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King's Fund Centre
126 Albert Street
London NW1 7NF

Tel: 01-267 6111

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I should like to thank the King's Fund for enabling this Conference to take place and particularly to David Towell and Joan Rush; and to Circle 33 Housing Trust for the support and continued interest in the problems of community care for (ex-) psychiatric patients and other vulnerable people.

Chris Heginbotham

HOUSING MANAGEMENT, SOCIAL WORK AND MENTAL ILLNESS

The Conference reported here is the second in a series aimed at bridging the great divides between mental health practitioners whether in the health, social services or housing fields.

Traditionally each functionalised service has had differing indicators of need, differing patterns of service provision and varying background philosophies of care or cure. Housing has often been left out of consideration altogether in any discussion of either the causes of mental health or the rehabilitation of the ex-patient.

Housing staff have not been trained to deal with mentally ill people, nor have they been expected to show much interest. Social work staff are better trained but current models of social work intervention seem geared to referral-on as soon as possible. Psychiatry, whether in hospital or in the community, is related underpinned by a medical-curative model and little interface exists with the life situation which will apply to the patient (client? tenant?) on discharge into the community.

This second conference aimed to bring together practitioners in housing, social services and psychiatry; to explore the links and the gaps, the successes and the failings; and to point out some signposts for future development of service to meet needs. In particular, the conference explored three themes:

the varying definitions of need within and between services,

whether a unitary definition of need was appropriate or desirable,

and considered a social and environmental model of psychiatry.

In doing so, an attempt was made to consider social descriptions of need to relate these to social models of the causes of mental ill health, and hence to build a framework for a social and environmental model of care.

This booklet contains the three papers presented at the conference, together with a discussion and partial summary of some of the main issues raised by participants.

The first paper by David Townsend considers if a unitary definition of need is possible, workable or indeed desirable. He concludes forcefully that such a concept is neither possible, nor desirable even within an existing functional service. In brief, the argument against not even trying to set a unitary definition are that even if it were possible to gain agreement amongst practitioners (which it would not be!), a unitary definition would not be in the interests of the client, would be restrictive and ultimately politically autocratic and even dangerous.

Alan Walker's paper on the other hand considers the various definitions that have been used and the reasons for their generation. He concludes that we require, not a unitary definition of need, but a development of a concept of social welfare beyond the casualty approach, towards one based on distributional justice. Need would be planned and coordinated across a number of services, departments and groups, and would not be seen in narrow isolation. This approach would stress the inter-relationship between needs rather than the segregation of social service organisation. The independent future of people with all forms of disability depends on the recognition of a wide range of social needs and the construction ot a coordinated preventive strategy.

Finally, Stuart Etherington considered models of mental illness and set out the rehabilitation career of the ex-patient as a continuum from hospital to community, where the patient as she/he "recovers" and moves into more independent settings, receives proportionaly less support at each step further towards independence. The failure of the medical model to consider the social and environmental factors is illustrated and the lack of the coordinated approach set out by Alan Walker. This lack of coordination does not recognise social needs and consequently starves resources from those community supports which do exist.

The conference and some participants responses are summarised in the following essay. This looks briefly at some of the issues, some solutions, and provokes a few thoughts which flow from the three papers. In particular, the conference highlighted the need for a thorough reappraisal of supports to mentally ill people in the community, and the ways in which these would be fitted in or around (or replace) existing provision.

Christopher Heginbotham October 1981

Is a Unitary Definition of Need Possible or Desirable?

Paper presented by David Townsend, Deputy Director of Social Services, London Borough of Camden and previously adviser to the Secretary of State, Social Services. He was until recently a member of Lambeth, Southwark and Lewisham Area Health Authority and a member of Lewisham Council.

The first question, in talking of joint services, is to find out those areas that can be agreed. The second is to ask how beneficial such an agreement - a "definition" or "qualification" of mental illness - would be? There are attractions in the idea of unitary definition. It would simplify matters for "professionals", beauracracy and the general public. If doctors, social workers, housing officials, lawyers and the police could all agree, would that necessarily mean a better and fairer deal for those who are clearly identified as mentally ill? Would such an agreement ensure them a first class service? Or rather is such an agreement a dream?

A number of questions flow from such a suggestion. Firstly, where do the individuals, thought to be mentally ill, have a say? Secondly, where do families of those said to be mentally ill have a say? Thirdly, does an agreed definition of those in need of help not tend to exclude people who may want it most? There are many examples where definitions tend to meet the level of service available; or if not, the interpretation of need is done in such a way as to make services appear adequate. And of course, if there were an agreed definition of need or requirement for intervention in a person's life, then they might get that intervention whether they want it or not.

A good example of this can be found in the intervention of Child Abuse registers. After the political panic created by a few well publicised cases of child abuse, registers were started in 1974, and all local authorities now keep them. Some are so long that it is impossible to review them properly and they go out of date quickly. The registers represent a coming together of professionals; doctors, health visitors, teachers, social workers, district nurses, etc., all of whom have a say in whether a name should be entered into the register in circumstances where even a suspicion is strong enough that child abuse might occur. The placing of a name on register is not necessarily, if at all, revealed to the family of the child or children. The fact that the register follows the family wherever they go is usually not revealed to that family. This invites a number of worrying questions on the freedom of professionals to act privately without the knowledge of the general public.

The next issue in any consideration of a unitary definition of need, is how many professional areas should be included within its boundaries? In considering this question the ethical background of each professional group and to whom they are answerable, is obviously of paramount importance. In addition there are issues of trade union activity, or professional jealousies between groups, each of which may have an effect on any form of joint organisation or agreement about a common definition of need and how to meet it. Two examples could be given here.

The first concerns Health Service staff. In the early 1970s, when revisions to the Mental Health Act were being discussed, hospital staff in a limited number of cases chose not to accept the ruling of Courts which, with the support of medical opinion would have placed patients under the relevant sections of the Mental Health Act in psychiatric hospitals. The staff simply refused to accept that person into hospital. Indeed the Confederation of Health Service Employees (COHSE) in a document published in 1977 on Management of Violent Patients, advised staff that they could decide on whether treatment would be appropriate in their place of work.

The second example concerns doctors. The doctors' lobby effectively defeated the proposed Mental Health Act revisions setting up multi-disciplinary teams in psychiatric hospitals. It might have been a major step forward in the treatment of patients in hospitals. Similarly they refused to take part in the "second opinion" proposals which would have been applicable in cases where compulsory treatment was considered necessary. Now it can be argued that each profession is so different as to afford a degree of protection to individuals said, by one opinion or another to be in need of help. Social workers have less an ethical than a legislative locus in their work. Their training in mental health work is often more idiosyncratic - where it exisits at all. Housing workers are often not trained in any way in the mental health field, whereas doctors may specialise for many years in a branch of psychiatry. It is both a good thing and necessary that the training of lawyers and doctors clearly differs from the training of social workers as well as from each other. The legislative function may be seen as a protection from society rather than as an aid to the person in need. Indeed, this can be seen in the arguments about the reform of the Mental Health Act where a "liberal" Social Services Secretary proved less powerful than a "status quo" Home Secretary who saw his responsibilities as protecting society using Section 60 and 65 of the Mental Health Act.

On the other hand housing workers are, at a local level, even more likely to see their duties in a wider social sense. They are more directly accountable perhaps to local area management panels or to Members of Housing Committees and will have one eye on the opinion of the elected representatives.

But apart from differences in the ethics, training and accountability, there is another matter which is relevant. That is who controls facilities, buildings or cash. Such control tends to make agreed objectives even more difficult to attain and certainly creating different perspectives on those objectives. The case which follows shows up all these differences clearly. This is the case of Mrs M, aged 70, the tenant of a one-bedroomed ground floor flat in a quiet house with communal entrance. The Estate Manager clearly saw this as a "management problem" whilst the Social Worker saw it as a very personal problem on an individual basis.

Report by the Director of Housing:

1. Mrs M was decanted into her present address on the 18 September 1978. She lives on the ground floor of a house converted into four flats.

2. At her previous address Mrs M felt she was being harassed by the family who lived above her and requested a transfer. However, the tenants themselves had made numerous complaints about Mrs M's behaviour. They claim she returned home drunk late in the evening often with men friends and then slept until lunchtime the following day. Consequently the slightest noise made by other tenants in the house resulted in Mrs M banging on the ceiling.

3. The estate manager visited her at her previous address on numerous occasions because of reports of her having been burgled. She had called the police out four times in a period of two weeks and was accusing the tenant above of breaking in.

   The police dismissed these accusations as ridiculous and were considering prosecuting her for wasting police time as each of her doors had a mortice lock and there was no sign of forced entry.

4. Since being in her present accommodation Mrs M has continually reported being burgled and locking herself out. The social worker was informed and kept a spare set of keys for a short time but with the lock being changed so frequently by Mrs M that this arrangement was unsatisfactory.

5. The tenants in the two flats above Mrs M complained in writing about her in November 1980. They claim that since she has moved in she has made their lives unbearable. They claim she brings home many strange men when she meets them in the local public houses and she gives these people keys so they can come and go as they like.

6. On one occasion Mrs M threw a lighted cigarettte into a cardboard box and the house became full of smoke. One of the other tenants had to put it out.

7. The estate manager arranged a meeting with Mrs M's social worker and informed him of all the complaints and that he would have to prepare a report recommending a compulsory transfer to accommodation without a shared entrance. The social worker did not think this would be suitable as Mrs M would be too isolated. He thought that sheltered housing accommodation would be more suitable.

8. On March 9 1981 the tenant on the top floor, Mr D, complained about Mrs M who had accused him of changing the entrance door lock and not giving her a key. Mrs M had arrived home that evening with a man friend, could not get in and called the police who rang Mr D's bell. When the tenant opened the door, Mrs M's friend assulted him. He retaliated and the policeman had to part them. An assult charge has been brought by Mrs M's friend against Mr D. It also states that Mr D changed the door lock to prevent Mrs M gaining entrance to her flat.

