SOME ASPECTS OF EUROPEAN PSYCHIATRIC INSTITUTES: AN OVERVIEW

Eric Byers
General Manager
Bethlem Royal Hospital and Maudsley Hospital
Special Health Authority

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INTRODUCTION

This report originates from an opportunity to visit joint psychiatric clinical and academic centres in Groningen (N. Holland), Mannheim and Munich (FDR), and Verona (N. Italy) in April 1987. It was made possible by the generous support of a King's Fund Travel Followship and the time of the S.H.A. To both organisations I am extremely grateful.

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SOME ASPECTS OF EUROPEAN PSYCHIATRIC INSTITUTES: AN OVERVIEW

A. STRUCTURES AND ORGANISATIONS

Given the varying historical, cultural and social backgrounds in Holland, West Germany, Italy and the U.K., there are predictably very differing approaches in style, context and content when looking at the organisations delivering health care. None more so than in psychiatry. Each has elements worthy of consideration in this country: it is a question of whether the wider context of our political and economic system would facilitate their successful adaptation. As an example, there are obvious advantages stemming from the delivery of a multi-disciplinary comprehensive social psychiatric service to the mentally ill in a defined community by means of a single agency. In particular the integration of health and social work staff in all these countries stands out as having considerable potential here.

However, all start from a common base of problems in providing effective psychiatric services, training and research. They include:

i. Government concern at the rising cost of health care and ways of reallocating the burden on central funding.

ii. How to reorientate and/or replace long established and powerful mental institutions.

iii. How to resource the considerable research training and investment costs of a major shift in emphasis away from hospital inpatient care.

iv. How to be assured that the directions in which psychiatry is heading will meet the real needs of the people.

v. A closer evaluation of University funding and the consequent dependence on third party financial support of research and development.

a. HOLLAND

The overall impression is that a lack of integration of the various structural components is a key weakness in achieving an effective psychiatric organisation for the nation. The Dutch University Hospitals are accountable to the Ministry of Education and Science and are not part of the embryo national health planning function. In fact, Groningen is the only one of the eight Dutch Universities with a psychiatric unit on site. Here the University and the University Hospital have distinct Boards of Management but are both separately accountable to the Department of Education and Science. The Hospital has an Executive Board of three: A General Manager and Clinical and Economic Directors. It is hoping to be the first in Holland to fuse the two organisations by incorporating the Dean of the University into the Executive Board.

At a lower level this is achieved by having a Professor of Clinical Psychiatry (supported by Professors in Biological and Social Psychiatry) acting as both Chairman of the Department of Psychiatry, the Head of the Hospital Department of Psychiatry and the Head of Clinical Training. There is some pressure to reduce University staff by reducing their service responsibilities in order to concentrate on training and research. Holland is in the fourth of eight years of national reductions in University funding.

The University Clinic is quite separate from both the State mental institutions (although there are local working relationships) and, in particular, the government funded Regional Institutes for Outpatient Mental Health Care (R.I.A.G.G.s). These are geographically-based coordinating agencies for domiciliary and outpatient services with catchment areas which unfortunately can differ from those of their nearby mental institutions. There are 59 RIAGGs responsible for extra-mural services for all ages but excluding day care. Each has a general manager and local Board of Management. They represent the most recent attempt to bring together the work of a variety of independent community agencies in defined localities: clearly a step in the right direction but leaving a need for further structural linkage to the other major mental care agencies. For example, the University Clinic has since 1980 been given responsibility for services to a local catchment population of 200,000 around Groningen, and this has led to overlapping outpatient services. There are also separate psychiatric outpatient clinics in general hospitals and some mental institutions. In another instance, it is alleged that there is a general tendency to release detained patients too early from mental hospitals with little or no consultation with the local RIAGG so that in some cases only 25% of patients are picked immediately on discharge.

The RIAGGs provide a 24 hour emergency service and have the power to compel a mental institution to admit a particular patient. They tend to have a strong psychotherapeutic ethos and psychological and sociological input.

One solution to the problem of establishing a more integrated service would be to set up a model in one province and to have it evaluated by the University of Groningen.

b. **WEST GERMANY**

The Central Institute for Mental Health (CIMH) in Mannheim offers a uniquely well-integrated social psychiatric service for a population of 300,000, closely linked to the municipal organisation of the city. The local Institute is part of the University of Heidelberg, purpose-built in the early 1970s in the centre of Mannheim to provide a 104 bed adult unit. There are also 48 beds each for children and adolescent, and psychosomatic services covering a wider national catchment.

