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The community psychiatrist of the future

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Purpose of review
The potential contributions of the community psychiatrist, are described, *via* the interdisciplinary team, to individuals and families dealing with mental illness, and to the communities of the future, along with the opportunities for, and barriers to, effective teamwork and community collaborations.

Recent findings
Health and medical training systems still provide perverse incentives deterring psychiatrists from becoming adequately trained in community psychiatry and full members of interdisciplinary teams, and skilled partners from improving the mental health of the whole community. Sources of potential role conflict should be resolved, and advantages of community collaborations, interdisciplinary leadership, support of teamwork, division of labour, cross-fertilization and hybrid vigour should be realized.

Summary
Truly essential and desirable roles and the skill base of community psychiatrists in interdisciplinary teams and local communities could be developed and strengthened by changes in basic and advanced psychiatric training, and by psychiatric professional bodies and training programs placing greater emphasis and value upon the roles of a community psychiatrist.

Keywords
bio-psycho-social, community collaborations, community partnerships, community psychiatrist, interdisciplinary team, leadership, multidisciplinary, professional role, psychiatric skills, psychiatric training, psychiatrist, recovery, valued roles

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Abbreviations

ACT assertive community treatment
GP general practitioner
NHS National Health Service

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Introduction

The role of the community psychiatrist is defined in both (a) the microsense of providing integrated community and hospital-based mental healthcare for individuals with psychiatric disorders and their families and (b) the macrosense of promoting mental health, resilience and well being within whole communities in partnership with other professionals and agencies. This includes taking a public health approach to the prevention, early detection and intervention of psychiatric disorders.

As this subject has not been squarely covered by *Current Opinions* previously, this review will provide an earlier context as well as focus on the limited relevant literature from 2003 to 2006.

The last partially related *Current Opinion in Psychiatry* review by Cox [1] extolled the advantages of collaborative multidisciplinary training as it encouraged medical students and those from other health disciplines to work collaboratively as colleagues in later professional life and of offsetting work-related stress and 'burn-out' by diversifying their skills with age. To this end, future multidisciplinary psychiatric training should be influenced by philosophical considerations in 'overcoming 400 years of Cartesian dualism', and ethical dimensions, including concepts of altruism [1]. Recently a workbook for values-based practice in mental healthcare has been disseminated in the UK [2] that emphasizes the 'two feet' and 'partnership' principles, which state that all decisions should be based on facts and values (evidence-based and values-based practice working together) and by the service users and providers of care working together in partnership. We are also encouraged to employ a 'multidisciplinary (service) user-centred model of delivery' by working towards a balance of different perspectives, with the first reference point for values being the perspective of the service user (and/or family) concerned. In-vivo experiential apprenticeship training should continue to be valued [1] for community psychiatrists, as for other doctors into the future, as 'the informal interstitial fabric of medical education with which the visible formal structures function' [3].

Community psychiatrists of the future should integrate all these dimensions into an increasingly holistic approach, comprising the followings:

(1) the realization that most disorders with which we deal have multifactorial etiologies demanding multimodal intervention responses [4•];
(2) a requirement to assess, intervene with and review the whole person, employing a bio-psycho-socio-cultural-spiritual paradigm, rather than treating disembodied symptoms or merely intervening on fragmentary biophysical subsystems [5•]. Explorations of the epistemological gaps between spirituality, religion and psychiatry [6] conclude that there is a strong case for intellectual and clinical pluralism;
(3) a focus on the service users' empowerment, strengths, abilities and role restoration and defocus on service-user submissiveness (which sometimes is held to equate with 'insight'), weaknesses, disabilities and role dysfunction; valuing the service users' agency and expertise rather than imposing professional control and vocational ownership ('we know what's best for you') [5•].

In research terms, this presents an intellectually stimulating interface between the social and biological sciences. In practice, psychiatrists are most effective in applying this multimodal approach when they are committed to the importance of good teamwork with other health professionals and disciplines.

Psychiatrists' roles in interdisciplinary teamwork: why have interdisciplinary teams?

