It may be 'Community' but is it Comprehensive: A Wrong Question?

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The debate on the place of community psychiatry is conducted as if it were a matter of choosing between service in the community on one hand and hospitals on the other. When expressed as a dichotomy the question, as illustrated by Scull's Dilemma (Jones, 1982), may be unanswerable. Instead, should we not ask what range of co-ordinated services are required to provide a comprehensive service for the mentally disturbed in a geographically-defined community? The key word then becomes comprehensive with community, in the sense of extra-hospital, important but subordinate. The hospital is then seen as part of the service; it is of the community, not alien to it. Other service components need not be anti-hospital, but hospital staff will need to avoid institutionalism and live down prejudice. The debate about what we can afford, although relevant, is separate.

The psychiatric needs of a community cannot be met by secondary care workers alone. Their efforts need to be complemented by primary care and social work. Within the psychiatric service sharing is necessary between the professions involved. Blurring of roles is essential but necessitates a clear understanding of how the components of an effective, efficient and comprehensive service fit together.

The components of a comprehensive psychiatric secondary care service

It would be naive to think that we know the right mix and precise clinical value of such service components as the domiciliary psychiatric personnel (community psychiatric nurses, crisis intervention teams), day facilities, residential services, district general hospital psychiatric units and the psychiatric hospitals. The latter, in modified form, may yet prove necessary for those patients who need either supervised care by reason of their social behaviour or asylum for severe disability. In these new style hospitals small will be more beautiful than past greatness, while recognition of the need for their existence will allow other components of the service to function more effectively. The older hospitals will then operate in a positive role rather than feel that they are asked to deal with everyone else's 'leftovers'. Within this comprehensive package there is a need for diversity and experiment.

Working within the system

Most patients will gain access to psychiatric services by referral from primary care (a service of first contact that can deal, at least initially, with any presenting problem), with or without social service involvement. Walk-in psychiatric clinics would not meet the definition. When secondary care workers leave the hospital they remain, by virtue of their specialism, secondary care workers and will work in conjunction with a GP. One consequence of the move towards community care by secondary care workers is that more psychiatry, both therapeutic and preventive, is practised in secondary care outside the hospitals, but also outside primary care. If, in consequence, an excessive workload develops within the psychiatric services, standards of mental health practice are lowered in general practice, and communication between primary and secondary care is dislocated, then there is a danger that the change will be detrimental, particularly to the currently less attractive hospital services. The total secondary care psychiatric workload is dependent on the resources available in that service and the position of the interfaces with primary care and the social services. Within the psychiatric service work is further divided between professions, particularly those of medicine, nursing, occupational therapy, social work and psychology. In the non-medical professions there is an influential movement towards autonomy and away from medical leadership.

At the moment consultant responsibility, though broadly defined by law, is ill-defined in practice. Although authority can be delegated, responsibility remains, and it must be emphasized, on a 24-hour basis. The capacity of individual consultants for meaningful interaction throughout the whole of their sphere of responsibility is stretched to the limit and sometimes beyond.

One answer may be to have more consultants, but certainly not if they are to be replacements for junior doctors. The consultant has a broad training and experience but he is not omniscient and in some technical respects junior doctors may be better trained. He cannot effect everything personally. Time and skill are both resources which, particularly in a world of compromise, have to be handled wisely. It is patients who generate the need for time, particularly those who require the 'talking' treatments and it is the professionals *between them* who must meet this need.

Another answer is work sharing, either between independent professions within secondary care, or with genuine primary care. Work-sharing with community-based social workers will be required, but is not central to the present theme and is not further discussed.

