

The future for psychiatry*

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Policy for mental health services in England is based on two straightforward principles. These are, first that care should be provided as locally to where a person lives as is reasonably possible, and secondly that treatment should be available in the least restrictive conditions that are compatible with the safety of the patient, of those looking after him and of the public at large. I make no apology for reviewing the history of policy and practice; it is not possible to understand the mental health services that we are trying to achieve for the future without understanding how the service has developed over the years. I shall use the mental illness service as an example—similar considerations apply to the mental handicap services.

The idea of a local service is by no means new. Before the Elizabethan Poor Law, abbeys and monasteries provided what care there was as a religious duty. The Poor Law Act of 1601 and the Act of Settlement of 1661 firmly tied services to the local community, making the parish responsible for the funding and provision of care. Indeed, when you have problems deciding on what local authority is responsible for the provision of social care for your patients when they leave hospital, I am sure it will comfort you to know that similar problems have existed since the Statute of Labourers was passed in 1341!

The development in the 19th century of non-local services for mentally disordered people is an abnormal phenomenon in this long-standing pattern of local mental health care. The 1808 Asylum Act gave local authorities permissive power to build mental hospitals and the 1845 Lunatic Asylum Act obliged authorities, within three years, to provide hospitals. However, no sooner was the asylum system actively developing than we see moves away from it. The first domiciliary crisis intervention service was set up in the 1880s. In 1889, the first out-patient clinic was started. In 1918, the Board of Control, which oversaw the Mental Health Service up to 1959, suggested that early treatment units in general hospitals would be helpful in speeding recovery. The 1930 Mental Treatment Act, among other changes, allowed treatment without certification. The proportion of

patients discharged from hospital began to rise as new and more effective treatments were developed.

It was against this setting of better treatments and a gradual reduction in the use of institutional care that the major tranquillisers were introduced in the mid-1950s. The effect of these combined events was dramatic (Table I). On 31 December 1954 there were 143,574 patients in mental illness hospitals and units in England. By 1969 there were just over 110,000 and at the end of 1990 there were 56,900.

Understandably, these changes in clinical practice and the resulting changes in the hospital population commanded great interest at the Ministry of Health as it then was. An influential paper by Tooth & Brook (1961) analysed the changes in the hospital population to date and predicted a further decline. The policy consequences of these changes in clinical practice was first set out in Enoch Powell's famous 'Water Towers' speech given at the MIND Annual General Meeting in March 1961 and they have been pursued steadily ever since.

The basic requirements of this policy are that health authorities should develop, as locally as possible, comprehensive services for mentally ill people and that this should be done in conjunction with local authorities and voluntary organisations. This policy was set out in detail in the White Paper *Better Services for the Mentally Ill*. In 1981, a Departmental Paper *Care in Action* identified three main tasks for health authorities in developing services for the mentally ill. These are:

- (a) to create a local, comprehensive, mental illness service in each district, reducing the catchment area of multi-district mental illness hospitals to their own districts
- (b) to create a psychogeriatric service in each health district
- (c) to arrange the closure of those mental illness hospitals which are not well placed to provide a service to their local district and which are already near the end of their useful life.

It is by no means a matter of chance that the development of local services is mentioned before the closure of hospitals. Closure of hospitals is not, and never has been, the primary aim of policy. However, with the dramatic fall in the resident population which continues because of better treatment and through the death of those elderly patients who have

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TABLE I
Patients resident in mental illness and mental handicap
hospitals (England) 1954–1990

