ON THE USE OF PSYCHIATRIC RESOURCES FOR INDIRECT SERVICE*

By Dr Colin Parkes

This article sets out the conclusions and recommendations of a multidisciplinary working party which from November 1975 considered 'the extent to which psychiatric resources should be devoted to collaboration and consultation with other care givers rather than to the provision of direct clinical service, and to look at the implications of this for the planning of services and training of psychiatrists'. The working party comprised four sub-groups covering collaboration and consultation with the Community Psychiatric Team, with the Primary Care Team, with volunteers and with educational bodies. Reports from these sub-groups were subsequently collated and edited to make up this paper.

The present model of psychiatric service encourages the majority of psychiatrists to regard face to face communication with the patient as their primary function, and they tend to give low priority to those aspects of their work which require them to spend time in consultation with other care givers or supporting community agencies.

In point of fact, as epidemiological studies have repeatedly shown, the primary care team and community agencies of various kinds already deal with the majority of psychiatric problems, and only a minority of people with such problems are referred for psychiatric help. Nearly all the skills of the psychiatric team are focused on a small group of patients who may not be those who will benefit most from our services.

At a time of financial stringency it is more than usually important to ensure that we make the best possible use of the limited resources at our disposal. Research studies have shown the wide variation in referral rates for psychiatric help which make it largely a matter of chance whether a person with a particular psychiatric problem is seen by a psychiatrist. Similar variation exists in the use made by psychiatrists of the primary care team and community agencies in psychiatric after-care.

There are few areas where a fully integrated service can be said to exist, and notwithstanding the lip-service which is paid to the importance of liaison between care givers communication remains bad and there is a yawning gulf between the psychiatrist and the people who do most of the work.

* The views expressed in this article are not necessarily in accord with the policy of the Royal College of Psychiatrists.

The Community Psychiatric Service

The creation of District psychiatric services with responsibility for a particular locality and of Sector teams within this locality serving particular social service areas (as envisaged in the Government White Paper *Better Services for the Mentally Ill*) is beginning to make it possible for each psychiatrist to get to know his own 'patch' and, with and through the other members of the multidisciplinary psychiatric team, to reach out to a range of care givers who would previously have been unsupported and unknown. It also gives him the opportunity to foster the development of local services where these are deficient or absent.

The nucleus of the Service is the Sector or District team of psychiatrists, community psychiatric nurses and social workers, some of whom are community-based and others hospital-based. In this way continuity of care across the hospital boundary can be assured.

Regular meetings of the team in the form of case conferences and liaison meetings are essential, and each member should also be supported by his own disciplinary group.

One area where the distinction between direct and indirect service to patients breaks down is in the *assessment of crisis situations*. A family crisis may lead to a request for the admission of a family member to a mental hospital in order to relieve an untenable living situation. Yet many persons in such situations are suffering from social stress rather than an overt mental illness. Once admitted to hospital, however, these people become 'mental patients'—an identity which is likely to stick. An alternative approach is that a mixed disciplinary crisis team should carry out a domiciliary assessment of all crisis situations, in close conjunction with the primary care team. A programme of support for the family as a whole will often be found to be a more appropriate and effective way of helping than will hospital admission. In the opinion of the working party no person should be admitted to a psychiatric hospital unless a domiciliary assessment has first been carried out by a team which includes members of the hospital's professional staff. This particularly applies to first-ever contact (for further details of this approach see Scott, 1973).

Following the establishment of a crisis intervention service general practitioners, social workers and other professionals soon begin to use the team

for an opinion before crisis, and a much broader community psychiatric service results.

The Primary Care Team

A. *General Practice Team*

Traditionally, the only contacts between the psychiatrist and the general practice team consist of letters and occasional telephone calls which pass between the psychiatrist and the general practitioner in relation to particular case referrals. Since neither meets the other in person or has much opportunity of assessing the other's potentialities, and since the other members of the general practice and psychiatric team play no part in these communications, it is hardly surprising that distrust and misperceptions are very common.

