Is psychiatry losing touch with the rest of medicine?

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What is happening in and around psychiatric services that raises fears of a harmful separation between psychiatrists and the rest of the medical fraternity? The last National Health Service (NHS) reforms at the beginning of the 1990s split some mental health services into separate organisations from their local acute services. Paragraph 5.14 in the Government's White Paper *The New NHS* (NHS Executive, 1997*a*) seems to favour specialist mental health trusts. Combined whole district trusts are under threat. Shotguns are loaded to 'encourage' the marriage with social services. All this may seem to conspire against psychiatrists maintaining close professional relationships with physicians and surgeons in general hospitals. Instead it puts the emphasis on aligning psychiatric work much more closely with social services and primary care. Much restructuring is already afoot. It is a time for sober reflection on what is in the best interests of patients now and in the future (see Box 1).

This paper will examine the key issues for psychiatrists to consider in influencing the management of their local mental health services.

Lessons of history

When the great 'mental hospital' system created by the Victorians separated patients from their communities, and psychiatrists ('alienists') from the rest of the medical profession, there were some benefits, but two great disadvantages. Patients were more stigmatised by what went on in these mysterious institutions and less able to recover social roles and return to their communities. Doctors and nurses were isolated from developments in mainstream clinical sciences.

The drive to set up psychiatric units in district general hospitals (DGHs) was motivated by the need to overcome both those serious disadvantages. The 1960s saw the blossoming of all the benefits that the medical model can bring to mental illness. It emphasised that the mentally ill had just as much right to all the benefits that society endows on those in the 'sick role'. Case definition became much more important and randomised controlled trials helped to establish the enormous benefits of pharmacotherapies like antidepressants and neuroleptics. Psychiatric patients received much better assessment of physical causes of their illnesses. Liaison with physicians and surgeons made them more aware of psychological factors affecting the presentations of their patients. Meanwhile, policy-makers and medical schools were responding

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Box 1.   Reshaping trusts

Trust configurations are changing: time to argue cases
Specialist mental health trusts are favoured in England
Mental health and community trusts are the model for Scotland
Can whole district trusts survive?
Could secondary care mental health flourish in a primary care trust?

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positively to the epidemiological evidence that a large part of the general practitioner's (GP's) case-load was owing to psychological disturbance.

Those were halcyon days for those of us joining the psychiatric profession. The status of the consultant psychiatrist was rising. Money poured in for research and teaching as the epidemiological evidence and pharmaceutical successes impressed everyone. The succession of enquiries into scandals within the mental hospitals only increased public interest and support for better mental health services from general hospitals and health centres. The major benefits that accrued for patients during the next two decades should not be underestimated.

However, patients with severe mental illnesses, and especially those with chronic disabilities, never fitted into the DGH environment, out-patient clinics or health centres. As homelessness and alcohol and drug misuse increased, making the management of severely mentally ill patients more and more challenging, the limitations of this approach became increasingly apparent.

Concerns about public safety, expressed in the media and by the general public, have made the care of people with severe and chronic mental illnesses a dominant theme of the past decade. The threshold for admission to hospital has fallen. Wards have become overloaded. Patients have become more reluctant to accept care informally. The Government, mental health professionals and the public are not satisfied. There is much evidence of user and carer dissatisfaction with mental health services.

But we must make sure that the pressing need for change does not cause the baby to be thrown out with the bath water.

The crux of the problem

The crux of the problem is the failure of existing systems of care to meet the needs of those with severe mental illness and especially those with chronic disability. With depressing regularity serious incident inquiries have criticised systems that are inadequate to maintain continuity of care. The mental hospital used to provide the 'glue' that integrated psychiatric treatment, housing, social and occupational needs provision. Many hospitals did not provide good quality of care, but out of sight was out of mind. Public concern was much less. The media had not latched on to homicides by people with mental illnesses, although these were consid-erably more common than they are nowadays.

The acute hospital model failed because it assumed that only episodic periods of care were

necessary for people who would seek help when they needed it and comply with advice given. True, many psychiatrists and mental health services made enormous efforts to develop community services. Success has been limited by lack of resources, lack of common purpose and lack of collaboration with other agencies.