Rehabilitation therapy, outpatient and research facilities are also included. There is a 20 place day hospital nearly off-site and a 12 place psychiatric day unit on-site; this is felt to be very inadequate. There is a shortage of sheltered workshops and employment. Outpatient services at hospital level are difficult to establish as their numbers are controlled by the local Medical Committee with licensing powers according to 'need'. The large number of private psychiatrists dominate this element of the service.

There are few effective working links with the nearest 1200 bed mental hospital some 12 miles out in the countryside, althugh it is expected to provide care for all those not admitted to the CIMH. However, no discharges are made from the CIMH to other hospitals; patients are returned home and given support by a community psychiatric team staffed by social workers rather than nurses.

Mannheim is an exception in the West German health care and academic system. It is largely the creation of one outstanding individual, Professor Hafner, and has not been repeated, partly due to the manner of its foundation and, it is suspected, partly due to its cost. In some other States, the general hospitals play a greater role in psychiatry; in the local State of Baden-Wurttemberg the five rural mental institutions have a high reputation. The Municipality of Mannheim has been closely involved in the development of the CIMH from the beginning and the obvious strong joint commitment continues to underpin the success of the social psychiatric service.

In sharp contrast, the two University psychiatric clinics in Munich have very tenuous links with the local community. They are openly selective according to catchment area and type and class of patient, with a strong bias to applied research. Social workers have little presence and there is no apparent interest in developing a community-linked approach. Outpatient work is severely restricted by the power of the many local private psychiatrists. In the new 1000 bed general University Hospital there is a medical liaison psychiatriy service but with no beds. The nearest mental institution has 2500 beds, and is quite separately involved in training and research.

c. ITALY

The National Health Service established in Italy in 1978 follows a similar pattern to our own in many respects. There is a central Ministry of Health in Rome and a national sub-division into 21 Regions. Each Region is divided into a number of local social health units (ULSS): the city of Verona constitutes one ULSS with 300,000 people. For psychiatric services, it is further broken down into 3 management units. The University of Verona is responsible for psychiatric services to a population of 75,000 in S. Verona.

Each ULSS is headed by a locally-elected political President, supported by six elected political members. To them are responsible three General Managers - administration, clinical services and social services. In line with Italian health law, there are only 15 beds in the University Clinic and a social psychiatric service focussed on a Community Mental Health Centre, four residential appartments and an outpatient facility. The 75,000 population is covered by three teams, each with a psychiatrist, a psychologist, a social worker and 3 nurses, with at least five doctors in training. There is also a research team of 8-10 people.

The Professor of Medical Psychology acts as clinical director of the total service as well as Head of Research and Training. As in Groningen and Mannheim, there is unified medical leadership for both service and research. There is considerable flexibility of staff movement, professional sharing and commitment in time devoted to the tasks. Compulsory admissions are extremely rare and there is a key 24 hour home emergency service provided from the CMHC. Domiciliary visiting is the basic building block. Rehabilitation services are deficient, but the strength of the family unit plays a major part in making the S. Verona model work well. Less than 10% of the population lives alone and Verona is a relatively affluent and stable urban area. Demand appears to be only some

60-65% of that identified by British psychiatric case registers. These factors influence and facilitate the particular model of social psychiatry to be found there. As in Mannheim, much of its success revolves around the key clinical leader, Professor Michele Tansella.

There are similar successful services elsewhere in Northern and Central Italy but the poorer and more Southern regions are adapting only slowly to the radical reforms since 1978.

In all these countries, drug addiction facilities are not part of psychiatric services but a separate organisation funded and managed by central government. This is in contrast to the U.K. situation. The Dutch Government is endeavouring to persuade those running them to amalgamate with the University Hospitals. Elsewhere this disparity did not appear to be a matter of concern.

B. MENTAL INSTITUTIONS

Relations with their local mental institutions vary noticeably between the centres visited: only some of the reasons are structural. In turn the policies applied to the institutions differ in each country from the U.K.