Mr D told the estate manager that he did not change the lock and that the council workmen had done this after an emergency call-out because the lock was jammed. The estate manager confirmed with the Building Department they did change the lock and that they also gave a key to each tenant.

9. The Department of Social Services have had a psychological assessment done on Mrs M with the conclusion that although she has no psychiatric illness, she does suffer from memory loss and lack of concentration. They feel that she needs the support of sheltered accommodation.

The Director of Housing stated "I am frankly doubtful of the wisdom of this lady living in sheltered accommodation and I would wish to examine the issue further with a view to reporting to Committee".

11. Recommendation: That Mrs M be transferred, compulsorily if necessary, to alternative accommodation suited to her needs.

Social Services comments:

A compulsory transfer away from the area she is known and receives exceptionally high level of support will only worsen the problems in her and for any neighbours. We can predict a series of complaints/transfers.

Long term solution: investigate sheltered housing. Look for responsible companion to live-in - she is amenable to this.

Short term solution: adapt present accommodation to provide own entrance. Discretionary rebates to other tenants to compensate for disturbance factor.

Transfer for Mr D .

Which view of the case should be taken? Is it reasonable to remove a difficult and anti-social individual in order to establish harmony for the majority of people? Or is it better to persist in creating certain freedoms for an individual to enjoy no matter what the cost in financial or human terms to society at large? Is the municipal housing department perhaps a bridge too far between vulnerable individuals, institutional care and community living. Perhaps the problem is the nature of local government bureaucracies whether in the housing department or social service department. Do smaller organisations, community based, lend themselves better to individual needs?

Housing Associations appear to have higher ratios of staff to properties and yet paradoxically are more economic. In any more comprehensive use of the community's housing stock it is inevitable that housing departments and housing associations would have to be more closely associated. Their agreement on mental illness and the provision of what is suitable to meet the consequent needs could lead to quotas from housing. In one sense where such an agreement in respect of homelessness has been agreed, the result more often than not is the poorest housing for the poorest people. Can we therefore feel that any agreement between local authority departments would lead to any better situation for any particular client group?

The next two cases illustrate the dilemmas of the different professions and ways in which a unitary definition of need would be extremely difficult to attain and if it was attained, could lead to the wrong decision.

CASE: Mrs V

The Community Physician telephoned me yesterday to say that Mrs V lives in insanitary surroundings and is demented. She is obviously an elderly lady and were she to be admitted to the Royal Free Hospital she would probably be discharged immediately on the grounds that there was nothing that could be cured. Dr B has been in touch with the psychiatrist who says that he has only 72 beds for the whole area to care for people like Mrs V. Dr B believes that the use of Section 47 is not necessarily a good thing but that our department should try to persuade Mrs V to accept residential care.

Apparently Dr S has said that if residential care does not work out he will accept Mrs V into hospital. Dr B feels that Dr S will make an issue if anything happens to Mrs V and it is one of her problems that she tends to wander about and frequently ends up in the middle of busy roads.

Response

Dr B is well known for his reluctance to invoke Section 47 for which he should be applauded. I sympathise but do not applaud his suggested alternative that this department should "try to persuade Mrs V to accept residential care". Mrs V is said to live in insanitary surroundings and is demented and that she tends to wander off and frequently ends up in the middle of busy roads. But should she be 'persuaded' in these circumstances?

CASE: Mr C E

Age 65.

History

Jan 1980 In patient at N E Hospital.

3.1.80 Admitted to EPH (see Note 1) as interim measure awaiting adult fostering. Started to wander, discovered by police. Readmitted to Royal Free Hospital. EPH refused to have him back.

From RFH to adult fostering by hospital social worker - placed with M family.

Apr 1980 Fostering placement begins to break down.

18.9.80 Senior social worker presents to Part III Allocations meeting. Allocated to EPH.

19.9.80 Admitted direct as an emergency by RF Hospital senior social worker ie without normal procedure. Very restless, demented, agressive on admission. On very large doses of medication. EPH therefore feel strongly that he should have been reassessed before Part III decision or admission.

Jan 1981 Dr H, domiciliary visit requested. Dr H told Mrs V, Head of home, that Mr C E was on his list for a bed. Subsequently information came to light that Mr C E had been seen by geriatricians and psychiatrist - all saying his problems were primarily psychiatric - all saying he was not suitable for Part III. Therefore at some stage a decision was taken that the most appropriate place was a psychiatric hospital and this information/decision does not seem to have been communicated to those being asked to provide Part III care.

Dr H considerably increased his medication. Mr C E continued to be a severe management problem eg he still went on walkabouts and was agressive at night.

On 12 February 1981 Mr C E went missing at about 5.00pm and at 7.00pm walked in front of a car and was killed. The Coroner's inquest is pending.

The most fundamental question which we have to ask ourselves is whether the agreement of all these professionals lead to a better deal for the mentally ill people and would the community be any more prepared to help and support? The 1890 Lunacy Act illustrates this point. There was agreement as a result of the magistrates intervention on who was mentally ill. But did it do more than put a rigid and destructive stamp on individuals? Organisations such as MIND argue that observed behaviour should be the main if not only consideration but many people could be excluded from any agreed definition. Where does individual liberty and the right of appeal come in?

NOTE 1: EPH means Elderly Peoples Home.

What we are in danger of doing, as 'professionals', is to deny choice. Cash, facilities etc are in short supply, but to have the 'corporate approach' to provision of services is to endanger personal freedom. Before the war the mix of housing was quite different from the present. Of course the quality was not as good and more often appaling and the level of home ownership by individuals was not as high. But freedom of movement was greater than now. Municipal housing has provided security but the benevolence of that security can become an imposition. There is in the nature of public housing, which may account for 50% or 60% of all a borough's total housing stock little or no personal service. Possibly housing associations, cooperatives and group homes provide a more individual answer, especially where individual needs amongst people who have difficulty in coping are high. Perhaps with unemployment in millions the recruitment of more rent collectors or home visitors by local authorities could put a more human face on municipal housing. It might even pay for itself by better rent collection. For the present scepticism must be the order of the day - individual living is too precious to be entrusted entirely to corporate professionalism.

Social Need, Social Services and Mental Illness

Paper presented by Alan Walker, Lecturer in Social Policy, Department of Socialogical Studies, University of Sheffield.

Introduction:

It is essential if social services are to be planned and coordinated to meet the needs of clients, to constantly review objectives and purposes. It is especially important in this International Year of Disabled People, to review services for people with mental illness because this group, for various reasons which I will go on to explore, have been the poor relation in social service provision that is generally inadequate. Moreover it is frequently forgotten that people with psychiatric disabilities suffer from many of the same disadvantages as people with physical disabilites and they are often excluded from discussions of social provision for people with disabilites.

Over the last 20 years there have been a long series of official documents concerned directly or indirectly with the care of those with mental illness: the Hospital Plan for England and Wales, 1962; Health and Welfare, 1963; the Mental Health Act, 1959; Hospital Services for the Mentally Ill, 1975; Priorities for Health and Personal Social Services, 1976; The Way Forward, 1977 and Care in Action, 1981 are the main ones. Critical readers of the first and last named might be suprised that despite the considerable time lapse, the concept of need, particularly in relation to community care for the mentally ill had not advanced significantly. Neither documents provide a clear rationale for planning services for this group and neither give any indication of a positive lead from the government. This suggests that at best developments in social service provision will not be any better planned in the next 20 years that in the past. At the end of that period the DHSS noted that on the issue of linking statutory and other services for the mentally ill and their families "Progress has so far been uneven" (1). Despite the official and professional activity and policy documents, services for people with mental illnesses are grossly inadequate and many people with psychiatric disabilities still remain in hospital. In 1979 some 0.1 day care places were provided per thousand population suffering from mental illness, one-sixth of the DHSS guideline. Residential places were one-third of the guideline (2).

An account of the failure of policy towards the mentally ill must encompass a discussion of need, since that is the chief yardstick against which policy can be judged. Furthermore the conceptions of need which prevail at different points in time and are institutionalised in social service, underpin the particular pattern of services provided. But, there is not a simple unilinear relationship between need and social services. For example, the fact that there may be an increase in the proportion of the population with disabilities who are hospitalised between two points in time while at the same time prevalence rates remain constant suggests that the relationship between scientific and social definitions of illness or disability is complex. This is my starting point and my theme is the absence of

of a planning framework in the growth and development of policies for the mentally ill (which itself is based partly on the adoption and application of narrow conceptions of need). It is not my intention to provide a detailed account of the history of mental health services, since that has already been done, (3) but to examine the conception of social need and in doing so throw some light on the failure of policy towards people with mental illnesses.

Social need and the social services

The concept of need is central to both the theory and practice of social policy. Most definitions of social policy or social services emphasise their objective in meeting need. For example, according to Brown, "collective provision to meet individual need is the hallmark of a social service" (4). It is important to recognise here the social distinction between need and demand and therefore that the argument sometimes advanced by economists that demand should determine the supply of social services is inappropriate.

Consider the position of a person who has been in a psychiatric hospital for 10, 20 or 30 years, is his lack of demand for alternative forms of care an indication of absence of need? The application of demand in this situation would impose artificial clarity on complex social relationships.

In fact in the social services there are groups of people, doctors, social workers, health visitors, housing visitors and so on, who in addition to politicians and administrators, decide who is in need. They are, effectively, gate-keepers, who determine access to and therefore ration scarce resources, regardless of the level of demand. Thus the definition and meaning of need depends on value-judgements and a range of other social factors. For example, the housing visitor who has to assess housing need and to contribute to a crucial decision in relation to the future housing of an individual or family, will clearly be influenced by prevailing standards of hygiene and cleanliness in forming an opinion.

