Invited commentaries on: Influencing the Department of Health†

The College – a leadership role in mental health services?

Influencing government mental health policy is clearly an important topic for the membership of the Royal College of Psychiatrists (Kendell, 1999). Kendell & Pearce (1997) have documented the dejection and professional alienation that many psychiatrists experience. There is a steady haemorrhage of experienced community psychiatrists from work in inner urban areas into early retirement, the private sector and less obviously demanding National Health Service posts. Morale throughout the profession appears low: 'Things have to get better' (Storer, 1997). The College is widely perceived as being marginalised in the development of policy. Its pronouncements appear to carry significantly less weight with ministers than those of other interest and pressure groups such as the Sainsbury Centre for Mental Health, SANE or even the leader writer of the *Daily Mail*. Effective pressure groups need a clear agenda for action and the capacity to respond to (or preferably anticipate) events. Arguably, the College's admirably democratic structure (Clare, 1999), leavened by a regrettable tendency towards bureaucracy, militates against the pressure group role.

In addition to tenure as President of the College and a distinguished career in academic psychiatry, Dr Kendell has of course worked as a senior civil servant. His views on how to influence the Department of Health therefore carry triple weight. However, before addressing the 'how' of influencing government, it is perhaps worth at least asking whether and with what agenda such influence should be exerted. The 'whether' is perhaps self-evident: any responsible professional body would seek to use its expertise in the future development of its field. Kendell has thought deeply and written cogently about the proper function of the Royal Colleges (Kendell, 1998), which are emphatically not trades unions involved in negotiating the terms and conditions of their members. Kendell appears to support an extension of the traditional College role in postgraduate medical education into the policing of standards of clinical practice by established clinicians. In psychiatry, standards of practice cannot readily be separated from the legal and institutional structures within which we work. Perhaps a function in policing standards would legitimate the role of the College in influencing the broad sweep of mental health policy. Setting the agenda of influence would presumably require the College to adopt a leadership role that is consciously ahead of the views and practices of the bulk of the College membership, much as the Royal College of General Practitioners is aspirational and developmental in its views about primary care rather than representative of all general practitioners.

Dr Kendell's practical advice on how to influence policy seems admirably sensible. However, he is perhaps over-optimistic about the power of rationality in the determination of public policy. The most striking feature of policy in the past decade has been an increasing focus on the dangerousness of the mentally ill, which amounts to a 'moral panic'. This focus has more to do with tabloid headlines and media management than empirical evidence. Major policy initiatives are, in reality, rarely evidence-based. I would suggest that there are some further approaches to influencing government that need to be explored. The first is being addressed by a far-sighted College initiative that seeks to modify stigmatising public attitudes towards the mentally ill (Cowan & Hart, 1998). Additionally we need to work more effectively with the other stakeholders in mental health services, including the frequently demonised managers, the often despised purchasers and our friends and colleagues in primary care. The profession needs to accommodate to the realities of multi-disciplinary teamwork and not expect automatically to adopt a leadership role in every situation. Our most important allies should be service users and their carers. Finally, we need to work harder to earn the respect of government. To do this the profession needs to improve its standards of care (necessitating ever more investment in training and continuing professional development) and to speak more cogently to the emerging agendas within public policy. This, in turn, will require even more effective leadership from the College hierarchy.

†See pp. 321–323, this issue

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Good health services research is the answer

This is a welcome editorial which I hope will be read as much by ministers and civil servants as by psychiatrists in the interests of 'open government' and 'transparency' (words I have to put in quotes because I am still not convinced that policy in this area has yet reached reality). Dr Kendell (1999) outlines the real difficulties in getting a genuine dialogue established between profession and government. If the government sees representatives of the Royal College as "spokesmen for a rather conservative profession with its own self-serving agenda" and we see the Department of Health and its ministers as a juggernaut which will drive through its policies regardless of anything but public opinion, we are unlikely to make any significant progress. In this respect Dr Kendell is perhaps being too modest about his own influence during the time he has been president of the College. Through his knowledge of the Civil Service and the upper echelons of psychiatry, together with steadfastness and personal integrity, he has played a major influence in making sure that the voice of our profession is heard, not in a self-serving way, but as a genuine expression of concern over the care of people with mental illness in our country.

I fully agree that one of the most successful ways in which psychiatrists can influence government is by providing incontrovertible evidence through high-quality health services research. The simple, but unfortunate, fact is that most of this evidence is not available because the relevant research has not been carried out. Although we have made considerable advances in recent years (and it is fair to say that we are ahead of most other countries in this respect) we are still remarkably slow to anticipate important research questions that will be asked by governments and health departments within the near future and, as a consequence, appear to be left in a vulnerable position when answers are not forthcoming.

This is illustrated by the recent debate over the care of people with severe personality disorder. In discussing the merits of various forms of care for such individuals, all of which are extremely expensive, we have not been able to give any advice beyond that given by the informed layman, purely because the research has not been carried out into the effectiveness of different approaches in this group. While we can bemoan the absence of funding for such studies, I think it is more a question of absence of will. I am a great believer of Lord Rutherford's dictum "we have no money so we will have to think", and there is no doubt that, with sufficient determination and resolve, the relevant research can be carried out to answer these questions. The same applies to a range of very important subjects that government has to have near the top of its mental health service agenda. These include: (a) does the policy of community care pose a threat to the general population?; (b) how many psychiatric beds are needed for a psychiatric service to function effectively?; (c) are new antidepressants cost-effective?; and (d) what should be the responsibilities of primary care in mental health service provision?

As I have long had an interest in health services research, the complaint that these subjects have not received the attention they deserve may be regarded as a form of special pleading. I accept this, but would also argue that psychiatrists, through their clinical skills and training, are best placed to answer these questions than the many others which seem to have them mesmerised at the present time. The future of neuro-imaging in the assessment of psychotic disorders is an important subject, but should it be preoccupying the attention of so many of our best brains in psychiatry when they could be engaged on subjects of more tangible benefit that are much more likely to lead to an outcome which helps patients? When I was an undergraduate and wanted to know more about a career in psychiatry I was frequently told the not particularly funny definition of a psychiatrist, a "doctor who when called upon to give a diagnosis can be guaranteed to disagree with his colleagues". Seldom do I hear this now, as we have moved beyond it in our definition and classification of mental disorders, but we can still be accused in a similar vein when asked our views on the management of psychiatric disorders. Open dialogue should be reinforced by clinical governance and, if this is to avoid the fate of so many other buzz words in the lexicon of health service reform, it must embrace a new attitude to research and its importance in improving health

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