It is easy to say that mental illness itself is the reason why patients do not like the services provided – they vote with their feet, avoiding contact while the illness is getting worse. But carers are also critical of our services, and many mental health professionals themselves have reservations about what is on offer should a relative need help. People from ethnic minorities speak of incomprehension of their needs and insensitivity as a consequence. The very word 'non-compliance' is under attack with the suggestion that 'non-concordance' is less patronising.

The resource problem is at least partly a matter of redistribution within the available resource envelope. Psychiatric wards are full-to-bursting because community support is so under-resourced and inadequate. People come into hospital who need not, or stay longer than they need for lack of provision to support them in the community. On average, mental health services spend 70% of their budget on hospital beds, and some as high as 85%. The challenge is to transfer resources from hospital to community services (including staffed residential accommodation) specifically designed to reduce the need for hospital beds. It is not only because hospital beds are very expensive, but also because patients dislike the experiences that they have in hospital: a national survey carried out by the Mental Health Act Commission and the Sainsbury Centre for Mental Health (1997) showed wards to be custodial, sometimes frightening, and largely bereft of any active therapeutic activity. Alternative methods of care in the community are usually preferred by users and carers, and so may lead to earlier intervention and continued engagement with services.

Two things are certain. The major social forces that will shape mental health services in the future are: the views of users and carers on what kinds of services they will engage with; and public perceptions of safety. The first of these is an important determinant of the second.

Government policies

Because of the weaknesses in individual care-planning revealed by serious incident enquiries,

central guidance has been handed down in terms of the Care Programme Approach (CPA), the Supervision Register and so on. This was sometimes felt to be oppressive by front-line staff: the general principles were often accepted but these policies were promoted or interpreted too prescriptively as if a blueprint could be applied to the whole country. Fear of 'naming and blaming' may have led to policy adherence seeming more important than professional judgement on what is in the best interests of an individual patient and the safety of the public. It is arguable that risk avoidance has done more harm than good, overpopulating acute wards where nurses are preoccupied with 'one-to-one' observation for a minority, and the majority of patients experience what Matt Muijen, Director of the Sainsbury Centre, has called a "care vacuum".

The long-waited *National Service Framework for Mental Health* (NHS Executive, 1999) has just been published. It contains most of what was recommended by the External Reference Group led by Professor Graham Thornicroft. It emphasises comprehensiveness, integration and focus. *Comprehensive* means that all populations be provided with the full range of services from 24-hour emergency access to long-term housing and social care under sheltered conditions, if required. The good news is that although it sets standards and suggests some models, it does not prescribe what is developed in each area. This means that users, carers, clinicians, social workers, nurses etc. can get together and be creative in tailoring things to unique local conditions.

Integration means that local authority and primary care professionals must be involved in this creative process of developing local services. The building block for mental health services is to be the 'locality', where inter-agency agreement on who leads is likely to be followed by pooled budgets.

Focused means services flexible enough to offer the level and type of response that is appropriate to the specific needs of individuals.

All this puts the emphasis on rebuilding mental health services from outside the hospital, with primary care and social services and user and carer preferences to the fore. Such a 'sound' and 'supportive' approach is more likely to improve 'safety' as long as hospital and secure beds are available when needed, with supportive legislation for compulsory treatment. However, it is recognised at a national level that progress depends on enabling and supporting creative change at the local level within this framework, rather than prescribed top-down instruction and guidance. There lies the hope and the challenge.

There is all to play for

For those who are involved in local discussions about choosing the right trust configuration for mental health, there is an excellent report from the Sainsbury Centre for Mental Health (Naya & Ford, 1998). The report contains a clear and rational discussion of the local issues to be considered when making decisions. It builds upwards from the needs of local users of secondary care mental health services. While it seems likely that the balance of argument will be in favour of the large metropolitan areas having specialist mental health trusts, options remain open elsewhere.

Indeed, the White Paper on the future of the NHS in Scotland (NHS Executive, 1997*b*) prescribes that mental health services will be part of community trusts. Primary care groups in England and Wales may take a few years to become trusts and be able to take on secondary care mental health, but this option being tested in Scotland might recommend itself south of the border. And on the principle that "if it ain't broke, don't fix it", combined acute and mental health services that are doing well in delivering the required improvements in mental health could survive in more rural areas. Any benefits that may be obtained from reconfiguration must always be balanced against the disadvantages of the change process. De-mergers and mergers consume an awful lot of time, worry and uncertainty for all those who are involved: service improvements may be delayed while a new organisation is settling down.