Involvement of the GP in crisis assessments, together with participation of psychiatrists in local postgraduate training programmes (e.g. Balint-type seminars) for GPs may go some way to improving matters, but the only method of working which seems to provide a satisfactory solution to the communication problem in the long term is for psychiatrists to visit the GP's surgery on a regular basis in order to consult with the primary care team. This enables joint decisions to be made about patient care, provides the GP with emotional support as well as cognitive understanding of patients whom he may find taxing, minimizes the risks of 'dumping' unwanted patients, enables both sides to discover their own as well as each others' potentialities, and provides the GP team with valuable learning experiences which will affect their general standard of care. It also enables the psychiatrist to give help with many situations of emotional distress which would not normally reach him and to do so without stigmatizing the sufferer.

There are, of course, practical difficulties in providing this type of service to every GP in a Health District, particularly when there are many one- or two-person practices. The increase in the number of health centres and large group practices offers some hope that this situation will improve and that satisfactory working relations can be established with a reasonable proportion of general practices. (Further details of this type of approach are given in Brook, 1967; Brook and Temperley, 1976; Tredgold, 1976.)

B. *Social Service Team*

The reorganization of the social services has led to considerable difficulties and sometimes breakdown in communication between psychiatrists and local social workers. To some extent this is mitigated by the attachment of social workers to psychiatric clinics and in-patient units, but this still leaves the community social workers unsupported. Yet the nature of their work is such that many of their clients have psychiatric problems and others are at special risk.

Approaches to the problem of providing psychiatric consultation services to social workers include:

(i) Attendance of community social workers at joint consultations with psychiatrists and GPs. (This is most likely to be successful when the social workers are linked with general practices.)

(ii) Inclusion of community social workers in crisis intervention teams.

(iii) Regular visits by psychiatrists to provide consultation in Social Service Departments.

(iv) Split appointments during which social workers work part-time in the psychiatric unit and part-time in the community.

Volunteers and Counselling Services

Volunteers have proved their worth in a variety of settings, but are still an under-used source of help to the psychiatric team both within and outside the NHS. In a variety of settings volunteers can work to support sections of the population at special risk (e.g. handicapped and neglected children and adolescents, one-parent families, unmarried mothers, young married couples, bereaved, divorced, unemployed, immigrant and other minority groups, retired, isolated, aged, physically handicapped, homeless and those of no fixed abode). They can also work with members of the care-giving professions to assist people in emotional distress (e.g. disturbed adolescents, parasuicide, threatened suicide, marital conflict, alcoholics, drug addicts, anorectics, mentally sick in hospital and mentally sick in the community). There is no difficulty in justifying time spent by psychiatrists in initiating, developing and supporting the headquarters of organizations serving large sections of the population. Some justification is needed, however, in the case of small local voluntary services which are in need of support. Two types will be considered:

A. *Organizations over which Health and Social Services have main control:* The key person here is the Voluntary Service Coordinator (VSC), and it is recommended that one or more should be appointed in each Health District. With the development of community psychiatry it is no longer appropriate for VSCs to confine their attention to the hospital environment. The VSC should be a member of the Health Care Planning Team (Psychiatry) and should be respon-

sible for reviewing voluntary services in his or her District, identifying priority areas in which needs are not met, identifying possible sources of volunteer help and drawing up a programme of voluntary service. The Health Care Planning Team (Psychiatry) should make available to the VSC whatever help is needed for the selection, training and supervision of volunteers and for producing a properly trained and responsible team with high standards and accountability to the group.

The potential value of this type of approach will ultimately depend upon the quality of the VSC and the extent to which he or she is properly advised and supported by the psychiatric team.

B. *Independent Organizations:* The VSC or other suitable person should draw up and maintain an up-to-date list of responsible voluntary organizations in the area and circulate this widely within the psychiatric team.

Working relationships with these organizations should include offers of consultation with professionals as appropriate at both management and case conference levels. Psychiatrists will have a part to play, but many roles can properly be shared with other members of the psychiatric team. When volunteers are to act as counsellors to the emotionally disturbed it is particularly important that psychiatrists should play a part in their selection and training. Clergy have special importance as providers of pastoral counselling which may be of a high order of competence; they also serve as hospital chaplains and as leaders of the largest social groupings in the country (church congregations with all their potential for voluntary service). Each of these roles brings them into contact with people at risk or in emotional distress, and there is no doubt that the provision of psychiatric consultation to clergy as well as participation in training of clergy in counselling skills is usually a worthwhile use of psychiatric time. In the long term the minority of clergy who have undertaken proper training in psychotherapy are able to take over quite sophisticated training activities themselves.

