Health Advisory Service

DEAR SIRS

I would like to support the call for the abolition of the HAS made by Dr Crow and his colleagues from Northwick Park (*Bulletin*, June 1986, **10**, 150–151). The original Hospital Advisory Service was established in 1969 following several public enquiries which exposed serious shortcomings in the long-term care provided to the mentally ill and mentally handicapped in some hospitals. It was a sensitive and tactful political move intended to improve standards and reduce the chance of further scandals and enquiries. By and large, it has been notably successful in this regard.

In recent years, however, the service, renamed the Health Advisory Service, appears to have concentrated on promoting one particular model of psychiatry and psychiatric services, support for which may be widespread, but certainly not unanimous. Dr Horrocks denies that there is an HAS 'party line' (*Bulletin*, June 1986, **10**, 145–146) but there certainly is consistency in HAS reports, such as the promotion of the concept of Mental Health Resource Centres and an associated run-down of hospital services.

Whilst there may not be a declared overall HAS policy, it is inevitable that the general approach will reflect the Director's own perception of psychiatric services from the perspective of a former Consultant in Geriatric Medicine; his particular concept would naturally influence his choice of team members, who would be unlikely to be persons taking a radically different view to his own. Moreover, the HAS is funded by the allocation of central department resources and the Service is unlikely, therefore, to feel able to other than foster Government and central department policies on the basis of 'who pays the piper . . .'. This was certainly my experience in relation to a recent visit, where it seemed that team members were quite unable or unwilling to confront a number of unsatisfactory issues surrounding the implementation of the Griffiths Report. I was also left with the clear impression of the HAS team members promoting a theoretical model of psychiatric services, possibly appropriate to a district such as Kidderminster, where 90% of the 100,000 population live within four miles of the hospital but was less relevant in Powys, with a similar population but no District General Hospital and the population scattered over 2000 square miles with two of its population centres over 100 miles apart.

The perjorative use of the word 'institution' to describe a psychiatric hospital service in such a situation revealed the team members' prejudices and preconceptions rather than an open-minded analysis of our services.

After 17 years the original HAS has done its work and perhaps has now run out of steam, and, rather like the Draft Code of the Mental Health Act Commission, is trying to proselytise a particular view of psychiatric illness, its treatment and management.

Dr Horrocks invites those who call for the abolition of the HAS 'to speculate on the potential acceptability of the replacement inspectorate which would undoubtedly be imposed instead'. However, the Education service and Social Services are both subject to an inspectorate answerable to a central government department, and in general this appears to be satisfactory and acceptable. In the post-Griffiths era, with increasing autonomy being given to district management, it would now seem appropriate for there to be a central department inspectorate which defines agreed standards of care and performance and evaluates district services against these criteria. Such an inspectorate would be a welcome safeguard against the wilder excesses of 'Griffith's' management.

MICHAEL A. HESSION

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DEAR SIRS

I have noted with considerable interest the vigorous correspondence in the *Bulletin* regarding the role and usefulness of the HAS, especially as we have been the subject of a visit by the Advisory Service under the personal direction of Dr Horrocks within the last month. The correspondence is of considerable interest to myself as I was trained as both an undergraduate and a postgraduate by one of the Academic Departments (Manchester) which has recently been complaining so vociferously about the Advisory Service's comments regarding the role and effectiveness of local psychiatric services in South Manchester.

I have to say that my own view was that the Advisory Service Panel very rapidly appeared to have come to a remarkably shrewd and insightful view of the structure and shortcomings of services in the Bury Health Authority area to which we currently contribute.

It seemed to me that Dr Horrocks and his team had identified very clearly, not merely the local difficulties, but also the interaction and interplay of various personalities responsible for the development and management of services, which I have observed myself whilst working as a clinician in the area for nearly two years.

Perhaps academic departments of psychiatry require to be reminded that the Advisory Service's main interest is the development of truly locally based patient/client oriented services and I suspect that the Advisory Service assumes that centres of academic excellence are undertaking excellent research without the need to comment on it directly.

Our own Health Authority, Salford, was itself the subject of an Advisory Service visit only two years ago and, yet again, I have to state that the Service appeared to have a very clear and well thought through view of our own problems at that time and it seems to be that the interdisciplinary nature of the panel is of singular advantage when it is necessary to comment on shortfalls in service provision by a variety of agencies and disciplines, not all of which are by any means the expert province of clinical psychiatrists.