Delegation and autonomy in secondary care

If responsibility is shared within the secondary care professions, as suggested above, the question of continuing 24-hour responsibility is crucial. A related problem is responsibility for continuing care when active therapeutic intervention fails. Any autonomous profession would surely have to make provision for living with its own failures. Nurses are

moving towards specialization and total responsibility for continuing care, but members of other emergent professions, such as occupational therapy and clinical psychology, may wish to think of the implications for themselves. At present continuity of care for the disabled over long periods is almost exclusively within the province of the GP in primary care and the consultant in secondary care. All other staff rotate at much too frequent intervals to make it otherwise. Should a pattern of multiple autonomous services develop, then decisions will be needed as to which service is appropriate for any given patient. Co-ordination of the independent services will be critical, difficult and time-consuming. The present solution to problems of co-ordination is the multidisciplinary team with a key worker. His appointment does not absolve the rest of the team from responsibility. If this was so, then the key worker could become little more than a scapegoat when things went wrong. But every decision cannot be referred to a team. The team's task should be to build an ethos well known to all members so that each, when required, can take individual decisions within the framework of team policy.

Can we move towards a similar policy with key professions in which some aspects of human misery are deemed more appropriate for social workers, some for doctors, some for clinical psychologists, etc? Leadership and co-ordination could easily be absent or ill-defined. Nevertheless, such a federation could develop contingent upon the points about co-ordination, 24-hour cover, and long-term continuity of care already made.

'Talking treatments', while important in medicine, are not the exclusive property of psychiatrists and within medicine, GPs are becoming increasingly adept; so too are social workers and psychologists. Within compartmentalized secondary care, if misunderstandings are not to arise, the relevant areas of specific professional concern would have to be agreed and the dangers of overload, excessive fragmentation and gaps between the services avoided. The GP would play a key role in referral, but problems of management would remain. Would the multidisciplinary team continue to function? Or disintegrate? Overall, this variant may be more troublesome than the alternative of enriching psychiatric practice in primary care.

Psychiatry in primary care

As suggested earlier, some psychiatric effort could be transferred from secondary to primary care. Whether, within such a scheme, other professions carried the same weight of authority as the GP would then depend on whether, like him, they were in a position to offer a service extending throughout the 24 hours and the course of an illness. The wish of many GPs to retain 'psychiatric' work within their own practice is in keeping with the broad tradition of British medicine as well as making economic use of restricted manpower in the secondary care services. The debate about which members of the secondary care services would join them would be interesting. Personnel so moved would require a degree of professional independence and sophistication only now found in more experienced staff. The practice of psychiatry, however, would be truly community orientated.

Shorter lines of communication and smaller localities would facilitate integration of professional effort. From a clinical point of view there are many ideas, originating within the psychiatric services, that psychiatrists no longer need feel possessive about. As they become better known, ideas that have originated in a specialized field become common property, first in the wider field of other caring professions and then to laymen. It no longer needs an expert in nutrition to promote the necessity for vitamins. Within psychiatry, and in a similar way, ideas should and are passing into primary care and on to the general public. In these circumstances the specialist can remain specialized in his work, develop his skills and continue to act as a consultant.

What can we afford?

In the present economic climate it is fair to assume firstly that we cannot afford everything desirable and secondly, and in consequence, that compromise and short cuts will be necessary. This is more euphemistically expressed as the need to establish priorities. Constraints may affect any client within the whole range of human miseries, from simple unhappiness to grave psychosis and include any service and profession. Certain consequences and risks will follow. Firstly, we shall either leave gaps within the comprehensive range of services or produce a dull and uniform mediocrity. Secondly, we may neglect the unattractive in favour of the exciting new frontier; the upmarket/downmarket dimension. Thirdly, someone must take decisions both clinical and managerial on when to act and when to cry 'enough'. In the end, the multiprofessional system will fail if difficult decisions cannot be effected. They will involve all professions, whether in small rural or large urban communities and health authorities from Districts upwards. If, within a team each profession decides its own priorities and constraints in an uncoordinated way the result will be chaotic. Where difficult decisions have to be made on the organization of local clinical practice, the ideal unit of size is a locality where professionals can have day to day contact with each other. Within broad strategy there are no ideal solutions, just those compromises agreed in that locality by the people who have to work them. Yet subdivision cannot go too far. There must be a certain minimum critical mass of like-minded professionals who support each other in their agreed mission. It should embrace all the relevant professional skills and be supported by secondary care. The population served might range from 15,000–40,000 persons, i.e. one or two 'localities' per consultant psychiatrist by present norms.

