the absence of psychiatrists from management would prejudice development of the future service which requires a flexible spectrum of treatment and care settings, delivered by caring well trained multidisciplinary staff. Managers expressed a desire for further meetings of this kind.

In a lunchtime discussion with Dr Lissmore of the DHSS at the College Social and Community Section meeting in Spring 1987, he described a management model which would likely be effective in planning, delivery, researching and monitoring comprehensive psychiatry services. A functional psychiatry unit would have an executive of its Unit General Manager, a Unit Medical Representative, the District Nursing Chief (for residential and community psychiatric nursing), and a paramedical staff representative. The medical and paramedical representatives of the Executive would be elected by their respective professional groups.

The Executive would report by their presence to a monthly multi-professional 'legislative' meeting of the whole body of consultant psychiatrists, the nursing chief, and the heads of paramedical professions or their psychiatry sections. The Unit General Manager with selected staff, e.g. the Care in the Community Co-ordinator, would be members of this body.

This policy-making advisory committee for the district's comprehensive psychiatry service would also receive minutes of the meetings of specialty advisory groups, care delivery teams, and project meetings convened at times to pursue policy and planning of such service components as day facilities, chronic patient care, and, for example, to consider teaching and training requirements.

Adoption of such a management and advice giving structure would avoid many difficulties of communication, and sharing of information and philosophy may promote rather than constrain the development of services for those for whom we care.

The threat of chronic patient care being given to local authorities and its possible funding by local taxation should be discussed locally and nationally and protest made through whatever structures exist at present. In the Mersey Regional Health Authority we have seen psychiatrists impotent to prevent, with or without their advice being sought, problems such as bed closures, patient movements within hospitals from ward to ward, for administrative reasons the removal from a department of psychiatry to primary care of a community psychiatric nursing service, gross underfunding of new DGH services, loss of resources for psychiatry and ensure the minimum requirements for the establishment of posts for psychogeriatric appointments, among many others.

Leadership by the consultant psychiatrists must be shown to be advantageous to our present management for our patients' future to be protected.

A further meeting in the North West Division in the autumn will pursue these matters but diplomatic and wise action now, informally and formally, should be pursued to regain influence, if only in damage limitation for psychiatrists.

# Comment

## 'Facts and Figures' and 'Reviewing the Regional Plans'

These two short documents from the National Schizophrenia Fellowship (*NSF News*, February 1988) provide a wealth of useful information.

The facts and figures refer to the 1987 edition of the DHSS Health and Personal Social Services Statistics for England. During the period mainly covered, from 1975 to 1985, the number of occupied mental illness beds fell from 87,000 to 65,000. This still represents 25% of all occupied hospital beds, although mentally ill patients comprise only 4% of total admissions. The number of psychiatric hospitals and units in contrast increased, both in total and as a proportion of all hospitals. They have of course become smaller; nonetheless, in 1985 55% of psychiatric in-patients were in hospitals with more than 500 beds.

The 1985 average cost of a person with mental illness in hospital was approximately £14,000 per year. The cost of mental illness services as a proportion of the total hospital budget is described as having 'only' dropped from 12.7% to 11.1% – 834 million out of 7.5 billion pounds: but the much more rapid turnover inevitably increases costs despite the reduction in beds.

The total number of admissions increased from 175,000 in 1975 to nearly 200,000 ten years later. The percentage of the population being admitted

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increases progressively with age and more than doubled for the 75 years and over group. In line with this, admissions for dementia increased from 9,660 to over 21,150. Admissions for schizophrenia and paranoia, which are grouped together, remained virtually unchanged at around 30,400 and those for affective psychoses rose from 22,269 to 25,646.

The 'revolving door' is still experienced by many patients: only a quarter of the 1985 admissions were first admissions. About half of these were of patients aged over 55 years and only one in seven of the admissions for schizophrenia were for the first time; a declining proportion.

Statistics for out-patients also reflect increased activity. New attendances increased from just under 188,000 to over 201,000, with total attendances up from about 1,500,000 to over 1,800,000. New day patients increased from 36,000 to 58,000 and attendances from 2,709,000 to 3,391,000.

There were 3,869 hospital doctors to deal with this work in 1985, representing about 9% of all doctors. This is an increase of 34% since 1976. NHS clinical psychologists increased from 626 in 1975 to 1516 in 1985, that is by 140% (not 240% as stated in the NSF document).

This picture of increasing activity in the NHS contrasts with that of local authority community developments. The 22,000 reduction in occupied hospital beds over the ten years was matched by an increase of only 1732 places in local authority accommodation; the overall cost of which still represented less than 1% of their total spending on personal social services. The number of staffed local authority premises has particularly lagged behind and especially so in the past few years – only 89 places were provided between 1983 and 1986. During the same three years the number of places in voluntary and private homes increased by 1,430 but the total remains under 4,000. Likewise, local authority day centres specifically for the mentally ill have only taken up a small amount of the extra need in the community, with an increase in places over the ten years from 3,386 to 5,670.

In the second document John Hilton, President of the NSF, reports gleanings from the onerous task of working through the ten year strategic plans of nine of the English regions. He remarks that content may be "spare and workmanlike, or overloaded with murky 'philosophy', turgid methodology and salesmanship". None of the plans is considered immune from serious criticism but the three best were thought to be East Anglia, Mersey and Trent and the three worst Yorkshire, Wessex and South Western in which he "could find little to commend, try as I would".

One point of criticism is reliance on local authorities, the dangers of which are largely ignored except by the Mersey and East Anglia RHAs. A quotation from the latter is pertinent post Griffiths: "It must be a fundamental weakness in any strategic plan. .... that attainment of any significant proportion of the objectives contained within it relies so heavily upon external bodies over which we have no control and which we can only seek to influence by persuasion".

There is considered to have been some improvement in plans over the past three years in that there is less stress on norms and more on trying to ascertain some of the facts. However, planning of alternative services for people likely to be discharged from hospital has often gone ahead without waiting for the results of patient assessments; and there is evidence of regional pressure on districts to maintain the pace of rundown despite difficulties over bridging money.

Moreover, services for the long-term severely ill already "in the community" were rarely mentioned specifically and the end of the first generation (since hospital contraction began) of caring parents is never recognised. Little evidence was found of a sense of responsibility for keeping track of the long-term severely ill patient if arrangements made on discharge fail to materialise or are not taken up or for any reason cease to operate. In spite of Baroness Trumpington's assurance that strategic plans would clearly show intention to use savings and proceeds from sales for mental illness services, this is not generally the case: "two or three Regions do state such an intention, even if qualified by 'normally'. The rest are silent".

The author comments that he has yet to see plans squarely facing the fact that nobody knows how best to provide for the long-term severely ill outside hospital. A great deal of reliance has been placed on small units of the hospital hostel type but regions containing such units do not mention them in their plans.

He argues that it takes ten to 15 years to evaluate the results of a shift in policy and that "nothing will be lost by slowing the pace and giving time to adjust policy to the results". The alternative view is that what might well be lost will be the quality of life of those patients who remain in deteriorating hospitals over this period. A much less *laissez faire* approach is surely urgently needed if hospitals are in some form to continue to play a part in long-term patients' care.

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