Psychiatry is arguably ahead of many medical disciplines in its recognition that most severe disorders have a multifactorial cause, requiring corresponding multimodal intervention responses. It is unrealistic to expect that each individual psychiatrist, even if comprehensively trained to appreciate all these needs, has either the time or training to provide all of these interventions effectively. It may be gradually dawning on other medical and surgical disciplines that all clinical disorders have such multifactorial predisposing, precipitating and perpetuating factors and that these disorders would resolve more quickly and completely if they also employ such a multimodal interdisciplinary approach.

Employing interdisciplinary teams may not be the cheap option but have been demonstrated to be the more cost-effective strategy, rather than mainly relying on traditional outpatient and inpatient psychiatric services, such as crisis, early intervention and assertive community treatment (ACT) teams [4•,7]. In any case, the supply of trainee and consultant psychiatrists worldwide (with a few exceptions, e.g. Italy) is too limited to fill many more positions in public mental health services and teams, even if sufficient funding were available.

Do we still need psychiatrists in the team?

Medical training and health delivery systems still provide perverse financial and status incentives deterring psychiatrists from becoming full members of interdisciplinary teams in public mental health service systems. Psychiatrists are still socialized to assume the central role and overall responsibility for the treatment of their patients and to expect unchallenged leadership of mental health services or facilities.

Other mental health professionals will no longer act as submissive handmaidens to doctors; they are increasingly becoming comprehensively trained autonomous professionals, sometimes with prescribing rights and control over hospital admissions; so the power differentials are changing in interdisciplinary relationships [4•,8•]. So do we still need psychiatrists in the team, when nurses or other interdisciplinary professionals are cheaper? Emphatically yes. For the description of these important roles and functions see Tables 1 and 2.

Should psychiatrists have a 'divine right' to lead teams?

The energy expended by psychiatrists in defending their accustomed 'divine right of leadership [4•]' could be fruitfully swapped for full membership of interdisciplinary teams and a wider leadership group, without loss of face, value or role definition [9]. Sources of potential role conflict should be resolved [10] by the principle that the service user comes first. It is usually much easier to reach consensus on the clinical management of a particular individual than it is to reach consensus on overall treatment philosophies. Team members should be willing to search for and swap evidence for differing positions, rather than falling back on pulling rank, or embroiling the service user in conflict over treatment approaches, which will only result in more turbulent behaviour. The dangers of dominant monocultures in mental health service systems should be examined, and the advantages of interdisciplinary teamwork support, division of labour, cross-fertilization and hybrid vigour should be realized [4•,11,12]. Then, specific and highly valued roles for psychiatrists in interdisciplinary teams could be further developed and strengthened by further vocational and postgraduate training (see Tables 1 and 2).

Valued roles for a psychiatrist in an interdisciplinary team

Diamond *et al.* [10] divide these roles into essential and nonessential, but desirable (see Table 1). These skills should be integrated to serve the purposes of modelling of the importance of not working alone, and becoming a contributing system builder of locally responsive, comprehensive mental health services.

Should the psychiatrist be accountable for all team care?

An unquestioned assumption underlies the traditional response to this issue: 'Obviously, in legal terms the consultant is responsible for (all) patient care'. Guidance

Table 1 Valued roles for a psychiatrist in an interdisciplinary team

Essential roles include the following:
- (a) Medical expert – assessing, investigating and triaging for medical illness, appropriate prescribing and medical translating.
- (b) Medicolegal signatory – for agencies, employers, courts that require a letter from 'the doctor' – often based on just having a medical or specialist psychiatrist qualification, rather than on particular sole expertise.

Desirable roles include the following:
- (a) Joint assessor – taking part in the holistic assessment of individuals and families presenting for psychiatric help. This includes information gathering, concluding and decision making and arriving jointly at an individual management and care plan.
- (b) Teacher – about mental illness, interactions with medical illnesses, medicolegal and ethical issues, biological underpinnings of psychotropic medications, other areas of developed expertise and interest. Co-teaching (e.g. with other disciplines, service users, GPs, families) can be mutually enriching.
- (c) Scholar – depends on being well trained and motivated to continue to read and research, – that is, making the time and commitment to do so, long after the formal training period is over. Coresearch with other service providers and service users is often more fruitful.
- (d) Generalist – continuing to broaden your knowledge to become a team generalist, modelling integrated, holistic approaches. This includes being prepared to develop expertise in many areas not covered in depth in traditional psychiatrist trainings (see section on skill base and Table 2).

