to develop. The environmental change, attained by the transfer to house/hostel accommodation, is conducive with encouraging patients to establish a greater degree of autonomy. Patient/patient and staff/patient relationships improve as individuals become more aware of each other's needs. Close working relationships and regular feedback from house meetings support this development. The staff/patient ratio varies depending on individual needs, allowing time to be spent with patients when they need it, rather than when the ward situation permits. The number of patients living in close proximity is considerably less, reducing the potential for interpersonal conflicts. On occasions, patients on rehabilitation wards exhibit disturbed behaviour, which may precipitate a volatile atmosphere. In response, particularly vulnerable patients exhibit violent behaviour. It is hypothesised that the reduced number of patients residing in the houses/hostels has substantially decreased the frequency of this occurrence, benefiting susceptible patients.

In this survey, the measure used for improvement (i.e. frequency of violent incidents) was invalid for non-violent patients, although it demonstrates that these patients did not exhibit violent behaviour as a result of transfer. Patients who displayed a high incidence of minor violence, while resident on a rehabilitation ward, demonstrated a significant reduction in such behaviour, following transfer to a health authority house or hostel. It is therefore suggested that such behaviour should not be an argument against, but should reinforce the argument "for" transfer from a ward to the more "normalised" environment of an adequately staffed house or hostel.

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Personal view

Resources available to develop mental health services

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The Audit Commission has drawn attention to local champions of change in mental health services. Good Practices in Mental Health (GPMH) (1985) has highlighted a district which has overcome some of the myths about the impossibility of transforming the service, and recently the Institute of Health Services Management (IHSM) Working Group (1991) has entered the debate with "good psychiatric services can be developed in areas where managers are determined to introduce improved services". The Audit Commission singled out Torbay Health Authority, GPMH highlighted Exeter Health Authority, and the IHSM Working Group have listed 12 exemplary health authorities (including Torbay and Exeter) where good local services have been developed.

The common theme running through each report is that much more can be done to redeploy existing resources within mental health services rather than simply asking for more money.

My view is that this is too simplistic an approach to apply globally, given the considerable variance in funding levels and site asset values available to each unit. The picture is further complicated by the relative priority given to mental health services by regional and district authorities which may (or may not) make capital or bridging finance available for service development.

The IHSM report makes the fundamental point that "considerable resources are currently available within the Health Service and more can be achieved

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by using them more effectively. Unlocking these resources rather than simply providing new money, is the key to progress in developing community mental health services". – I couldn't agree more, but where staffing levels are very low, the prospects of releasing substantial resources (finance or staff) to develop community services is remote.

In my opinion, the best predictors in assessing which authorities would be the most capable of developing good quality local psychiatric services are their existing staffing levels; their size; and their present level of unit costs. The latter is very crudely the total revenue budget for the particular institution divided by the number of patients which gives an average unit cost per patient.

There are enormous variations in resources (i.e. unit costs) tied up in the hundred or so psychiatric institutions in this country with (generally speaking) the Wessex, Oxford and South Western regions being better off and the South West Thames, Yorkshire, Mersey and Northern regions being worse off (Mahoney, 1989). If one were to test the proposition that unit costs are one of the key indicators for success, one would expect that regions and districts with lower cost hospitals would come in for more criticism. This has in fact been borne out by past research, e.g. GPMH (1985) mentioned that there was a cause for great concern about the future of services in the Yorkshire region and most health authorities in the Northern region have been strongly criticised (Richardson, 1988).

If we go back ten years, (again to test this assumption) one could have predicted that the most comprehensive and best community psychiatric services would be developed from those hospitals with high unit costs and that districts with low cost hospitals would experience the most difficulties. A survey of 57 institutions in England in 1983 showed the differences in size and the massive variations in unit costs in hospitals throughout the country.* Many of the hospitals at the top of the scale would be spending more than double those at the bottom on each patient and were obviously in a more favourable position.

This survey lists data on eight of the 12 health authorities listed as exemplary in the IHSM document. Five of these eight district health authorities contained psychiatric institutions which in 1983 appeared in the top 10 of the list of 57. These were Brighton, Exeter (also praised by GPMH), Newcastle, Nottingham and Torbay (also praised by the Audit Commission and more recently by the Department of Health). Gloucester also appeared above average. What is truly surprising to me however is that South Bedfordshire appeared in this list of exemplary districts when its hospital, Fairfield, with over 700 beds appeared in the bottom quarter of the list. St John's in Lincoln was also below average. I would be far more interested in how these two district health authorities developed a comprehensive community mental health service with what I would call these inbuilt disadvantages.