The Dutch policy is to reduce the institutions to a maximum of 500 beds: many are already well below that figure. The principal way of achieving this is the development of sheltered homes run by municipal authorities and charities with 20-45 beds for elderly care. Currently they provide some 18,000 places, in contrast to the 23,000 hospital beds. One reason for the slow rate of expansion is the method of institutional funding, which still bases reimbursement on daily occupied beds, irrespective of the amount of resources consumed. It is possible therefore to make a 'profit' on care of the chronic long stay element. Lack of sheltered employment is a further impediment to the pace of discharge to alternative settings.

Increasing financial pressure on the Government in the form of escalating health costs has forced it to intervene more directly in the role, scale and future of the institutions. Since 1980 each has had a designated catchment population according to the needs of each province. This was first applied only to emergency cases but now covers all in-patients. Until 1980 they had had freedom of choice as to admissions. They are further constrained by the overriding right of each RIAGG to demand that a patient be admitted, whatever the circumstances.

There are further changes in hand. Funding based on projected usage is being introduced more generally. Central government is playing a stronger part in negotiating daily charges with the sickness insurance companies and in fixing the rises in insurance premiums.

The designation of catchment areas has enabled the more enterprising institutions to create acute admission and outpatient units and to provide a more comprehensive hospital service. In some cases, traditional wards for the long stay have been replaced by small home developments on the perimeter and outside their considerable acreages. Of course, many remain far from major centres of population, but this is not necessarily a handicap to progress. Links are being forged with DGH psychiatric units, and although they will continue to have revenue removed many of the institutions will continue to play an important part in Dutch psychiatric care. The pressure to run down to the point of closure is being avoided, and who is to argue, but that this could well be the most sensible policy?

In contrast, although their numbers have fallen greatly over the decade, in W. Germany many of the mental hospitals remain very large by U.K. standards - 2500 beds in Munich, down from 5000 - and no obvious policy exists to accelerate their rundown. In Mannheim, the nearest institution has no working links with the Central Institute providing the urban psychiatric service. Yet the latter cannot cope will all acute admissions for the city of 300,000 with only 100 beds, and the overflow is referred to the institution. The Institute is selective in its case mix, and the aggressive patient is particularly avoided. It would be interesting to gauge the attitude of the mental institutions to such a situation, which is to a varying degree replicated elsewhere in Europe. This situation is particularly obvious in Munich. Yet the institutions train staff, carry out research and provide the bulk of the national service.

The famous Italian reform of 1978 which stopped all admissions to mental hospitals created a different, yet difficult situation. They have retained the bulk of national revenue invested in mental health services, presumably because they already possessed it and it has been found difficult to dislodge their power and influence. As a result, over 80% of the national mental illness expenditure goes to the mental institutions and the resources are not being withdrawn in line with their shrinkage through attrition and discharge. This remains an outstanding issue as it clearly prevents the development of alternative services, notably in the traditional South.

All this contrasts with our declared intention to run down and close our institutions with all reasonable speed. More than nagging doubts remain about the wisdom and practicality of such a policy. Not every psychiatric patient will be capable of living in a sheltered community environment. There is much to be said for a realistic assessment of the long term success of transferring chronic long stay residents to new facilities, and of the real needs of the new breed of patients for whom some humane form of permanent clinical care will be necessary.

C. FINANCING

Funding of health care in Italy and the U.K. is a centrally-financed system largely free at the point of consumption. Holland and West Germany have basic compulsory insurance schemes with central support as necessary.

In Holland, the sources of funding break down roughly into 70% from employer insurance, 25% via private insurance and 5% direct from central Government. The latter has a strong interest in cost containment and is intervening more directly in fee and premium rates with the national insurers. Its success is limited by the organisational pluralism in the system and the Government's inability to exercise sufficient direct control.

There is similar pressure on Universities. In Groningen, the psychiatric unit is being asked to reduce inpatient beds from 101 to 90 and to convert this reduction to day places. This will exacerbate the clash between local and national service and research interests.

Dutch Mental Health services consume some 13% of total health care expenditure: of this, 83% goes to hospital care, 3.5% to day care and 13.5% to the RIAGGs for extramural services. In turn, health care costs in 1982 reached 10% of G.N.P. and the Government is now applying management, planning and performance criteria in an effort to stem the tide. Although some attempt is being made in Groningen University Hospital to evaluate the use of clinical budgeting, there is no ready evidence that anything is being attempted on the scale of the U.K. in the 1980s. Certainly real financial pressures do not appear to be a key issue in most minds.

