SUPPLEMENT

TALKING POINT

Organisation and management problems of mental illness hospitals

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There has been a general welcome in the medical profession for the principles of unit management in *Patients First*.[1] But little attention has been given to a report referred to in the consultative document—the report of a committee chaired by Mr T Nodder, deputy secretary at the DHSS, on the organisation and management of psychiatric hospitals.[2] This is unfortunate, since the report dwells extensively on some of the issues only hinted at in *Patients First*.

The Nodder Committee was set up by the then Secretary of State, Mr David Ennals, in 1977 because of a widely agreed need to solve some of the problems identified by committees of inquiries into psychiatric hospitals and discussed in reports of the Hospital Advisory Service. The brief therefore was to make recommendations for the future management of these institutions. The committee has executed this competently, and its report is a well-organised and expounded guide to firm, clearly defined management organisation, which deserves to be noted not just by psychiatrists but by doctors in all parts of the Health Service.

The underlying principle is one of self-government for psychiatric services, not restricted to the hospitals themselves but spanning the extramural activities that are necessary to provide a comprehensive service: day hospitals; units in general hospitals; a community psychiatric nursing service; and linking in with social service provision of day centres, residential accommodation, and social work support. This seems to echo principles inherent in *Patients First*, though the time span of the committee's work suggests that these were formulated before that document was written.

Autonomous management teams

To achieve all this, a psychiatric service management team (PSMT) should be created as a sector of the area health authority but with a large degree of autonomy, including budgetary control. Members of this management team would be drawn from the major professions concerned, some elected representatives, some appointed ex officio, producing a group redolent of HMC days. Their functions would be general management, planning, and setting objectives. Strong management depends on setting clearly defined tasks, policies, and objectives to be followed by a lower tier, that of the hospital management team; setting standards of performance that can be monitored; and adjusting all of these as change takes place. The team would be responsible to the district management team for the provision of psychiatric services, but that responsibility would be autonomous, mirroring the call for strong unit management in *Patients First*.

A simple trunk depends on an equally simple but important root system. The nourishing point of the tree is the ward, and ward management is clearly the responsibility of the charge nurse, with control of domestic, clerical, and other support services in order to achieve satisfactory patient care. The prime purpose of the ward has been forgotten over recent years in the proliferation of separate management systems; good patient care demands a return to past practice, with the charge nurse in command. The philosophy of care within the ward, policies such as how to deal with violence, and individual treatment programmes all need to be worked out in a multidisciplinary manner, with the responsibilities of each member spelt out and clearly understood. The seeds of trouble have often been sown over the problems of who is responsible for what, with the consequences reaped in the courts and committees of inquiry. If the way in which the ward works can be put right other issues fall into line. The chapter on multidisciplinary team work and ward management is thus the core of the report.

Between ward and PSMT a hospital management team is suggested, a trio of nurse, doctor, and administrator. This group would provide the day-to-day management of the institution and ensure that the agreed policies of the PSMT and of individual clinical teams and ward management are followed and standards are maintained, and is where disagreements can be sorted out. Budgetary responsibility would be delegated by the PSMT to this group, for the report makes the case for there being an all-embracing psychiatric service budget, allocated to the PSMT in line with the plans produced by that body. This would give the psychiatric service flexibility to provide an efficient service able to determine priorities and move resources without unnecessary interference from outside. This is another return to HMC days but one which will be welcomed by many and which perhaps offers the only way towards responsible budgetary control.

Certain subjects are picked out for special mention. There is a chapter on the elderly, the group which poses the biggest threat to any organisation and management scheme. The number of confused old people in the country over the next few years will be such as to swamp even the most well-ordered service. The chapter spells out the problems and, without offering neat solutions, describes how some of these may be overcome. Current DHSS guidance is adhered to but until this has been put into practice, and in many parts of the country it has not, there is no point in adding new ideas or in criticising this overall policy. The Nodder committee hoped that the organisation systems discussed in the report would be beneficial in helping the old to better care but also recognised that what was required at present was good, strong, and enthusiastic leadership. Enthusiasts have a way of not allowing others to forget their chosen subject and of infecting others, both very necessary attributes for people concerned with psychogeriatrics. The report emphasises the value of working closely with social services and with geriatric services. What could be more firmly argued is the need to work closely with those who carry

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the major burden of care—relatives and families. Supporting the supporters, both lay and professional, sharing care between the various agencies, will be the only means of coping with the problems.

Frequently, even with a dynamic, forward-looking service, old people become long-stay patients, though newly admitted old people form only a small part of the total population of any mental hospital. Another chapter identifies the important issues relating to such patients, necessary because it is around this group that the scandals of the past 10 years have occurred. Again, there are few specific recommendations. The committee obviously rightly refused to offer panaceas, but the principles are outlined and reference is made to a working party of the Royal College of Psychiatrists expected to report soon. The emphasis is on rehabilitation and repatriation, with not too much on the care of remaining patients. Nobody should be assumed to be a long-stay patient until numerous attempts at resettlement have been made, but when all the possibilities have been explored the quality of life in hospital is important. Mental illness hospitals are not the only places to have long-stay patients but the compartments in the NHS inhibit learning across specialty boundaries, so that progress in geriatrics or mental handicap has not spread to psychiatry. The report recognises this, at least in one aspect, by referring to the green book of the mental handicap world, *Helping the Mentally Handicapped in Hospital*.[3]

The overall effect is of an important step in evolution of management in the Health Service, even if it seems to be advocating a turning back to the older styles, a revolution. Most of the views will be acceptable and welcomed by those in psychiatry, but there are three issues which demand highlighting.

