In order for a multidisciplinary team to work, there must be someone whose job it is to hold the team together and also who has the power to do this. Where, through the consultants not filling this role, there is a vacuum some other member of the team will either be sucked into this role, or blow themselves into it. However, usually they will not, or are not able, to fill all parts of the leadership role in the team. Some other mental health professionals are extremely good at providing a service, but not so good at assessing requests for treatment, and there is, therefore, a tendency for them to drift into areas where they have not been specifically trained, and to deal with people who cannot really benefit from their expertise. For example, the most effective use of a community psychiatric nursing service lies in answerability to a consultant psychiatrist with referral of patients to that consultant, although working with general practitioners.

A patient, who usually communicates with her therapists by letter, wrote the following: "... Can I ask the questions? Should I come off the sick? Should I go to the day centre? Will I ever be like everyone else? Will my body work right? What's wrong with me? Why do I feel swollen? The anguish feeling, what is it? Why am I in two minds? I keep feeling tearful, irritable, why? I seem to be getting softer, can you tell me what I should do?". It is very uncomfortable for a consultant to be bombarded with a battery like that, but that is the nature of the job. It is very difficult to find the narrow path between reinforcing her neurotic importunity on the one hand, and proving to her yet again that everyone rejects her on the other.

What is the role of the consultant psychiatrist in the clinical team in the community? Although the setting has changed, the spacious lawns of the mental hospital have been replaced by the cramped streets of the inner city, the role has not in fact changed. The consultant continues to have the two duties that she has had for the last 40 years since the inception of the National Health Service. She is the consultant or specialist giving advice on patient management and provision of services to general practitioners, social workers, managers and so on, and she is the leader of a multiprofessional team responsible for providing care for individual patients who are in the community.

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Locally based community care

A personal view

KEITH RICHARDSON, formerly Campaigns Organiser, Northern MIND

A cynic might regard the plethora of reports on community care as a study in how to create the impression of activity while doing nothing. Demands or suggestions for action are easily deflected by holding up the spectre of a forthcoming inquiry – for example the Griffiths' report on community care. Only six months after its launch, one could be excused for thinking that Sir Roy's report never happened. But it would be short-sighted to view Griffiths as a non-event. It embodies a workable framework for implementing community care, emphasises the importance of individual choice and demonstrates the foolishness of relying on those above to wave magic wands and produce instant national solutions. Community care is about localising services and must evolve locally.

Current approaches to transferring care from institutions to the community result in levels of cost and complexity which make a small scale approach difficult because the proposed solutions are far from community based. A solution that is truly local can be implemented step by step, area by area, without the need for an all or nothing transition. This is what has been found at Northern MIND with the model developed for a local adult mental health network.

TABLE I
The mental health network

For an average district of 200,000 people broken down into 20 constituency wards the following staff would be necessary, assuming it is an area of average need.

Staff	
Referral workers (3 per ward)	60
Activity workers (4 per ward)	80
Residential support workers (12 per ward)	240
Ward manager (1 per ward)	20
Total ward level staff (20 per ward)	400
Psychiatrists (1 per 3 wards)	7
Clinical psychologists (1 per 3 wards)	7
Psychotherapists (1 per 3 wards)	7
Occupational therapists (1 per 3 wards)	7
Employment workers	2
Crisis intervention team co-ordinator	4
Intensive care workers	20
*Total staff**	454
Premises	
Acute care houses (6 bedrooms)	20
Long-term care house (5 bedrooms)	20
Ward staff offices (12–13 people)	20
Intensive care house (6 bedroom)	1
Mental health service headquarters	1

*This total does not include domestic, administrative and higher management staff.

The model is based on the principles outlined in *Common Concern – MIND's Manifesto for a New Mental Health Service* with key concepts of accessibility, integration and a view that people, not buildings, should be the basis of a service. Taking these concepts to their logical conclusion led to the idea of a mental health network as opposed to a mental health service, which made use of existing community facilities and avoided the pressure to create separate, stigmatised buildings to base services in (Table I).

