

## Reviews

### **The Heart of the Matter**

'The development of a mental health service within Central Nottinghamshire Health Authority'. By Barbara Kennedy in *Hospital and Health Services Review*, February 1988. Pp 9–12.

In 1985, the closure of Saxondale County Asylum was targeted for the end of 1988. This manager was "faced with the awesome task of developing a comprehensive mental health service by the end of 1988". The blueprint described in this paper is admirable. Each of its component parts has well tried examples elsewhere in the country, providing a high standard of care for patients. Put all together they do form a comprehensive service. But much of the service was "still at the embryonic stage" when this paper was published in February 1988 and the closure of Saxondale Hospital was imminent.

Managerially, this gap between the closure of the mental hospital and full implementation of alternative services is not as bad as it seems. For 20 years, psychiatrists have been gradually reducing the hospital population with little transfer of resources to community care. Fewer and fewer in-patients have cost more and more on big hospital sites with spare capacity. More and more chronic psychotic patients have shared what little community care is available. And so if it takes two to three years to re-invest all the capital and revenue then at least when the money is spent a great many patients should be better provided for than they have been for decades.

The heart of the matter is whether managers, consultants, nurses and the other professions have the same vision and the commitment to make it all work. This paper describes reduction in the number of DGH acute psychiatric beds, sectorised services, community teams, resource centres, staffed bungalows, day centres shared with social services, proposals for a community alcohol team and community based mother and baby service. Heady stuff with tremendous potential but unless those in leadership positions, which includes all consultants, senior managers, senior nurses and the Director of Social Services, have common purpose, it may fail. The dowry from the mental hospital could be spent on white elephants. I hope Barbara Kennedy might write a follow-up paper on how that scenario is avoided.

How are the sectorised teams getting on? Community mental health teams can be a battlefield with leadership struggles, conflict over priorities, and confusion over delegation of responsibility. The very term 'team' may be muddlesome because all of the

members who come together on common business also have independent responsibilities and goals. It is vital that a proper analysis of the consultant's role in managing this network, with other managers, is properly worked out. The unique contribution of each professional needs to be clarified and accepted by the others. The leadership role of the doctor may well involve him or her in *coordinating* the work of other professionals but *medical management* of other professions does not work: the professional development of nurses and occupational therapists, for instance, withers unless they have powerful functional management from their own kind.

The organisational structures required for effective community health care will not be sorted out by trial and error in so-called community mental health teams. First-class management consultancy advice may be required by psychiatrists and the other professional heads in Districts. Professor Andrew Sims (personal communication) has raised the question with our College President as to whether some work at national level might provide a framework and save many the pain of re-inventing wheels.

Rationing of care gets more difficult in community mental health services. The plan in Central Nottinghamshire talks about meeting the "growing local needs of general practitioners" and about the intention to "sell" the CPN service to GPs. This might worry consultant psychiatrists, who fear that CPNs will take on a new clientele of neurotic patients and have less time to support chronic psychotic patients. It is what happened in Salford, as described by Wooff (1986). Similarly, sharing day centres with Social Services risks displacement of chronic patients by more articulate and interesting people in family crises. The setting and monitoring of clear priorities is crucial.

There is an exemplary programme in Central Nottinghamshire for tracking discharged long-stay patients. Individual care plans will be reviewed at 9-week intervals. The psycho-social effects of relocating institutionalised psychiatric patients will be measured to discover factors resulting in good or poor adjustment in a new environment. These monitoring systems are not easy to set up and in order to keep them running the staff who actually collect the data must believe in them and gain something in terms of helping them organise their own work.

Perhaps we ought to consider tracking and monitoring the welfare of staff during major change like this? Are we good at identifying the enthusiasts and deploying them where that enthusiasm is most needed? One can be sure that if consultant or senior

nurse has serious doubts about whether a new facility will function properly it won't. Exit interviews with staff leaving for other posts would reassure if they have blossomed in developing the new service and want to spread the word, and will warn if they are leaving frustrated with a sense of failure.