So, we have distinguished, implicitly, two main conceptions of need in the literature on social policy: normative and subjective need. The latter, a conception of need or standard applied by the state and/or those working in the social services, is not necessarily related to the former: the individual's feelings and perceptions. Thus need is both a relative and a socially defined construct. Need is relative both within societies over time and between different societies. For instance, a person living in a Salford slum dwelling 100 years ago would probably not consider a flat on the 27th floor of a high rise block undesirable, similarly a Mexican living in a shanty-town. In the same vein, the response to the questions what is mental illness and what should social policy towards this group consist of would be very different in the mid-nineteenth century and today.

In 1845, as Kathleen Jones points out, it was held that insanity was an affliction of the mind, quite different from physical illness, and entailed deviant behaviour. Furthermore insane people should be sent to asylums, where they should be locked up to keep them away from the sane and be subjected to compulsory treatment. Today it is believed (by experts if not the general public) that mental disorder has some relationship with physical disorder and that there is no clear division between 'normal' and 'abnormal' behaviour. Rather than being shut away it is believed that those with mental illness should be provided with a range of services from hospital treatment to community care (5).

The extent to which normative definitions of need - the Parker-Morris standard, the supplementary benefit level and so on - are restrictive or expansive, will, in turn, determine the nature and pattern of social service provision. But these departmental standards of need are not derived from a scientific and apolitical process of evaluation, they are formulated within the constraints of broad social principles of distribution which embody different conceptions of need. We might distinguish three such models of social distribution: conditional welfare for the few, minimum rights for the many and distributional justice for all (6). These principles can be identified on the basis of different political philosophies and the first two can be observed in the development of British society and the welfare state over the last 100 years. Conditional welfare for the few characterised the poor laws of the nineteenth century, when poverty and disability were seen as predominantly the fault of the individual. This philosophy can be clearly identified in the treatment of the mentally ill. The dominance of eugencists arguing that those of limited intelligence would reproduce their kind disproportionately and contribute to a decline in national intelligence reinforced the moral case for their exclusion and custodial care. It was only in the mid-nineteenth century after-all that the first 'idiot-asylum' was opened by a voluntary society (from the Fourteenth Century there was a legal distinction between 'lunatics' and 'idiots' but most people with mental disorders were in practice noused in work-houses and later asylums) and an increased proportion of people with mental illnesses were institutionalised.

The second principle, minimum rights for the many, was discussed around the turn of the century but received its best known expression in the post-war reconstruction, and particularly in the measures following the Beveridge report. Rights were more widely and generously defined than under the wholly conditional welfare system of the poor law, but were and are still largely confined to minimum standards of living and social services. The 1950s witnessed a major change in attitudes towards the treatment of mental illness, together with a switch from hospital based treatment to community-based care (a change, in poor law language, from indoor to outdoor relief). The emphasis in psychiatric hospitals began to shift from custodial confinement to rehabilitation (although in a very restricted form). The third conception, distributional justice for all, has never been consistently pursued in British social services. It is a conception I will return to in my conclusion.

It is within these broad social conceptions of need and distribution that individual social service departments and social groups define need. In recent years, especially since the last election, the organisation and distribution of social services has become an even more uneasy mix between conditional welfare and minimum rights through, for example, public expenditure cuts and the erosion of national insurance benefits. It is important to establish, therefore, that the social definition of need applied through the social services in Britian is very limited.

Social services in this country are complex and fragmented and the organisation and structure of those services reflects and reinforces restricted definition of need in British society. The recognition of need has tended to be encompassed within the existing structure of services rather than developing new structures. Those administering and working these services have tended to favour and press positively for the differentiation of tasks on the basis of occupational skill. In addition, there is the division between local and central government, with central provision by the state often being seen as a last resort. Beveridge had to justify the central provision of social security, on grounds of uniformity of rates, central funding and economies of scale. The existence of two tiers of administration in other services has, however, resulted in important inconsistencies between services in different areas and complicated problems of coordination. As well as those 'horizontal discontinuities' there are important vertical divisions in social services (7). These reflect in part the pressure from those working in the social services referred to earlier, but the state itself has willingly categorised need in relation to the organisational skills required to meet them. For example, in considering the relationship between Area Health Boards and local authorities in the reorganisation of the NHS, it was stated that:

> 'After carefully considering the contrasting views expressed on these questions, the Government has decided that the services should be organised according to the main skills required to provide them rather than by any categorisation of primary user' (8).

In other words need has been socially divided to reflect division of labour in medicine, social work, housing and education. Thus like most other organisations, once established, social services tend to become ends in themselves rather than instruments to achieve objectives, organisational survival becomes paramount and radical change is very difficult.

'Need' becomes severely circumscribed by the structure and management of the organisation. Needs are translated into the pattern of services that an agency has to offer: the elderly 'need' home helps, meals on wheels, residential care; the mentally ill 'need' hospital treatment, sheltered accommodation and so on. This social division of need has reinforced the tendency towards the narrow departmentalism in local authority services which provides professional groups with career structure, professional independence and a discrete sphere of influence (9).

Limiting the scope of services and therefore the recognition of need also makes the organisation and development of individual services more manageable. The benefits for the majority of those working at the lower reaches of the departmental hierarchy, not to mention clients, is less clear. The problem has been summarised by a recent New Society comment:

> 'When the NUT complains about the education services, and the BMA criticises the level of expenditure on health care, are they really concerned with the pupil and patient? Or is it the income and working conditions of their members they are worried about.....? Social Services Committees, when called to make cuts, don't sack social workers or reduce their salaries: they tend to make reductions in direct services like aids and adaptations for handicapped children, financial support to various voluntary organisations, or home helps' (10).

This narrow departmentalism, however, has considerable disadvantages. It requires a segmentation of need that may bear no relationship to the problems confronting the clients of the social services. Secondly, it creates difficult problems of coordination between different services. Thirdly it results in conflict between different departments and competition over resources which are not necessarily in the interest of clients. This requires, fourthly, the establishment of narrow planning goals which as I shall argue in more detail later, has helped to confine the purposes and therefore the achievements of social planning. Finally, it tends to result in an inadequate service for clients. According to Forder:

> 'Specialists tend to diagnose a problem in relation to what they themselves can offer. If the kind of treatment they can offer seems to provide any hope of improvement they are likely to try it, if, before or after such a trial they feel they cannot help, they are likely to turn the client away. They generally know too little about the skills and assistance from other sources to be able to make effective referrals, or to compromise their own criteria for determining action in order to make a joint attack on a problem' (11).

In the face of these structural divisions, the needs of clients are rarely neatly compartmentalised. Needs such as those created by mental illness require a response for several departments and coordination is necessary to ensure the right mix of services. Unfortunately it is often the client that is left to do the co-ordinating. Voluntary services have often mirrored the fragmentation of statutory services and often create the same problems of coordination for clients. Some of these adverse implications of the organisation and structure of British social services for the definition of and response to need can be illustrated with reference to individual social services.

Social services and mental illness

There has been a long series of developments in social services over the course of this century which have directly or indirectly affected people with mental illnesses.

In health care the medical profession has successfully annexed mental health and because of the predominance of hospital based medicine, treatment has been based primarily in hospitals. The Ministry of Health was established in 1919 and the Local Government Board abolished (the Board was the successor to the Poor Law Board). Within one year the Ministry of Health took over powers in the control of lunacy and mental deficiency given to the Home Office under the Mental Deficiency Act 1913. (12) According to Jones "The way was now open for the ultimate assimilation of the treatment of mental illness with that of physical illness" (13).

Eventually, through a series of Acts culminating in 1959, enormous power was vested in the hands of a willing medical profession. This partly reflects the belief that doctors acting according to a code of ethics would not abuse the delegated powers given to them by Parliament (14). Regardless of whether or not this is the case, approaches to mental illness in the health services have been dominated by medical conceptions of need and treatment. The centralised, institutional character of medical treatment has proved a considerable barrier to alternative, community-based care. When the problems of resource constraints are added, developments in community care have been painfully slow. This means that many people have been confined unnecessarily in large isolated institutions, in some cases for the whole of their lives. Moreover, because of resource constraints and the dominance of certain specialisms within medicine, the standards of care and quality of life of those in psychiatric hospitals have often been very low, and is likely to decline further.

The medicalisation of mental illness has not been of universal benefit to people with mental illnesses. Medical bureaucracies are rigid, hierarchical, conservative, and have been dominated by hospital based provision. The mentally ill have been segregated in overcrowded, and often degrading hospitals. Institutionalism has lead to a gradual deterioration in functioning and has reinforced dependence. Nurses can move successfully into the community as community psychiatric nurses illustrate, but it is questionable whether the same flexibility could be demonstrated by the medical profession.

In view of the powerful position occupied by doctors in British society the result of this medicalisation is that medical need has tended to over-ride other aspects of need in the care of the mentally ill. Other needs related to mental illness such as poverty and deprivation have been subordinated to medical factors and the problems are never considered together.

As early as 1908 the Royal Commission on the Care of the Feeble-Minded noted that "The mental condition of these persons, and neither their poverty nor their crime, is the real ground of their claim for help from the State" (15). Clearly a Commission which follows this general principle would not be expected to make detailed recommendations in respect of the income, employment and other community needs of the mentally ill.

From a peak in the early 1950s there has been a steady decline over the last 25 years in the number of beds occupied by in-patients within hospitals, due largely to the changed pattern of care of schizophrenics (over half of mental hospital patients who have been in hospital continuously for more than 2 years). There has at the same time, been an increase in the total numbers using the specialist psychiatric services, due partly to the discharge of patients and partly to the increase in the population seeking psychiatric help. The spread of community services for the mentally ill has however, been slow. Moreover the 'therapeutic teams' of psychiatrists, social workers, community nurses, psychologists and occupational therapists have not succeeded in unifying services for those with mental illness.

