Correspondence

Missing points

In response to an editorial by George Lodge[1] and a commentary by Helen Killaspy[2] I feel, with respect, that the authors have missed two terribly important points. First, that our enthusiasm for community services overcame us and second, that we forgot that admission to hospital can be a very powerful intervention.

The 11th report of the now defunct Mental Health Commission wrote cogently in 2003:[3]

> 'The systemic relation between hospital and community elements of mental health care make it dicult to determine whether inpatient overcrowding should be addressed by increasing bed numbers or further concentration on community support.'

It also gave information about in-patient care:

> 'the number of psychiatric beds has reduced dramatically from a highpoint in the early 1950s . . . The number of [National Health Service] mental illness beds available to services in England in the last twenty five years (up to 2002) . . . shows a 40% reduction since the [Mental Health Act] 1983 . . . however, as these figures do not include beds in the independent sector . . . the available but incomplete data on NHS and independent bed provision [appear] to show that, while the numbers of available beds in NHS facilities fell by around 20% between 1994 and 2001, the overall decrease in bed availability during that period was approximately 5%, once the growth in the independent sector is taken into account . . . In our view it is appropriate to note that independent sector services, whether profit-based or not, will rise and fall according to the dictates of the market. Given our estimate . . . that the actual reduction in beds was 5% up to 2000/1 . . . it could be that we have already attained the minimum number of psychiatric beds for a viable service.'

It seems that the road taken was to invest in community services over the following decade, quite commonly at the expense of in-patient care. Now some services are reducing the number of functional teams; few seem to be re-investing in acute in-patient care.

I remain to be convinced that developing community services across multiple functions (or specialisms, if you prefer) or putting these resources in catchment-based teams would solve the issue that most of us (clinicians and patients) have faced sometime painfully recently – where and when might we get a bed? Do not get me wrong, my threshold was high enough, but sometimes admission is the kindest thing.

1 Lodge G. How did we let it come to this? A plea for the principle of continuity of care. *Psychiatrist* 2012; **36**: 361–3.

2 Killaspy H. Importance of specialisation in psychiatric services. Commentary on . . . How did we let it come to this? *Psychiatrist* 2012; **36**: 364–5.

3 Mental Health Act Commission. *In Place of Fear? Eleventh Biennial Report 2003–2005*: pp. 102–35. TSO (The Stationery Office).

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Author's response: I agree with Dr MacMillan that unguarded enthusiasm for community services has led us into uncharted waters and that it is important to recognise the value of hospital admission. Every day psychiatric professionals conclude that admission is necessary for hundreds of patients.[1] In my editorial, I referred to the draconian reduction in psychiatric beds which has occurred in England over the past decade, a reduction driven, as Dr MacMillan says, by the need to fund the new multifarious community teams. In turn, the current focus on preventing hospital admissions is largely driven by bed shortages rather than by the needs of patients. These shortages frequently result in the transient placement of patients far from home, contributing further to the fragmentation of care pathways, distancing patients from family and friends and presenting challenges and delays in liaison. It is ironic that a service model intended to keep patients in their own environment has resulted in many being placed so far from home. A further irony is that it has led to the diversion of huge sums away from the National Health Service (NHS). In 2010/2011, out of the £925 million spent by primary care trusts in England on secure and psychiatric intensive care unit services, 34% was with non-statutory providers.[2]

Hospital admission may be the only practical way of keeping the patient or the community safe or the only environment in which the patient can be provided with the care they need. It can take the patient out of an adverse environment in which their mental state is deteriorating. However, it is always right to consider whether hospital care is necessary or whether treatment could be safely and effectively provided in the community. Hospital is an alien environment. Many will recognise the wish to be home and that long periods in hospital risk habituation, institutionalisation and disempowerment.

Though accused by Dr Killaspy of nostalgia and looking back through rose-tinted spectacles, I can assure her that, having worked in both acute and rehabilitation psychiatry, I do not need convincing of the benefits of community treatment and developments in treatment approaches for schizophrenia. However, all doctors should engage in reflective practice, carefully evaluating developments and modifying practice accordingly.

Dr Killaspy quotes the 2009 National Institute for Health and Clinical Excellence guideline,[3] but she has been selective in her quotations. The guideline also says: 'Continuity of care from professionals capable of communicating warmth, concern and empathy is important, and frequent changes of key personnel threaten to undermine this process' (p. 24). On crisis and home treatment teams, it says: 'While such teams can offer a responsive service, they can at times struggle to maintain continuity of care' (p. 24). Also, 'Other service changes have seen the development in some areas of separate teams for inpatients and community-based individuals. These service changes present further potential seams and discontinuities' (p. 24). The NHS Institute for Innovation and Improvement observes: 'As patients pass through boundaries within and between organisations on their healthcare journey, there is often duplication, inefficiency and waste'.[4]

Dr Killaspy also cites Parker *et al*,[5] but does so extraordinarily selectively. The more complete quote is 'For

people with severe mental illness, flexibility and longitudinal continuity are the most important aspects' (p. 102). Flexibility is defined as 'to be flexible and adjust to the needs of the individual over time' and longitudinal flexibility as 'care from as few professionals as possible', a key element of the continuity which I value. A more careful reading of this 140-page review and re-interpretation of 10 studies, of which only 2 relate to mental health, reveals more evidence in support of my case. Interestingly, 'the most striking thing to emerge' from questionnaires from professionals was 'the relative lack of enthusiasm for specialist teams such as home treatment (crisis resolution) teams or assertive community treatment (assertive outreach) teams' (p. 68).

