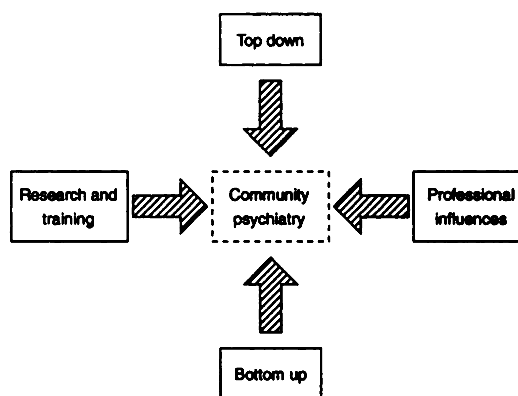

Fig. 1 A framework within which to understand policy and stakeholder influences.

Trends in service delivery

Current concepts of community psychiatry can be summed up as:

(a) the purpose of the 'hospital' is to achieve stability;
(b) the 'community' is a place to live and maintain stability.

These are deceptively simple statements with profound implications. What they imply is a radical reorientation of services away from acute hospital care to service models that aim to achieve long-term stability and a decent quality of life in the community (Test & Scott, 1990; Rosen, 1992).

Model community mental health programmes – of which the Madison model (Stein & Test, 1980), combining hospital, home treatment and assertive outreach, is the best known – have been evaluated against standard hospital treatment in international health care (Stein & Test, 1980; Hoult *et al*, 1983), and in the National Health Service (NHS) in Britain (Marks *et al*, 1994; Connolly *et al*, 1996). Some conclusions can be drawn by combining findings from these studies. Model community programmes do not result in statistically significant improvements in clinical outcome, though outcome trends do support them. Social and personal functioning is enhanced, satisfaction on the part of patients and carers increased, and length of stay in hospital reduced by the model programmes. Health economic evaluations of the model community programmes demonstrate advantages for society in the form of reduced time off work and maintenance of normal social ties and probable budget savings for health providers (Weisbrod *et al*, 1980; Knapp *et al*, 1994).

'Real life' implementation of model programmes have been described and evaluated where implementation has been within existing health-care systems and budgets, and the results have been in line with the conclusions drawn from model programmes (Creed *et al*, 1990; Dean & Gadd, 1990; Merson *et al*, 1992; Burns *et al*, 1993; Scott *et al*, 1994). Wholesale implementation of these programmes are tempered by the risks of community 'failure', with the attendant inquiries (Coid, 1994*a*), the cost in 'burn out' of staff (Connolly *et al*, 1996), and the lack of hard evidence of clinical gains from the model programmes.

Whether the model programmes are enthusiastically adopted at a local level will largely be a result of the interplay of local voices in the development of a local strategy and hence the relative allocation of resources to different elements of service. The Audit Commission (1994) points out that there is

considerable discretion available to both purchasers and providers in how resources are used and in the relative distribution of resources to different elements of service (for example home *v.* hospital care). What mix of services will emerge locally will rest upon the interplay between policy and its local interpretation, key voices in shaping services and the readiness of providers to alter existing service patterns. Figure 1 provides a framework within which can be understood the competing forces that shape local service delivery.

Top–down influences

Ignoring for a moment the issue of resources, central NHS policy on mental health care is now driven by a set of coherent and internally consistent policies concentrating service effort on those with severe mental illness through combinations of hospital, community and social care (Department of Health, 1991/92, 1994, 1995; NHS Executive, 1995). The closure of large mental hospitals and the development of local services has been and remains a central plank of policy for mental health services (Department of Health and Social Security, 1975). However, central policy also urges purchasers to implement "Towards a Primary Care Led NHS" (NHS Executive, 1994), which places increasing emphasis on the purchasing of services by fundholding general practitioners and increased influence of general practitioners in shaping contracts. Inevitably there will be a clash of policies unless primary-care teams hold the same set of priorities for mental health delivery as envisaged by national policy.

Professional voices

General practitioners have contact with, perhaps, 300 or 600 people with anxiety and depressive disorders and seven people suffering from schizophrenia (Jenkins, 1992). Not surprisingly, primary-care teams, though acknowledging the priority given to the long-term mentally ill, are keen to see the development of mental health services that meet the demands of those with whom they have daily contact. The shift in purchasing to general practice brings with it tensions between the practice-level perspectives and the national policy emphasis on people with severe, enduring mental health problems. There is good evidence that fundholding practices shift the focus of purchasing for mental health services to the general-practice level of morbidity (Kendrick, 1994). Where community teams become more integrated with general practice, there is a shift from targeting the long-term mentally ill to providing services to the primary-care level of morbidity (Woolfe & Goldberg, 1988; White 1991; Gourney & Brooking, 1994). This fundamental incompatibility between different policies has the potential of severely limiting the targeting of services on those with severe mental illness in the community.

