The Role of the Health Advisory Service in Psychiatry

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Background and remit of the Health Advisory Service (HAS)

The climate in 1969, in which the HAS was created, was one of increasing anxiety and embarrassment about the quality of long term care being offered to elderly, mentally ill and mentally handicapped patients in England and Wales. The need for a body to advise the Secretary of State, independently of the Department of Health and Social Security, was recognised and, with the wise guidance of Dr Alex Baker, the concept of multidisciplinary review by professional colleagues was established. Both these important principles have been maintained and stoutly defended by subsequent Directors, including myself.

In 1976, the remit of HAS was sensibly widened to include community health and social services. Emphasis on advising authorities and local professional bodies was increased, reflecting the increasing perception of Reports as useful and constructive guidance on service development. However, the 'direct line' to ministers was preserved.

Promulgation of good practice identified by teams became a stated objective and has been formalised in recent years as an HAS service for the NHS, consulted on each working day. Interest in particular sub-specialties has been stimulated by publication of advisory documents on services for elderly mentally ill people and adolescents.

Annual reports from the Director, resumed in 1984, give the opportunity to publicise current difficult areas in the provision of geriatric and psychiatric services. In 1985, the Annual Report included a special plea for psychiatrists and geriatricians to be consulted more effectively in planning and for their special difficulties to be given wider recognition.

HAS currently visits about 25 District psychiatric services annually. In the period covered by the five recent letters to the *Bulletin*, a total of 68 Districts (one third of all Districts in England and Wales) have had major visits and others have had shorter follow-up exercises. Most visits are in fact well received and Reports are put to positive use, being seen as useful external support for the improvement of services all too often subject to low priority and local misunderstanding. Follow-up visits confirm the progress which is achieved.

Before each visit, teams receive background information supplied by the health authority and the written views of professional leaders in the District. Consultants are individually invited to give their views to the team in advance of the visit and each visit includes a meeting between the team and the consultant body. Team members are expected to bring their own experience to bear on the situations they find; they have no 'ideal service' briefing from HAS and no checklist of 'desirable' features. This would inhibit the intention of HAS to find local solutions to local problems, acceptable to and capable of implementation by local people. There is therefore, to use the phrase of one of your correspondents, no 'party line'.

Visiting teams are composed of representatives of five or six different professions and have no designated leader. Their findings, and the advice which they subsequently offer, are, with rare exceptions, agreed by the whole team. In the year 1984–5, 139 individuals joined HAS teams, including 21 consultant psychiatrists, hardly 'concentration of power in a few hands' as is being suggested.

The Nature of HAS Advice

In accordance with our remit, advice is directed at methods of management and patient care organisation, interdisciplinary collaboration, co-operation between agencies and education and training. To comment on other areas, such as research, would not be our responsibility except insofar as research activities in a District affect service provision.

Advice is developed as a blend of team members' experience, but it is also generated by listening carefully to the opinions of as many local groups and individuals as possible. No two reports are alike; it is commonly stated that HAS is too inconsistent, solutions offered in one District being at odds with those proposed in another. Advice is not constrained by DHSS-approved policies.

There is no 'statutory' power. HAS advice is offered for what it is, namely the combined view of a multidisciplinary group of widely experienced, professional people with no axe to grind, unencumbered by local history and politics. It is open to any body or individual to disregard any or every item of advice in our Reports; what we do believe to be important is that any problems revealed by the visit are given due attention in the wake of the visit. If alternative better solutions are found, so much the better.

Some correspondents complain that advice given by HAS is over-inclusive and categorical; others resent advice which disregards existing knowledge or, alternatively, goes into areas which are not subject to existing proof at all. All these contradictory statements are true. As in many areas of clinical practice, most activity in psychiatry is unevaluated and 'unproven' in a scientific sense and our advice reflects these uncertainties exactly. It does however represent a fair view, given by colleagues, of existing methods and practice.