Adapted with permission from ref. [10].

from the National Health Service (NHS) and Royal College of Psychiatrists National Steering Group [13] states that consultant psychiatrists 'have the ultimate responsibility to diagnose illness and prescribe treatment. This authority may be delegated to other professionals, but the responsibility cannot be abrogated'. This type of authoritative statement becomes a two-edged sword and can result in assumed centrality of the psychiatrist's responsibility and blame when anything goes wrong during intervention. Some argue the need for psychiatrist supervision of all other health professionals and insist on direct psychiatrist overview of and accountability for every case. Detre and McDonald [14] state that the need for such supervision arises from the routinization of complex clinical tasks so that they can be performed by 'lower level' professionals, a term I find objectionable. Such insistence would waste scarce and much-needed medical expertise, delay effective treatment as waiting lists to see 'the doctor' get longer, allow people in need of services drop out and leave medical staff with no time for home visits or participating in service-system building or service management [4•].

The opposing view [15••,16] emphasizes the difference between responsibility and leadership in stating that because of the circumscribed nature of professional responsibility, no professional can be held accountable for another professional's actions except in part by negligent delegation or inappropriate referral. This resolves the unhelpful conflation of medical responsibility and ultimate clinical responsibility. Medical responsibility is best regarded as a particular instance of professional responsibility whereby practitioners are accountable for those tasks for which they are recognized as competent as a result of their medical training. Ultimate clinical responsibility is often claimed by the senior medical member of the team when he/she asserts that he/she is accountable for the work of the team as a whole should disaster occur or that though personally blameless she/he may be held accountable after the style of a military commander. This assertion, however, is almost certainly unjustified. The UK Nodder Report [17] concluded that there is 'no basis in law for the commonly expressed idea that a consultant may be held responsible for negligence on the part of others simply because he is the responsible medical officer'. In Australasia and the UK, unlike the North American documented experience, nonmedical members of the mental health team, including case managers, are much more likely to be clinical professionals who take professional responsibility for their work. They are held clearly accountable for their own work by their professional bodies [18] and by state government regulation [19]. The NHS (UK) Guidance [13] advises that doctors in psychiatry are not responsible for the quality of care provided by another team member, and there is no requirement to have a consultant's name on the file of any service user who is not actually seen by that consultant.

At the same time, interdisciplinary peer review of all caseworks should occur regularly with psychiatrist involvement, for example, formal interdisciplinary debriefing of all intakes, peer review at predetermined intervals, and each case manager doing in-person assessments, family interventions and follow-ups jointly with the psychiatrist or other team professionals as required. This ensures that all other team members see and know each others' work, give advice and provide informed cover when people are away.

The psychiatrist's role in relating to other medical disciplines

A significant proportion of patients presenting to general practitioners (GPs) surgeries have some diagnosable and treatable psychological problem. Many physical illnesses can present with psychiatric symptoms (e.g. hypothyroidism presenting as depression) or can precipitate or be complicated by specific psychiatric disorders. Most

specialist surgeons and physicians these days are very keen to involve our specific general-hospital-based consultation and liaison psychiatric services, either to consult urgently about a particular problem patient or to receive regular input into their case reviews.

The major interface in general hospitals between psychiatry and other medical specialties is the emergency department [20••]. Ilchef [20••] reviews evidence revealing that more than one-third of emergency department presentations comprised patients suffering from a psychiatric disorder, of which nearly 80% attended for medical reasons. Arguably the consultation–liaison psychiatry model of service is also a useful approach to working with GPs [21•,22].

Community psychiatrists and psychiatric registrars (now among other psychiatric professionals) work closely with GPs (often in Division of General Practice shared mental healthcare programmes) [22,23•] and with the Australian Royal Flying Doctors Service or equivalents elsewhere and base hospitals and community teams in remote areas, increasingly *via* interactive tele health conferencing [24•,25].

Partly because of their medical socialization during training, GPs and doctors of other specialties, at least initially, and from time to time, want doctors in psychiatry to relate to them, until they appreciate the virtues of relating directly to a highly accessible, responsive, interdisciplinary team. Direct doctor-to-doctor communication is also useful when discussing or negotiating complex medical interactions or medication issues.

Skill base for community psychiatrists: Are the skills of a high-quality 'community psychiatrist' any different from a 'good psychiatrist' in general?