I know that units costs may not be the only predictor to a successful outcome but (looking at the survey) I would put money on the fact that Plymouth, Southampton, Northampton, Cambridge and West Dorset are also well ahead of the field in developing local psychiatric services and that many of the districts in the bottom quarter are having the greatest difficulty, unless of course the regional health authorities have made available substantial extra bridging funds. From my own experience, I know that Bromley will be one exception to the above rule as Bromley and the user districts of Cane Hill Hospital have developed sufficiently to enable its closure. This was brought about however by substantial capital and revenue bridging being made available from the South East Thames Regional Health Authority and the districts involved. I wonder if the others have, or have had, the same advantages.

It is also interesting that regional expenditure per head of population (although there are significant variations) does not seem (from the research) to be the critical factor leading to progress. For example, few of the districts in South West Thames RHA with one of the highest levels of expenditure per head of population appear in examples of good practice. More importantly (in my view) in 1984, they had the worst staff per bed ratio, having for example 30% less nurses per available bed than the best provided regions – Wessex and South Western (DHSS, 1985). Differences in staffing levels are, as one would expect, also reflected in differences in funding levels, – staffing would account for 70% of hospital costs. South West Thames had a large number of hospitals with low unit costs in 1983.

Finally there does appear to be differences in what I would call the scale of the management task. There does seem to be a correlation at regional level between demand (occupied beds per 1000 population), size of hospital and level of deprivation, (Mahoney, 1989) i.e. the more needy areas having larger hospitals and a higher occupied bed ratio. They also seem to have this added disadvantage of a larger homeless population. Research has demonstrated the link between social deprivation and psychiatric morbidity (Hirsch, 1987).

Of course, it may be the case that those districts in the forefront of service developments have consistently attached a high priority to developing services for people with mental illness and commentators quite rightly focus on the key issues that they have addressed. I still feel, however, they are missing perhaps the fundamental point that some districts do seem on the whole to have had a financial and logistical head start.

**A copy of the survey is available on request to the author.*

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Innovations

Lothians post disaster counselling service

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In mid 1988 after Piper Alpha but before the Lockerbie disaster, the Social Work Department and the Mental Health Unit independently began to discuss plans for a post disaster counselling service. Over the next few months a joint working party was set up which during 1988 and early 1989 evolved the service described below.

Lothians area has a well worked out disaster plan (the Lothians Displan) but there was no mention in this of post disaster counselling or psychiatric support other than support that would be immediately available at the rest and refreshment centre. In all the UK disasters up until now the post disaster response has had to be an *ad hoc* one and people have had to develop a service during the post disaster phase learning their skills on the job.

Our aim was to develop a response that was at least to some extent pre-planned and where personnel would have had a degree of training and experience both in post disaster organisation and in counselling. We were aware from the start that such an aim might be unrealistic and that to maintain morale, cohesiveness and expertise over a period of many years while waiting for a disaster to happen might not be possible.

The structure of the service

A Post Disaster Steering Group was formed during 1988; its composition is described in Table I.

Table I
Composition of LPDCS Steering Group

Deputy Director of Social Work
Senior Social Worker
Consultant Psychiatrist
Voluntary Agencies
CRUSE (Counselling Services for Widows and Widowers)
Marriage Guidance (Relate)
LMCS (Lothian Marriage Counselling Service)
Samaritans
PLUS (Self Help Association)
SAVS (Scottish Association for Victim Support)
Health Board Emergency Planning Officer
Lothian Regional Emergency Planning Officer
Lothian Regional Information Officer
General Practitioner (Member Lothian Area GP Sub Committee)
Senior Police Officer
Senior Fire Officer
Senior Ambulance Officer (Receives Minutes and can attend if wishes)
(Recently a psychologist has been co-opted)

This steering group meets regularly about six times per year. Its purpose is to provide representation for all interested parties and to provide direct channels of communication from the service to all the groups listed above. The day to day running of the service is by a small core working group which reflects the tripartite nature of the service. Currently this group consists of a senior social worker, a consultant psychiatrist (myself) and a representative of the voluntary services (currently from CRUSE). This

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