The place of the consultant psychiatrist

In a locality and within the organization of the medical profession and psychiatric services as discussed, the consul-

tant psychiatrist could operate in the following roles:

(i) *Leadership:* Leadership, whether exclusive or shared, is essential and must be founded on a broad education and an appropriate temperament. It must be earned rather than regarded as God-given. The strictly medical and conventional component of the consultant's skill is, of course, necessary in psychiatry but it is not always sufficient. Some knowledge of psychology, sociology, management, the processes of education, and even the arts is also desirable if the clinical orchestra is to be wisely conducted.

(ii) *Special skills:* Within the complexity of modern psychiatry special skills will be needed and interest and practice in these fields will promote job satisfaction. The skills may be derived from strictly medical/biological models, from more psychologically-orientated disciplines, or from special client groups such as forensic and psychogeriatric.

(iii) *The general psychiatric role (community psychiatry?):* With the development of care beyond hospitals, particularly if this care is to be truly primary, it will be necessary for a consultant, even though he is highly skilled within some area of psychiatry, to practise also in a more general role. When bearing their own psychiatric case load GPs will require ready specialist support. Each locality will need at least one consultant who is known, who is readily available and to whom the GP can turn for advice. Between them they can work out their styles of interaction, including decisions about constraints, limits and priorities. In this respect the consultant acting is different from either of the roles previously described. He is the facilitator who knows the community and is known to it. He will also need an allocation of time in addition to that devoted to special skills and leadership.

(iv) *Miscellaneous roles:* Teaching, management, research and public relations are all roles that should be embraced by consultants, providing again that the true cost in time and finance is accounted for. They could perhaps be regarded as special skills within category (ii), but the essence of the present hypothesis is that there is a difference between the approach dependent on special skills and the approach dependent on getting to know a locality and its problems.

A model such as the above, through its specialist roles, would allow the consultant to express his individual interests, skills and styles with a consequent increase in job satisfaction. It would also value and set in perspective service to a community as complementary to special skills and go some way to avoiding prejudicial distinctions between hospital and community practice.

Within a District it would be the responsibility of management to see that a range of consultant skills, appropriate to the needs of the whole community, is provided. Individual clinicians would cross refer when their own special skills were insufficient to meet the needs of a patient from their own local community.

REFERENCE

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Zimbabwe's New Diploma in Psychiatric Health

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Psychiatry in a land of 7½ million (National Census, August 1982) people with relatively advanced general medical services, but only eight psychiatrists, has great problems. The facilities have been described elsewhere (Murdoch, 1982). Historically poorly related to population needs, and with immense difficulties in serving the rural communities that still comprise over half the population (National Census), Zimbabwe has concentrated its post-independence effort on the development of primary health care in village, district and small town. With a medical school expanding (current intake 80 students per annum) and good central facilities for training and specialist care, primary care in public health and general medical services are developing on a sound basis. In psychiatry, a mere 1200 beds for the country (only 141 in the capital, Harare, which, with dormitory towns, has an 'official' population of 1.1 million and serves a further four million in remote rural areas) the training and specialist facilities are sketchy indeed.

The new Government's aim to bring basic health care into the remotest village relies on village health workers (volunteers) and various grades of health inspectors and medical assistant (State Enrolled Nurse) in more central clinics. Through the 55 District Hospitals in the smaller towns and centres, increased training of personnel is intended to diffuse the services of the highly developed general medical centres to the benefit of the whole population, instead of the privileged few in the half dozen major towns.

Psychiatry, too, is being taught to new trainees and at