Clinically no. First, a community psychiatrist must be a competent clinician. Second, the term 'community psychiatrist' should not be romanticized as a lone ranger riding off into the sunset after solving each local crisis. Arguably the term is useful to denote a wider training in how to relate professionally to the mental health needs of a whole community or catchment *via* full membership of an interdisciplinary team, integrating community-based and hospital-based care with both clinical and communal partnerships.

Third, we need psychotherapeutic skills to provide the practitioner with a map and a compass to enable us to balance empathy with self-preservation, while being mindful and reflective about the potency and meaning of our everyday interventions. For example, is a home visit experienced as caring and bolstering safety, or as an intrusion or invasion? Is medication seen as a respectfully negotiated aid to recovery or as enforced control? Have the interpersonal struggle and victories involved in novel crisis resolution been fully acknowledged and celebrated?

Fourth, the term 'community psychiatrist' should signify an exhortation to 'go wider' in seeking rigorous training and experience in both the microsphere of direct clinical care and the macrosphere of improving the well being of whole communities (see Table 2) [26,27,28,•29•,30, 31••–34••,35•,36,37•,38••,39,40••–43••,44,45,46].

The community psychiatrist's role in clinical leadership

Interdisciplinary teams have become the principal vehicle for the delivery of integrated, comprehensive services in modern mental health systems. Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks and requires sound leadership in terms of both team management and clinical supervision. No single profession should hold a monopoly on leadership and management. Management of an interdisciplinary team is not necessarily the domain of the psychiatrist. Management should be performed by the person in the team best qualified, experienced and most committed to performing the management role independent of the type of clinical professional background. Psychiatrists should be encouraged to learn to understand and participate in management and particularly in leadership roles, and future training for psychiatrists must help equip them for these roles [4•].

Administrative demands

Public psychiatry involves increasing demands for administration form filling and data gathering in the often laudable but sometimes questionable name of accountability. Many mental health professionals, including a survey of psychiatrists [47], complain that this results in less time for direct clinical care, particularly when health systems fail to provide clinicians with appropriate support to meet these new demands [47].

'Those who've never burnt out have never been on fire'

Charismatic leadership is sometimes useful in establishing innovative service models but can get in the way during the more stable and enduring implementation of a regular service, when a broader leadership group often serves better [12].

Burn-out is not found to be greater in public psychiatrists than in other mental health professionals and is sometimes less [48••], particularly when psychiatrists exert some control on the type and flow of work they are required to do and if they are positively identified with and supported by a well functioning interdisciplinary team [4•,48••]. Work-related stress remains an issue

Table 2 Skill base for community psychiatrists

(a) In the microsphere of direct clinical care:

Clinical and operational skills in balancing community and hospital care [26] and integrating both, so that there will no longer prevail a false dichotomy between them [27]. Meanwhile the balance should shift increasingly towards community care as the centre of gravity of services 'in-reaching' (the opposite of 'out-reaching') to hospital only as necessary.

Clinical skills in home assessments and reviews and evidence-based interventions in community as well as hospital settings with individuals, families and groups. For example, in home delivery crisis resolution teams [28•,29•], early intervention programmes, psychoeducation and problem-solving techniques [30,31••,32••].

A working knowledge of and expert skills in a broad range of comprehensive psychiatric assessment and intervention, including those from biophysical, psychological, social and microcultural domains, for example, more judicious and rational use of psychotropic medications, and full understanding of current medical investigations, including brain imaging [33••], cognitive behavioural and interpersonal psychotherapies [30,34••], educational/vocational and family interventions [30].

Working as a full member of an interdisciplinary professional team, including community pharmacists [35•] and substance abuse and vocational rehabilitation professionals working within the team, whenever possible.

Resource management and collaborative leadership of the team, both clinically and operationally [4•].

Ability to systematically apply current early-detection screening tools for most psychiatric disorders, routine cognitive tests and outcome measures to share clinically with service-users, to provide feedback to teams and to monitor of outcome trends for health services. For example, mental health professionals' growing familiarity with the applications of the Australian suite of nationally mandated outcome measures, particularly the Health of the Nation Scale and the Life Skills Profile (see www.mhnocc.org).