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## Reference

WOOFF, K., GOLDBERG, D. P. & FRYERS, T. (1986) Patients in receipt of community psychiatric nursing care in Salford 1976–82. *Psychological Medicine*, **16**, 407–414.

## Community Mental Health Centres: Policy and Practice

By Nigel Goldie, David Pilgrim and Anne Rogers. *Good Practices in Mental Health*, 380–384 Harrow Road, London W9 2HU. Pp 28. £4.00.

Community Mental Health Centres (CMHCs) have popped up on the mental health map with outstanding rapidity, with more than 120 in operation or in a planning stage since the first ones surfaced in the late 1970s. A passing fad, you may wonder? Or an indication of the substantial changes that have taken place in community mental health that have accompanied the move to close large institutions? This short review asks many relevant questions about CMHCs, and it will not surprise you to hear that it provides few answers.

Based mainly on evaluations that the authors carried out on two existing CMHCs, they quickly establish their own position by stating that they are “committed to the transformation of current services” and “... welcome the development of CMHCs ... as providers of (services) with better access, less stigma and psychological and social models of assistance to users”.

In attempting to deal with a number of rather complex issues, this report only provides stark headlines which could be productively used by any community mental health team working or planning to work in CMHCs. Doctors: should they be leaders? Do CMHCs recruit generic mental health workers or professionals with specific skills? Staff selection: does the team have any say? Full time or sessional contracts? All hot chestnuts that need peeling and tasting.

Some more time is spent, quite rightly in my view, on management issues. The particularly thorny problem of management of a multidisciplinary group of staff, which can undercut traditional professional line management, is discussed in some detail, as well as the philosophical necessity of involving consumers

of the service in a centre that aims to offer relevant sensitive psychiatric care. No help here on how you go about finding “community representatives” that don't have too many axes to grind. Or maybe they should?

Problems of equality of access to CMHCs have been highlighted by a number of authors in this country, and more appropriately, in the USA, where the CMHC movement started in 1963. A great deal of attention, misguided in my opinion, has been focused on the notion that CMHCs only deal with the “worried well”, a term which I personally despise. In the first place, because it supports the idea that any professional can determine levels of personal suffering, and judge that individuals with chronic psychotic conditions deserve more attention than those with equally handicapping neurotic symptoms. Secondly, because in my own experience, sector responsibilities in the NHS make it less likely that any particular client group will be ignored, especially if a final common pathway of care can be identified to all referrers. What must be addressed, however, is the impact on resources that these new developments will engender. There is no doubt that easier access to services increases the number of people that use them, not necessarily by reducing the number of chronic psychotic conditions, but by increasing substantially the number of often serious family and relationship difficulties (including incest and sexual abuse) and intractable neurotic symptoms, such as phobias, obsessional disorders and chronic anxiety states.

There is naivety running through this report which I found irritating at times. Clearly this must come from evaluators who have had little “on hand” experience, but a lot of ideological assumptions to colour their views. The suggestions that Social Services will make referrals to CMHCs because they are likely to be “ideologically compatible”, or that CMHCs should accept people under section 136 (have they not heard of place of safety?), or that self referrals, by defining the nature of their problems, will clash with the judgements made by staff, thus “... (reducing) the autonomy and control exercised by the consumer ...” seem to me to be quite daft.

The authors set a challenge to professionals working in CMHCs to change old psychiatric ‘habits’. They would like to see more consumer choice, an emphasis on non-biological interventions and priorities given to social resources over therapies of all types. Nothing wrong with all of this, you might say, but does a CMHC then also become a hybrid Citizen's Advice Bureau, non-specific Counselling Centre and Social Services Department all rolled into one? It was precisely because of this lack of definition, and grandiose all-encompassing goals, that some American CMHCs fell into disrepute, and the scenes of never ending local political disputes.