Year	Mental illness	Mental handicap
1954	143,574	50,515
1955	143,022	51,018
1956	142,218	51,553
1957	140,522	52,131
1958	138,400	52,963
1959	135,197	53,908
1960	131,076	54,945
1961	130,661	54,489
1962	128,568	54,455
1963	126,495	54,706
1964	124,615	56,100
1965	121,700	56,200
1966	119,800	56,500
1967	117,615	56,800
1968	114,400	56,800
1969	110,648	56,256
1970	107,846	55,434
1971	104,641	54,409
1972	99,109	53,155
1973	94,326	52,075
1974	89,426	50,923
1975	87,102	49,839
1976	83,320	48,959
1977	80,686	47,947
1978	78,205	46,863
1979	76,364	45,596
1980	74,831	44,444
1981	73,174	43,091
1982	70,881	41,712
1983	69,023	40,183
1984	66,056	38,370
1985	63,970	36,340
1986	60,280	34,180
1987		
1988	57,560	
1989	56,200	27,700
1990	56,900	24,909

spent very long times in hospital, it may be sensible to close a hospital to ensure the best use of resources. Ministers, reaffirming their support for the policy of local care as a civilised and humanitarian one, have reiterated, most recently in *Caring for People*, the White Paper on the future of community care, that no hospital should close until adequate alternatives have been provided.

Of course, we have to be sure that the policy which has been set is working across the country as we would want it to. Over the last year or so we have been looking closely at what services there are on the ground and consulting with regional health authorities. This has not been done in any spirit of criticism about past difficulties, but with the aim of examining

what problems exist in the implementation of policy. On the basis of this work which is now drawing to completion, Ministers will consider whether there are any additional steps which it is right and practical to take to improve the care of mentally ill people.

There is one particular area where we know there is a problem with the implementation of policy and I will describe the action we are taking. The problem lies in ensuring continuing care to people with long-term mental illness. The Government, in response to the Social Services Select Committee 1985 Report on Community Care, agreed with the Committee that the real measure of the success of a service was not whether it met adequately the needs of those who least need the service but whether it met well the needs of those who most needed the service. One group of people most needing the service are those who suffer long-term serious disability because of illness. Reports showing that up to 40% of destitute homeless people (Timms & Fry, 1989) are suffering from serious mental disorder and research showing an untoward number of mentally ill people in the prison system (Coid, 1988a,b) indicate that all is not well in the continuing care of this group of patients.

Often, these problems are attributed to a shortage of beds for mentally ill people and seen as a consequence of hospital run-down and closure. However, you will find that at the end of 1986 there were, in England, some 10,000 empty staffed, mental illness beds and some 8,000 vacant day hospital places. While clearly empty beds will not always be of the right type and in the right place when needed, it is difficult to avoid the conclusion that part of the problem is one of effective distribution of resources rather than a shortage of beds or day hospital places. I was pleased to find this conclusion confirmed by research presented at the recent Cropwood conference on services for mentally disordered offenders at which an interesting paper showed the weaknesses of the so-called "transcarceration" hypothesis (Fowles, 1991). Moreover, if you listen to the accounts given by destitute homeless mentally ill people and those in prison, although some may report having been discharged to a hostel for the homeless, a much commoner story is that they had been discharged from hospital to suitable accommodation and suitable care, but later lost touch with the services, moved and fell out from care into destitution or the criminal justice system. Failure of continuity of community care appears as a common feature behind many of the cases of which we hear.

Recognising this, we are requiring health authorities and social service departments to establish a "care programme" approach for patients under the care of consultant psychiatrists who are being considered for specialist care outside hospital. Essentially, the "care programme" is a system of case management, community review and more assertive

follow-up based on current best practice. We very much welcome the Royal College of Psychiatrists' Guidelines on Discharge and Follow-Up Practice which are very much in line with our "care programme" approach.

The care programme, among other things, aims to improve continuity of health care. But effective care for mentally ill people in the community often requires more than health care. So far local authorities have not been able to afford mental illness services a high priority. Only some 3% of Social Service Department expenditure is on the mentally ill. In order to improve significantly the level of social care for mentally ill people, as you will know, the Community Care White Paper announced the creation of a Specific Grant to improve social care facilities for seriously mentally ill people. Details of this and guidance on the care programme have recently been published (DH, 1990a,b).

In implementing this policy, the NHS faces many pressures. With the growth both in what medical science can offer, and in consumers' expectations, the challenge is to get more and better services from available resources. In facing this challenge, absolutely central to the nature and traditions of the NHS is the particular nature of the doctor-patient relationship.

