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experiment with producer cooperatives by allowing the staff of the foundation trusts to run themselves. Staff responsible for their own institution are much more likely to welcome strong management—instead of resenting it—than if they see themselves as manipulated by others: this is, perhaps, one of the lessons to be drawn from the success of the Kaiser Permanente organisation in the United States. A necessary condition would, of course, be rigorous accountability for the way in which the trust's resources are used. But Mr Milburn's scheme of things has no shortage of accountability mechanisms.

On the contrary, the problem is an excess of accountability. In the first place, foundation trusts will be accountable to the newly created independent regulator who will license them, monitor them, decide what services they should provide, and if necessary dissolve them. In the process, the regulator will be able to impose additional requirements on the trusts, remove members of the management board, and order new elections. The regulator will also determine the limits of the trust's capital spending and will be informed by the reviews carried out by the new Commission for Health Audit and Inspection. Foundation trusts will also have to answer to the overview and scrutiny committee of the local authority (which may interpret the wishes of the local population rather differently). Finally, foundation trusts will be accountable to primary care trusts (who may have yet another, yet again different view about the local population's needs) for fulfilling contracts.

Overlapping accountabilities are likely to mean conflicting pressures: how far, for example, can national priorities be adapted to local ones?

So there is much for the Health Committee of the House of Commons to sort out in its inquiry into Mr Milburn's radical but flawed plan. Not only do the governance arrangements of individual foundation trusts need to be sorted out, but so, most crucially, does the role of the independent regulator who is to be accountable to parliament through the secretary of state. Will he or she be the secretary of state's creature or act as a baffle, protecting foundation trusts from political intervention? Who will answer questions from members of parliament and who will react to newspaper headlines if not the minister's private office? Potentially Mr Milburn offers the vision of a transformed NHS, but if the promise of a devolved service with greater autonomy for those actually doing the work is to be achieved the model needs a great deal more development.

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Reinstitutionalisation in mental health care

This largely unnoticed process requires debate and evaluation

Since the 1950s mental health care in most industrialised countries has been characterised by deinstitutionalisation, with national reforms varying in their pace, fashion, and exact results.^{1,2} The development of comprehensive community mental health care is widely regarded as not yet complete. In England the national service framework and NHS Plan aim at establishing new community based services—for example, for home treatment, assertive outreach, and early intervention. Yet despite the apparent evidence of ongoing deinstitutionalisation, we argue that a new era in mental health care has already started—reinstitutionalisation. It is displaying a synonymous pattern across Europe, as with deinstitutionalisation, but this time it has been occurring largely unnoticed by the scientific community and unscrutinised by politicians and the media.

What are the signs of reinstitutionalisation? Firstly, the number of forensic beds is rising, in the United Kingdom, with dramatic increases in the private sector. Plans to increase this number further are in hand. Secure units are extremely costly, with no evidence as to their effectiveness, although we live in an era of evidence based medicine. The cost implications are sucking funds away from the more financially stretched areas, especially in London; the process is fuelled by the straitjacket of risk management despite evidence that deinstitutionalisation did not increase homicide

rates in mentally ill people.³ Little systematic research has been conducted into the matter, although other countries, such as Germany and Austria, have also witnessed a steady increase in the numbers of forensic beds over the past 10 years.⁴

Secondly, attitudes to compulsory treatment have changed. The relative numbers of compulsory admissions of psychiatric patients across Europe vary by a factor of 20, but, independent of this mainly unexplained variation,⁵ compulsory admissions have risen in many, although not all, European countries including the United Kingdom. In Italy, Bavaria, and the United Kingdom new legislation or new directives to handle existing legislation have been proposed, to widen the options for compulsory treatment.⁶⁻⁸

Thirdly, placements in supported housing at varying levels of dependence have increased enormously. Data as to how many and which patients are in what schemes and for how long are largely missing, and little substantial research has evaluated whether the schemes are effective in achieving whatever their precise aims are.⁹ Supported housing seems to be taking the place that used to be held by the old style asylums, and many facilities are run by private providers. This and the aforementioned rising number of privately provided secure units might lead to the conclusion that "private madhouses" are back, no matter the official names.

Fourthly, assertive outreach teams have been established throughout England. Their aim is to minimise hospitalisation and care for those patients who have been “difficult to engage” or who—in plain English—want nothing to do with services. Although teams do not formally exercise any legal power, patients are undeniably put under pressure to comply with treatment. Whatever the therapeutic intentions, administering treatment to someone who does not want it without a legal basis for compulsion poses an ethical dilemma.¹⁰ It is also a proactive institutionalising step, although the institution in this case is a community based service and not defined by bricks and mortar.

Similarly, the new early intervention teams might be seen as being in line with reinstitutionalisation. They aim to turn individuals who otherwise would not yet be treated into psychiatric patients and subjects of ongoing treatment interventions. This approach is supported by little if any research evidence¹¹ and is based on the assumption that early psychiatric treatment will prevent a more negative course of illness—an assumption prevalent among psychiatrists in the 19th century, which made them successfully demand more and bigger asylums.¹²

One might disagree with our interpretation of some of these phenomena, but it would be hard to dismiss them completely. They may provide the historical and international context for the current debate on the draft Mental Health Bill in the United Kingdom. Mental health care has entered a new era of reinstitutionalisation in its long historical balancing act between social control and therapeutic aspiration. We may now even start to witness a clearer split between the two, with an increasing market for patients who actively seek treatment and can directly or indirectly pay for it, contrasting with reinstitutionalisation for patients with more severe mental disorders who may upset the public. This split is likely to affect primary as well as secondary care.

What seems needed, in any case, is an informed debate on the values behind reinstitutionalisation and systematic research on its reasons, costs, and effects. As with research on deinstitutionalisation, a non-parochial perspective will be required alongside reliable and comprehensive data that are currently so difficult to obtain. A proper understanding of deinstitutionalisation and reinstitutionalisation can help avoid the stigmatising policies that so often marginalise mental illness.

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Competing interests: None declared.

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BMJ Learning

A suite of online services to meet doctors' needs will be launched this year

The surprise about appraisal and revalidation for doctors in the United Kingdom is not that it is happening but that it was not introduced earlier.¹⁻³ For appraisal to be successful it will have to be centred on learning, which in conceptual terms allows the learner to take control in the way that education—with its top down connotations—rarely seemed to. This change in emphasis is also reflected this week in an interview with Professor Graeme Catto (p 183), president of the General Medical Council, and the start of an ABC series on learning and teaching in medicine (p 213). Helping doctors to learn is central to the *BMJ* mission, which is why we are launching BMJ Learning.

The proposition is simple. If doctors have access to online learning resources, based on the best available evidence, they will be better equipped to improve quality of care. If they can record their learning experiences systematically they should feel more confident about

appraisal. As five successful appraisals seem likely to be the main requirement for revalidation, it may make that hurdle seem less daunting. We envisage that this service will develop into a learning resource for all doctors internationally, but the initial emphasis will be on appraisal in the United Kingdom because that is where many of our readers are hurting.

How should we build a successful medical learning service? We have looked at possible models from around the world and reviewed available evidence. In the United States, much online continuing medical education is driven by the need to accumulate points and by the product awareness campaigns of pharmaceutical companies. Among the exceptions is a website devoted to the medical response to weapons of mass destruction, with 10 modules covering subjects ranging from anthrax to smallpox.⁴ North of the 49th parallel, the story is more positive. The Royal College of Physi-

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