For Debate

Even better services: a psychiatric perspective

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The influential white paper of 1975, *Better Services for the Mentally Ill*, was “a long-term strategic document indicating the general direction in which we should move and the general background against which we should be taking decisions,” according to Barbara Castle, then Secretary of State, in the foreword.¹ As we are now celebrating 150 years of British psychiatry since the establishment in 1841 of the Association of Medical Officers of Asylums and Hospitals for the Insane, and 20 years since the award of a supplementary charter that established the Royal College of Psychiatrists, it is timely to review progress in psychiatry. A leading article in the *British Medical Journal* stated that if the objectives of the new Royal College of Psychiatrists in 1971 were “to be achieved, the standards of psychiatric practice at all levels must be improved so that the patients themselves are beneficiaries.”²

The intention of *Better Services* was to shift the emphasis towards community care, with social services departments responsible for hostels, day centres, group homes, and their staff and psychiatric services providing inpatient care in district general hospitals and community hospitals, and more of the psychiatric work to be carried out in health centres. The whole edifice of comprehensive community mental health care was based upon the structures of the local authority and the health district, so that “the future pattern of services for the mentally ill [is] based on a comprehensive network of health and social service facilities in each district.”³

Some of these aspirations have been achieved, yet we are still aware in 1991 of major deficiencies in psychiatric care—for example, the homeless mentally ill, people with psychiatric illness in prison, the lack of skilled personnel in many districts so that only psychotic disorders can be adequately dealt with, and the lack of local developments following the rundown of the large mental hospitals. Common to these various problems is that new services have not been established before running down the old ones. *Better Services for the Mentally Ill* took as its goal provision for a single health district, but it did not prescribe clinical care for the individual patient in need.

The personal physician

Better Services aimed to create local comprehensive mental illness services in each district, to establish a psychogeriatric service, and to close hospitals not well placed to provide a service to the local district. Why do we not now have an excellent mental health service? What went wrong? “Absolutely central to the nature and traditions of the NHS is the particular nature of the doctor/patient relationship. This relationship derives

from a founding principle of the NHS, namely that, on referral from his/her general practitioner, an individual becomes the personal patient of the consultant.”⁴ Most patients receiving care rate most highly the relationship with the individual carer: the ability to talk about “my doctor” or “my district nurse.”

As far as the individual patient is concerned, the personal service of the consultant providing comprehensive acute psychiatric treatment and after care and ensuring that all the other services work is valued most. The National Health Service has to a remarkable extent succeeded in providing a high level of care anywhere in the country and in any medical specialty. However, this does not happen automatically; the consultant needs to be enabled to be the personal physician, which implies:

(1) Reasonable control by the consultant of clinical resources.

(2) The consultant should not have an excessive number of patients.

(3) Inpatient beds are best provided in an appropriately sited district general hospital.

(4) It is fundamental that the consultant is encouraged to see patients; continuing medical education is also essential. Emphasis on a “personal physician” will help both ends of the clinical spectrum, ensuring treatment for sufferers from neurotic disorders and also, by encouraging the doctor-patient relationship, providing better care for the chronic schizophrenic patient who might otherwise become homeless and vagrant.

The need for change

There were more than 150 000 inpatients in mental illness hospitals in 1955 and fewer than 60 000 in 1990, but there are known to be many patients with severe mental illnesses who are not at present receiving adequate psychiatric care. There are also many patients with known psychiatric morbidity currently being seen in general practice, the majority of whom will probably not require psychiatric referral. Is it not likely that among those not referred there are patients who would benefit from the intervention of modern psychiatry?

The introduction of comprehensive community care in psychiatry implied “nothing less than the elimination of by far the greater part of this country’s mental hospitals as they exist today...there they stand, isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined, rising unmistakable and daunting out of the countryside—the asylums which our fore-fathers built with such immense solidity to express the notions of their day.”⁵ The changes required can be itemised.