With employers meeting the bulk of insurance costs, employee on-costs are high by U.K. standards at some 60% of salary, so any reduction in payroll numbers is significant. Daily costs in a sheltered home are about 50% of those of a mental institution, which themselves average only 40% of a University Clinic place. These do not differ greatly from our U.K. experience.

West Germany's Ministry of Health is regarded as weak in status and influence. The Landes or States have considerable autonomy and, as in Italy, the level of funding reflects political will and influence. Private insurance covers 90% of health costs.

There is some evidence of belt-tightening in Mannheim after the interesting use by the Ministry of Education of a third party efficiency audit team. The mental hospital costs run at about 65% of those in University Clinics. With such a high level of private practice and private insurance, little data was readily to hand on the national position and how psychiatric services featured.

Italy's pattern seems to reflect past U.K. policy with, first, RAWP and then the "business efficiency" approach of recent years. National allocations are based on a mixture of population, current volume, relative "need" and special developments. Political priorities are prominent and they are just beginning to recognise that such techniques as privatisation, efficiency studies and cost centred budgeting would bear investigation in

order to expand real resources. Meantime the rundown of the mental hospitals and the consequent withdrawal of funds proceed very slowly and provide a considerable barrier to the further extension of the progress of psychiatric reform. Nationally, health only accounts for 6.5% of G.N.P.

One particular feature in all four centres is the very considerable capital investment in new and replacement health facilities. Major construction is evident in all the Universities and psychiatry appears to attract some priority: in Munich the original Kraepelin mental cinic with some 200 beds is being replaced in full. The mental institutions also display the benefits of favourable capital funding, a situation to be envied!

D. RESEARCH

The current British Government is enduring heavy criticism for an apparent lack of commitment to scientific research: the Department of Education and, to a lesser extent, the DHSS receive their share of this attack. The Institute of Psychiatry is now dependent on sources other than the University Grants Committee for some two-thirds of its income. It is interesting to compare this with the situation to the centres visited.

In Groningen, the ratio is similar to our own Institute. The Dutch equivalent of the Medical Research Council is biased to basic sciences and forms the principal grant-giving body. Industrial/commercial sponsorship has been slow to develop due to a 'tainted' attitude, but economic necessity has brought a noticeable change of heart. The main thrust of research is into social dysfunction, a pilot comparison of day care and inpatient treatment and the considerable analytical fields created by the application of a psychiatric case register to a provincial population of 400,000 in 1985. The University Hospital's Clinical Director identified a lack of evaluative research in general in most specialties.

In Mannheim, one quarter of the State's annual financial allocation of 28m DM for the Clinic is available for research. A further 2.4m DM is received each year from third parties. The situation is strengthened by the creation by the Federal Government of a long term - 12 year - commitment program for research within a broad subject area: this is worth 2m DM p.a. It is broken down into a number of individual schemes within the agreed research framework and a review is carried out every 3 years. The WHO also gives long term funding undertakings, so the 60 research staff have a relatively stable prospect. This is one practice that could be beneficially adopted in the U.K.

The two University Clinics in Munich stressed the importance of applied research and the close working with service delivery. As an illustration,between 300 and 400 patients from throughout West Germany have been treated in a sleep research program. Concern was expressed about the danger of creating a two-tier medical service if research was not accorded primacy as an objective of the Institute. Both Clinics are very selective in patient admissions and their academic interests and policies are the most obviously voiced and implemented in the management of their facilities. 'Unashamedly elitist' many could say. However this attracts very considerable funds from third parties.

The Italian funding in Verona benefits more obviously from a mixture of official sources. There is a national health fund providing small sums and the University itself provides rather more generously. The CNR/MRC body is interested in 5 year target projects and at present this is a major support. The psychiatric case register costing some 130m lira a year is met from the Regional NHS authority. On top of these, money comes from private and charitable sources, but for psychiatry it is comparatively small.

It is clear that University centres in general are expected to be active 'commercial' organisations, spending considerable time seeking sources of finance, and having to justify their policies and results. This highlights the need for our SHAs and Institutes to review the existing directions of research in a coordinated manner to make sure that they are in line with long term aims, have a clear purpose and identified outcomes. We should analyse the internal strengths and weaknesses of the institution and be able to justify the confidence required by those bodies and individuals prepared to fund research. On the other side, confidence would be improved by longer term central Government undertakings such as those provided in West Germany: they provide the important underpinning and continuity needed in many developing fields.

