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Keynotes

The consultant psychiatrist and community care

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It cannot be ignored that community care is now a fact, and not merely an issue. Some mental hospitals have closed and the number of mental illness beds have been reduced overall by about 40% over the last decade and a range of hostels, multidisciplinary rehabilitation teams and community mental health centres have been launched. The move towards well integrated and well coordinated community care has been urged by a large number of reports, white papers and policies including the second Griffiths report, *Working for Patients, Caring for People, The Health of the Nation*, the Care Programme Approach and care management, with social services becoming the lead agency in community care.

The real issue remains how to implement community care optimally, since it would be hard to argue that it is fulfilling its promise. The transformation from a hospital based service to community care requires comprehensive and fundamental changes in roles as well as structures, and some of these are targeted by *The Health of the Nation: Mental Illness Key Area Handbook* (DoH, 1993).

Consultant psychiatrists, often represented by the Royal College of Psychiatrists, should take an active part in developments, and should be recognised as representing the best interest of the consumers, i.e. their patients. However, clarity and vision is required about the function of the consultant in community care. It cannot be assumed that a perpetuation of the traditional division of power will be acceptable to other stakeholders, and unless the psychiatric profession takes the initiative others may do so instead, as has happened elsewhere, not always with positive consequences for the quality and equity of care delivery (Scherl & Macht, 1979).

Present role of the consultant psychiatrist

The role of the consultant psychiatrist is discussed in some detail in *Mental Health of the Nation: The contribution for psychiatry* (Royal College of Psychiatrists, 1992). The consultant psychiatrist is considered to be the fundamental unit of service delivery. The role of the consultant consists of three components: leading the multidisciplinary team, active involvement in management, and functioning as a personal physician (Table I).

This is a very demanding job description, requiring great expertise and close involvement at every service level. It also implies a high degree of centralised power in the hands of the consultant. It is argued that this is the most effective way of organising the health

TABLE I
The traditional consultant's role

Consultant fundamental unit of service delivery:

1. *Leader of multidisciplinary team*
   Act as coordinator: supervising referral to appropriate key worker and treatment of individual patients, responsible for functioning of team.
2. *Active in management*
   Decisions about service priorities and resource allocation.
3. *Personal physician*
   Required:
   (a) reasonably low number of patients.
   (b) management of clinical resources, including personnel, beds, day care, out-patients, range of facilities for treatment and investigation in range of setting, admission of discharge policies, liaison, information systems.
   (c) Sufficient time and resources for: continuing medical education, research.

Royal College of Psychiatrists (1992)

service, and that consultants are equipped for this role because of their comprehensive training. This could be questioned, however. Most psychiatric training is still based on in-patient units, concentrating on assessment and treatment of the severely mentally ill. Expert training in a wide range of psycho-social interventions is certainly not the rule, education in the principles of public health and epidemiology is rare and leadership and management skills training are minimal, if available at all. Moreover, such a version of the consultant psychiatrist is based on the medical model. The consultant is captain, with other professionals supporting him (Zwerling, 1976). The doctor is considered as central to the treatment of patients suffering from illnesses with known aetiology, course, treatment and outcome. Such a model fits in with weekly ward rounds chaired by the psychiatrist, who allocates tasks to others. For community care it is inappropriate.

Implications of community care

The move to community care requires a profound professional readjustment, rather than a simple exchange of "home for ward". Changes have to be accepted in model of care, interventions, staff responsibilities and leadership.

(a) In hospital the emphasis tends to be on the elucidation of psychopathology and symptomatic treatment, within a larger context of care and asylum. This is not possible in the community, since clinicians are faced with a range of priorities such as food, finance, housing, dangerous behaviour to self and others and carers' needs, all of which demand instant action. Regular interaction with patients and carers takes place on their territory, and great flexibility and empathy is essential. This yields a psycho-social model of care.

(b) A wide range of interventions is required, based on individuals' needs. These include support with any presenting social problems, often jointly with local authorities, as well as psychological interventions and medication. It will be rare for patients to require only a single intervention, and a multidisciplinary approach is inevitable.

