

Correspondence

The Health Advisory Service

DEAR SIRs

I think there are even more serious questions to ask about the Health Advisory Service than those raised by Professor Goldberg (*Bulletin*, February 1986, 1, 36). I will leave readers to formulate most of those questions themselves once they know the following.

A report in the mid-1970s showed that the nursing staff/population ratio of this hospital's catchment area was 78 per 100,000. Since that time there has been a small increase in absolute numbers of staff and also a calculated decrease in the catchment area population, which seems inconsistent with the evidence of one's own eyes, a considerable house building programme including several large new estates. Nevertheless, if one takes calculated figures the ratio is probably 80–85 per 100,000.

In its comment on nurse staffing the 1985 HAS Report for the hospital says: . . . 'The full community-based psychiatric services envisaged by this staffing target [Better Services for the Mentally Ill 100: 100,000] has not been achieved in any substantial measure for the population served by Highcroft Hospital. Few Health Districts in the *country* (my italics) have been able to fund or recruit sufficient numbers of registered mental nurses to meet the requirements . . . There is nothing exceptional about overall nurse staffing at the hospital . . .'

In the Government's Response to the Second Report from the Social Services Committee, 1984–85 Session on Community Care there is a passage . . . 'The White Paper goal of 100 nursing staff per 100,000 has now been exceeded (again, my italics) in most parts of the country.'

Readers will note a gap between the two parts of the quotes from the HAS Report. It is worth filling it, because it raises one question I will ask. The missing passage is: ' . . . It is unfortunate and misleading that 'shortage of nursing staff' is the focus of dispute, criticism and adverse publicity about Highcroft Hospital. It has become a handy excuse for those with limited vision of where mental illness services should be going and a pronounced interest in maintaining the status quo. . . .'

The same Government document on Community Care (Cmnd 9674) says in para. 45 'The need to avoid developing services for those of milder disorders at the expense of those with more serious disorders is recognised.' The question therefore is whether the authors of that Government Response suffer from the limited vision found in the hospital staff by the HAS or whether the HAS is preaching yesterday's dogma.

B. H. FOKES

*Highcroft Hospital
Erdington, Birmingham*

DEAR SIRs

We write from a peripheral mental hospital to support Professor Goldberg's views on the Health Advisory Service. We have received exactly the same advice concerning sectorisation and specialism as we knew we would before the visit because this has for a long time been the party line, regardless of the views or experience of others.

Consultants in this hospital do have their areas of special interest and their different ways of doing things. However, we try in the face of HAS advice to uphold the principle of freedom of choice for patients and general practitioners and for continuity of care. Their advice can be seized upon by others with less immediate responsibilities for patient care and it is timely that this problem should be aired now as new General Managers may consider advice from outside to carry more authority, however stereotyped it is and whatever the local conditions are. In a speciality such as psychiatry when there are so few proven rights and wrongs in how a service should be provided, it is surely better to allow different patterns to evolve to suit local circumstances as long as they are not manifestly inefficient or uncaring.

We think that the Health Advisory Service should explain why freedom of choice of Consultant and continuity of care for individual patients is unacceptable, since their advice runs so consistently counter to these aims.

ELIZABETH J. MACDOUGALL

J. N. HAWORTH

D. P. SRINIVASAN

T. M. SINGH

V. S. ANAND

MICHAEL. P. K. TWOMEY

*Harlands Hospital
Carlisle*

DEAR SIRs

With reference to Professor Goldberg's letter, I should like to confirm that similar experiences with HAS visits have been shared by other colleagues, at least in the South West Thames Region. Three broad aspects of HAS reporting were mentioned. The use of over-inclusive, categorical statements which are difficult to substantiate or to refute is one; favourites are 'lack of multidisciplinary work' and 'lack of Consultant leadership'. There is also the insistence on the strict application of certain organisational devices, regardless of local experience and needs, and without evidence of their usefulness; the example of sectorisation, given by Professor Goldberg, is a case in point. Furthermore, opinions and assumptions which run contrary to established clinical knowledge are sometimes expressed; in one district, for example, a well developed rehabilitation

system based on researched and proven methods, could disintegrate if such opinions were taken seriously.

