Encouraging Changes in Practice

Psychiatry, especially community psychiatry, in the United Kingdom used to be flexible, adventurous, creative and bold. With the many changes imposed from policy managers in recent years it has become constricted, controlled, limiting and self-serving. Autonomy for practitioners has almost entirely disappeared and been replaced by a rigid system of care that leads to patients encountering a bewildering number of health professionals who carry out specific regimented tasks but who rarely have the chance to develop meaningful relationships with the people they treat. As a consequence the aim for seamless care that has long been the ultimate goal of good community psychiatry has disappeared, and there is now much needless argument over models of delivering care that ignore its main philosophy. We need to return to the old principles of community psychiatry, an environment where practitioners feel supported by their colleagues, have a varied case load including intensive intervention and crisis care when appropriate, demonstrate continuity of care by keeping in contact with their patients when they enter institutional care of any sort, including prison, and can use in-patient care wisely, with short -term respite when needed, without others with much less awareness and sophistication exercising control and making non-clinical arbitrary decisions that at best, interfere with good care and, at worst, sabotage it altogether. The current creaking structure groaning at its joints needs a well-oiled overhaul. It is not good enough to blame the present problems on the economic downturn; they had developed long before the economic climate changed. The evidence shows that good community care is cost-effective and so is even more needed nowadays.

Cost-effectiveness is rarely achieved by practitioners being heavily monitored and wasting valuable time in activities that have nothing to do with direct patient care. It is achieved by services that are patient-led and therefore flexible, following the individual pathway necessary without it being imposed by a uniform generic automaton generated from a department of health. The way community psychiatry can free itself from its ossifying bonds is to remind itself of its core principles of good care, which are also heavily endorsed by the patients who receive it :

(i) if good facilities are available for patients to be treated outside hospital they should be used as much as possible;

(ii) if a hospital bed is necessary it should be available when required and should be as close as possible to the patient's home, and should be able to serve as a place of refuge and respite as well as a treatment centre;

(iii) continuity of care may not always be possible but should be striven for as a matter of principle and all community teams should stay in touch with their patients no matter where they are placed,

(iv) individual or team-based treatment both have merits and their choice should be determined in collaboration with the patient and his or her carers, and maintained irrespective of treatment setting.

All these principles are being undermined at present. In particular, avoidance of admission has not only become more important but now seems to be equated with good community care, when admission does take place there is frequent discontinuity, and individual therapeutic relationships are extremely difficult to develop and maintain. It is not often

appreciated that it is not the model of care that helps patients; it is the practitioners who provide the treatment, and shoe-horning them into one team structure after another does nothing for their morale or performance.

But what I suggest is not just a pipe dream; the community practitioners are fighting back. The principles of good care can still be practised in the community mental health team, the unsung 'control' treatment in many studies that remains a highly cost-effective form of care, and the necessary flexibility to maintain continuity can be provided in a team structure that allows all elements of early intervention, assertive outreach, crisis resolution and recovery to be practised at appropriate times in the course of a patient's care. Although such a completely comprehensive team remains elusive, it has a successful evidence-based pedigree and recent adoption of a similar approach has attracted great support in both community and liaison psychiatry. In this model all elements of good liaison and community care can be combined and deployed when needed, and the clinicians in the services also have a more satisfying working relationship with patients with a greater degree of variety than at present.

This does not mean that specialist teams are unnecessary, especially for some in-patients such as those in longer term rehabilitation and for other disorders where there is much room for improvement, but for acute care an integrated system makes better use of expertise and brings community and hospital services together. Another way of implementing a streamlined service that ensures all staff develop comprehensive skills is to rotate each health professional through different services so that they do not become fixed in their views and can at least understand the viewpoint of the patients who pass through them. In the current bureaucratic maze this may seem an impossible enterprise but it has been implemented in the past.

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