(c) A greater individual responsibility is expected from team members. Key workers have to decide instantly on the most appropriate action, and cannot wait until the next team meeting for advice. This leads to change in staff role, with a rejection of rigid hierarchies. A "star" model which exists in hospitals, with the consultant at the centre, is replaced by a "spiderweb", with many people towards the middle. This creates a shift in accountability, and roles and responsibilities need to be made explicit in order to avoid anarchy and malfunctioning.

(d) Many team members have leadership functions, and this requires considerable readjustment. The team manager is responsible for the daily functioning of the multidisciplinary staff, including shifts, budgeting and liaison. The treatment supervisor offers training in specialised treatments. The clinical leader is responsible for overall clinical care (but not for the consequences of individual clinicians' actions) and the strategist determines the philosophy of care and guards adherence to the model. Depending on the size of the team and its remit, all these functions can be taken on by the same person or some of these roles can be carried out by a range of people.

At present few psychiatrists are trained for the roles they take on in the community, and they have to develop their skills *in situ*. It is clear from experiences of community services that psychiatrists make major contributions to the care of the severely mentally ill (Muijen *et al*, 1992), and that the absence of psychiatrists can lead to poorly focused care, as reported in the USA. Considering the relatively low number of psychiatrists, their long training and high cost, a less than optimal use of their skills would be a waste. However, the role of consultants has to be based on an assessment of their strengths, as well as on a realistic estimate of what can be achieved by one person in an average 40 hour week.

The contribution of psychiatrists to community care

A characteristic of British psychiatry is the emphasis on the comprehensive responsibility of the consultant psychiatrist for all components of service delivery, as illustrated in Table I. Any belief in the reality of such comprehensive responsibility could be easily challenged, since in practice psychiatrists are unable to control all service elements, nor is such authority universally accepted by other professions. In most other countries psychiatrists can be clearly identified as either clinicians or managers, with some minor overlap. This allows a greater deal of specialisation, and although comparative international studies of professional roles and skills have never been performed, it could be postulated that such specialisation would produce greater expertise.

The centralisation which is an attribute of hospital care cannot be successfully achieved after a shift of resources away from the institution. Hospital provides most services in a single setting, and it is relatively easy for these to be coordinated by a manager/clinician. In the community the many functions of hospital care have been distributed to a range

of services, demanding more input at point of delivery as well as more resources at the centre because of the increased complexity of coordination. Community care requires a greater commitment of psychiatrists to a specific role. Clearly, the clinical and manager role must be separated.

Models of care

The role separation yields several models of care, ranging from the consultant as full-time clinician to full-time manager.

(a) Psychiatric team

The consultant works exclusively as a member of the multidisciplinary team. Depending on the objectives of the team he or she may have a range of responsibilities, but they are within the clinical boundaries of the team. Since the consultant is a highly trained and relatively expensive professional, it can be expected that a specific and central role is designed, using his skills in an optimal manner. The main task would consist of assessments, crisis intervention, management of suicide risks and major mental health problems, care of people with the most severe mental health problems, drug treatment, medical care and some specialist interventions. The consultant is likely to chair case discussions and supervise clinical care, and be closely involved in liaison with other services.

The consultant may represent the team in strategy and liaison meetings, although this depends on the role within the team, and will be responsible for the training of junior psychiatrists. Whether he or she will assume clinical responsibility for the work of the team is an area which demands urgent discussion regarding the implications of community care and the consequences of individualised care as operationalised by the key worker concept.

(b) Sector psychiatrist

The consultant is responsible for the psychiatric care of a specific target population in an area, mostly those with severe mental health problems. The size of the population should depend on need and deprivation, rather than a standard figure such as 40,000 head of the population. The consultant carries responsibility for the clinical coordination of services in close liaison with primary care and community teams, but is not professionally managing other disciplines. Most of his or her time will be given to direct clinical input, including the responsibility for hospital beds.

(c) Specialist consultant

In this model the psychiatrist contributes as a resource, or a "consultant' in a non-medical sense to a team or other service elements. Clinical involvement is limited, probably to about two sessions. These sessions may consist of team meetings, supervision or direct treatment. This model can be in addition to any of the others.

