Editorial: The pivot of a well-balanced service

Andrew Sims

The main target for *Advances in Psychiatric Treatment* is the body of consultant psychiatrists, and as the journal is produced in Britain, this necessarily implies those working in the National Health Service. Is there a particular stereotype of consultant that authors conjure up when they write for *APT*? Probably not. However, those working single-handed in their speciality, perhaps ill-supported by other staff, isolated both geographically and intellectually, and those who construe management and their non-psychiatric colleagues as hostile obviously need as much help and encouragement as we can possibly give them to try and maintain as high a level of psychiatric care as they can.

It might also be asked whether *APT* is attempting to promote any particular model of psychiatric care, for example, either primary care based, or based upon community mental health centres, or even advocating a return to institutional care. None of these is exclusively advocated although we certainly want to encourage good working relationships with general practitioners and others in primary care; we see the advantages of having a sufficiently large group of mental health professionals in a community centre to form a "critical mass"; and we certainly recommend the appropriate use of in-patient beds for acute treatment and other aspects of the treatment of the severely mentally ill. By emphasising the continuing professional development of the consultant psychiatrist we are giving implicit support to a neglected but significant tenet of care within the National Health Service – the role of the personal physician (Reed, 1991).

The emphasis of *APT* is more directed at patients receiving care outside the hospital than inside. This simply reflects their current distribution and we do regularly publish articles describing the elements of good in-patient treatment. We particularly emphasise working with a multidisciplinary team and recognise its crucial importance in producing satisfactory levels of care for the mentally ill; we regret that to some extent and in some places the multidisciplinary team has been eroded in the last few years. We also assume a position that consultant psychiatrists are pivotal, and perform an essential function in the smooth and effective running of the specialist mental health service.

It is very clear that if a consultant is to fulfil her or his pivotal role in linking and coordinating and mobilising effective services for individual patients, then this makes great demands upon training, especially at the senior registrar level, and even more demands upon maintaining and improving skills as a consultant through continuing professional development.

The demands upon a consultant psychiatrist to achieve standards of good practice has increased the need not only to be well trained before taking up the post but also to maintain and learn new knowledge, skills and attitudes. Clearly consultants need to be well informed in all areas relevant to treatment, physical, psychological and social; to have opportunities for discussion and debate with colleagues and peers; to know what are the aspirations and the intended directions of those in local management and of the National Health Service more generally; and to know the views and ways of thinking of those in related professions. This is our scope for future articles.

Reference

Reed, J. (1991) The future for psychiatry. *Psychiatric Bulletin*, **15**, 396–401.

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