Whilst there are variations in provision between different health authorities, local authority personal social services are even more segmented, with wide variations in the provision of home helps, aids and adaptations and telephones. Again institutional care dominates provision. In 1979/80 expenditure on the residential care of the mentally ill (£9.3 million) was nearly double expenditure on day care. While the interests of many of those working in the social services are in defining need in institutional terms, the vast majority of people suffering from mental illnesses need care in the community and especially in the family. Other interests, such as architects, caterers, builders, local politicians, administrators and planners may also tend to favour institutional forms of care. Achievements can be registered permanently in the form of bricks and mortar.

Over the post-war period the state has required the personal social services to meet certain basic needs. There is some consensus amongst political parties on the role of the state to intervene when an individual can no longer meet his own basic needs or is considered a danger to himself or society. But intervention is usually only carried out after the need has been demonstrated. Intervention is crisis or casualty based and not preventative. Furthermore, as Moroney points out, although the state substitutes for certain functions, it is partial substitution not complete substitution (16). So, the state's role is marginal, being concerned with a relatively small proportion of the population in need. The vast majority of elderly people and those with mental illness or handicap live with their families. Again the organisation of the personal social services reflects particular conception of need and how it should be met.

Underlying the pattern of social service provision are assumptions concerning the responsibility of the family and the division of labour between the family and the state and between family members. Family relationships are privatised and therefore family need and the division of labour between family members is also privatised. Where no family exists the situation is relatively clear cut for the personal social services. It is assumed that where an individual lives with a family, the family itself should cope and can cope. The intentions of the Mental Health Act's emphasis on community care were more clearly spelt out a year later by the Ingleby Report on Children and Youth:

> 'The State's principle duty is to assist the family in carrying out its proper functions. This should be done in the first instance by the provision of facilities such as housing, health services and education. Some families will need greater and more specialised help through the welfare services, but such help should always be directed towards building up the responsibility of parents whenever this is possible' (17).

In other words the meaning and development of community care for the mentally ill and other groups have been severely circumscribed by assumptions about the role of the family and in practice the state's intervention is concerned primarily with substitution rather than support or assistance. In addition to some extent the policy of 'community care' has become one of humanising institutions as well as enabling some groups to continue to live in the community. The National Assistance Act, 1947, replaced the workshouses with powers for local authorities to establish special homes. Facilities to enable the elderly, mentally handicapped and mentally ill to live independently in their own homes have developed slowly and falteringly. Moreover those who live alone are more likely than those living with others to receive domiciliary support from the social services. There is an important problem here, if the function of the personal social services is narrowly conceived as providing only family substitution, the overwhelming majority of those in need of support will not be helped and the importance of those providing care will not be officially recognised.

The implications of the organisation and structure of the personal social services for the recognition of social need was demonstrated by the Seebohm Committee:

> 'The present structure of the personal social services ignores the nature of much social distress. Since social need is complex it can rarely be divided so that each part is satisfactorily dealt with by a separate service. An integrated social service department will impose fewer boundaries and require less arbitrary classification of problems (18).

Following the Seebohm Report, the Local Authority Social Services Act 1970 amalgamated the children's welfare and mental health services into social services departments aimed at a more flexible and holistic approach to social need. The reorganisation of the NHS and local government in the early 1970s resulted in closer cooperation between the social services and the NHS (which joint funding

has further encouraged). But there are still different perceptions of need in the 'social' and medical spheres and their amalgamation in one department, the DHSS, has not resulted in a less rigid division of human need.

The objective of DHSS policy on mental health ".....is to develop in collaboration with the professional groups concerned, a high-quality locally based, comprehensive psychiatric service" (19). This assumes that there is a clear division between the need for treatment and care and leaves unanswered questions concerning the precise relationship between hospitals and personal social services? What is the division between medical and nursing treatment and social care and support? It is assumed, moreover, that different professional and other groups are willing to collaborate.

The implications for people with mental illness of the compartmentalisation of need by the social services may also be illustrated by reference to housing. Housing provision has been concerned almost wholly with families and the lack of council housing for single people is of particular significance for people with mental illness. There have been a number of experiments by local and health authorities and independent organisations such as MIND into hostels and group houses. The housing needs of the mentally ill are now better recognised and the 1975 white paper recognised it as an important government and local authority obligation. But provision is still grossly inadequate.

Again the definition of housing need is severely limited, with the state being concerned primarily with the ownership and management of a residual stock of council housing while concentrating on the support of owner-occupation. This effectively excludes some of the poorest groups in society, many of whom are mentally ill. A large number of the mentally ill are homeless and an even larger number of places which should be made available in the community, to replace the number of beds lost in hospitals, overlooks the fact that a person becomes homeless as a result of a social process which may have many different aspects beyond the availability of accommodation.

While there may be a move towards cooperation in health and personal social services, there appears to be little coordination with housing policy. Recent government policies have simply worsened the lack of recognition of the housing needs of people with mental illnesses. For example cash limits imposed on housing associaitions have severely curtailed provision for this group. In each of the three years before 1980 the Housing Corporation had approved building and rehabilitation work to provide over 33,000 homes through housing associations. In 1980-81 there were less than 12,000 approvals.

If the needs of the mentally ill have not been clearly recognised in coordinated policies in health, personal social services and housing, one of the most significant aspects of rehabilitation, income, has been almost wholly ignored by other social services. Social security is rarely considered as an integral part of the social services for people with mental illnesses, yet there is a close relationship between rehabilitation and financial support since one of the objects of rehabilitation is to ensure financial self-sufficiency and inadequate finance can result in the failure of this.

Restricted definitions of need in social security have created a hierarchy of claimants, based primarily on contributions paid in the labour market, and generally low levels of income for those depending on the safety net. The mentally ill have not been distinguished as a special group under the social security system, like the blind, but more importantly, the physical bias in definitions of disability in recently introduced benefits, including the attendance allowance, mobility allowance and housewives non-contributory invalidity pension has tended to exclude the mentally ill. Those suffering from mental illness do not qualify for free prescriptions (mental illness is not included in the list of chronic illness) but many rely on medication for a stable existence and for some they are essential for them to remain in the community.

The absence of coordination between different social services is particularly true for the relationship between social security, health and personal social services. The effect of a stay in hospital is financially as well as socially depriving. Sickness, invalidity and retirement benefits are reduced after eight weeks and further after one year, and supplementary benefit is reduced on entry to hospital. Since many people with mental illness are dependent on social security benefits prior to hospital admission financial difficulties are a familiar aspect of the lives of people with mental illnesses. The majority depend in whole or in part on supplementary benefit. The take up of SB is notoriously poor and people with mental illnesses are amongst those groups least likely to claim or to fit the definition of need applied by the DHSS. For example, Creer and Wing note:

> 'One problem is that the scheme of sickness and unemployment benefit is designed to cater for people who live at a permanent address and are temporarily out of work or sick. Patients suffering from schizophrenia often move about a great deal, take jobs they are too ill to manage, and then give them up after a few days or weeks. The patient is not then eligible for unemployment pay because he has left the job of his own accord. He could claim Supplementary Benefit, but arranging this quickly is notoriously difficult. If he has no permanent address it is even harder. Patients often took one look at all the questioning and form-filling which was required and gave up' (20).

Unfortunately in the face of this uncertainty those working in the health and personal social services have not consistently provided the advice and support on social security needed in these circumstances.

Even this brief review of social services is sufficient to illustrate the limitations of the response to the problems created by mental illness. I have not had time to discuss the most fundamental aspect of social need in industrial societies, employment. For people with mental illnesses employment is crucial for finance, self-respect, confidence, providing new contacts and friendships and to ease friction within families.

But unemployment is high amongst people with disabilities and the lack of coordination between different social services, particularly social security and employment often creates a disincentive to work. The rehabilitation services is dominated by a rigid bureaucratic structure and administration. Rarely do the mentally ill have influence over the allocation of tasks, systems of payment and so on. Again need is conceived in narrow terms which centre chiefly on the number of places available. Unless at the same time there is adequate staff training, evaluation of services and experiments with new methods of work and organisation the service is likely to remain inadequate.

Social needs and social planning

What are the common features in the development of social services which have acted to the detriment of people with mental illnesses and other disabilities? First, there is the social definition of need and the role of social services in British society which, at best, is concerned with the establishment of minimum rights and more generally with the selective provision of welfare. In this situation those with the least power and subject to the most social stigma are likely to be the worst served. Secondly, because welfare services are viewed socially as residual and not an intergrated part of the development of British society and as a corollary, family and industrial relationships are privatised, the social services have acted in the limited role of a casualty response to need rather than a preventative or developmental one. Since the earliest organised social service provision (seventeenth century poor law) the assumption has been made that the family is responsible for the needs of its members. The state intervenes only if the family fails, as a last resort. There have been a large number of specific policy changes over the last 300 years, but the underlying assumptions of policy have remained the same. The obverse of this assumption is the allocation of stigma for family breakdown. The victims of social organisation including many people with mental illnesses, are blamed as part of the social control mechanisms which are exerted to prevent reliance on the state. The rise of institutions and corrective and custodial care are also part of this control mechanism and reflect a particular conception of need.

Thirdly, because need is socially defined and to some extent socially created (21), it is socially divided, as is the response to need. Therefore some poor groups, such as people with mental illnesses, receive a poor level of service. The development of community care services has been severely constricted by restrictive definitions of the role of the state providing help and support.

Fourthly there are important divisions in the organisation of social services, particularly that between central government and local authorities. Social services have developed along similar but separate paths and have become independent bureaucracies with their own organisation, management and most importantly, assumptions of need. This social division of labour has been reinforced by professionalisation and unionisation; which tend to stress and independence of their discreet spheres of work. Yet the person with a mental illness is more likely to need a unified and coordinated approach. In some services, such as medicine,

the exercise of professional self-interest has acted directly against with interests of people with mental illness, theirs is a Cinderella service. The social division of labour and power has also created a division of resources and a hierarchy of expenditure. Thus there are often wide variations between health and local authorities in the quality and quantity of services.