Traditionally, services have been designed from a District or Regional level and have not produced a truly community based service. It was decided that the constituency ward, with a population of about 10,000 people, was small enough to have a community feeling but large enough for most services to be based on it. The ward would then be the basic unit from which the local authority's service was built. Guidelines suggest that each ward would require five places for long-term care, six places for acute care and 13 places for day care (DHSS, 1975). For elderly people the following would be required: four day places and five residential places. These seemed ideal figures for providing a local service.

The basic constituency ward level network would comprise staff trained as community care workers, as suggested by Griffiths, specialising in particular areas of mental health care. There would be no large District General Psychiatric Unit to which people might have to travel to use, no signs saying 'Day Care Centre for the Mentally Ill' to humble users and no purpose-built 30-bed hostels for people to be isolated in. But how can a mental health service exist without day centres and hospital wards? It is actually easier to do without these fossilising edifices. The real question is why they should even have been necessary in the first place. Specialised machinery and facilities are needed for cardiac units and justify a centralised approach. But what specialised machinery is needed for psychiatric care that justifies psychiatric units? What goes on in a day centre for mentally ill people that is so special that it requires a separate building?

What is special are the staff who run hospital wards and day centres, but nurses or residential social workers (residential support workers as we call them) can work equally well in small converted houses. Day centre staff (or activity workers) can run relaxation classes in health centres or libraries, or support mentally ill people to use the same relaxation classes as anyone else. Because the network is truly integrated it is largely invisible. The most obvious signs are the care houses which would be based in converted housing stock. Elderly mentally ill people will be cared for in existing residential homes with support given by residential support workers who will also, with home helps, community support workers (paid or voluntary "good neighbours") and others will help people to live independently. They will also provide support for people in the acute or long-term care houses.

The referral workers would be based in GP surgeries or health centres where they would provide the access point to the network and refer people on to its appropriate aspect. In many cases the referral workers could deal with the problems themselves. It would also be their responsibility to function as professional advocates, retaining contact with users to ensure that their needs are met by the network.

The ward based network would provide the majority of the care necessary but there would also be the need for more specialised services in psychiatry, clinical psychology, psychotherapy and occupational therapy. The demand would not justify a worker for each area in each ward. One psychiatrist, for example, could cover three constituency wards, allocating time to working within each.

Some needs would have to be met by services covering the whole area such as for employment, crisis intervention and intensive care. No need is seen to segregate employment facilities by building costly sheltered workshops; mentally ill people should have the opportunity to work with the rest of the community. Employment workers would be responsible for ensuring sufficient placements with enough variety to meet the demand.

The intensive care service is the most contentious aspect. It is envisaged that security for the public and users will be met by using staff rather than locked ward facilities. We feel that the current use of a custodial service to deal with difficult people brutalises users and staff, is over-employed and counter-productive. The intensive care workers would work in the intensive care house and also provide support for the ward based care houses for users who require short-term intensive care. The intensive care house would be similar to the other care houses but have the advantage of greater staffing ratios and a modified design. This small scale integrated approach dealing with people who need intensive care would seem more humane as well as more effective. Containing people in locked wards is too often a stop-gap measure used as an alternative to dealing with people's problems.

The final part of the network would be four crisis intervention team co-ordinators for running a 24 hour crisis intervention service covering the District and made up by on-call members of staff.

That is the basic outline of the network. Much research would be needed to determine the demand and therefore the numbers of various types of workers. Even when this was done the model would need fine tuning when it was functioning. For instance, people at present have to become quite seriously mentally ill before getting professional help. This model makes it possible to get help much earlier and might therefore reduce the number of people who become severely mentally ill.

The model is flexible and lends itself to coping with areas of differing need and new developments in therapies. The service offered by each ward would be unique and evolve over time. The concurrent implementation of Griffiths' ideas and of this network makes considerable sense. Compared to most existing models for community care, the network eliminates the need for traditional hospital care. Therefore it is appropriate for local authorities to be responsible for mental health care as Griffiths proposes.

Any method of making the Griffiths proposals a reality will radically affect mental health services. Using the approach outlined would be no exception and thought would have to be given to how psychiatry would be structured, given that there would be no hospital base. Whatever the outcome, there can be no doubt that the community will be a more stimulating environment and potentially more rewarding.