This relationship derives from a founding principle of the NHS, namely that, on referral from his or her general practitioner, an individual becomes the personal patient of a consultant. This form of doctor/patient relationship has important advantages both from the doctor's and the patient's point of view. Indeed, in effect it brings into the NHS the best feature of private practice: the direct, personal relationship between a patient seeking help and a doctor prepared to try to offer that help.

It is worth spelling out exactly what the advantage is to the patient of this personal doctor form of service, as I think this can readily be overlooked. Whenever anyone falls ill anxieties are stirred. Questions will arise in the patient's mind about the seriousness of his or her condition; the nature of the treatment being recommended; the prospects of recovery; possible limitations on future lifestyle; the chances of recurrence. With our NHS arrangements, the patient has his own doctor, at the highest medical level, in whom he can place his trust and confide the most intimate of his aspirations, fears and secrets in the assurance of confidentiality. He has, in short, his own consultant who has agreed to take personal responsibility for trying to diagnose the nature of his illness or disability; for proposing treatment, drawing as necessary on the contributions of other professional colleagues, and for offering a prognosis. The advantages of this personal doctor service, where responsibility is accepted by and anchored in a named individual, the consultant, rather than "a service" or

"a team" are clear and certainly appreciated by our patients.

The personal doctor service does, with its advantages to patients, impose responsibilities on consultants. One important aspect of consultant practice is clinical autonomy. Sometimes this is discussed as if it were some kind of hereditary right of doctors, arising from the mystique of the profession, and conveyed with the taking of the Hippocratic Oath. Rather, clinical autonomy is a necessary corollary of the founding principle of the NHS – that patients should have a personal doctor service – and thus means that no other doctor, or manager, has the right or responsibility to instruct a consultant to change the diagnosis or treatment plans for his individual patients. It does not, however, mean that the clinically autonomous doctor works entirely without limits. All doctors are responsible for staying within the law, the broad limits of acceptable medical practice and the resources made available to them to practice.

This is hardly an original view and it has recently been put very eloquently by the immediate Past President of the Royal College of Physicians, Sir Raymond Hoffenberg, who is on record as saying:

"There is no such thing as clinical freedom, nor has there ever been. Nor, for that matter should there be!" He went on to say, "Absolute freedom to make clinical decisions without taking into account the preferences or wishes of the patient could not be countenanced. It is therefore proper that personal, moral, ethical and even legal constraints should be observed. *To these must now be added the constraint of limited resources*" (Hoffenberg, 1986).

Clinical autonomy does not mean that a consultant has the right unilaterally to commit resources not already agreed – explicitly or implicitly – to be at his or her disposal, any more than doctors in private practice would embark on treatment that would be beyond the means of their patients. Within policies and priorities established by authorities, managers have the responsibility of trying to ensure that all available resources are used to best effect.

Let us consider some of the major changes proposed for health and social care services to improve the way we use resources. I will take as a composite the consequences of the appointment of Directors of Public Health, the new GP Contract, the NHS White Paper and the Community Care White Paper. Not, I can appreciate, necessarily the most popular grouping of subjects with a medical readership. May I give you a picture of how all these can work to the advantage of your patients who, after all, are the centre of our attention as much as yours?

Firstly, the Directors of Public Health who have been appointed by each health authority whether district or region. An important part of their remit will be to publish annually reports on the health of the population they serve. These DPH reports give

a unique opportunity which does not exist at the moment, for each district to study the epidemiology of illness and to measure the mental health care needs of the population for which it is responsible. In particular, the reports will be able to take account of groups such as the homeless mentally ill where there are, at present, significant unmet health needs. These reports will play an important part in determining the plans of the health authorities when they set contracts for health care. In my Division in the Department of Health, we have been monitoring the first batch of DPH reports. Although some are good on mental health issues, others are, frankly, disappointing. One, that shall be nameless, devoted eight lines to mental health and nine lines to what dogs do on pavements!