Working in partnership with service users, and family carers and indigenous, multicultural and other special needs groups (e.g. those related to comorbidities) by imparting information and skills to them while recognizing and mobilizing their expertise in their own circumstances, and as consultants to service development [5•]. This requires extensive skills in active listening and providing information that is timely, precise, accurate, up to date, evidence based, and humane, about their disorders and their course, treatments, risks and realistic expectations (G. de Girolamo, personal communication, 2006).

Working with GPs in systematic share care arrangements [21•,22,23•]

Working closely in cooperation with medical specialists and other public agencies, as well as private and nongovernment service providers, formalizing these arrangements with service agreements, which should be reviewed regularly.

(b) In the macrosphere of improving the mental health and well being of whole communities:

Taking a sociological and an anthropological viewpoint, which takes into account the resilience [36], 'social ecology', 'human capital' and 'capacity building' potential of the local community [37•,38••] and cultural tools and healing practices available to that community [5•,39]. Attending to these factors becomes critical when working with rural/remote, indigenous, culturally diverse or traumatized populations [24•, 25,39].

Utilizing a public health perspective that assesses the unmet or undermet needs of a circumscribed local or regional population and endeavours to meet those needs with early detection, prevention and intervention programmes, such as for first-episode psychosis [31••,32••]

Promoting mental health awareness and teaching mental health survival and response skills in the lay community to enhance resilience [36], mental health and well being and to increase the number of informal resource people in the general community. For example, improving mental health literacy by providing general communal access to a 'mental health first aid' course, practically taught like a physical first-aid course [40••,41••]. Such courses can also be shown by randomized control trial (RCT) studies to improve both the knowledge base and willingness to help others with a mental health crisis as well as the mental health of participants [41••,40••].

Sociopolitical empowerment and demarginalizing strategies and community wide programmes to challenge stigma and discrimination against people with a mental illness. Although psychiatrists often lead such programmes around the world [42••,43••], it is doubtful that psychiatrists are ideal role models and advocates in this sphere. As Lauber *et al.* [44] among others have demonstrated, psychiatrists' attitudes towards mentally ill people living in the community and social distance measures do not differ from those of the general public. They conclude that psychiatrists should improve their knowledge about stigma and discrimination of mental illness to replace myths with more accurate perceptions, through psychiatric training.

Planning and promoting of mental health service system reform and development [45]; commenting publicly on sociopolitical issues of the day, particularly with psychiatric ethical and human implications [46].

particularly in urban areas where resources are cut back or services are merged, shrunk or dismantled. It helps to survive in the system if you can take an absurdist view of the bureaucracy and if you do not take too personally what havoc they may wreak administratively upon your service, as in reality they would probably do it to anyone.

The dilemmas of clinical leadership

Clinical leaders sit on the team boundaries, facing outwards when representing the team to management and other agencies and facing inwards when supporting the team. Living on the boundary can be difficult and lonely [16]. Clinical leaders can neither entirely join the team group nor distance themselves from it [16]. They [4•] have an important role in containing difficult team emotions and an equally important role in articulating and standing up consistently for the team and service values and vision based on the experienced needs and safety of its clientele, their families and its staff. Otherwise, bureaucratic pressures (e.g. to save money) can easily eclipse clinical priorities and rapidly denature well functioning teams.

Transactional vs. transformational leadership

Transactional leadership entails influencing others to engage in the work behaviours necessary to reach organizational goals. Transformational leadership goes beyond management and involves challenging the *status quo* to create new visions and scenarios, initiating new approaches and stimulating the creative and emotional drive in individuals to innovate and deliver excellence [4•,15••]. The superiority of transformational over transactional and laissez-faire leadership styles in mental health service teams is emerging in evidence. Studies [15••] demonstrate that training to improve leadership and team functioning is feasible.

The psychiatrist's role in community leadership

A clear majority of Australian and New Zealand psychiatrists (64%) and even more psychiatric trainees (76%) strongly support college spokesperson psychiatrists speaking out on sociopolitical issues of the day [46]. As the increasing constituency of female psychiatrists and trainees of both genders are most strongly supportive of this practice, this trend is likely to be reinforced in the future [46].

