Who cares about the highly specialised services?

Arthur Crisp

It is a paradox that many areas of specialised and highly specialised practice in psychiatry are commonplace within medical practice in general. Problems of mother and baby psychiatry, chronic pain, psychiatric aspects of brain injury and related rehabilitation, resistant affective disorder, personality disorder, disorders of eating, sleeping and sexual dysfunction, all judged to have major psychopathological elements, are ubiquitous, many throughout the lifespan. Certain treatment approaches such as behavioural and cognitive psychotherapy and family psychotherapy fall into the same category. All of them have generated one or more National Health Service (NHS) services within the UK under the umbrella of psychiatry. Some of them impinge on *Health of the Nation* concerns.

Many of them also fall into the realm of human biology rather than neuropathology which is often a more mainstream interest within psychiatry. Yet many of them also significantly overlap with and sometimes underlie mainstream psychiatric illnesses.

The specialised services have a definite standing in our College. In contrast, the highly specialised services usually develop under the wing of academic clinical psychiatry and are fragile. A senior clinical academic retires and the service must be picked up by an NHS appointee if it is to survive. These days it must be obviously financially viable for it to stand a chance of being considered – it must earn its keep including around 30% for management costs.

For those of us working in these apparent fringes, the evidence of the last few years has been depressing. Some highly specialised services have disappeared abruptly before serious consideration could be given to their merits in terms of wider clinical need, professional development and other teaching and research potential.

If this haemorrhage is to be staunched, then certain steps had best be taken now.

A nation-wide identification of existing highly specialised services

A survey to achieve this is currently under way and Professor Brockington, Dr Beasley and I hope to publish these data shortly.

Assemble evidence for their need to exist

This has to be a statement about quality of life, cost of the disorder to the public purse, ability of health care services to improve natural history of the condition in its various dimensions, and the cost-effectiveness of this intervention.

The motivation to do this may only come from patient and client groups concerned, their families and those with the expert professional interest. For instance, it is currently being done for eating disorders through the initiative of Professor Russell supported by the Royal College of Psychiatrists through the creation of an Eating Disorder Sub-committee to the General Psychiatry Section. This also involves the Eating Disorders Association – a lay 'self-help' organisation. Such initiatives do not often seem to arise from within the body of the College itself, as part of any forward looking philosophy.

Consider the relevance to medical education and health care education in general

(i) *Undergraduate.* A case can be made for all the services described here as having a contribution to make to core teaching, and also to special study modules, as now envisaged by the GMC Education Committee (1991).

Armed with the information derived from above, University (Medical School) Liaison Officers need to persuade the Dean that such services and expertise are needed for undergraduate education as part of the

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Service increment for teaching (research) (SIFT (R)) allocation. Such vision must filter through to the ultimate determinant – the content of the final professional examination.

(ii) *Postgraduate.* Trainees who have the opportunity to dip into such highly specialised experiences often report that they find them surprisingly stimulating and relevant (e.g. Yousaf & Rozewicz, 1994). If these subject areas are to survive and expand they require that there be adequate training, especially at higher professional training level. They can only flourish if they are taken up by the College and the Joint Committee on Higher Psychiatric Training (JCHPT). At the end of the day they will depend upon the College's sense of its own identity and goals.

(iii) *Health sciences.* The subjects concerned are important in such teaching at undergraduate, diploma and MSc levels for a wide variety of health care professionals in training and continuing professional development.

Muster the results of relevant research

Such services have often arisen within the context of ongoing systematic research. Research results are the potential fuel for the clinical case for sustaining and developing the service. Outcome studies are essential and research and development funds are intended for such purposes and should be targeted. This needs the collaboration of the local service management because of its immediate and long-term implications.

Explore prospects of collaboration with other disciplines and management systems

Some of the practice domains are not exclusively 'psychiatric' – sleep disorders is a good example. The Royal College of Physicians was sufficiently persuaded of its importance to mount a conference and publish the proceedings. In market terms there is money to be made in sleep disorders and territory to be carved up.

Some such developments might best be promoted by two or more Colleges or other professional associations. Areas of overlap clearly exist, not only with physicians but also general practitioners (most areas), obstetrics and gynaecology (sexual dysfunction), and anaesthetics (pain).

Meanwhile, if mental health Trusts show no interest then, in some instances, acute service Trusts and community health Trusts may prove to be equally natural hosts.

Persuade managers of provider units

This may depend on personalities and local factors. Some of the services are of a tertiary referral kind and of limited interest to local purchasers or hard-pressed mental health unit trusts or mental health unit trusts with limited vision. Managers may be fearful of uncertainties surrounding the tertiary referral system related to unpredictable national changes in such service availability and also the greater medical power that goes with such esoteric expertise. Local managers may need to be shown clearly where the gap in the market is. It should be expected that they then have the capacity for entrepreneurial input. This is their job and not the doctors'. Short-term contracts may be necessary.

Persuade central government

Many *Health of the Nation* targets are seen to have social rather than clinical themes. There is an absence of powerful patient lobbies for many of the disorders addressed within the highly specialised services in psychiatry, most of which are intrapunitive in form and not associated with the kind of social crises and complaints that alarm managers at all levels. Each of the services probably needs to fight its own corner on the national stage, making clear its cost-effective aspects and other contributions. For instance, suicide reduction is a major national target. This has been demonstrably achieved within the context of provenly effective treatments for anorexia nervosa and such methods might have much wider applicability to other at-risk clinical groups.

Note the private sector

Those who claim that the government's intention has been to dismantle the NHS or reduce it to being a largely nurse-led and safety net service can point to the fact that the private sector is now increasingly providing services to NHS purchasers and also that doctors are beginning to migrate to the private sector in greater numbers. However, the private sector is not accountable to the local population in the way that NHS trusts are and is often also subject to international commercial whim, nor is it yet in the mainstream of medical

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education and research. Meanwhile, it appears to have much more motivation and capacity than the NHS to explore the potential for developing such highly specialised services as have been touched on in this article, some of which do not require major in-patient services.

Conclusion

The highly specialised services need to demonstrate their worth. Often they have already achieved this to a greater degree than core services. Meanwhile, some of them are being prematurely affected by managements who are indifferent or have other agendas. Presumably the highly specialised services within psychiatry have their many counterparts in other branches of medicine. Before this aspect of the progress of medical science over the last 30 years is lost within the NHS framework, such services deserve systematic, thoughtful attention at a national level.

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