From problems to solutions

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One of the more memorable principles taught by my clinical teachers was that 'the first requirement of a treatment plan is diagnosis, the second is diagnosis, the third is . . . '. Well, in a research paper recently published by the National Association of Health Authorities and Trusts (NAHAT) in conjunction with the Sainsbury Centre for Mental Health (Moore, 1997), we have a diagnosis based on a survey of health authority and trust managers which will find such consensus with psychiatrists that it is a good basis for moving on to treatment. It is that the mental health services are suffering from: "underfunding; rising demands; staff shortages and low morale; lack of collaboration between health and social services; poor communications; and the sheer complexities of working with numerous agencies to ever-changing and sometimes conflicting policies and processes".

While acknowledging all these problems, Philip Hunt and Matt Muijen in the preface to this remarkable 20-page document are optimistic. They believe that the time is ripe for progress. Since they are both renowned realists, the reasons for their optimism deserve attention. Hunt is now Chief Executive of the National Health Service (NHS) Confederation, with more experience than most of lobbying and second-guessing what governments will do. Muijen is a psychiatrist who from the Sainsbury Centre searches out the best in mental health services, and is sought out by the worst seeking help.

They point out that "the high public profile given to mental health services has obscured their successes and accentuated their failures". Even mental health professionals have become mesmerised by the media and public interest in the worst of care, the victims, and the alleged culprits. Has morale fallen so far that we have started to believe the tabloids rather than the facts?

We are dogged by a reputation of mental health services in the public mind based on rare, serious incidents blamed on community care. Yet figures show that homicides committed by mentally ill people doubled in the two decades leading up to the mid-1960s, when the mental hospital system was at its peak. Homicides by mentally ill people have been decreasing ever since, while the number of homicides generally has more than doubled over the past three decades (Audit Commission, 1994). Perhaps before we can change the public view we need more confidence in ourselves.

We have dismantled a system of institutionalised care that blanketed the country in the 1950s and was the cause of scandals and public enquiries from the 1960s until the 1980s. We have replaced it with services that are locally-based, and more flexible, with more choice, dignity and participation of users and their carers. It has not been a headlong rush into untested forms of care without hospital beds, as the papers would have it. Seventy-five per cent of NHS budgets for the mental health services is still spent on NHS beds. If one adds the number of NHS beds to the number of staffed residential places for the mentally ill, there are nearly as many beds in 1997 as there were in 1980.

The author of the NAHAT research paper (Moore, 1997) believes that, at the very least, we can bring the worst mental health services up to the standards of the best. But her optimism is wrapped around some challenges. The level of resources is not the main distinguishing feature between the best and the worst of mental health services. More important are the quality of local leadership, the extent to which services are tailored to needs and whether investment is based on evidence of effectiveness.

I lost count of the times leadership at local level was mentioned as essential for progress in the NAHAT document. This does not mean zealous campaigners – sadly they have not achieved much for mental health. It means people who can create, from all the mess and complexity, a real plan, within real resources, that others are committed to realising. I was recently encouraged to hear our College president, Bob Kendell, dispel the myth that a consultant psychiatrist is by right the leader of the multi-disciplinary team. Leadership has to be earned, he said, so that others want to follow. That must be the right place to start. But anyone who thinks it might take decades for stronger leadership by general psychiatrists to blossom across the country might reflect on the amazingly short period of time it took during the late 1970s and early 1980s for powerful, medical leadership in elderly medicine and elderly psychiatry to emerge across the country from a troubled, muddled and deprived sector of the service. Large sums of

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money were soon being transferred out of facilities serving the wrong patients badly into effective services that attracted more investment.

The targeting of resources to priority patients and their priority needs is still not done well in many areas. Whatever one thinks of the Care Programme Approach it could be an information base for targeting resources, but it is not enough to target the right people and the right needs. The investment must be effective. The NAHAT research paper highlights some models of good practice which have been evaluated. The dissemination of good practice is still a slow, haphazard process, and the elimination of outdated, less effective methods of care is unconscionably slow. Perhaps the large sums of money spent on conferences would be better spent on visits to other services.

Ensuring that investment is based on evidence of effectiveness can be an incredibly simple matter. How many community mental health teams in this country have clear objectives? And for those that have, how many can show evidence that they are actually fulfilling those objectives? How many monitor their patient cohort for in-patient bed days, and whether simple indicators of social functioning are showing improvement or deteriorating? You do not have to travel far to find a team set up to look after the needs of the severely mentally ill, which in practice, and often unwittingly, is preoccupied with other patients, even may be excluding anyone with a history of violence or suicidal behaviour.

How might the morale problem be tackled? Some recent research on stress levels in the NHS workforce may be relevant (Hardy *et al*, 1997). There was a twofold variation in case-rates, identified using the General Health Questionnaire, across 19 Trusts. Managers, doctors and senior nurses had the highest rates and the case-rates were very much higher than comparable rates in supposedly more demanding and less secure, private sector organisations during recession. What distinguished high rate Trusts from low rate Trusts was management style. High rates were found where there was lack of clarity about where the service was heading; people did not feel involved in decisions affecting their work; they were confused about what was expected of them personally; and there was no feedback on whether their service was seen to be doing well or badly, and whether individual contributions were valued. It is usually impotence that demoralises people, not major problems and challenges. This brings me back to the importance of leadership, and the opportunities needed for psychiatrists to prepare themselves for leadership of clinical teams, whole services, and Trusts. As Bob Kendell recently reflected: "It may be more important for psychiatrists to know the ABC of leadership than the first rank symptoms of schizophrenia!".

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