But whatever the shape of the trust in which mental health services are to be provided, there are always challenges in managing the interfaces that are important to delivering mental health services. No organisational structure in health care will ever contain the complete universe of relationships required to deliver a comprehensive service. So, deliberate planning is needed to ensure that any disadvantages likely to occur from separations and new interfaces are counteracted (see Box 2).

Keeping in touch with the rest of medicine

There may well be lessons to learn from psychiatrists who have worked over the past few years in specialist mental health trusts where efforts were successful in managing the relationship with the local acute hospital. These trusts may be doing better

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Box 2.   Managed interfaces

No organisational structure can contain the universe of relationships required for a comprehensive service
Interfaces have to be well managed with:
- general medical services
- social services
- tertiary mental health services
- acute hospital specialities
- non-statutory organisations

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than combined trusts where it has been taken for granted that inter-professional learning and clinical service development will be alright because everyone is in the same organisation.

Many accident and emergency (A&E) departments do not have the backing of a lead consultant psychiatrist to ensure that good practice protocols are developed and maintained for dealing with deliberate self-harm and other psychiatric emergencies. Psychiatric emergencies on wards and the subtle problems of comorbidity in general hospitals are often dealt with in a fragmented fashion by a number of psychiatrists, rather than by developing the kind of specialisation that is required to do the job well. Good interpersonal relationships between child and adolescent psychiatrists and paediatricians usually surmount any organisational barriers, and, similarly, between psychiatrists for the elderly and geriatricians. However, like all the other cross-speciality relationships that are essential for good clinical care, they need formal arrangements and accountabilities to make sure they work well, irrespective of informal medical networking.

It is suggested that there needs to be one consultant psychiatrist identified within each mental health service to lead and coordinate the links that need to exist and develop between specialists in the acute sector and specialists in mental health. This needs reciprocation with a lead consultant from the acute hospital. Both should be supported by managers of sufficient seniority to solve interface problems quickly. They should foster the educational side as well, ensuring that case conferences and clinical governance events include the diagnosis and management of comorbidity.

It is not simply a matter of professionals keeping in touch, but rather formalising interdependent relationships that are essential for good patient care. Reconfigurations are not an excuse for neglecting these important relationships, they are a reason for managing them better. It is my experience that acute

hospitals that are separating from mental health services become very interested in liaison psychiatry arrangements, psychiatric cover of A&E and alcohol and substance misuse services to patients in the general hospital. It is unlikely to be a one-sided relationship.

Better engagement with primary care

It is probably important for patients with severe and chronic mental illness that their psychiatric service is more closely engaged with GPs and primary care staff than it is with professional colleagues in the acute hospital. Effective care programmes that maintain such people with disabilities in the community heavily depend on mutual understanding and coordinated action between the psychiatric team and the primary care team. Most trusts and health authorities are now good at ring-fencing resources for the specialist mental health services and stopping them being ripped off by the ever-hungry acute sector. But the threat now lies in the possibility of shifts of resources away from those with severe mental illnesses to deal with less severe morbidity in primary care, as primary care groups and trusts begin to exercise their purchasing power.

There is much work to do to get that relationship right and it would not be a bad idea if more attention were given to keeping in touch with medicine in primary care than has, perhaps, been given in the past. The *National Service Framework* (NHS Executive, 1999) recommends that practices and the community mental health team serving them should agree a register of all patients with severe mental illness who must be given priority. Community mental health teams might identify one community psychiatric nurse to link with the practices, not to attract more referrals, but to advise GPs in selecting patients who should be referred and finding alternative ways of managing those who should not. In most areas, there is a huge job to do in reviewing the large investment in 'talking therapies'. Counselling/psychotherapy is being provided by a wide range of personnel whose methods need to be checked against the evidence we have about what works and what does not work. They need improved training and supervision if they are to work effectively and refer on the right patients.