I do not criticise Directors of Public Health for some brief reports on mental illness. Psychiatric epidemiology is a difficult subject and few people have the necessary skills to survey the mental health of their local community. I would suggest to all of you that making yourselves and your Directors of Public Health acquainted with the basics of psychiatric epidemiology will be a vital skill for the future if mental illness is not to lose out to more easily measurable pathologies. To this end, we are very glad to have funded two joint conferences between the Royal College of Psychiatrists and the Faculty of Public Health Medicine to discuss how mental health issues can best be addressed in the DPH Reports. A clear message from these meetings is the great need that public health medicine doctors feel for good quality advice on mental health matters. Remember that for public health doctors the *British Journal of Psychiatry* is not a front line journal!

These public health reports, then, will influence the contracts which health authorities, once they are freed from the responsibilities of day to day management of services, will set with providers of health care. For the future of psychiatry, it will be important for you to make sure that contracts specify adequately not only relatively simple measures such as volume of activity, but also include good measures of quality. I do not know whether any of you have seen the draft contracts recently published. Some of the quality measures that these included I found impressive. Many of them were simple things like always having an appointment time for an outpatient clinic, always being seen within half an hour of that time, and always being told the name of the doctor who saw you. These may appear trivial but are of great importance to patients and form an important element in their perception of the quality of the service. Obviously, you can write in as many additional elements of quality as you wish and as you can afford.

Having surveyed the health needs of the population you serve and set contracts for the quantity

and quality of the health care you require (and can afford), you next need to measure the consequences of what you have done. Has the health of the population improved? At present we concentrate too much on recording inputs and processes and too little on measuring outcomes. This is another area of work that we are actively engaged in within my Division (Jenkins, 1990) and I was surprised to see the extent to which it is possible to construct a system of outcome measures so that we can examine improvements or deterioration in the health of the population that we serve as a consequence of clinical activity.

Finally, in terms of the new developments in the Health Service, let us look at the GP Contract. As you know, one very important element of this is that general practitioners must offer people over the age of 75 an annual assessment of their health and social care status and offer the same to younger people once every three years. The importance of primary mental health care is clear when you consider the epidemiology of mental illness. We know that only a small proportion of people with significant mental disorder are referred to secondary care services. Of 230 people attending their general practitioners with significant psychological symptoms, only 17 will be referred to psychiatrists and only six admitted to hospital. There is good evidence that better detection and treatment of affective disorder by the primary care team leads to improved clinical outcome and lessened burden on patients and their families (Johnstone & Goldberg, 1976). Yet we know that at present significant amounts of psychiatric disorder are missed in primary care (Goldberg & Huxley, 1980). The new GP contract offers a unique opportunity for the early detection and treatment of mental disorders. It is not just the number of cases that makes primary mental health care an important subject. The burdens which depression, anxiety and alcohol and drugs impose are very heavy. They weigh not only on those suffering from the illness but also on the families of sufferers and on the care services. And, of course, there are also very significant economic implications both for the individual in terms of lost wages and nationally. I am sure you will all know of the work by Caroline Croft-Jefferies and Greg Wilkinson (1989) which estimates a cost of £2.6 billion per year from lost production through depression and anxiety. This is roughly twice the NHS mental illness budget!

These then are some glimpses into the future as seen by the Department of Health, but it is important to remind you that the future of the mental illness service is very much more in your hands than it is in those of the Department of Health. I have spoken already of the central role of the consultant, and as you will see over the years of the NHS's existence there has been a great expansion both in the number of consultants and in the number of registrars and senior registrars in the mental health service (Table

TABLE II
Consultants, senior registrars and registrars in mental illness

Year	M.I. consultants	M.I. sen reg/reg
1950	454 (all mental health)	
1955	568 (all mental health)	
1960	507	415
1965	693	538
1970	810	644
1975	900	773
1980	1002	899
1985	1100	982
1989	1269	1013

II). The exact pattern of the mental health service at the end of your professional lives I would hesitate to predict. To explain why I am uncertain I would like to briefly take you through the changes that I have seen in psychiatry since I became a registrar at Bexley Hospital in the Autumn of 1960.