(d) Clinical director

The main task is the planning, coordination and management of the range of services required for community care, with responsibility for a budget. A close liaison with purchasers, local authorities and primary care should be maintained. Regular meetings with representatives of provider services take place, which could include other psychiatrists and team managers from other professional backgrounds.

Requirements

The impact of a community service will depend on the quality of its practitioners and their training. In order to achieve the most effective role for psychiatrists in the new-look mental health service, some urgent changes need to be implemented. Training is central, however, since the role of psychiatrists demands a mixture of new skills and a different application of old skills. Areas for urgent consideration are given below.

(a) Clarification of the consultant's role in a changing service. Psychiatrists should take the initiative and decide where their priorities lie. This should happen in close consultation with other professions, however, since changes cannot take place in isolation.

(b) Medical, clinical and legal responsibility in the community has to be tackled. This is at present very confused and is leading to interprofessional conflict. It is also used as an obstacle to change. The responsibility of key workers for their clients and the relationship with line managers and senior clinicians needs clear guidance, as does the issue of referrals to a team versus named clinicians. Is any one person ultimately responsible?

(c) Training should be thoroughly revised, as has already happened in other professions (e.g. nursing project 2000). Psychiatric training should be targeting new skills, experiences and attitudes. These should contain common clinical and management basic abilities with a greater degree of specialisation at the senior registrar level.

Components contributing to clinical skills should include: social sciences as well as psychopharmacology and biological sciences; training in psycho-social interventions; good knowledge of role of other disciplines and organisations; interdisciplinary training

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components; intensive clinical community experience with close supervision; and rotation in some posts every year, not six months, in order to gain an understanding of the importance of continuity of care.

Management and leadership training; principles of public health/epidemiology; and research appreciation should be offered for management roles.

(d) An ambitious programme of continuous medical education for consultants should be set up. Unless current consultants are retrained, new attitudes and skills are unlikely to be passed on to the next generation. Moreover, it would cause an unacceptable lag time. Areas of training should include those components of the above skills which are appropriate to the role of the individual consultant. This requires modular training programmes, which are already being developed at some centres, including RDP (Research and Development in Psychiatry).

(e) A shift in resources should take place from biological research to social and health services research. Many service questions need urgent evaluation, such as optimal skills mix, staff patient ratios and effectiveness of different types of services.

(f) Finally, and essentially, more psychiatrists are required, a conclusion also put forward in *Mental Health of the Nation*. In 1989 the national number of general adult psychiatrists was 1100 f.t.e. (1/43,000 or 2.3 per 100,000 per head of the population). All psychiatric specialties combined yields a figure of 3.5 per 100,000. Half of the district health authorities had only one consultant per 50,000 head of the population. Moreover, an unknown proportion of time will be spent on teaching, research and committees. It is hardly surprising that a consistent complaint from patients is that they rarely see their psychiatrist, since there are almost none. A comparison with other countries explains much of the differences in service models and the relative lack of the British psychiatrists' clinical involvement (Table II). In Verona eight psychiatrists (not including trainees) are responsible for 75,000 residents! These figures put the rate of 9.6 per 100,000 as recommended by the Royal College of Psychiatrists in perspective. However, equally important as consultant numbers is the balance with other disciplines and skills mix. Very little is known about this.

TABLE II
National rates of psychiatrists per 100,000

England	3.5
Greece	7.8
Denmark	8.8
Australia	10
Belgium	10
Netherlands	10.9
USA	13.6

Hutchemaekers *et al* (1992)

Comment

The restructuring of the health service is reminiscent of a decision to change from sailing boats to steamers, but forgetting about the fuel. This is compounded, however, if the retraining of the crew is also overlooked. It would not be surprising if the ship had problems leaving the harbour, let alone drifting in the right direction.

Within the present limitations of the NHS an ideal mental health service may appear somewhat illusory, and it is obvious that the present state of mental health care needs a sweeping transformation. Psychiatrists carry considerable status, and we should use our influence to determine such change. This should not lead to a preoccupation with the stunning shortfall in numbers as compared to the rest of the Western world, but should address the ways in which we can make our profession a force of innovation, recognised as advocates on behalf of our patients.

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