It is suggested that there are enormous opportunities for improving the efficiency and effectiveness of mental health services, by joint planning of secondary and primary mental health care. The

same goes for social care provided by local authorities: it would be foolish to try and get one relationship working better without addressing the other at the same time.

Integrated locality service

It is now a statutory requirement for local authorities to work with health trusts and primary care groups in providing comprehensive mental health services. How much time, money and creative energy has been wasted to date in all three services through lack of common purposes and properly coordinated action?

These three authorities working within the health authority's Health Improvement Programme have the job of defining localities, agreeing which service will be the lead authority for providing mental health care and jointly appointing a manager for each locality who would be accountable for managing all staff and the pooled budget. The CPA and care management will have to be integrated, if that has not already occurred. Voluntary organisations involved with people with severe mental illnesses might be brought into the locality manager's sphere of responsibility. There will have to be innovative thinking about how to involve local users and carers in developing proposals for change and in auditing the effectiveness of services.

This is a real opportunity for improving the lot of patients with chronic and serious problems. It vitally depends on the engagement of psychiatrists at the leading edge with locality managers or as locality managers. There is the potential for releasing resources from the area in which most of the mental health budget is still spent – on hospital beds. It would be a tragedy if keeping in touch with the rest of medicine was used as an excuse for not embracing these new relationships with sufficient interest and vigour.

Frogs

Unwillingness to change in a rapidly changing world can be fatal. Charles Handy likened it to the behaviour of frogs that apparently take no action when the water in which they are floating is gradually heated. Eventually they boil to death.

I have read depressing articles and letters in journals suggesting that general psychiatrists may become obsolete as social workers, psychologists and psychiatric nurses competently take over work

that was formerly the exclusive province of the consultant. It has even been suggested that the only safe retreat for the consultant psychiatrist is practising 'proper medicine' in a liaison role within the general hospital. Nothing could be further from the truth – absence has made the heart grow fonder, with around 400 vacant consultant psychiatry posts in the country. Health authorities and trusts have found that they cannot substitute for the consultant psychiatrist. Even the user groups with more extreme views who have been dismissive about the need for consultants, are now saying that they are essential.

It is true that the medical model has its limitations in mental health, but psychiatric training and practice never confined itself to the medical model.

Some key issues

In conclusion, therefore, the new requirements of modern psychiatric practice can all be achieved without losing touch with the rest of medicine.

In most areas, there is still time to debate the options about configuration of mental health services with or without acute services. The best arguments will be based on what is in the best interests of people with severe mental illnesses. The Sainsbury Centre for Mental Health report *Laying the Foundations* (Naya & Ford, 1998) is as good a text as any to start with.

All organisations have important interfaces that need to be managed proactively. Where mental health

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Box 3.   Reverse the vicious circle

There is a vicious circle operating:
Patients dislike services and disengage
Media and public anger follows serious incidents with patients who have been 'lost to follow-up'
Professionals lose confidence when blamed and dictated to by central direction

A benign reversal of the circle could be:
Professionals redesigning services with patients and carers
Fewer people 'lost to follow-up' as a consequence
Service failure not the reason when disasters inevitably occur

services are in a separate organisation from the local acute services, deliberate plans are required to maintain, manage and monitor working relationships between psychiatrists and clinicians in acute hospitals. Whole district trusts that may have taken these things for granted would do well to emulate those specialist mental health trusts where the interface has been managed well. Many will find that it is not all push from the mental health sector to sustain the relationship – there is plenty of pull from surgeons and physicians who realise the importance of liaison psychiatry and the necessity of a good emergency psychiatric service to the A&E department and the general wards.

Much closer engagement with primary care medicine in organising community care has enormous potential. Done well it could make the work of a consultant psychiatrist far more rewarding by filtering out referrals that others can deal with. Joint registers of people with severe mental illnesses can help to ensure that they remain the priority. The cost-effectiveness of 'talking therapies' and other interventions in primary care could be much improved by application of the evidence on what psychological and social interventions actually work.

Building mental health services with local users and social workers from outside the hospital could make acute psychiatric wards function much better.

Consultant psychiatrists are needed out there in the lead as architects of locality services. Beware of emulating the frog. Reverse the vicious circle that undermines everyone's confidence (see Box 3).

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