The growing role of the psychiatrist is indicated as a public advocate for issues of community welfare, sociopolitical policy and cultural trends with psychiatric ethical and human rights abuse implications. Those undertaking these roles need to become highly skilled at regularly consulting their colleagues about the issues for which they are collegiate spokespeople (e.g. by interactive electronic communication) and at public and media presentation.

Implications for psychiatric training

All future psychiatrists should be essentially abreast of neuroscience advances in our field [33••], including the contribution to the cause and possible interventions of complex genetic disorders, gene–environment interactions, neuronal dysregulation and brain systems as markers for early diagnosis. Future community psychiatrists should ensure that individuals with severe mental illnesses do not continue to be deprived of the latest preventive programs for physical risk factors or medical interventions for their physical diseases [49,50]. Comorbidities with mental illness of all flavours should be addressed squarely in training, particularly in relation to substance abuse, which is causing such a huge increase in demand for psychiatric services and yet can be resolved by well integrated dual-disorder services [51•,52••]. At the same time, we must recorrect the balance between the dominant biomedical model and the increasingly marginalized ones derived from psychosocial psychiatry [43••]. They conclude that we need to reprofessionalize psychiatrists and complete a social reengineering of psychiatry to be more like the community wants from us, to balance our scientific and medicolegal authority, with the regaining of moral relevance and social influence. Our training similarly needs to be not just scientific but more syncretic, reconciling and uniting diverse practices that work.

Bloom [37•] laments that Engel's bio-psycho-social model has been displaced largely by a narrow psychobiological perspective, both in the undergraduate medical curriculum taught by psychiatry and in psychiatric residency/registrar training programmes.

The prominent exceptions include very creative models like the interdisciplinary second pathway at Harvard and the 4-year course strand on the doctor–patient relationship at both University of New Mexico and University of Sydney, which also has a 4-year strand in community–doctor interactions.

An extensive review [53] of US residency training curricula demonstrates that experiential training of psychiatry residents in community settings is feasible and has been emerging as the rational choice for much of the psychiatric residency training, considering the progressive shift from inpatient to community loci of care for most service users, most of the time. The authors then show that few residency programmes pay more than gestural lip service to these trends, at most providing an optional brief rotation into a community mental health centre or even briefer outpatient sessional visits displaced to such a centre.

The few notable exceptions include the community-oriented psychiatric residency and registrar training programmes in Oregon, Colorado and Madison, Wisconsin in the United States and the East London and the City Mental Health NHS Trust, UK. These progressive programmes often depend on initiation and sustenance by high-profile product champions.

In the light of these evidence-based shifts in the locus of most psychiatric care, the authors conclude that there is a critical need for more psychiatrists capable of community practice.

Recovery-orientated training

For example, the evidence base for models for pursuing long-term psychiatric rehabilitation in community settings is blossoming, including ACT teams [54] and vocational [55•,56], residential [57,58,59••,60•], family [30] and medication adherence [61–63] programmes. Many psychiatric trainees are, however, perplexed, apprehensive and sometimes overwhelmed with therapeutic pessimism when they try to purposefully treat patients with long-term disabilities, particularly in hospital-based 'maintenance' placements.

Optimism, hope of recovery and continuing growth are easier to encourage in real community settings even if high levels of supervision, intervention and monitoring are required [53]. Psychiatrist training and roles required for effective psychiatric rehabilitation have been reviewed by Torrey *et al.* [64••], and these include becoming a collaborative interdisciplinary player, employing therapeutic optimism and ability to instill hope, prioritizing, whenever possible, service-user goals over staff goals, skills acquisition in evidence-based psychosocial interventions, intertwining treatment and rehabilitation, valuing service-user self-determination and control over their own recovery, and promoting systematic family interventions and routine involvement and working with confidence in community setting. In contrast, few psychiatrists receive any training in these attributes and skills [64••].

