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Letter from . . .

Dumfries

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My work has four main strands – patient care, membership of the unit management team, clinical research and the College. At different times I can, or have to, place greater or lesser emphasis on any one of these areas – the result is a job virtually devoid of routine. Let me tell you about each area. I hope by doing so you will also learn a little about what is going on in psychiatry north of the border. You will know we arrange things rather differently from the rest of the United Kingdom.

First, patient care. We are still struggling with the concept of 'community care' at the Crichton. I think myself it is a meaningless term and should be abandoned. I much prefer 'local services'. There are now many fewer in-patients at Crichton Royal, of course. From a peak of 1,200 in the late 1960s, we are now below 400 and still falling. There are two main reasons for this – schizophrenic patients are living outside the hospital and the private sector is admitting many people with dementia to residential and nursing homes. Where are schizophrenic patients living? Largely at home, either on their own or with hard-pressed relatives. In a catchment area as large as ours (2,000 square miles – and ours is by no means the largest in Scotland), home support can prove difficult to arrange and day care is feasible for only a minority. Most schizophrenic patients *do* prefer to live out of hospital but we must be careful where we develop group homes, core and cluster accommodation, hostels etc. Did you read the recent report from Glasgow University (MacLennan *et al*, 1990) pointing out that state benefits were the principal source of income for three-quarters of those living on council estates – what this country is creating are ghettos of the disadvantaged.

You will know that north of the border there are no firm plans to close any psychiatric hospitals – indeed a new one has recently opened, Parkhead in Glasgow, and major rebuilding will take place at Royal Cornhill in Aberdeen. There are a number of reasons why Scottish practice differs from English (I believe some hospitals have already closed down south). Certainly important is the fact that in Scotland most psychiatric hospitals are relatively small and are right in the centre of their catchment area. In Scotland, we believe that although dispersal of services is necessary, there still needs to be on one site a concentration of specialised care (e.g. acute admission unit, intensive psychiatric care unit, rehabilitation unit, etc) – we are trying to develop the concept of the mental health campus (Scottish Home and Health Department, 1989).

Second, the unit management team. I am the doctor on the Mental Health Unit Management Team. Am I a director, a manager, an administrator? My title is Director of Clinical Services (but I only hold the medical staff and training budgets), the Health Board secretariat call me the Clinical Services Manager (but whom do I manage?), and some of my consultant colleagues still refer to me as the Medical Administrator (it is true that I sign the travel expense claim forms). In fact, I see my principal role as that of medical adviser to our unit manager – he must be made fully aware of the clinical implications of any decisions he makes. I know that this 'role confusion' exists among my colleagues holding similar posts in Scottish psychiatric hospitals. It is no suprise, therefore, that a management group has sprung up within the Scottish Division of the College and that Dr John Basson of the Scottish Home and Health Department has set up regular informal meetings of 'psychiatrist managers'.

I often wonder what other unit management teams talk about. We rarely seem to talk about patient care. Current issues are: business plans, purchaser/provider relationships, management structure, trust status, and income generation. This last topic *does* appeal to me as, so far, any money that we can make goes back into psychiatric patient care. We now have quite a number of empty buildings on the Crichton site and they are leased (*not* sold) to a variety of people: a local radio station, a merchant bank, an employment training unit, the Tourist Board, and an artist's studio. We also have a garden centre and an ice-making plant. (Do you realise that when you fly British Airways the ice in your gin and tonic comes from Crichton Royal?). There are also plans to develop Easterbrook Hall as a conference centre – indeed the Lockerbie air disaster Fatal Accident inquiry is currently being held here. So in a way the 'community' is coming into the Crichton. What I would like to see now is a couple of our empty wards

(elegant red sandstone buildings) converted into residential accommodation – not for patients or staff, but the general public.

When management gets too much, I usually go for a walk in our gardens (see photograph).

Third, clinical research. Scotland is a small country and most consultant psychiatrists are on first name terms with each other ('first name terms' – what an old fashioned phrase! Student nurses call consultants by their first name nowadays). This makes it much easier to get multi-centre research off the ground. The tremendous cooperation of busy NHS consultants has made possible, for example, the Scottish Rehabilitation Surveys (McCreadie *et al*, 1991) and the Scottish First Episode Schizophrenia Study (Scottish Schizophrenia Research Group, 1987). We plan this year to carry out a major review of rehabilitation and after-care facilities in the catchment area of all Scottish hospitals. The results, among other things, will give us a baseline for our examination of the implementation of the Community Care Act, especially the mental illness grant.

Important work is being carried out elsewhere in Scotland. For example Dr Douglas Blackwood and Dr David St Clair in Edinburgh continue with their exciting work on the genetics of schizophrenia (Blackwood *et al*, 1990). Because of the relatively static population it is more possible than elsewhere to obtain extended pedigrees. Drs Guy Goodwin and Klaus Ebmeier, also in Edinburgh, are now examining patients with affective disorders or schizophrenia using SPECT. In Glasgow, Dr Reg Herrington is a co-author (not co-editor) of the book *Biological Treatments in Psychiatry* (Lader & Herrington, 1990) which I think will rapidly become the standard text in the field. The Alzheimer's project in Glasgow, funded by the Wellcome Trust, continues.

The gardens of Crichton Royal Hospital.

Finally, the College. For the past four years I have been Secretary of the Scottish Division. One of the most important things I have learnt is that the College gets its business done on the cheap north of the border! I look with envious eyes at the secretariat in Belgrave Square. For example, I imagine that the Scottish Home and Health Department sends as many consultation and other documents to us as the Department of Health does to Belgrave Square. How do we cope? It is quite simple – the work is farmed out among the members of our Executive Committee (and their NHS secretaries). Recently one of the most important tasks has been to respond to the many consultation papers relating to the Community Care Act. Dr Jim Dyer of the Royal Edinburgh has chaired the working group which has done this – quickly and in detail. We do a lot of other things. For example, we have regular meetings with such bodies as the Mental Welfare Commission and Directors of Social Work and intermittent meetings with Social Work Services Group and medical officers at St Andrew's House. Does all this do any good? We can only hope the steady drip, drip, drip does wear away some people's prejudices about the mentally ill. We think that we have had a number of specific successes in the past couple of years. For example, many of our recommendations on the draft Code of Practice were incorporated in the final Code; our campaign (along with others) to extend the range of psychiatric patients exempt from the Community Charge was successful; and the guidelines to the implementation of the Community Care Act now coming from SHHD do contain some of the changes we suggested.

One of the Scottish Division's strengths are our regular quarterly meetings (ably organised by Dr Ian Pullen of the Royal Edinburgh Hospital). They are a way of keeping in touch, not only with recent advances (the content of each meeting is largely scientific), but also with friends and colleagues from all over Scotland. The perennial question facing us, of course, is what sort of meetings do our members want. By far and away the best attended in recent years was the 1990 autumn meeting at the State Hospital in Carstairs – it was standing room only in the Great Hall. A chance to visit the gaunt, windswept hospital and to hear the Margaret Methven lecture, delivered by Professor Eve Johnstone on the

nature and management of schizophrenia, proved an irresistible draw.

So that's it – a mixture of patient care, management, research and College matters make up my psychiatric day. I greatly enjoy my job. I count myself lucky.

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