A visit is often the opportunity to re-examine long-nurured local grievances in an objective way. 'Shortage of nurses' has been regularly adduced to teams in Districts where scarce nursing manpower is in fact being wastefully squandered. There are certainly insufficient trained nurses working in mental illness (contrary to the belief of the government quoted in one letter), but this can hardly be a

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reasonable excuse for not re-examining current practice to see if alternative methods might not be better.

Advice and findings on HAS visits are often based on information which in the ordinary course of events does not come to the surface. Too often, general practitioners, community nurses, night nurses, junior doctors, community health councils and many others do not have a chance to influence the way in which services are provided or even to comment on them. It is reasonable to listen and to report what they say, though HAS teams are far too experienced not to seek substantiation before attaching any final significance to evidence, received from whatever source.

The Current Climate

Management changes in the NHS, altering standards of education for doctors and nurses and the Mental Health Act are each resulting in increasing pressure on clinicians to review and demonstrate the value of what they do. While, for some, the HAS visit is merely a further intrusive visitation, many others look to the HAS for the unbiased assessment of its team members and for constructive advice in a rapidly evolving specialty.

External support for development of mental illness provision is surely a valuable tool in an increasingly under-resourced health service. HAS offers precisely this, both locally and nationally. Where HAS support is linked to local evaluation of services and measurement of need, the combination is very powerful.

Publication of HAS Reports has added to their effectiveness; it is no longer the privilege of authorities to cloak the shortcomings of their services in secrecy. Publication also places an even greater responsibility on HAS to ensure accuracy and fairness in what we say. For this reason, consultation at the draft report stage has been widened and much more time allowed for a wider range of comment. No comment received at the draft stage is ignored or brushed aside; in some cases further local discussion takes place to clarify the message intended or to remove possible misunderstandings of meaning. At the end of the day, differences of opinion may well remain; facts will be correct to the best of our ability.

The recommendation that consultant psychiatrists should adopt more locally directed responsibilities appears in many of our Reports and has caused much annoyance to some of your correspondents. Teams now frequently take the view that psychiatry is essentially a community specialty; in doing so they are reflecting very widely held perceptions. They do not seek to abolish the specialisms of psychiatry or the rights of general practitioners to refer to whom they like and advice is couched in ways which reflect this. What most teams do wish to see is a change in emphasis, welcomed by the majority of psychiatrists to whom I have spoken, so that the discipline is no longer bounded essentially by the hospital perimeter but reaches out positively to treat and support most of its patients close to their homes. I do not underestimate the magnitude of the challenge which is facing traditional psychiatry, nor do I believe that the changes will be achieved without significant additional resources.

The Future

The HAS has contributed much to the development of present day psychiatry and will continue to play a similar role in the future. The constitution of the visiting teams means that recommendations in HAS reports continuously reflect current perceptions of 'good practice'. It is heartening that so many skilled practitioners of psychiatry continue to respond to invitations to join our teams. A personal disappointment has been the reluctance of many psychiatrists practising in academic departments to assist the work of HAS, reflecting perhaps the exceptional pressures under which their departments are being placed at the present time.

Successive Directors have welcomed and responded to advice and constructive criticism about the work of HAS, believing that its strength derives essentially from its credibility and flexibility. It is less easy to respond to assertions which are themselves based on fallacies, unhappily characterised by some of your correspondents. The caricatures of HAS as 'running wild', 'bureaucratic' (with an office staff of seven people!), with an 'ill-defined remit' (see HC(84)16), 'centralised' (yet recruiting and visiting in every part of England and Wales), 'costly' (less than £5,000 per health authority per annum) and so on perhaps betray more about the prejudices of their authors than about HAS.

In a climate of increasing emphasis on evaluation and monitoring, the HAS offers a professionally-based, proven system of review which has increasing applicability. Those who call for its abolition might wish to speculate on the potential acceptability of the replacement inspectorate which would undoubtedly be imposed instead.