There are two main factors which perpetuate the current, unsatisfactory situation. Firstly, the rules of reporting on visits protect the HAS from change. At the feed-back session given by the visitors, questions from and discussion by the audience are not allowed. The draft report which follows, and whose circulation is usually restricted, is apparently sent with the instructions that only 'factual' errors should be corrected and that no comments should be made. Secondly, while the final report is in danger of being adopted by managers as their 'bible', clinicians are reluctant to criticise or ignore parts of it, in case the whole (including sound advice) is discredited in the eyes of health authorities.

M. Y. EKDAWI

*Netherne Hospital
Coulston, Surrey*

DEAR SIRs

Professor Goldberg and his colleagues in South Manchester (*Bulletin*, February 1986, 10, 36) question the methods of operation of the NHS Health Advisory Service and, in particular, the advice which was recently offered about their mental illness service. What we actually said in our Report about South Manchester and the advice it contains are matters of public record and interested observers would be welcome to have copies. They would find major discrepancies in style and content between the Report and the distorted interpretation now being put forward.

I will try to answer the four questions the letter poses, while avoiding the bluster and moving goalposts of the South Manchester arguments. To do so is important, not least to reassure those not recently visited by the Health Advisory Service who might justifiably fear any review conducted in the way that Professor Goldberg describes.

The Health Advisory Service does not 'hold strong beliefs'. There is no HAS philosophy and neither does HAS issue checklists, guidelines or advice to team members on desired organisational or therapeutic solutions. Instead teams are asked to bring their own experience of psychiatry to bear on a local situation, to comment on the weaknesses and strengths which they perceive and to give advice. Selection of team members is based on wide consultation and is constantly reviewed. Psychiatrists participating in the work of the Health Advisory Service have included many of the social psychiatrists to whom your correspondents refer.

We do not, and have no power to, 'impose' solutions. Neither do HAS Reports 'instruct', 'disrupt' or compel 'rigid' requirements. What each Report offers is *advice*, based on the wide experience of professional colleagues with no axe to grind and unencumbered by local history and politics. In the vast majority of visits, such advice is welcomed and seen as valuable support by clinicians battling to promote their services. In the process of following up our visits, there is less emphasis on whether advice has been carried out than on whether the problem to which our advice was directed has been overcome.

Making HAS advice locally relevant is given great emphasis. Teams usually spend no less than three weeks in the district under review, listening, observing and testing the applicability of their ideas. Much of the advice eventually offered is derived directly from local opinion, released by the informal processes of the visit. Each visit includes contacts with general practitioners, community health councils and voluntary organisations as well as all grades of staff in health and social services departments. Our reports contain few 'stock' solutions; instead they represent the best combination of the team's experience and the local situation.

Since Reports are not verdicts there is no question of 'appeal'. It is open to those receiving them to disregard their content and advice. Nevertheless great efforts are made to ensure that Reports are correct. Psychiatrists are able to review a draft version of the report, and propose amendments where the team has misinterpreted its findings, before publication. In the case of South Manchester, your readers will be interested to know that detailed collation of local medical opinion occurred followed by a further visit to the District by myself. As a result, the Chairman of the Division of Psychiatry (not a co-signatory of the letter you published) wrote to thank HAS for a document which was 'a very helpful contribution' which 'will help us in our efforts to develop better services from the base which we now have'.

PETER HORROCKS

Director

*NHS Health Advisory Service
Brighton Road
Sutton, Surrey*

Nigerian psychiatry

DEAR SIRs

I have recently gone over a very interesting collection of papers *Psychiatry in Developing Countries*,¹ but would like to comment on the paper on Nigerian psychiatry written by Ayodele Obembe.

Nigeria, as you know, is a multi-national, multi-lingual and therefore multi-cultural state and it is in fact this diversity of culture that has been one of the greatest problems of that country. What Obembe's paper describes is really the practice of psychiatry in the Yoruba areas of Western Nigeria rather than the practice of psychiatry in the whole country. The terms used in his description of certain aspects of psychiatric practices, such as *Babalawo*, *Onisegun* and *Olarisa* would only be comprehended in Western Nigeria and would have no relevance to any other part of the country.

I thought it might be important to insert this clarification for the benefit of all those who come across this fine selection of papers.

I. O. AZUONYE

Locum Consultant Psychiatrist

*St Augustine's Hospital
Canterbury, Kent*

REFERENCE

- ¹BROWN, Stephen (ed.) (1983) *Psychiatry in Developing Countries*. London: Gaskell (The Royal College of Psychiatrists).