My own view is that the Advisory Service should in fact be strengthened with statutory powers, both to restrain the stiffling effect on the development of conterminous district services due to the voracious demands of academic departments for staff, the justification for which would appear to be patient flow figures which largely reflect the absence of a local service in the deprived conterminous districts as well as the need to promote adequate provision of Local Authority resources for the mentally ill by those Authorities which would appear to be reluctant to countenance the development and provision of a truly comprehensive mental health service which reflects current models of good practice.

IAN STOUT

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DEAR SIRS

The letter from the Director of the Hospital Advisory Service (*Bulletin*, May 1986, **10**, 115) and his subsequent article (*Bulletin*, June 1986, **10**, 145–6) enshrine some misapprehensions about its approach.

His claims that the HAS 'does not hold strong beliefs' and that 'there is no HAS philosophy' are surely disingenuous. Its organisation is based on belief in a multi-disciplinary approach, which he vigorously reaffirms, that is no less a philosophy for being by now conventional. A range of beliefs such as that 'psychiatry is essentially a community speciality' underpin other aspects of its activities and inevitably so; it is hard to see how it could function without what is in effect a philosophy, however loosely articulated.

Equally, the claims that HAS team members have no axes to grind and are unencumbered by local history and politics conflict sharply with the experience of many of those visited. Indeed, the last few lines of his letter confirm how easy it is to become sucked into the host District's politics; and they are certainly not unencumbered by the history and politics of their own districts.

It is surely time for the HAS to accept that a range of assumptions inevitably underlie its teams' activities, rather than continue to pretend to itself and others that none exist. The Director of an organisation that expects others to examine their preconceptions should not be so complacent about its own as to suggest it has a 'proven system' and to offer no choice except more of the same or replacement by an inspectorate.

The third alternative is surely for the HAS to stimulate reviews, debate and research on themes which underlie its approach and on the effects of its interventions on the development of mental illness services. Its 'direct line' to ministers might appropriately be used to fight for the resources required.

DAVID ABRAHAMSON

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ECT on OPD basis

DEAR SIRS

It is surprising to learn from Dr Snaith's letter (*Bulletin*, March 1986, **10**, 55) that out-patient ECT is administered sparingly in the UK because of fear of mishap, disaster and so forth. I wish to support Dr Snaith's views and say that, in India, ECT is administered on an out-patient basis at most centres. In my centre, which is a postgraduate department, modified ECT has been given on an out-patient basis for over 25 years without mishap. Written instructions for pre- and post-ECT care are given to patients and relatives, who follow them well, even though less educated than those in the UK.

Out-patient ECT is more acceptable to patients and their relatives because admission, which has social stigma in our country, can be avoided. Thus many early cases can derive its benefit. Moreover in India out-patient ECT is less expensive than in-patient ECT where there are a very limited number of psychiatric beds (25 000 only) anyway.

Hence for various reasons such as more acceptability, low cost, wide coverage and practically no risk, out-patient ECT merits more use. Otherwise many patients in the community will be deprived of an effective and safe therapy.

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MRCPsych Preliminary Test

DEAR SIRS

I write to express my increasing disquiet with the MRCPsych Preliminary Test. Not one of the junior doctors at my hospital passed this exam last time round. This might not have caused much surprise seven years or more ago when it was difficult to attract good doctors to work in large mental hospitals. However, times have changed; Long Grove is now linked to St George's Hospital for general psychiatric training and as a consequence of this link with one of the most highly rated training schemes in London, we are now able to attract many outstanding young doctors. In addition, the College has been most influential in increasing the attractiveness of psychiatry as a speciality, with the result that many of the best and brightest products of British medical schools are opting for a career in psychiatry.

So, if our trainees are so talented, enthusiastic, hard working and conscientious, as I believe they are, how is it that not one of them passed this Preliminary Test?

The only feasible explanation seems to be that the proportion of candidates who 'passed' the exam is fixed, so that regardless of standards, only a certain number of people can be allowed to get through each time. If true, I believe this situation to be unfortunate, if not demoralising and potentially destructive.

When the College established the MRCPsych and Preliminary Test to supersede the DPM it essentially modelled it on its predecessor. The ideal of the Preliminary Test, as I understand it, was to stimulate study of the basic