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(1) Capital released by selling mental hospitals and their land should go to provide district general hospital units, community mental health centres, and hostels. The Department of Health has quite clearly stated that proceeds from the hospitals for the mentally ill and mentally handicapped "should be specifically used for development of services for the client group concerned."⁵

(2) Revenue expenditure on what could be described as hotel services should partly be converted into the employment of highly trained mental health professional staff in all disciplines. Unfortunately, the mental illness revenue spending as a percentage of all hospital spending dropped from over 15% in 1961 to about 11% in 1986, and the total revenue expenditure on mental illness adjusted by the retail price index decreased marginally from 1980 to 1986.⁶ There is a vital need to identify the revenue of the mental health budget and preserve it from the encroachment of other demands before transferring from the old "district" to the new "provider" unit; there has been evidence of financial loss to other parts of the health service.

(3) Bridging finance is required. Although it has repeatedly been stated that the new facilities must be in place before the old are discarded, this has not happened because the necessary finance has not been provided.

(4) Control of the resources used by the individual consultant is vital. The consultant in the community is the leader of the multidisciplinary team⁷ and needs to be able to deploy the resources available, including staff in the different relevant disciplines trained to a satisfactory level; beds must be appropriate in site, in number, and in the facilities and structure of the ward; admissions must be under the consultant's control; a computerised service register is helpful in providing a higher quality of aftercare and also has a valuable research function.

More consultant psychiatrists

To provide a personal physician for community mental health services, more trained psychiatrists are required. Andrews compared psychiatric services in Australia with those in New Zealand in 1987, and with England and Wales and the United States in 1982 (table I).⁸ Australia provided a more community based service, with more patients seen as outpatients and fewer inpatient beds, while New Zealand provided a predominantly public sector, hospital based service. The definition of a psychiatric bed, the use of diagnostic labelling, the type of psychiatric training, the urban/rural distribution, and the racial origin of the populations were broadly similar in the two countries.

TABLE I—Mental health services per 100 000 population

	Australia (1987)	New Zealand (1987)	England and Wales (1982)	United States (1982)
Psychiatric beds	74	128	187	108
Qualified psychiatrists	8.8	4.3	2.4	14

TABLE II—Comparison of Australian and New Zealand mental health services

	Australia	New Zealand
Percentage of patients inpatients	12	25
Percentage of patients "impaired"	43	49
Percentage of patients with neurosis or personality disorder (not psychosis)	50	25
No of consultations per month per patient	2.0	1.3
Duration of index visit (minutes)	45.0	36.0
Expected total length of treatment (hours)	101.0	48.0
Cost of psychiatric care per 100 000 population per year (\$)	5.17	7.43

There were fewer than 60 000 inpatients in mental illness hospitals in 1990

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The table shows that (apart from in the United States, which has a different style of primary care) there is a strong inverse correlation between the number of beds and the number of psychiatrists per unit of population.

When psychiatric practices in Australia were compared with those in New Zealand, twice as many of the New Zealand patients were found to be inpatients, more of the New Zealand patients—but not grossly more—were found to be "impaired," and twice as many of the Australian patients were found to be suffering from neuroses and personality disorders (these were treated with psychotherapy) (table II).

In Australia, a wider range of patients were receiving treatment and more of the treated patients were receiving community care. Australian psychiatrists saw their patients significantly more often and gave longer consultations so that the mean time spent for treating each patient was twice as long for Australian psychiatrists than for those in New Zealand.

Andrews calculated that Australian psychiatric care per population cost only two thirds of that in New Zealand. This was based upon the income of psychiatrists and the cost of hospital beds. Thus, Australia provided in 1987 a better community service with more exposure to a "personal physician" at two thirds of the cost, but it required twice as many trained psychiatrists. In England and Wales in 1990 there were 3.9 psychiatrists per 100 000 population (4.0 for the United Kingdom); that is, about the level of New Zealand in 1987 and about half the rate for Australia then. It is not surprising that in Britain we have only a mediocre community psychiatric service.

Across all specialties of psychiatry recent changes have resulted in a need for more consultants for community work and for meeting the increased patient demand with a greater range of time absorbing treatments. Also, the time needed for audit, administration, and clinical management; decreased junior doctors' hours; continuing medical education; and teaching, research, and carrying out the requirements of mental health and other legislation make increasing demands.⁹ Thus "it is staff, rather than facilities which are the most precious assets for a psychiatric service."¹⁰ I am

working out the needs for each psychiatric specialty in more detail.