Responsibility of consultant psychiatrist

The committee, like others, delves into the responsibility of the consultant psychiatrist. In this it follows the clear position of the Royal College of Psychiatrists' statement[4] that the diagnosis and prescription of medical treatment are the responsibility of the consultant. The college went beyond this, however, in suggesting that the consultant had a role as co-ordinator of the various people who might provide care and treatment, and was by implication the leader of the multidisciplinary team, with responsibilities for that team. Like the Normansfield Report,[5] this report draws distinctions between various components of this agreement. "The determinancy of the patient's individual therapeutic programme is for the multidisciplinary team, though sometimes with a single professional taking the lead. The responsibility for maintaining a suitable environment in which this can take place is also for the team." Clearly the consultant is not even primus inter pares in this definition. In the Normansfield Report he was given a task of selection from among the opinions put forward; in the Nodder Report the working of a multidisciplinary team is viewed as a fugue, with the lead being assumed at various times by various members, in relation to their skills, the stretto providing the therapeutic goal.

Is this variance to be seen as true evolution, with a modification of attitude over time as to the interrelationships of various professions? If so, does it matter? Many would think that the acceptance of equality of value of various professions, especially of nurses, was long overdue; others might be wary; some such changes question the job of the doctor in the discipline of mental illness. For others the committee has really breached the doctors' castle walls by saying that there is no basis for the commonly held view that the "responsible medical officer" is responsible for negligence on the part of others, as if he were a minister or military commander. Such a statement really does leave the psychiatrist as a defenceless maid, ripe for the ravishing.

A different point, but with its own important implication, is made elsewhere in the report. It suggests that two of the members of the psychiatric services management team should be from the social services department, one a senior officer, the other the line manager of the hospital social worker. They should be full members of the team, with equal rights with the other team members. Thus they are directly concerned in the management of part of the Health Service, while specifically being excluded, as individuals, from accountability to the DMT or the health authority. In theory this may not be a bad thing, for the effectiveness of the psychiatric service relies on provision by social services, as well as on the Health Service component. Co-operation is essential, but should this extend to the invitation to participate in management? The social workers' powers need to be spelt out; do they, for instance, have the power of veto in the PSMT? Their task vis à vis the social services department also needs to be clearly defined. Are they holding a watching brief or acting as counsels or plenipotentiary ambassadors with the authority to commit their department to lines of action? This latter would be against usual local authority practice, since it would bypass the usual hierarchical arrangements within social service departments, while few councillors would give up their decision-making powers. The ideas embodied in the suggestion, the spirit of the recommendation, is acceptable, but there are too many drawbacks in the practical application.

The third oddity in the report is the complete lack of participation of community medicine, despite the presence on the committee of a community physician. One of the jobs of community medicine outlined in several documents, from the Hunter Committee Report[6] and the "Grey Book"[7] to *Patients First*, is that of identifying needs and of planning services in order to meet these needs. This means joint planning with local authorities and voluntary groups, an activity which the report recognises as important and which it suggests will involve members of the PSMT on joint care planning teams. This is the same activity which in *Patients First* is delegated to community physicians. Members of the committee cannot claim to be ignorant of the contribution individual doctors in that specialty have made to developing services for the disadvantaged. The inference is that community medicine was deliberately ignored either in the hope or knowledge that it is a dying specialty or with the deliberate design to keep inquiring minds firmly out of the arena. Exactly the same can be said about the absence of general practice representation in any part of the planning and management of services. Is this part of a nefarious design or a Freudian lapse of understanding? Either way it bodes ill for the future of the Health Service, just at a time when fresh attempts are being made by the Government to improve the co-ordination of the whole Service.

There is much in the Nodder report for dissent and for debate. There is also a great deal of commonsense and practical advice. Whether or not the report receives formal recommendation by the DHSS or whether its ideas are built into the final guidance on which the Health Service is reorganised, it should be carefully read by all those concerned with mental illness services. The committee have made a worthwhile attempt to gather together many past suggestions and current good practices and to mould them into a pattern of organisation, warts and all. Much can be adopted by health authorities now with benefit to both patients and the Service. The report should not be allowed, as many others have been, to gather dust on office shelves.

References

1 Department of Health and Social Security. *Patients first*. London: HMSO, 1979.
2 Department of Health and Social Security. *Organisation and management problems of mental illness hospitals*. London: DHSS, 1980.
3 Department of Health and Social Security. *Helping the mentally handicapped in hospital*. London: DHSS, 1978.
4 Royal College of Psychiatrists. The responsibilities of consultants in psychiatry within the National Health Service. *Bulletin of the Royal College of Psychiatrists* September 1977:4.
5 Committee of Inquiry into Normansfield Hospital. *Report*. London: HMSO, 1978.
6 Department of Health and Social Security. *Working party on medical administrators*. London: DHSS, 1972.
7 Department of Health and Social Security. *Management arrangements for the reorganised NHS*. London: HMSO, 1972.

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