E. MEDICAL MANPOWER

The European approach to control of the numbers of doctors available or to be made available appears much less structured than in the U.K. In all three countries there is a consideralbe surplus of young clinicians and many of them are either unemployed or working in alternative fields. There are no obvious national attempts either to tackle any of the consequences of this situation or to take a hard look at the training implications.

In Holland there are some 2000 doctors without a medical post, yet shortages continue in both care of the elderly and mental health. The number of psychiatrists in general hospitals is growing however at the expense of office or private ones: there is already a national total of 1200 psychiatrists for the population of 14 million. Some attempt has been made to foster early retirement in the last five years, but without any notable impact on the employment situation. Meantime, the number in training also have not diminished.

The German picture is dominated by the 66,000 doctors in private practice, of whom about 29,000 are the equivalent of our general practitioners. However, the latter suffer from low status, lack of professional support and uneven quality. Private practice controls most outpatient treatment in W. Germany and it is possible to gain access other than via a G.P. Medical accreditation is administered by State Medical Committees and is a rationing system whose rationale is not initially obvious: they continue to authorise and train potential medical staff surpluses. There are 150 private psychiatrists around Munich alone and they provide a major barrier to the development of any system of linked hospital and community psychiatric care. Neurology and psychiatry were only separated officially as specialties some 20 years ago. There remains a very strong neuropsychiatric overlap and in private practice it is said that the neurological investigative work yields most of private income. On the other hand, half of all University psychiatric staff have been trained in psychotherapy. The number of psychiatrists in the mental institutions is rising as part of a program to improve conditions and care for the large number of patients remaining there now and for many years to come.

The Italian picture differs little overall and you find young doctors working for nothing in order to gain training and experience: alternatively they take posts as nurses or other professional staff in order to participate in health care. In S. Verona up to 25% of the community team could be medical staff. Psychiatry appears to attract good applicants and as the 1978 reform has gathered momentum it is providing an interesting field of medical development. This is particularly so in social psychiatry, in common with Groningen and Mannheim. Yet there is in general a concern to reinforce training linkages between neurology, neurobiology and general psychiatry, and a view that psychiatrists should remain closely in touch with developments in the field of brain research. Some fear the development of two branches - the "brainless" and the "mindless" - in psychiatry.

One source of envy is the breadth of training experience available in the top psychiatric facilities in the U.K.; although this is seen as still too hospital-based. There is an acknowledged clash of priorities between the benefits of having 480 beds in a specialist centre to provide such breadth, and the perceived avoiding of positive concern for the population that uses them. In contrast, the largest centre in W. Germany contains only 208 beds.

F. NURSING MANPOWER

Alone among the four centres visited, Groningen has no University-based nurse training in psychiatry. This is provided by the mental institutions in all 17 provinces. Dutch Government policy is to move towards eight national day school training programs.

The Mannheim and S. Verona integrated social psychiatric services have no role for a community psychiatric nurse in the U.K. model as social workers cover most of the duties. In Italy nursing staff move more flexibly between hospital ward, mental health centre and domiciliary work, so avoiding the 'specialist' approach.

The two Munich University Clinics provide attractive nurse training schools, regularly oversubscribed, but offering a range of experience narrower than in the U.K. In both Holland and W. Germany there is a serious shortage of male nursing staff, particularly important in the case of locked wards. As in the U.K. there is also a clash of interests between the needs for stable care by older staff offering practical reinforcement and the training requirements of the young, career-minded with a higher turnover.

Verona shares a chronic national deficiency in qualified staff: it is not clear that this is merely a question of pay. Psychiatric experience is provided as part of basic training and staff therefore move more freely and regularly between specialties. With only 2 nurses on each 15 bed ward at any time, this reflects a difficult recruitment and training situation in the general hospitals. The mental institutions remain too strongly the prime employer of qualified psychiatric staff and impede the transfer in the balance of services towards a social community pattern.

G. DISCUSSION

There are significant differences between each of the countries which make their individual approaches to mental health equally varied. Many of these are based on social values, history and political climate. I have tried to illustrate some of them. I would like now to see if there are areas of possible interest to us in the U.K., with particular reference to the options facing the Institute of Psychiatry and the Special Health Authority.