Educational Services

It is clear that at the present time direct clinical help is reaching only a small proportion of those potentially in need. Since the number of psychiatrists available to meet these needs is unlikely to increase it would seem logical to pay attention to means of improving the counselling skills of others who are in a position to help children and young people in difficulty. The point is also worth making that help given by teachers and tutors does not raise the same resistance as that offered by psychiatrists.

Within the field of general education at primary, secondary and tertiary levels there is an established tradition of cooperation with co-professionals. From the psychiatrist's point of view this is mostly concerned with providing consultation and support to members of the child guidance team, teachers in special educational establishments and counsellors in tertiary education. At primary and secondary level teachers have little contact with psychiatrists, but are likely to receive support from educational psychologists, whose skills are usually more relevant to their needs. It is therefore particularly important for the psychiatrist to consult with the educational psychologist, and this may not be easy if there is a split between the school psychological service and the local child psychiatric service.

Staff of children's homes, assessment centres and day nurseries can benefit from regular consultation sessions with child guidance staff of any discipline.

In most educational settings there is a tendency to see problems in terms of the individuals who get into difficulties rather than in terms of the family of origin and the institutions in which the difficulties arise. The notion that institutional factors may play a significant role in the genesis of student problems is gaining ground in some quarters, particularly in higher education. It is reasonable to suggest that consultation roles in any type of institution should not be confined to individual case consultation but should include management-oriented consultation. (For further consideration of these issues see Black *et al*, 1974; R. C. Psych., 1974.)

Consultation in other Institutional Settings

The same general principles apply in other institutional settings. In general hospitals, for instance, the psychiatrist has to choose how much of his time to spend in giving direct help to patients whose health problems are thought to have a psychological component, how much time to spend discussing such patients with ward staff and how much in consultation about wider problems of patient and family care. The psychiatrist who works in an industrial setting is faced with similar problems.

It is not our contention that the psychiatrist should always be the one to work at all these levels, but we contend someone should. In the industrial setting this may well be a psychologist or sociologist. In medical settings it is more likely to be the psychiatrist.

Logistic and Organizational Issues

It will be apparent from the above considerations that the problem of providing care to all those members of a community who are emotionally disturbed or at risk of becoming so is enormous and

will never be met by the provision of more and more direct service by psychiatrists. Faced with this problem psychiatrists have attempted to avoid the issue by drawing a line around one small section of the population who are termed 'mentally ill' and confining their attention to this group. While there may be some justification for devoting more time to those who are most disturbed than to others, no definition of mental illness has provided us with a satisfactory distinction between illness and health, and we are faced with the fact that many of those who are most 'ill' are least able to benefit from our help.

From the viewpoint of the economical use of scarce and expensive resources the following considerations apply:

(1) DHSS recommend a minimum of one consultant psychiatrist for 60,000 population. A consultant psychiatrist conducts, on average, 4 out-patient clinics per week, that is, one session for 15,000 population. A general practice team of six partners caters for about 15,000 registered patients. It is, therefore, reasonable and economic for a psychiatrist to spend a part of his out-patient time (say one session per fortnight) in one or more large group practice in the locality. No increase in psychiatric resources would be needed.

(2) The introduction of Crisis Intervention Teams of psychiatrists and social workers has already been shown to result in a considerable drop in the need for in-patient services (Scott, 1974), and Langsley's random allocation study has demonstrated that such services cost as little as one sixth of the cost per patient of a traditional approach (1969).

(3) Weekly consultations held in Social Service Departments each serving a population of 30,000–50,000 would enable much of the time which would previously have been used in ward rounds to be devoted to assessment of the same patients at home and to improving standards of community care.

(4) Time spent in consultation with front-line care givers often enables them to cope with problems which might otherwise lead to referral. It also ensures that those referrals which are made are appropriate. Thus, at Woodberry Down Child Guidance Clinic in London an increase in referrals of infant-school children was dealt with by establishing a psychiatrist/educational psychologist/social worker team which worked with teachers to set up 'nurture groups' and to provide support to parents. This response contrasts with the more common solution to over-referral, which is to provide a clinical service which is so slow and inadequate that referrals cease, so that neither preventive nor significant therapeutic work is done (Boxall, 1973 and Gorell Barnes, 1973).