Dearth of a prevailing theory and codes of practice of community psychiatry

We used to rely on Gerald Caplan and Len Stein in the United States, Franco Basaglia in Italy and Dennis Scott and Douglas Bennett in the UK as major reference points for community psychiatry. A key problem to address is that we no longer have any leading theories or practice codes of community psychiatry around which we might coalesce as our field has become increasingly biomedicalized and focused on individual treatment [65]. This transformation has been hastened by the shift to 'economic rationalism', high-tech consumer globalization, with communities being disrupted by individualistic ethos and segmented into markets, and the lip service paid to a solely quantitative paradigm of evidence-based everything. On a more positive note, argues that Cohen *et al.* [65], at least we have very little obsolete theoretical baggage to discard. The Caplanesque heritage of Community Psychiatry Consultation, however, continues to be revived, for example, in the consultant psychiatrist's role in outback remote Australia, systematized through the National Mental Health Integration Program [24•,25]. This involves the psychiatrist visiting small townships with local community and indigenous mental health professionals and providing direct consultation and teaching for diverse community agencies, lay telephone counselors, flying doctors and GPs in surgeries and aboriginal medical services.

Idealism vs. cynicism in community psychiatry

Applying a matrix method of scrutinizing services and professions prior to reform [45], Tansella [66] distinguishes two types of psychiatrists. The 'archeologists' focus on individual psychopathology and potential for change, examining and treating the roots of disorder and sometimes suffering from a psychodynamically informed viewpoint. Meanwhile the 'architects' concentrate more on groups and populations and on the development, organization and reform of services for them. The psychiatrist 'architect' particularly helps deprived populations with psychiatric disorders to live constructively without loss of respect or renouncing their identities and ideas.

Community psychiatrists often identify with this latter category. To me, no dichotomy is needed. We need both types of psychiatrists to satisfy 'met need' (treated prevalence) and deal with 'unmet need' (untreated prevalence). The 'archeologist' aspect may also provide the intervention content, whereas the 'architect' can provide the most effective vessel or vehicle and both should be evidence-based to optimize outcomes. Thornicroft [67] distinguishes between ACT as a service delivery vehicle, and actual ingredients (e.g. cognitive behavioural therapies or family intervention), which are often underemphasized and work synergistically to power a cost-effective vehicle to produce optimal outcomes. A community psychiatrist should work at both individual and population levels of complexity.

In response to an earlier dialogue on this topic with Tansella, Bernadetto Saraceno (personal communication, 1999) suggested that there is a third category of 'barman-psychiatrist' and who sees a passing parade of patients coming in and out of his office, public or private, and who listens for some minutes before prescribing from a random list of drugs, without explaining anything or with only superficial reassurance or cursory civilities, like a barman. This proposed third category is a Rylean category error of course, not relating to the initial 'dichotomy' at all, but setting up a new one, between cynical, passive response, disengaged practitioners, and committed active response and engaged practitioners. The former may be still the most common in psychiatry (as in most professions), resulting in casual polypharmacy, iatrogenesis ('met un-need' or 'treated unprevalence') and needlessly lifelong patients. The latter type of practitioner may be the minority at present but represents a legitimate aspiration for the future, which may be fostered by more appropriate selection, training, role modelling and systems of reward.

Conclusion

As well as improving the effectiveness of our work with individuals, we need to rebuild a community psychiatry of whole communities, invoking concepts and evidence relating to social justice, social capital [37•,38••] and resilience [36], to assist to revitalize traumatized and 'socioeconomically deprived' populations, while bridging both the chasm between qualitative and quantitative research and the dichotomy between science and fervour for meaningful constructive change [65].

Some health departments and mental health administrations deal with mental health services *via* the 'triple-whammy' imperatives of

(1) the law and order/security agenda, resulting in reversion to 'fortress psychiatry' and reinstitutionalization,
(2) the 'economy of scale' agenda forcing formerly accessible community mental health services back onto hospital sites and back into sedentary outpatient practice roles,
(3) the prevailing biomedical dominance of psychiatry, leading some psychiatrists to just prescribe and maintain, rather than relating to their clientele and encouraging their recovery.

Such health services relate to community psychiatrists as if we are a quaint and endangered species, and the sooner we all die out, the better.

Service users, families, fellow service providers and local communities do not necessarily share this assessment or prescription. They welcome professionals who are prepared to organize themselves to respond to their perceived needs where and when they experience them, to advocate for marginalized people and their families and to promote therapeutic optimism and the regaining of full membership of the community.

If these constituencies prevail, then there is likely to be a bright, if buffeting, future for community psychiatrists and for their wide tapestry of richly interwoven roles between the microclinical and macrocommunal levels and societal and cultural levels, working in the context of the interdisciplinary team and multiple partnerships.

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References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:
- • of special interest
- •• of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 000–000).

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