One obvious conclusion that can be drawn is that the successful involvement of a University Psychiatric Unit in innovative social psychiatric practice is based on clearly defined responsibilities for a full range of services from home to hospital bed. This obligation for service provision provides the platform for experiment and research for training and new approaches and a practical test-bed on which to learn and to improve.

Its success is assisted by having as simple a management and funding control framework as possible. The more types of professional staff that the managing agency can employ and direct the simpler and more effective the scope is for good quality and performance. The integration of social work within the health delivery agency appears to be successful and beneficial to the community. The latter gains from the relatively generous resources and skills to which it has access in the form of service and academic staff.

In the U.K. the plethora of "interested parties" is a barrier to progressive integration of the range of facilities and support staff needed by the mentally ill at different stages. Any moves in the direction of a 'common agency' concept can only be of benefit in this field.

It should also serve to emphasise the need for the Institute and the Authority to pool their skills, resources and plans to their mutual benefit. In the absence of the common structure under academic medical leadership found generally on the Continent, an effective correlation mechanism is an overriding requirement.

We should be prepared to adapt our interests and services to the particular social, cultural and economic characteristics of the catchment population. This will involve a greater understanding of how the community functions and what needs it displays which we could meet. Groningen, Mannheim and Verona are all making considerable use of a psychiatric case register. It would be helpful for the SHA and the Institute (the Joint Organisation) to consider whether it might usefully be modified and reintroduced as one component in the current discussions about the creation of a single mental health service for Camberwell D.H.A. If a proper evaluation of such a service is rightfully demanded at the end of three or five years, it could only be carried out if both the 'opening' and 'closing' conditions of the service are studied and known.

U.K. planning norms for psychiatric bed provision have been falling in recent years but are still above Continental levels. We understate the true cost of providing inpatient facilities by ignoring the capital cost of the investment: they are also inherently less flexible than community-based services. More work needs to be done toestablish the optimum mix of non-hospital support which would minimise the need for hospital care. None of the centres visited has carried this out, although their differing circumstances has dictated quite different approaches to this question of balance of resources: the Italian reform is the most obvious radical example. Each illustrates the need for an open-minded approach to the

package according to the competing needs of the community, training and research.

The place of the mental institution varies between all four countries. Holland displays the most flexible changing response in relating to the new concepts of psychiatric care and is realistic in not seeing early closure as either practical or necessary. The pace of rundown and adaptation is much slower in W. Germany and Italy and a barrier to further progress towards community developments. The U.K. seems to be rushing ahead without sufficient investment in alternative facilities. It is becoming clear that we will be forced to reconsider the more realistic European acceptance that some form of protective 'asylum' will be required for some categories of the mentally ill incapable of true residential care among the public.It is an area to which the Joint Organisation should be directing its interest and leadership.

No one knows what the right amount of funding should be in the field of mental health. It is clear that insufficient is known both about the size of existing expenditure by the various agencies involved and the cost-efficient value this yields. This is a difficult and neglected field for organisations such as those visited. We need to provide initiatives in health care evaluation so that the resources, which will never be seen as sufficient, are put to best use. Somehow quality of outcome has to be measured and included.

The rising cost and potential of medical technology is a concern all the centres have in common. The potential of neuro-imaging and neurobiology is seen everywhere as a key issue and the availability of the full range of advanced scanning techniques as mandatory, particularly in European eyes for an institution of the quality and repute of the Joint Organisation. All are facing the problem of rapid technical advances and costs, and looking to any possible sources for sympathetic funding beyond their own Ministries. It is an issue of great concern, otherwise R & D establishments like those visited will soon lose their edge and the ability to progress. We face that problem directly in the neuroimaging field.

In manpower training and quality we remain in many ways in the lead, in comparison to many part of the Continent. However, there is much we can do to improve: one area is in the further breaking down of professional barriers and roles in the name of real teamwork. Wherever positive moves have been made away from the 'security' of a hospital base, they have led to a more flexible form of work-sharing, a more willing involvement by staff of any professional background, and a greater concern that the interests of the patient should be the prime concern. There is also a more willing interchange between the different service components. This helps to provide the groundwork for a more responsive and more appreciative mutual health service.