I went to that job from having been a medical registrar at Guy's. In those days we were resident on duty for a week at a time and, looking again at some of the letters that I wrote to my wife while I was on duty, I recognise some themes that are quite topical today. I could never find a bed for an emergency, people were always being kept waiting in casualty, and I earned the enmity of the entire hospital by having to refuse admission to the wife of the local publican because there were no beds.

To hear people talk now you would think that life for both doctors and patients in a mental hospital in its heyday was idyllic. It was not, although in some ways it was nice for the doctors – my lunch was carved for me every day by the Medical Superintendent and my car was cleaned for me, free, three times a week by patients. That was their occupational therapy. In other ways, working in psychiatry was not particularly pleasant. I turned down the first job I was offered because a necessary part of it was to parade at 08.30 hours in the Medical Superintendent's office to receive my orders of the day. There was no question then of being an autonomous consultant. Hospitals then were huge; 2,000 beds were common. Staff shortages were intense and always featured on page one of the Board of Control's annual report. Wards with 40 or more patients were usual; often you could scarcely move between beds. Outbreaks of paratyphoid were commonplace and out-patients clinics a rarity. The rule of action given to a doctor arriving was "admit first and ask questions afterwards". By order, we saw patients twice a year to assess their mental state and once a year to do a physical. You knew when the

day for doing 40 mental states had arrived because the patients would be sitting in line passing a newspaper from one to the other learning the date and what was in the news. It was important to keep the doctor happy! Regular physical examination did not prevent one of my patients dying in a ditch on the hospital farm from adrenal insufficiency.

Moving on through time in my career, we then come to a District General Hospital Unit which although not beautiful at least was local and patients no longer refused to come into hospital because they knew that it meant the "loony bin" and separation from their families by 25 miles with the only access for visiting a once a week voluntarily-run bus. When we talk of a local DGH-based psychiatric service, I sometimes hear anxieties expressed that psychiatry will not be able to compete with surgery and medicine; whether it can will depend on you. In our case, district-based psychiatry started with two wards, three doctors and no research. It ended as the second biggest department in the district with the biggest research income and physicians and surgeons feeling threatened by the remorseless development of psychiatry.

We move on again, from the District General Hospital to domiciliary psychiatry. When I left the Health Service I had given up all my in-patient beds and was running a domiciliary service for people with long-term illness – even for the very severely disabled. Both I and my patients appreciated the greater freedom inherent in being outside hospital. My move to domiciliary psychiatry, however, was not part of a long-term district plan imposed by the health authority (though it was agreed by them) but the result of a decision made by the body of autonomous consultants as being a worthwhile experiment in alternatives to long stay in-patient care. We, the consultant body, decided to change the way we worked.

My point in telling you about the changes in psychiatry during my career is not to pretend to any particular personal significance, but to make two points to you. The first is that the mental health services are changing very rapidly, and secondly that the form of these changes and hence the future of psychiatry is dependent in large part on yourselves as the consultants of the future. You will determine how the service develops and how the future of mental health care is shaped. I hope that I have shown you that the way in which our present mental health service has developed was determined only to a limited extent by central policy and by health authorities. More fundamentally it was shaped by the research and the commitment and drive of a whole host of individuals, mainly consultants in the NHS. If I was to single out one person who has exemplified this it would be Duncan McMillan of Mapperley Hospital. By making changes in the service in Nottingham he demonstrated clearly to the profession at large what

could be achieved and how the service could be improved. He and other clinicians in the late '40s and early '50s brought about the changes in clinical practice which influenced bed occupancy, which in turn influenced Ministers, who established the policy that we are trying to implement. The future for the mental health service depends now as it always has done on the skill and commitment to improvement of its consultants. The future for psychiatry lies with you.

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