(5) Enthusiasm for a particular voluntary service sometimes causes psychiatrists to spend time in administrative or other activities which could be carried out equally well by others. If, however, his time is properly used, the psychiatrist can be the key to effective and responsible services. Thus, at St Christopher's Hospice, Sydenham, a bereavement service enables 400–500 families per year to be screened following the death of a family member, and about 100 of those who are thought to need support are visited in their homes, usually by volunteer counsellors. The consultant psychiatrist spends an estimated two hours per month providing consultation with counsellors, plus an additional hour or two giving direct help to the very small number of bereaved people who are thought to require his specialist help.

In many cases consultant support to voluntary services can be given by properly trained social workers, the psychiatrist being called in when particularly tricky problems arise. The time commitment for the psychiatrist need not be great but the pay-off in human terms is very considerable.

(6) The consultant to a general hospital or other institution should aim to make himself redundant by raising the capability of staff members to cope with an increasing range of psychological problems. Turnover of staff will ensure that he never achieves this aim, but significant reduction of referrals can be achieved.

Implications for Training

Many of the work settings which have been mentioned above provide excellent opportunities for training medical professionals in the skills of mixed disciplinary collaboration and consultation.

Medical students can make excellent counsellors, and opportunities for them to work with volunteers and others to support the bereaved, the pre-surgical patient, neonatal mothers and the like provide excellent training in aspects of counselling which are important for all doctors.

At postgraduate level, junior psychiatrists can best learn how to collaborate with other professionals and with volunteers by working alongside them in domiciliary assessment teams and attending group consultations. New appointees should be introduced to

their Voluntary Service Coordinator as part of their regular induction process. This will enable their VSC to educate them with regard to the potential use of volunteers in their hospital and/or District.

Training in the use of volunteers and relationship with them should be a part of all postgraduate programmes in psychiatry, psychiatric nursing and psychiatric social work. Since all members of the team are involved, this could well be an element in mixed disciplinary training programmes (themselves a logical way of teaching inter-disciplinary collaboration).

The basic sciences underlying much of this work include group psychology, sociology and family dynamics. At advanced level, psychologists, medical sociologists and psychotherapists all have contributions to make to training in family psychiatry, organizational psychiatry, community psychiatry and preventive psychiatry. These topics should henceforth be given greater prominence in the training of psychiatrists than they have in the past.

In the end the aim must be to produce a psychiatrist who can adopt a balance between the full range of psychiatric approaches. He should be not only a specialized diagnostician and therapist but an 'enabler'. He should be ready to listen, to encourage, to respect the expertise of his fellow team members and to share management with them in a non-authoritarian manner. He must also be willing to take final responsibility for the management of difficult situations.

The members of the Working Party included Drs Alexis Brook, Rudolf Freudenberg, Josephine Lomax-Simpson, Colin Parkes (Chairman), Anthony Ryle, Dennis Scott, David Wallbridge (psychiatrists), a general practitioner, community physician, nursing officer, three social workers, a chaplain and representatives of educational psychology and voluntary work.

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CORRESPONDENCE

REGIONAL MEDIUM SECURITY UNITS: SOLUTION OR DISASTER?

Dear Sir,

For the last decade I have earned my living as a forensic psychiatrist and recently I have been deeply concerned that our profession is being persuaded to participate in an idea that will bring us public ridicule, and perhaps even scandal. I refer to the establishment of medium security units. Public ridicule, I believe, may ensue because psychiatrists will be inefficient (and dangerous) jailers. Our failures will be exposed in open court. Scandal may also result because, unless the Government are prepared to spend millions of pounds, the quality of life in these units may leave a great deal to be desired. In fact, if they are small, cramped and lack adequate facilities, then they will compare unfavourably with the Special Hospitals.

I believe the concept of these units springs from the embarrassment that was engendered by the large number of patients crowded into the old buildings of Broadmoor, with the consequent lack of privacy and space for personal possessions. The idea seems to be that these units will cater for a large number of Broadmoor patients, either acting as brief staging posts on the return to the community, or as treatment units for a longer period under conditions of lesser security. Secondly, I believe the intention is to deflect as many mentally disordered offenders away from the Remand Centres and the prisons. The feeling is that the secure units will produce better medical reports and there is less chance of the ill offender being missed.