Fifthly, given this hierarchical division between services, public expenditure cuts have fallen heavily on already hard pressed services, which has not only reduced the level of service given to clients, but also the morale of staff. In fact the unfair burden of being borne by people suffering from mental illness during the current economic crisis, directly parallels the experience of the second world war when mentally handicapped and ill were discharged from hospitals and many more were not admitted, to make way for those with a higher priority. (22). It seems that in times of national crisis the largest social costs are borne by the least able members of society.

Finally, and most importantly for the construction and analysis of social policies, this review of the social service response to mental illness shows that there has been a failure to coordinate the apporach of separate services to meet different needs. This segmentation and lack of coordination has prevented, and in turn reinforced, the absence of planning in the social services. This absence of planning was demonstrated by the House of Commons Social Services Committee:

> 'On the basis of the evidence we have heard, we are struck by the apparent lack of strategic policy-making at the DHSS: the failure to examine the overall impact of changes in expenditure levels and changes in the social environment accross the various services and programmes for which the Department is responsible' (23).

Where attempts have been made to plan services for people with mental illnesses, the plans have been dominated by restricted definitions of need. For example in the white paper, Better Services for the Mentally Ill, emphasis was placed on treatment and supervision rather than active rehabilitation. Too little attention has been paid to the majority of the psychiatrically disabled. The assumption that people who live in their own homes have been successfully integrated into society is at the very least, questionable.

What can be done to improve the responsiveness of social services to the needs of people with mental illnesses? In the first place a planning framework is required to coordinate and develop services. A social planning of social development agency could be created to construct plans in relationship to the needs expressed by and on behalf of people with mental illnesses. Secondly, different conceptions of need are required which reflect the range and depth of needs of people with mental illnesses - most importantly the need for integration and community support and not simply discharge from hospital. This would entail a fresh approach to

public expenditure, giving it a role in economic and social development rather than, negatively, in economic decline. (The current economic crisis has created needs, for example mental illness, and therefore increases demand for expenditure). Thirdly, the rights of people suffering with psychiatric and other disabilities to financial, social and legal independence must be pursued remorselessly.

The absence of a planned approach to services for people with mental illness is a reflection of the overall poverty of social planning in Britain. Wide variations in service provision have survived a long series of consultative documents because, clear specific priorities have not been spelt out and applied. Secondly clients have been characterised as passive recipients rather than positive resources. Thirdly, planning has been narrowly conceived in terms of systems management rather than being based on an analysis of needs. The construction of corporate managements in local social services, following the Mand, Mallaby and Bains report, has tended to take for granted the objectives of the services and the mechanisms for meeting need. This management structure has, of course, perculated through to those working in the social services and has limited their perceptions and established their freedom to innovate. Thus social workers have become bureau-professionals. The Seebohm reorganisation was based primarily on tidy administration rather than a response to social need. The needs of the mentally ill, for example, were not discussed at length.

Contrary to the restricted conception of social planning operated so far in British society, planning must involve a search for the objectives inherent in current provision and a rational discussion of what the objectives should be in relation to need. The needs of people with mental illnesses are primarily social - educational, financial, occupational and emotional and only medical for very limited periods. Moreover these needs imply integration in local communities, to exclude or banish them to the fringes of society in large or small institutions reinforces many of the problems confronting people suffering from mental illnesses. Thus a fresh approach to community care is called for, with the central purpose of integrating individuals in the community and not segregating them. This would entail re-examination of the aims of social services departments. This re-examination would include the dominant treatment models in social work which contrast with the need of many clients for practical help and advice, the training of social service workers which is inadequate in relation to people with disabilities, and the nature of planning in the social services.

Conclusion

This review of the social need and social planning suggests that both have had very limited applications in the development of British society.

Meeting the needs of people with mental illnesses as much as any other minority group rests on the development of the concept of social welfare beyond the casualty approach which has dominated thinking and practice for many years, towards one based on distributional justice. This would consist of the redistribution of social

resources to groups such as the mentally ill through policies such as a comprehensive disability income, a progressive employment service and community support. Need would therefore not be conceived as narrowly departmental, but planned and coordinated across a number of departments and voluntary groups. Thus an open door policy could not proceed without coordination between health, personal social services, housing, social security and employment services. This approach would stress the inter-relationship between needs rather than the segregation of social service organisation. In the medicalisation of mental illness and the fragmentation of the social service response, for example, the link between mental illness and social class tends to be forgotton. In other words, people with psychiatric disabilities are often some of the poorest and most dependent groups in the population before the onset of mental illness.

The basis for this planned approach to mental illness has been spelt out by DHSS officials at the seminar in 1977 on Social Care Research. They recognised the importance of defining "the scope for developing preventative strategies". One example was "the development both centrally and locally between and within government departments of strategies designed to prevent the development of social ills. The coordination of policies to prevent socially damaging effects which might have been foreseen had they developed in isolation (for example, social services input into housing policy, JASP and CPRA studies)" (24). The independent future of people with all forms of disability depends on the recognition of a wide range of social needs and the construction of such a coordinated approach. Without it social service provision will continue to be incomplete and segregating.

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The Rehabilitation Career of the Ex-psychiatric Patient

Paper presented by Stuart Etherington, Research Officer, Mental Health Project, Circle 33 Housing Trust Limited, London.

The purpose of this paper is to outline three major areas which impinge on the rehabilitation process of the ex-psychiatric patient. These involve the differing basis of conceptualising mental illness, the varying basis of some organisational definitions of need and the differential access to types of resources at different times by people who have been hospitalised for mental ill health.

I will suggest that the variations in definitions of mental illness and the corresponding different basis for assessing need have been a major reason for the deprivation in which the mentally ill find themselves and that this is more important than the lack of resources devoted to the community care of the mentally ill provided by Government over the last 25 years.

I shall begin with looking at different perceptions of mental ill-health and continue my second line of argument by illustrating some of the problems posed by a departmentalised and 'pigeon-holed' definition of social need. The context in which these two factors interact has been described by Alan Walker, and one can only imagine that set against smaller amounts of resources, the deprivation attributable to alternative concepts of illness, and thus needs, is of even greater significance.

Conceptual differences in models of mental health constitute a fundamental problem for mental health workers. This is true of those concerned with control as well as those concerned with therapy. It is easy to find research which supports or refutes the perception of mental health that you share, but we must ask the extent to which shared perceptions are reflected in different departments be they health, social services or housing. Perhaps the nearest housing comes is to refer to either health or social services according to the type of problem being presented. To assess the importance of models of ill health against a rigid departmentalism we need firstly to develop our ideas about their models, no easy task as definitions of mental dysfunction overlap and some may be influenced by others. To what extent can we designate paradigms in this area? Certainly we can distinguish between organic theories and psycho-social ones, but beyond this difficulties arise.

Turning now to examining the problem in more detail, I wish to identify six major paradigms which have helped to define different conceptions of mental ill health.

I wish to look firstly at two areas which have contributed to questioning accepted definitions of mental disorder, namely those ideas developed by Szasz (1) and those loosely termed labelling theorists have consistently turned the focus of their research on the definers of mental illness rather than those so defined. Although these two contructs have not directly impinged on policy making they do constitute a valuable criteria of our existing services. Ideas about need would require more stringent evaluation than at present if we were to consider the possibility of the definers of illness and therefore of need as primary agents in an examination of services for the mentally ill.

Although the ideas of Szasz and lately of labelling theories throw up interesting dimensions to the problem the impact of policy has been of necessity less demonstrable. The conclusions of such an appraisal as these may well be to lessen services in an attempt to de-label large tracts of the present 'sick' population. Few would advocate this reduction now, in the face of cuts in expenditure they would find themselves with rather dubious allies.

If we are thus to lessen the policy value of labelling theory then we must turn to examine other more prevailing paradigms of mental ill-health. We would dismiss at our peril physiological aetiologies, for this historically dominant position in psychiatry still influences the work of mainstream mental health work in both the treatment of neurotic and psychotic conditions. If need is characteristically 'pigeon-holed' by professionals, then the categorisation system attributable to genetic and physiological theories has given psychiatry this dimension. One of the difficulties with this approach has however been the lack of sympathy given to social indications of mental ill-health. Chemo-theraphy is a feature of physiological treatments, and need is firmly defined within the parameters of 'sickness'. Anything falling outside this description means services are no longer provided. It is difficult to estimate the extent to which psychological theory still dominates in the treatment of mental illness, certainly more in the psychotic than the neurotic conditions. Because of the tendency to blend this approach with psycho-social theories the distinction has been lost and evaluation has therefore become more difficult. This brings us to a position where we can consider psycho-social theories of mental ill health, which I shall suggest constitute two models rather than one. The first can be termed developmental theory and in itself covers many perspectives. Essentially like physiological theories it is highly positivist in its suggestion that early childhood experiences tend to dominate current abilities to cope with varying levels of stress. Second, but related to this view, the social environment (bad housing, poverty, inadequare schooling etc) can directly impinge on people and cause breakdown. The two are not in opposition as one could argue that bad environmental provision affects the character of family life and hence its developmental potential.

In recent years community psychiatric studies have looked towards stress theory to solve some methodological dilemmas. Here the emphasis is on change in circumstances. The twin attributes of breaking point and coping capacity are seen to be linked to life change events of varying importance. We must be careful here however as this perspective contains previous theory rather than providing new theory. For example, we could say that physiological dysfunction led to high stress and lack of coping capacity, or alternatively that bad housing was the culprit. What I hope to have illustrated here is that stress theory can only help in providing a framework, and decisions regarding causation still need to be made.