It is a truism that specialists tend to do what they do better than generalists. However, against this should be balanced the impact of the short duration of contact these specialists will have with a patient, something unlikely to foster the good relationships the Parker *et al* study says patients and carers value. Patients' experience 'was often that repeated staff changes led to feelings of helplessness and isolation. Having continually to retell their story to new staff was experienced as devaluing the story' (p. 43).[5] The result can be that the story is never fully told or recorded, thus reducing the chances of an effective patient-centred care package.

Dr Killaspy expresses the concern that it is 'unrealistic' for every psychiatrist to 'remain fully informed and competent to treat all mental health conditions in accordance with the best available evidence'. However, in my experience, teamwork can provide specialists from within the team or specialists can be called in from outside, when needed, without having to change the whole team.

I have made it clear that I support the principles of helping patients to remain at home, of psychoeducation and family interventions. What I object to is the disjointed way in which services are typically provided today, which, in my experience, is inefficient and often ineffective.

1 Hospital Episode Statistics Online. Primary diagnosis: summary 2010–11. NHS Information Centre, 2011 (http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=202).

2 Mental Health Network. *Mental Health and the Market – Briefing*. NHS Confederation, 2012.

3 National Institute for Health and Clinical Excellence. *Schizophrenia: The NICE Guideline on Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care* (Updated Edition). British Psychological Society, Royal College of Psychiatrists, 2009.

4 NHS Institute for Innovation and Improvement. Joined-up care: delivering seamless care. NHS Institute for Innovation and Improvement, 2012 (http://www.institute.nhs.uk/qipp/joined_up_care/joined_up_care_homepage.html).

5 Parker G, Corden A, Heaton J. *Synthesis and Conceptual Analysis of the SDO's Programme's Research on Continuity of Care*. National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre, 2010.

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Personal therapeutic relationship does matter

The commentary by Killaspy[1] rather dismisses literature evidencing the value of the personal therapeutic relationship. It refers to a single publication which provides a qualitative theoretical classification of continuity issues by synthesising nine studies, most of which have no mental health component. The personal therapeutic relationship is the vehicle for delivering one of the most potent interventions in clinical medicine – the care (or 'placebo') effect.[2]

Killaspy talks up the scientific basis for new developments, but the nature of randomised controlled trials is that they have significant exclusions which limit generalisability: the difference between efficacy and effectiveness. In particular, multimorbidity is common in the community and greatly diminishes the applicability both of a single trial and of guidelines which synthesise research findings. Killaspy appears not to respond to the issue that novel services developed by enthusiastic champions tend to lose efficacy when foisted on reluctant or inexperienced staff by government policy and/or managerial bureaucracy. She makes no reference to the poor implementation of proven research and the fact that government policies are not merely without evidence base but devoid of the mentality of scientific evidence. Scientists should be clear about generalisability, implementation and other caveats.

Further, the commentary does not answer the point that any change involving reduction in available beds will be associated with reduced bed usage. It claims that tariff-based healthcare will bring increased efficiency, whereas there is evidence that marketisation leads to financial inefficiencies and gaming the system, fragmentation of healthcare and blinkered specialism;[3] whereas what patients want is some continuity and someone to see the 'big picture'.

The current multiplicity of teams inevitably increases interface issues which are often highlighted as causing problems in high-profile inquiries. It calls into question the claim Killaspy makes that 'the service-line approach will reduce the need for many patients to move between services'.

I endorse the value of a therapeutic relationship with a single practitioner, particularly for long-term conditions (often multimorbid), and which often entails the other benefits noted by the commentary, including the efficiencies of personal knowledge standing astride balkanised interfaces. I do not wish to portray therapeutic relationships as a panacea free of side-effects – we know they are not always good and can even be damaging – but it is a recognised starting point with strong positive elements.

Of course, there are trade-offs between personal knowledge and other desiderata such as rapid access or specialist skills. We also know that re(dis)organisations have destructive elements and often overestimate the speed and magnitude of their benefits.[4]

One conclusion might be that secondary care workers should abandon any intention to reap the benefits of continuity, and delegate this important role to our primary care colleagues. I personally consider that primary care, too, has its interfaces and discontinuities, and that mental healthcare for long-term conditions without long-term relationships would be sterile, soulless and counterproductive. As the National Health Service budget is being cut by 4% annually, the era of separate specialist teams may already be over.

1 Killaspy H. Importance of specialisation in psychiatric services: Commentary on . . . How did we let it come to this? *Psychiatrist* 2012; **36**: 364–5.

2 Moerman DE. *Meaning, Medicine, and the 'Placebo Effect'*. Cambridge University Press, 2002.