At first glance the network appears to be comprised of many new untried ideas, but this is not really the case. Most of the above ideas can already be seen in practice. Gateshead Health Authority has no locked facilities for severely disturbed people. Individual social workers and community psychiatric nurses often make use of community facilities for therapy sessions or social clubs and Sunderland Social Services will shortly implement a day care service based on five members of staff working in the community and not in day centres. Attachment of a mental health specialist to GPs has been shown to be effective. MIND-in-Furness will shortly be opening a long term care house for six mentally ill people. Elderly mentally ill people in North Tyneside are cared for in the same facilities as elderly people.

The number of psychiatrists in the network is at the low end of what would be expected today. However this arises because there is a clear distinction made between psychiatrists and psychotherapists. In practice the network would employ more psychiatrists than is stated as it is likely that many of the psychotherapists would also be psychiatrists.

Psychotherapy is an important service. At present an area has such a service or not depending on the skills and interests of staff, notably psychiatrists. Clearly such a delineation between psychotherapists and psychiatrists is essential if the importance of psychotherapy is to be recognised.

What is new about these proposals is putting these good practices together for a network of care. Mentally ill people would be able to use a network that provided care that was local, integrated and non-stigmatising, and could deal with changes in need and has the flexibility to provide a wide variety of care options.

What may prove to be the most attractive reason for implementing this approach may well be financial. A major obstacle in developing community care has been the need for bridging funds to run two complete mental health services during the transition from institutional to community based care. This model can be introduced incrementally ward by ward without the need for a large bridging fund. Also, there would be a major reduction in the need for capital investment which would be invested not in depreciating assets (hospital buildings) but in appreciating assets such as houses. Approximately £34 per head of population was spent on mental health care in 1986/7 by Health and Social Services in the Northern District. Senior managers in the Northern Region working in mental health have estimated that the network described here would cost only £39.50 per head of population per year.

Of course, the model would require additional expenditure to provide for people under 18 and for drugs and alcohol addiction. Even so, an area providing an adequately funded traditional psychiatric service should find that it need only increase expenditure by 20% at most to implement the model. We feel that this is a small price to pay for such a service which would dramatically improve the lives of up to a quarter of the population suffering from mental illness in any year. There can be few areas of health care where such a small amount of money could make such a dramatic difference.

We set out to produce a blueprint for the kind of mental health service MIND would like to see implemented. From the outset we dismissed the idea of producing another model that would simply be the *status quo* by another name. We went for an approach that we hoped would be regarded as innovatory and visionary. As such it will doubtlessly be seen in some circles as unworkable idealism. However, we think that it will work. We are convinced that it is an intelligent synthesis of what we know and a logical extension of what Griffiths has meant to us. And we are confident that there are enough people interested in mental health to give our ideas serious consideration.

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Co-ordinating care for people disabled by long-term mental illness living in the community

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The Community Psychiatry Research Unit at Hackney Hospital have established a support team for the care of people disabled by long-term mental illness living in the community. The work of the support team in coordinating and managing the care of their clients in supportive accommodation using a review system and an information package is described.

The recent Griffiths Report (1988) contained the recommendation that people with long-term illness or disability should not be discharged into the community without a named keyworker and a package of care. This has long been a guiding principle for the support service provided through the Community Psychiatry Research Unit (CPRU) at Hackney Hospital for people disabled by long-term mental illness.

In 1979 CPRU was set up to investigate the needs of mentally ill people within the district, to explore ways in which these needs could be met, and to develop a comprehensive range of services in the community. CPRU was expected to take whatever role was necessary, such as catalyst, instigator, helper, or coordinator, to develop projects which demonstrated how these improvements could be translated into action (Lovett, 1979).

The support team

As part of this original brief CPRU set up several accommodation projects. The early projects revealed the need for support workers who could assess people's suitability for the different types of accommodation, and provide a support package based on an individual's needs. With the cooperation of the local housing department, the CPRU Support Team has developed two main supportive accommodation schemes, the Independent Living Scheme and the Family Support project.

The support team now have 40 people living alone in accommodation negotiated by the team with the Housing Department, eight people in shared flats, two in adult fostering, two in sheltered housing, four live independently in their own accommodation, five families living in family accommodation set up by the team with the local Housing Department, and two families in housing association accommodation. Two clients have ceased to live on their own and now live with their families and receive intermittent support. A further 20 clients live in other accommodation, are being assessed, or awaiting accommodation.