Where is this discussion of causal theories leading us? we really need to establish whether these interpretations of mental ill health, and their relationship to definitions of need predominate within particular departments, that is, to what extent to distinct organisations represent different interest in defining mental illness in particular ways.

Psychiatry has been largely influenced by physiological aetiologies, and this is still prevalent in many hospitals. Many would argue that the move to psychiatric units in general hospitals has endorsed this view. Against this some consultants have begun to see some meeting ground with psycho-social theories, but their professional training and collegiate relationships militate against. Similarly other groups within the institutional setting may have an interest in arguing the case for physiological definitions and consequent treatment methods.

Central to social work training are psycho-social skills, the model of mental ill health tends towards a developmental psychology although few would claim that one model within this prevailed. Many social workers and doctors see a direct relationship between environmental stress and neurosis particularly in the sense that it provides a direct, measurable account of a persons difficulties.

I would not wish to deny the enormous importance of developmental and physiological theories of mental ill health, but I do want to focus on environmental stress as a concomitant factor.

I want to do this for two reasons, firstly it provides a good framework in which to examine the relationship of housing workers to other professionals, notably social workers. Secondly it allows the possibility of developing some ideas about different spheres of influence on people under stress at different times. This latter reason will be of importance in suggesting that at different stages in the rehabilitation career of the ex-psychiatric patient different needs are defined by different people, which may cause gaps in provision.

Given that environmental stress is seen as an important factor, and that housing conditions are an important component of this I wish now to examine the relationships

between social workers and housing officers. My intention is to attempt to document the differences between these two functions in terms of different perceptions of human need which may lead to short term conflict.

Historically housing management traces a number of strands of development which lie along a continuum from concern with the property to concern with the tenant. That end of the spectrum concerned with property management is a legacy of landlord representation, later moves to tenant advocacy lie furthest from those historical roles. Whilst housing managers have consistantly retained the financial aspects of rent collection as central to their job they have often been ambivalent about their role with regard to tenant advocacy and property management.

To an extent the growth in aid, advice and more radical alternatives to management represent moves towards tenant advocacy and feature prominently in the expansion of rights work. However because of the structure in housing management involving the splitting of various functions within departments, large numbers of housing staff were separated out from more radical alternatives and now lead an uneasy life balancing their traditional roles with those of tenant advocacy. This balance is struck within the practical operation of the work of housing workers in most spheres, ranging from the implementation of allocation and transfer policies to the collection of rent arrears.

In contrast the social workers role represents a much more camouflaged attempt to balance control and advocacy, and the diffuse nature of practice allows them to relate to the advocacy aspects of their work with less concern for control. This is not to say that the extent to which social work is concerned with modifying the behaviour of individuals either by the use of statutory intervention or other methods is underestimated by workers or commentators but it does suggest that the social work task, particularly in patch organisations and in operating the unitary model is allowed to play out this conflict in a way which is not possible for housing workers.

The idealogical difficulties faced by both sets of workers play a distinctive part in forming the conflicts between them, and is mirrored by different organisational structures and training opportunities. Take for example the size of relative case-loads, social workers deal with maybe 40-50 cases, housing officers over 500, the difference is striking and not solely dismissed by the arguments of different function. The scope for housing advocacy is limited by the workloads, the workloads are related to a philosophy of management which advocated traditional methods. The resulting differences in social and housing worker perceptions of the problem are not difficult to see.

Similarly in training, housing officers are given no help in resolving these conflicts. Their training is undervalued and a smaller proportion of workers are trained than those in social work.

The practical significance of the differences in philosophy as reflected in different training and organisation is enormous and explains to a large extent the conflicts that emerge between the two groups of workers. The client/tenant suffers ultimately as a result of this conflict, but in what way does this play itself out. To look at one example the provision of social information to make decisions regarding housing allocations. In some authorities this is now largely abandoned in general waiting lists, but has assumed an increased significance with some priority groupings, notably but not exclusively mentally ill people, elderly people and people with mental handicap. Several systems now exist which allow some groups to be rehoused at the cost of others. Many workers in both housing and social services departments realise that the purpose of this process is to ration to certain people an increasingly scarce resource. a system which given increased scarcity will demand more and more social and medical prioritisation. Managing and allocating to housing stock is becoming more and more of a problem and often social work agencies are becoming involved in aiding this rationing process.

Social workers are right to stand up against this process, often under criticism from colleagues whose support for individual clients hamper their ability to appreciate wider community needs.

This example of allocation illustrates not only the difference in approach of housing staff and social workers but also leads us to see the lack of consistency in the advocacy appraoch. Far too many social workers, when adopting advocacy based stances for clients, do so only for the clients as individuals and I would not claim that housing workers could benefit in abandoning their traditional positions solely to become individual tenant advocators. Social work and housing management could, however, move in similar directions were they to adopt a collective advocacy approach to tenant and client problems (in many cases the same people).

Concentrating on the needs of groups either on a client or geographical basis may help to establish new, more rational priorities. In many cases regarding mentally ill people social work involvement is confined to assessing and aiding the client through an allocation system; after this, involvement often stops. Housing managers concerned with rent collection, protecting other tenants and looking after the fabric of the property may not be sympathetic to the needs of the client and may lack the relevant skills to aid the persons re-adjustment to community life, yet the housing officer may be the only 'official' link with a rehabilitation system.

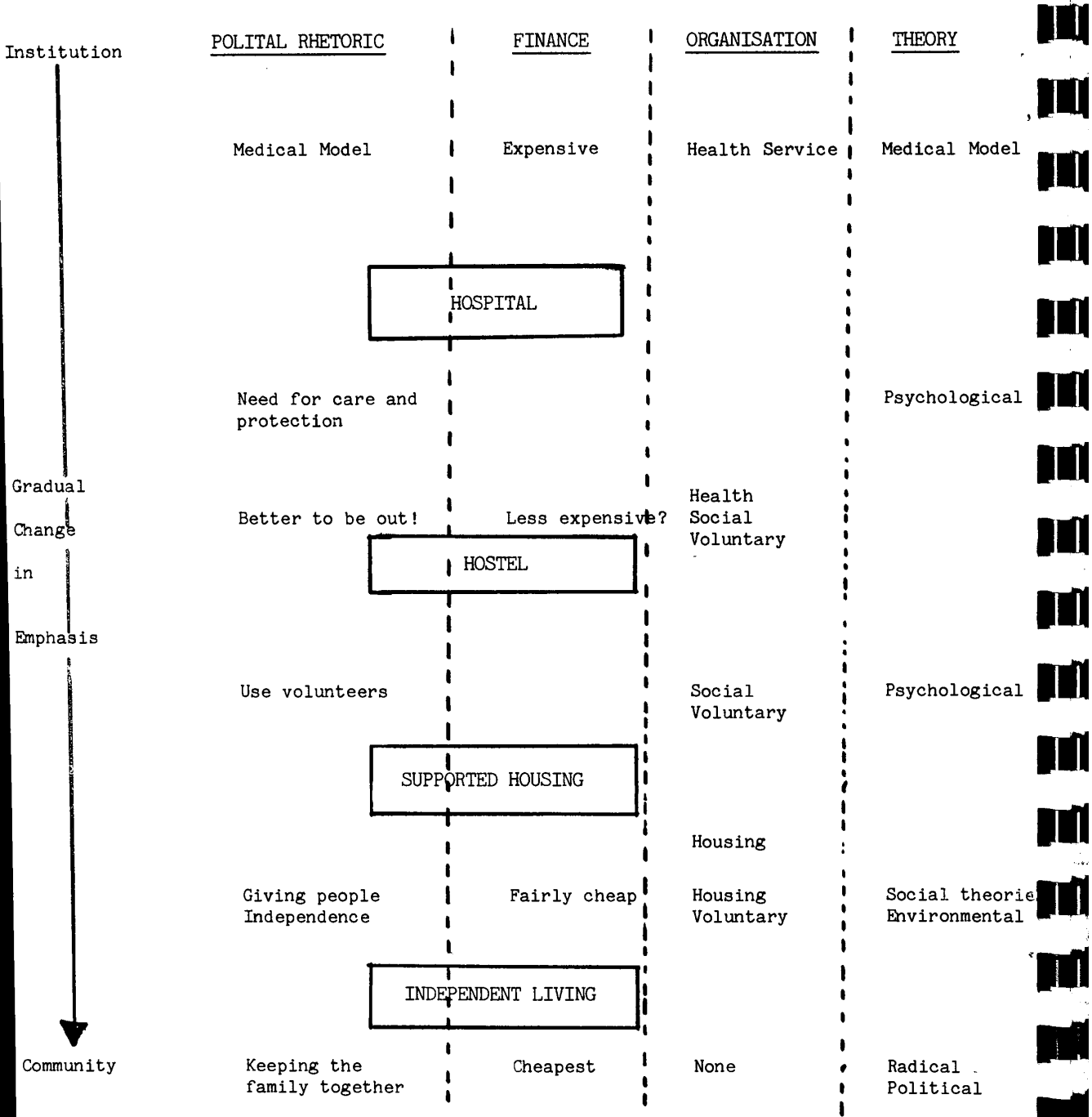
The solution to the dilemma seems to have both training implications and organisational ones; the relevantly trained housing worker alongside social work and medical personnel may aid the clients resettlement and provide a link with the community which fails to care.

This type of approach is appropriate to many client groups, particularly those for whom community care may be at present no more than a pipe dream. If we are to take seriously the desire to care for people outside institutions then we must begin to examine the interdependence of different departments and services. Surely, now, few would look in isolation at the various aspects of income maintenance system and yet we consistently fail to examine the way in which different services, often provided by the same local authority, interact in the community. This is not just a problem of re-organisation, but rather is a problem which relates to changing attitudes. In my short time observing the workings of a housing organisation it is certainly possible to see how change could be achieved, but frustrations between social workers and housing officers will continue to mount unless their mutual problems are faced together.

