Psychiatric Bulletin (1989), **13**, 246–247

Conference report

Mental Health, Psychiatry and Management

IAN B. COOKSON, Consultant Psychiatrist, Sefton General Hospital, Liverpool

A symposium was held on 30 November 1988 at Prestwich Hospital, sponsored by Lundbeck Limited.

A regional view: Mr G. R. Scaife (Assistant Regional General Manager [Planning], Mersey Regional Health Authority) found some £85m of £600m in the Mersey Region are devoted to mental illness and a further £30m to mental handicap. Are services for special groups of patients or for districts? Are professional and managerial relationships defined? Major resources are in large institutions and tribalism, and many different levels of responsibility prevent change. He saw little role for district health authorities in his planning task. He had convened a group of managers and health care professionals to study and report quickly on mental health, and subgroups currently pursued several topics.

(a) *Principles and values* These would express such concepts as multiagency participation, minimal patient disruption from home during treatment and the building of trust between managerial and professional staff.

(b) *Financial allocations* Recognition of population size and its age distribution, social deprivation, and rural sparsity would be taken into account as finance should be equitably distributed.

(c) *District services* Populations of 30/60,000 and all agency involvement with NHS resources would relate to primary care and layers of specialisation in response to need serving up to 2/3,000,000 population, and occasionally supra-district specialist services, would likely be described.

(d) *Manpower and training* This group would take account of national, regional and district trends, e.g. 'Project 2000', 'Achieving a Balance', and consultant delivered or led service, would be considered.

(e) Monitoring would be essential in managing a service effectively but how should this be done? Suitable measures are to be refined for mental health. No directions would follow the report but response from the Region would be sought.

A district view: was given by Mrs E. H. Law (Unit General Manager Community Services, South Manchester District Health Authority). The past decade had seen Government white papers and reports on community care, resettlement, civil rights monitoring, quality outcome, key management authorities, and lastly in the White Paper on primary care of 1986, choice of facility or service for the patient. The current situation was finance led, concerned with income generation, audit, accountability, and targeting. Objectives were integrating the service, with national policies, innovation, evaluation, effectiveness and outcome being considered, she said. Integrated response for community care would include housing and voluntary service representation and be influenced by consumer pressure.

The future would likely have:

(a) key authorities for client groups, NHS for mental illness, Social Service Department for mental handicap

(b) an agency for community care

(c) private sector provision

(d) possibly a primary care authority, comprising Family Practitioner Committee, with elements of Social Services Departments responsible for community care, and other primary care staff involvement.

(e) consumer choice, with contracting out or buying in of services of general practice, consultant and or teams providing services.

The Mental Health Act Commission opinion: Mr E. Bromley (District Clinical Psychologist, Liverpool District Health Authority, Chairman Mental Health Act Commission [North West]) discussed the value of consensus from his experience of the working of the MHAC. He cautioned professionals to beware of authoritarian attitudes. The standards of multi-disciplinary practice varied enormously he said. Finance in the NHS was at times inadequate. So, listen, work from a knowledge base, avoid authoritarian imposition, and understand attitudes within organisations was the message he gave for all of us, professionals and managers.

Primary care: Dr B. E. Marks (Senior Lecturer in General Practice, University of Manchester) said of

average general practice consultations, of ten minutes each, during the face to face contact of six hours five days a week, 25% i.e. nine or ten patients every day, have significant psychiatric problems. A third or more of GP trainees have no psychiatric experience. The need for more expertise of mental health professionals was obvious. He commended consultant psychiatrist and multidisciplinary mental health team contacts with groups of general practitioners. This should reduce work for the psychiatrists by 50% through shared patient management.

The recent White Paper suggests counsellors and social workers might be employed, presumably to deal with less severe emotional distress; 70% of their salaries may be reimbursed but cash limits have been set!

Professor Freeman spoke of financial problems. There was a credibility gap between government expressed intentions and the behaviour of districts. Priority is not shown at district level. Research and development usually takes 1% of the turnover of large companies. A study of the Friern Hospital with MRC funds will not be complete until after the closure! Other measures of psychiatric services were largely inappropriate. Financial targets of senior staff may not be in the patients' interest. The case register project has been partly destroyed by lack of funding, he said. Management without it is hindered. He described a £70,000 per year normalisation fiasco concerning a mentally handicapped patient inappropriately discharged, whose needs, living alone, were provided by a profusion of professions and agencies. He left us to ponder the problem of the future of the multidisciplinary team with very inexperienced members of professions or sometimes professions not represented, making discussions difficult and the patient's life poorer.

Psychiatry at Prestwich: Dr H. B. Kelly (Consultant Forensic Psychiatrist) described management at Prestwich. The UGM had beneath him the Director of Nursing Services, an Assistant Director of Social Services, the District Occupational Therapist, the District Psychologist and a doctor elected for two years by the medical and dental staff – a concession to consensus management.

Mrs Stout described the Salford Network Scheme, moving some 50 patients to their own homes with whatever support required. This development of community care allows the psychiatrists and psychiatric nurses to remain in contact with the ex-patients though attracting DHSS supplementation but with reliance on attendance and/or disability allowance for disposable income. The case review system includes clinical, behavioural, quality of life and staff review measures.

Supra-regional problems: Dr J. S. Madden (Chairman of the Royal College of Psychiatrists Addiction Group) described the urgent need for consultant sessions in every district to deal with the problem of drug dependence and AIDS. Local in-patient and laboratory facilities for urine drug screening should be created directly – a national problem requiring district action.

Dr P. G. Wells (Consultant Psychiatrist, Young Peoples Unit, Macclesfield) described how his unit for adolescent conduct disorders was necessary and complemented the other unit in the North Western RHA while half its activity served the Mersey Region. A supraregional specialist service was functioning and research showed its value.

Psychiatry 'Elsewhere': Dr M. Green (Consultant Psychiatrist, North Manchester General Hospital, Medical Adviser, North West Fellowship) feared particularly for chronic schizophrenic individuals let alone those who would derive benefit from a comprehensive service. By 1993 the in-patient services will have contracted, not least as good nurses will run their own nursing homes and there will be fewer young people to recruit into nursing. The phasing out of board and lodging allowances may be the final straw following the movement of clinical psychologists into psychotherapy, the withdrawal of social workers for economic or ideological reasons and the pressure of financial constraints on primary care and the voluntary organisations reducing their contribution. There will be little involvement of community psychiatric nurses in mental illness, their desire for independent practice being realised in the self limiting disorders common in primary care.

In discussion it was felt money must be available for care in the community; 50% should be 'ringfenced'. Mr Scaife questioned how long 'ringfencing' of psychiatry services could continue. Social Services departments spend 1% on mental illness. Quantification of types and numbers of patients who do not slot satisfactorily into our customary settings for treatment and care was required at regional and perhaps national levels.