Health-authority purchasers tend to take the whole-population view, which is more in keeping with national priorities. Implementation of policy at local level will also be influenced by professional voices such as royal colleges, social services, the police and criminal justice systems, each of which will lobby for their own particular concerns to be addressed in local service design.

Bottom up

Users of services, when asked, tend to emphasise the need for choice, flexibility and alternatives to hospital care, with open access, 24-hour crisis services and user-led services (Shepherd *et al*, 1994). These perspectives are legitimate but often clash with the demands on providers to deliver services which ensure safety in the community. Users of services may wish to take greater risks than service providers with their own safety in the community, particularly at the point of discharge from hospital. The introduction of powers of supervised discharge (currently before Parliament) may bring into the open sharp divides between the wishes and aspirations of users, carers and society, leaving mental health professionals with the daunting task of accommodating very different perspectives on choice and risk.

Research and training

The shift from hospital treatment to programmes to maintain stability in the community and the increasingly sophisticated psychological approaches for the treatment of severe mental health problems (Birchwood & Tarrier, 1995) require not just a shift to the community but investment in comprehensive training to underpin alterations in clinical practice. Without such long-term training, service change may simply consist of the transfer of old ways of working to new settings. The successful community programmes have been characterised by investment in acquisition of skills, but investing in the necessary long-term training does not sit easily with short-term contracts in the NHS.

Managing risk and transition

Under the influence of the forces described above, most community mental health services are changing. As services are in transition, there is the ever-present risk of 'things going wrong', and public inquiries into the failures of community care (Coid, 1994*a*, *b*).

Three central issues should underpin efforts to manage risk during this phase of transition:

(a) full and complete implementation of the care programme approach (Department of Health, 1995);
(b) adequate provision of secure accommodation, particularly local low-security services;
(c) an adequate network of social care provision.

Tyrer and Kennedy (1995) point out that in a dispersed system like community care, a systematic method for coordinating care is essential, particularly to track those at real risk of 'falling through the net'. The care programme approach is a tangible embodiment of national priorities. Proper monitoring can highlight deficiencies in the delivery of community care and effectively monitor the availability of resources. The results of the Daily Living Programme in London (Connolly *et al*, 1996) and the failure of a unidisciplinary approach to intensive community care (Muijen *et al*, 1994) demonstrate the need to embed approaches like the care programme approach within well organised multidisciplinary community team structures utilising a systematic model of care. Implementation of initiatives such as the care programme approach will otherwise simply become a bureaucratic exercise.

Medium-secure units are a focus for comprehensive forensic psychiatric services and are not designed to meet local needs of patients with severe disturbance and challenging behaviours, whether offender or non-offenders. To fill the gap between open psychiatric facilities and regional secure units, low-security services provide a safety net for community psychiatry, ensuring that those with the most severe and challenging behaviours can be safely managed within a community psychiatric service (Faulk, 1985; O'Grady, 1990).

People with severe enduring illness have long-term problems achieving competency in tasks of everyday living such that lifelong social support systems are necessary, but these are difficult to achieve with the split between health and social care.

Once these three elements are in place, the question of "how many beds" (Thornicroft & Strathdee, 1994; Watson, 1994) can be addressed. Shifting to home treatment or other alternatives to hospital care can then be achieved with reasonable safety. Published figures on bed utilisation in London (Flannigan *et al*, 1994) provide useful data on the minimum safe levels of hospital-bed provision required.

Conclusion

The pace of change within mental health services increases daily. This has led to dislocation and bewilderment among those who deliver services. This editorial has described a model which shows that this is understandable if one takes into account the multiple perspectives and policies involved. The task facing providers of mental health services is to devise services that take account of these complex and often contradictory influences. The consultant community psychiatrist of the future will not only need to acquire clinical skills but also the managerial skills involved in complex service change and in managing the 'politics' of local service provision.

Traditional physician training has emphasised the acquisition of clinical skills. To work with the complexities of delivery of community care, psychiatrists will need skills in the management of complex social systems, the management of change and the political and managerial skills necessary to work effectively with health and social service management systems (see Muijen, 1993). Leadership and teamwork skills are not innate but require training and development (Reed, 1995; Smith, 1995). There is a very real danger that the pace of change within mental health delivery will rapidly outstrip the training systems' ability to deliver the consultant psychiatrists of the future with the requisite skills to work within new-style community services. The gap created may well be filled by other professionals.

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