In conclusion then, what I have been suggesting is that at different stages in their rehabilitation career, ex-psychiatric patients experience primary contact from different departments, be they hospital, social work, or housing department, at each stage their needs are being interpreted by different groups of people using different criteria. I have focussed my discussion on one part of this process, the relationship between housing and social services, but an extension of this to other areas is not difficult to see. For the future we need to better promote some more general appreciation of peoples needs in order to judge the services they are offered as I have suggested. This may have organisational and training implications but we must begin dialogues which look for consistent interior departmental boundaries rather than retreating into narrow pigeon holed definitions which mediate against peoples mental health.

FIGURE 1

RESEARCH MODEL



Mental Health, Housing and Social Services

A Discussion by Christopher Heginbotham

Introduction

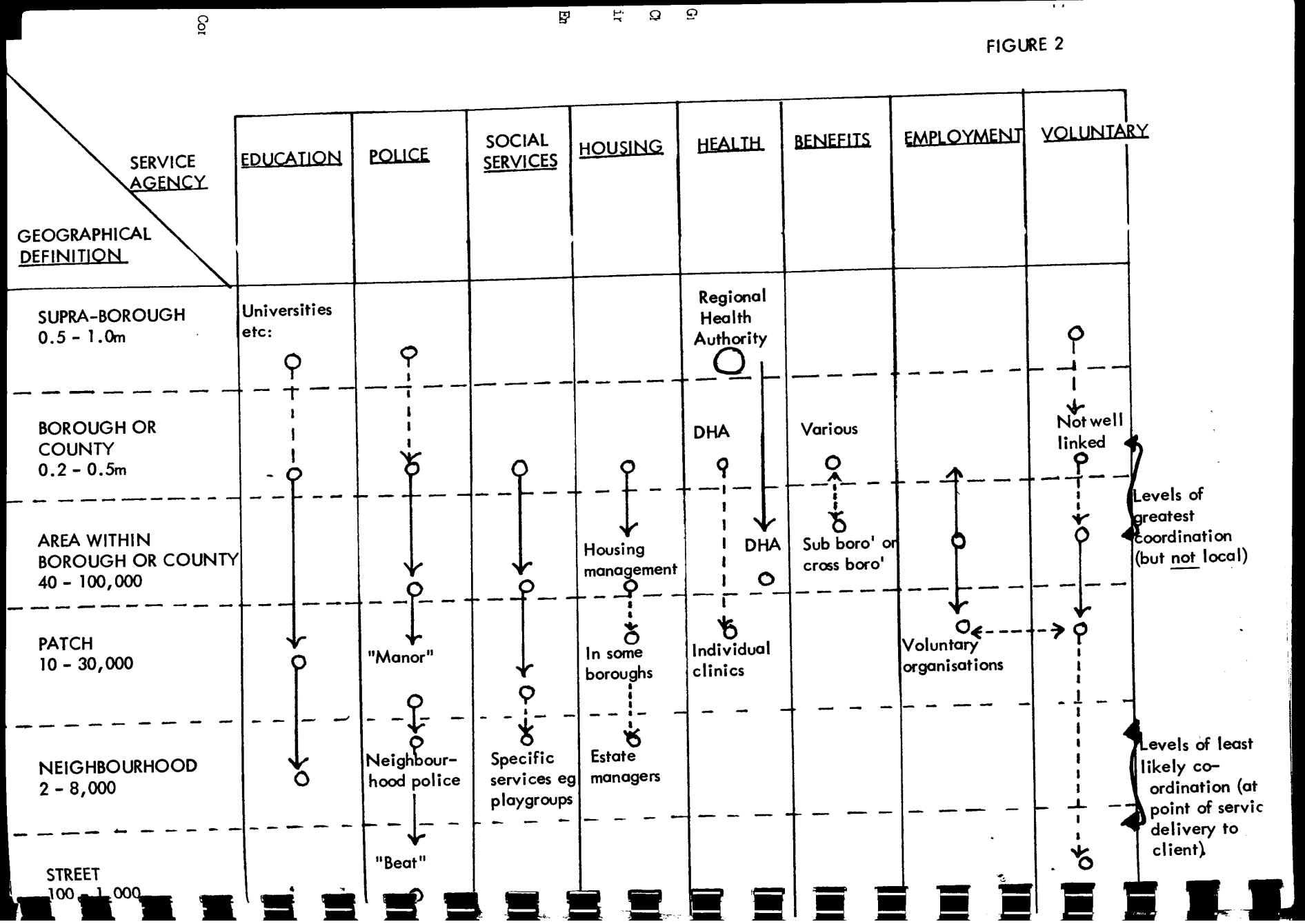
David Townsend and Alan Walker have stated arguments quite clearly against a unitary definition of need. Alan Walker's paper argues strongly for a coordinated and integrated approach to social needs including income maintenance, employment and leisure as well as traditional social work aspects of mental health care. Such an approach is obviously desirable, but how can it be obtained out of the current multi-functional split services and with such widely varying models of care? There is no one answer, though certain suggestions are made here to round off the record of the conference and to provoke new thoughts for future services.

Models of Mental Illness

Before proceeding further we need to consider briefly the functional splits based on different perceptions and consequent approaches to mental illness. Fig.1 shows a rough spectrum of theory labels and associates these with the institutions or organisations providing the care; with the overall cost of care; with the type of residential style of the patient/client/resident; and with an open ended political/discursive framework or backdrop. It is over simplified in a number of ways. Different models of mental illness, and models of support interact rather than being isolated serial models; 'community care' is not always the cheaper option - it tends to be, or at least for a given degree of care or support it is cheaper; and financial measures are dangerous or misleading if unrelated to an evaluation of the 'success' in preventing or curing mental illness, or do not include wider considerations of the social cost of say, non-employment or hidden capital costs. Political rhetoric is not always consistent and may favour traditional medical models whilst at the same time requiring the 'cheapest' form of approach (the conservative line); or, favour the community care and social-environmental model, yet not be content with the use of volunteers and demand a paid workforce to provide what may be a very personal and social form of support (the moderate left of centre line). Perhaps 'community care' has gained all party support precisely because of this dichotomy and across-the-board appeal. So a degree of inconsistency exists within and between types of models of illness and support, and differing agencies pick parts of the total spectrum as suits themselves.

Space does not permit us to go further into the various theoretical models set out by Stuart Etherington. It is clear though that dysfunctions in service can come about not simply because different organisations are working on different models and theories, but because they may think they are agreed, when they are not, as

FIGURE 2


SERVICE AGENCY
GEOGRAPHICAL DEFINITION
EDUCATION
POLICE
SOCIAL SERVICES
HOUSING
HEALTH
BENEFITS
EMPLOYMENT
VOLUNTARY
SUPRA-BOROUGH 0.5 - 1.0m
BOROUGH OR COUNTY 0.2 - 0.5m
AREA WITHIN BOROUGH OR COUNTY 40 - 100,000
PATCH 10 - 30,000
NEIGHBOURHOOD 2 - 8,000
STREET 100 - 1,000
Universities etc:
Regional Health Authority
DHA
Various
Not well linked
Housing management
DHA
Sub boro' or cross boro'
"Manor"
In some boroughs
Individual clinics
Voluntary organisations
Neighbour-hood police
Specific services eg playgroups
Estate managers
"Beat"
Levels of greatest coordination (but not local)
Levels of least likely co-ordination (at point of servic delivery to client)

certain elements of their philosophy appear to be the same. Lack of communication bedevils the provision of a good supportive coordinated and integrated approach, but to obtain that communication requires all practitioners to climb down off their prejudices and openly discuss real or imaginary differences.

Community Care

With the tendency towards community care there is a noticeable shift in personal models and attitudes. Gradually these ideas filter through and changes appear in the various functional organisations. Housing, Social Services, NHS all have different models for different client groups at different levels within their hierarchy and these change at varying rates. Obtaining agreement to one aspect of service to a particular client group based on one agreed aspect of differing models is immensely difficult. A good example is the allocations process to Warden Assisted accommodation for elderly people. Social Services have certain, often vague, criteria about who should be nominated; Housing have a rigid space standard or shared amenities yardstick - and only at a personal contact between senior officers enables decisions to be made as to who should be offered the latest vacancy in such-and-such a scheme.

Such functional bureaucracies operate rather like the Earths geological plates. As agreements are forced to line up in one area, sudden slippages occur in others; internal rows break out; and Directors of Services ring each other and, at best, agree to differ. The slippages can work to the good in one area, but chances are the ripples spreading from epicentres will create further sudden slips elsewhere, in all probability just at the right moment to wreck an initiative on behalf of another client group.

Is there a way forward? Alan Walker has most clearly set out one approach - towards coordinated planning with recognition that housing, employment and particularly income maintenance are essential to any successful approach.

The Community Level

One part of the integrated approach must be to create a team approach at a highly localised level. Figure 2 illustrates how different institutions are organised on varying geographical bases (leaving aside boundary considerations and differing agencies in different parts of the country). Very few services work on a truly local level. It is possible to suggest housing and social services do so because they work with individual clients, but this is to miss the point. Real genericism in social work, housing and policing (law enforcement) can only come from a generically trained worker dealing with all cases in one small geographic location, with appropriate specialist resources. It is no good each social worker trying to be all things to all people across a wide area, without specialists to call on. Nor is this helpful in building a team approach with other agencies. Either the 'street level' social worker acts as coordinator, or a more involved change may be required coordinating the separate functions of social administration and 'social counselling' where either or both may be at the local level.