The relationship with management

It is axiomatic that the purpose of management is to facilitate the treatment of the individual patients by the relevant mental health professionals. Doctors and managers need to remember that everything else should be subordinate to the one aim of facilitating health professionals in serving their individual patients. With this in mind, and with the aim of the "personal physician," how should management work? The most important unit of management is the individual consultant and his or her multidisciplinary team providing a service for individual patients, and it is the job of managers to facilitate this; this has been likened to a group of small businesses sharing the provision of support services.¹¹ The purchaser-provider model of *Working for Patients* fits well with this, but it needs to be realised that the "providers" are ultimately the individual consultants and their teams.¹² It is difficult to see how in mental health the clinical director or coordinator can be other than a consultant psychiatrist if he or she is to be effective.

The consultant working in the community is a "consultant" to the local authority, to voluntary organisations, and so on, and also a "responsible medical officer" with the direct care of individual patients in the community, working with a multidisciplinary team. In this latter role the consultant is the leader of the clinical team. When working in the community it is necessary for a group of consultants, their staff in training, and those in other disciplines working with them to have a defined base for coordination, peer review, postgraduate training, and so on; integration of community care with hospital care is important.¹³

The multidisciplinary team is crucial for effective mental health care in the community. It is accepted that as well as an increase in trained psychiatrists for work in the community there will also be increased needs for other professional disciplines, including psychiatric nurses, occupational therapists, clinical psychologists, and social workers. There is a need for greater clarification of working relationships and responsibility. For example, community psychiatric nursing has developed as a specialty very rapidly, and it has been shown that those who were isolated from the specialist psychiatric team and who received little supportive supervision from their professional managers carried caseloads of increasing size. Failure to improve the way in which services for the mentally ill in the community are coordinated is likely to perpetuate the worst characteristics of life in the old back wards into the era of community care.¹⁴ Community psychiatric nurses should be working with individual named consultants for each of the patients whom they see. Good practice precludes their receiving direct referrals of new cases from primary care.

After the recent Manpower Planning Advisory Group report for clinical psychology, clinical psychology is unlikely to form a universal component of each multidisciplinary team.¹⁵ There will therefore be a continuing need for psychiatrists to be skilled in a wide range of psychological treatments for different conditions, to have sessional time to carry out such treatment, and also to train and supervise those in other disciplines. There is increasingly a very useful role for occupational therapy in the community as well as in hospital in the treatment of those with mental illness.¹⁶ The Community Care Act 1991 emphasised the need for social workers in the mental health field to work with colleagues in psychiatry and other previously hospital based disciplines.¹⁷

Conclusions

It is possible to produce better services for the mentally ill without a massive increase of resources by improved deployment of the resources we already have. To do this it is essential that there is identification and control of the mental health resources, both capital and revenue; the budget for mental health could to some extent be moved between districts if necessary.

Bridging finance will be essential to cover the changes in each locality from predominantly institutional to community care. The new service must be set up before the old is discarded.

Continuing medical education for consultants is vital for adapting to new methods of working and treating new groups of patients with new effective therapies. The new setting will require considerable adjustment and retraining for many established psychiatrists.

Clinical audit in psychiatry is essential. There is a need to evaluate working patterns not only of consultants but of the whole multidisciplinary team.

To achieve effective community care it has been shown that there will be a need for more trained psychiatrists. It has been suggested that doubling the present level of four trained psychiatrists per 100 000 population in the United Kingdom could provide a substantially improved level of community care without necessarily incurring a great increase of cost.

The emphasis of management should be to enable mental health professionals to spend more time with and provide more effective treatment to individual patients. As far as the practice of psychiatry is concerned the aim should be to make available to those suffering from mental disorders a well trained, therapeutically effective personal physician with enough time available to make adequate treatment possible.

This article is an edited version of the Freudenberg lecture given at Netherne Hospital, Coulsdon, Surrey, on 2 May.

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Correction

Preventing needlestick injuries

An authors' error occurred in this article by Professor D C Anderson and others (30 March, p 769). The last sentence of the section on reasons for resheathing should read "Forty seven nursing sisters and 55 doctors . . . intended to continue to resheath needles" and not 96 nursing sisters and 63 doctors, as published.