Importance of specialisation in psychiatric services

Commentary on . . . How did we let it come to this?†

Helen Killaspy[1]

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[1]Mental Health Sciences Unit, University College London and Camden and Islington NHS Foundation Trust, St Pancras Hospital, London

Correspondence to Helen Killaspy (h.killaspy@ucl.ac.uk)

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Summary In this issue, Dr Lodge makes a plea for continuity of care in the face of the increased specialisation of mental healthcare over recent years. However, continuity of care is not a straightforward concept and its relationship to clinical outcome is not established. The increased specialisation of mental healthcare reflects an evolving evidence base that has increased our understanding of mental illness and the treatments and delivery systems that are most effective. In other words, specialisation is the sign of a progressive field.

Declaration of interest None.

In his editorial in this issue of *The Psychiatrist*, Dr Lodge makes a plea for continuity of care, making a case that the increased specialisation of mental health services in recent years has led to fragmentation of patient care.[1] Dr Lodge suggests a return to the catchment area-based generalist approach. Although some may consider this a perfectly reasonable view, there are difficulties with this nostalgia and I present three main arguments to support my position.

Difficulties with the concept of continuity of care

First, continuity of care is not a straightforward concept. It is difficult to define and its association with clinical outcome is unclear. Over the past 10 years or so, the National Institute of Health Research has funded a series of research projects on continuity of care that has defined the concept as comprising six dimensions: the experience of a coordinated and smooth progression of care from the patient's point of view (experienced continuity); excellent information transfer (continuity of information); effective communication between professionals, services and with patients (cross-boundary and team continuity); flexibility to adjust to the needs of the individual over time (flexible continuity); care from as few professionals as possible (longitudinal continuity); one or more professionals with whom the patient can establish and maintain a therapeutic relationship (relational or personal continuity). Collation of the results of the studies identified that the most important of these for people with longer-term, relapsing and remitting conditions, including mental illness, was flexible continuity.[2] In addition, having a good relationship meant more to patients than familiarity with a known professional, and patients recognised that different professionals had different roles and they were therefore likely to see a range of different people. In other words, there seemed to be a willing trade off between seeing the same person and seeing the right person or people at the right time. It is also important to note that the studies did not establish whether better continuity of care was associated with better clinical outcomes.[2]

Specialisation as a reason for celebration

Second, the fact that psychiatric services have become more specialised is a reason for celebration rather than complaint. It suggests an evolution in our understanding of mental health problems, appropriate treatments and the configuration of services that can support people experiencing these problems to recover and regain control over their lives. This understanding has been informed by evidence from research. The National Institute for Health and Clinical Excellence (NICE) distils results from multiple trials to guide NHS investment in the most effective treatments and service delivery configurations. As our evidence base expands, providing us with a better and deeper understanding of exactly what works best and for whom, it becomes increasingly unrealistic to expect every psychiatrist and other mental health professional to remain fully informed and competent to treat all mental health conditions in accordance with the best available evidence.

The decision to implement crisis resolution, early intervention and assertive outreach services through the National Service Framework for Mental Health[3] was based on the international evidence available at the time. The impact of these new services on clinical outcomes was then assessed in the UK context through well-conducted randomised controlled trials.[4–6] The findings from these and other studies have been mostly supportive of continued investment in early intervention and crisis resolution services, but less so for assertive outreach services.[7] Further

†See editorial, pp. 361–363, this issue.

research has helped to identify the 'critical ingredients' of assertive outreach[8] and a case has been made for adapting the approach to maintain these.[9] Many services are doing so by offering a less intensive but more flexible and responsive form of assertive outreach,[10] albeit perhaps catalysed by the economic downturn. Policy and evidence do not always follow the same timelines, but the UK has an excellent track record in evaluating the impact of changes to service delivery through nationally funded research and, as such, the context within which mental health systems operate in the UK facilitates responsiveness to emerging evidence.

Beyond large-scale trials, it is also important to consider the qualitative improvement in service delivery that has been brought about by the greater specialisation of services. The National Service Framework for Mental Health[3] not only represented the largest policy initiative and investment in mental health services since the closure of the asylums, but forced us to consider the needs of patients in a radically different way. For example, where once someone presenting in mental health crisis would have been admitted to hospital, now there are effective, safe alternatives to support them at home or in a homely and non-stigmatising environment such as a crisis house. This has meant that fewer in-patient beds are needed and support to individuals in crisis can therefore be provided in a more cost-effective manner. This is surely a good outcome for patients, the National Health Service and the taxpayer? Provision of care for those presenting with a first episode of psychosis has improved beyond recognition. A specialist team who focus on the needs of people (often young adults) who are at an early stage in coming to terms with a possible diagnosis of a serious mental illness, must be an improvement on sitting in the waiting area of an out-patient clinic or community mental health team office with people who have longer-term and rather different needs, wondering 'will that be me in 10 years time?' Furthermore, NICE guidance on the treatment of schizophrenia specifically mentions that the smaller case-loads and team-based approach of assertive outreach and early intervention services facilitate the management of continuity of care.[11]

Ensuring efficiency in service delivery

Third, however much we may struggle with the idea, there is no escaping the fact that, in England, tariff-based mental healthcare will soon be implemented. We therefore have to organise our services in a way that allows us to report on our activity and outcomes of care for the patients we treat in order to receive income to run services. It seems logical to do this in a way that enables the most efficient delivery of evidence-based treatments and interventions that are specific to the needs of our patients and that support them in their recovery. The increasing specialism of psychiatry over recent years lends itself to this process, and the use of 'service lines', being adopted in many areas, that relate to different patient groups, broadly defined by diagnosis, allows for greater clarity for patients and for those delivering care about the treatment and support an individual can expect over a defined time frame. In the same way that the National Service Framework for Mental Health[3] forced us to review our approach, tariff-based care is likely to sharpen our focus in supporting individuals to get better, stay out of hospital, get back to work and maintain their supportive relationships, rather than continuing to provide less focused and time-unlimited care that poses a risk to individuals in reducing, rather than promoting autonomy. Once established, it seems quite possible that the service-line approach will reduce the need for many patients to move between services, although a pragmatic evaluation of the clinical and cost-effectiveness of tariff-based mental healthcare is certainly indicated.

Conclusion

Rather than looking back through rose-tinted spectacles to a time when we knew much less about the most effective ways to help patients, it is time to acknowledge and reflect with some pride on the fact that we have a progressive discipline that is responsive to its expanding evidence base.

About the author

Dr Helen Killaspy is a reader and honorary consultant in rehabilitation psychiatry in the Mental Health Sciences Unit at University College London and at Camden and Islington NHS Foundation Trust, St Pancras Hospital, London.

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