Presently too much is expected from undertrained, often inexperienced generic workers who try to do too much and are bound to fail occasionally. Social workers are expected to be administrators, counsellors, mothers, fathers, friends, cajolers; to be sympathetic but firm; friendly but pushy; helping, not smothering. An individual simply cannot offer this roundness and blend of skills, and it is impossible to mould people via training to do two essentially non-compatible tasks. Counselling work requires certain skills which are not always compatible with efficient administration. The end result is a mish-mash of neither real genericism, nor specialism.

This, of course, begs a radical and political analysis and set of solutions to disability in our society. If we accept there are mental illnesses which are not economic system specific then we need improvements in current services aimed at helping people with those illnesses. It may well be true that mental illness is exacerbated, caused, or made greatly more difficult to cure and arrest because of economic and political constraints. Bad housing lack of leisure opportunities, cultural attitudes of materialism, unemployment, or types of employment geared to certain economic goals, all contribute to mental ill health. Mentally ill people must be encouraged to voice their concerns, feelings and attitudes towards their illnesses and services they receive. The task of the radical social worker is to make those 'clients' more aware of cultural and political forces shaping their 'illness' and open up ways of changing those constraints.

The danger with this line of attack - taken to the extreme - is that we stop worrying about service delivery and concentrate instead on wider social goals. But if we accept that people are ill and do need direct services, we must look at how those provided in the best way to help the client (tenant or patient).

One approach to suggest is structural and largely stems from the crass handling of Seebohm. The consequent explosion of poorly thought out 'generic' working has led to a lack of suitably trained staff at all levels.

One answer, given below, sounds contradictory but is not. More specialism and more generalism are required hand-in-hand. If a problem is structural, it has to be tackled at that level, and perhaps requires new breeds of worker, the social administrator and the social counsellor.

In other words, the current role of most field social workers would split. Those interested and able to help clients in organisational and material ways, would develop that aspect; those interested in social counselling would train to deal with the deeper emotional and psychological needs of the client. The social administrator would specialise in welfare benefits, systems of referral, would know where individual clients might obtain help, be in contact with the various appropriate statutory and voluntary agencies and maintain links with the whole

range of specialist workers and institutions. The social administrator would have a variable workload, depending on cases requiring attention, though each person would have a set of clients. One innovation would be for the intake team and the local worker to be all social administrators. The social administrator would find an appropriate social counsellor other service and then remain in contact with that client, providing a continuing link. The social counsellor on the other hand, would take the present counselling functions of social work without the administrative overhead. Each person might train in one or two specialisations plus general counselling and psychological aspects of their specialism. Their work would be with a group of clients with broader similar problems, such as mentally ill people, or families with young children. Evidently a background of general training is needed for both streams, as it is unwise to proliferate workers with a particular client or client family.

Counsellors and administrators could work together as a team with their own main functions but sharing other arrangements. There are many advantages to this approach. Clients are offered continuity - when one person leaves there is someone with whom the client is familiar; two heads are generally better than one, and by close contact and communication, the team would benefit from sharing problems; specialism and generalism can be welded to give a cohesive strong service and there is the opportunity to work with and coordinate other services. More importantly the individual counsellor should be able to develop a greater understanding and ability to deal with the needs of a particular set of clients. In no other profession is genericism taken so far - and indeed, Social Services are splitting down into almost separate departments because it isn't working.

Obvious benefits occur in this approach in dealing with mental health problems, but even in statutory child care cases, two people working in tandem would better handle a case - one with (hopefully) deeper insights into the family problem, the other organising case conferences, visits, court appearance, etc.

Having such a 'two-pronged' approach would more easily involve other specialisms, such as community psychiatric nursing. A client would not require a social administrator and social counsellor but a SA and CPN. The CPN as a specialist becomes the client counsellor and the administrator and welfare back-up from the link back to the SA. Developing this approach further, it would be possible to start linking other agencies too, such as housing management staff, OTs etc. A client may not need a housing officer, community nurse, social worker, all with clerical and administrative back-up. A more economic process in terms of professional time, and probably client support, should be brought about by this structural change precipitating a team approach not only within social services, but with housing, hospitals, psychiatry etc.

Indeed, the social counsellor can become the 'named person' as Warnock suggested for mentally handicapped children. Given the ability of the named person to fulfill a range of criteria (which could be laid down) the social counsellor could be teacher, nursery nurse or other person in a position to offer the individual or family the best under-pinning relationship during a particular period.

One of the integrated team might be a very localised worker with the individual client. A suggestion which emerged strongly from the conference was for a peripatetic care or social skills worker providing a varying service to individuals in their own homes or local area.

Peripatetic Care Workers

Such a worker could cross departmental boundaries and fill a gap left where main stream social work, housing management and community nursing do not overlap.

At present mentally ill people and ex-patients living in ordinary flats or houses or small unsupported group homes are often left to manage for themselves without much direct care intervention. On the one hand the social worker will give welfare benefits, help and advice; on the other hand the estate officer (if in public sector housing) will deal with property repairs and chase arrears of rent; in between there may be a volunteer providing a befriending role.

Many mentally ill people in this situation live unfulfilled lives. They are often poorly clothed and fed, do not budget well, are not following hygienic ways, and get into arrears of rent and fuel payments. Clearly there is a need for an intermediate worker between the social worker and housing worker, who has a wider role than a home help and is able to take on jobs a volunteer may be barred from by not being part of the statutory services.

At meetings of housing management committees in many local authorities, numbers of cases come forward for serious arrears, of noise nuisance associated with families or individuals who are, or have been psychiatric patients. Little can be done directly by housing staff; social services have few resources; home helps have a predominatly domestic role; and community nursing are not geared to social skills support on a regular basis.

An increasing number of referrals to Housing Emergency Groups, or Home Families Units and through normal applications for housing, are of individuals who are mentally ill or suffering from alcoholism possibly as a result of, or in combination with, being homeless and rootless. Often these individuals are placed in ordinary units within the community, either because of the lack of group home or hostel places, or because there is no good reason why they should be placed in a more supportive environment. Additionally there are those already living in flats or houses who are in serious arrears or who cannot cope well with general independence in the community. This does not mean necessarily that they could not live fuller lives (or create less nuisance for others) given some form of regular support. However, our present services do not appear geared to providing the type of regular home help/befriending/rent collection/social skills work that seems to be required.

At present we have a number of individuals who are involved with cases of this sort. The housing officer or estate managers deal with the overall housing management particularly with the problem of rent and arrears. The social worker aids the individual with general financial benefits, and helps to bring other services in when required and proves a counselling role. Where home helps assist they provide a cleaning, sometimes domestic function, but cannot be expected to clean up serious mess on a regular basis (for example, fouling by dogs) nor do they have a function of helping the individual budget their money for fuel, food, clothing or leisure. The community psychiatric nurse, if one is attached to the client, will have a role in providing regular medication and referral to hospital when required.

An area exisits in between all of these workers, occasionally provided for by volunteers. There is a limit to what volunteers will do, and there is a limit to the number of volunteers available. Statutory housing services are unlikely to accept a volunteer collecting rent on behalf of the Service; even if allowed, dangers attach to regular normal rent collection which may require paid staff.

Role of Care Worker (Social Skills Worker)

There appears to be a need for a care worker providing:

i) a low key support role
ii) help with budgeting
iii) possibly the actual rent collection
iv) a training or teaching function in helping the person to cope with ordinary independent living, for example making sure that dogs do not foul the inside of flats
v) educating the individual in common cleanliness and domestic hygiene
vi) providing advice on welfare benefits to a point and then referring to the social worker.

Such a care worker might deal with 10 - 15 clients on a regular basis, although each client would receive a differing amount of attention dependent upon their needs. In doing so, pressure on other agencies would be considerably reduced. The cost in rent arrears and members and officers time attending committees would be much less, social work time giving advice time after time which is either ignored or which the individual is unable to heed without regular reinforcement would be better spent, not to mention the nuisance and unhappiness caused to other tenants in some cases living next door to flats which are filthy or noisy or whatever.

Organisational implications need to be thought out, but possibly the easiest solutions are either a centrally based team of peripatetic care workers; or one worker attached to each area team; or if a solution similar to that proposed above could be worked out the peripatetic care worker fits well into a two-person 'team'.

Team Work

The most important issue arising from both speakers and participants was the need for greater team work between services, and for better communication at all levels. Many participants felt clients should not have to 'coordinate their own service'.

Alan Walker asked for coordinated planning of 'resources to meet need' across a number of departments and services. He included not only social services and housing, but employment services and especially income maintenance. David Townsend agreed similarly. If a unitary definition of need is illusory at least services could try to come to some agreement about where they differ. Stuart Etherington took this a stage further in consideration of the reducing level of service as a patient moves on to greater independence. Sudden changes in amounts of support occur, different agencies take on the main caring mantle and have different approaches, methods and definitions of the clients' needs.

Two points emerge. There must be greater, much greater communication between all levels in services to at least come to some understanding of where differences in approach may occur or be occuring. A team approach should be set up on a local level with regular debate and involvement of staff. Such a proposal has been made for mentally handicapped people in the Court Report - a District Handicap Team - bringing together professionals from different disciplines, with various training and organisational bureaucracies. It is not suggested that these workers change their managerial responsibilities but that they work together as a team, recognising the inherent limitations of each others organisation and powers. Communication is then improved and hopefully, service.

One further issue comes out which was not adequately tackled by the conference - and is that raised by Stuart Etherington. The patient finds less help as he/she moves out into what may be a more and more 'hostile' environment. Further consideration must be given to ways of offering clients continuity and support and gearing rehabilitation to the real situation existing for the client.

Conclusion

The foregoing is a brief summary of the strands of debate catalysed by the three papers presented. Much concern was expressed about the current provision of services and the lack of communication between service agencies. Any way forward must address three linked themes - communication, local domestic support to individuals and improved team work - and one major issue - coordinated and integrated approach to social needs including income maintenance and employment in addition to the more usual social work or housing consideration. Only by tackling these matters could it be possible to build a more effective approach.

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