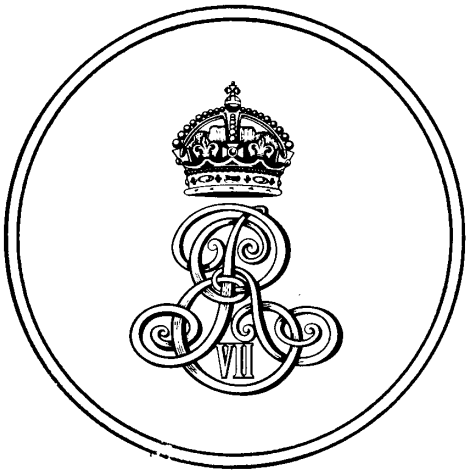
Creating local psychiatric services



Papers from the Long Term & Community Care Team King's Fund Centre

March – September 1983

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King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

CONTENTS

N.B. Yellow papers refer to information or examples mainly from London services

INTRODUCTION

In early March 1983 a one-day conference - The Development of Comprehensive District Psychiatric Services - took place at the King's Fund Centre. It formed part of a series of events addressing Issues for London District Health Authorities and was directed principally at Authority Members but 'with officers in mind'. This pack of papers has been built upon the plenary and group presentations from that event, together with some background documents prepared for the day. Over the following six months the King's Fund Centre's programme of work on Psychiatric Services has progressed and other potentially useful contributions to the discussion have emerged. One particularly rich source of ideas has been the Centre's Workshop in September 1983 'Planning Local Psychiatric Services' - led by John O'Brien and Connie Lyle of Responsive Systems Associates, Georgia. We felt that many of those concerned with the development of services in London and elsewhere would appreciate access to some of the additional papers, and the pack as it stands now includes items from the September event, together with one or two contributions collected from other meetings and training days.

The origins of the materials have influenced the production of this publication in pack rather than book form but there have been other important reasons for adopting this format. Within Psychiatric Services this is a time of action and change and a wide variety of people are looking for guidance and advice. The information available is rich but incomplete and ever-changing. We are a long way from a full consensus, and a number of distinct perspectives deserve attention. Our aim here has not been to produce a standard text or blue print but a flexible package of observations, questions, examples and suggestions which can be used by a variety of people as tools in the process of developing services.

Overview

The papers contained in the pack reflect the magnitude of the challenge which Authorities face in creating comprehensive local psychiatric services. This represents, as Donald Dick's paper[5] suggests, a 'revolution' rather than a minor adjustment. To a great extent it means exploring unfamiliar territory, where there are scattered examples of small scale good practices to guide us, and a body of research which remains to be fully exploited, but where there are major gaps in our knowledge and uncertainties about the way ahead. We are not starting with a clean slate. While looking ahead to future patterns of provision we are also attempting to respond to immediate needs and to cope with the legacy of services (and mistakes) inherited from our predecessors. Concepts and strategies are needed to deal with a complex set of problems which are tightly inter-related and which cannot be successfully tackled in isolation.

On the whole, past attempts to move towards new local services have not been notable for their success. They have often replicated previous problems in new settings and left long standing and difficult questions, such as how best to provide effective support for 'chronic' patients, unanswered. A variety of forms of local services achieve the transfer of service users to within District boundaries but a model of 'community care' which aims for fuller participation and integration will require not just new buildings and staff but new ways of planning and managing, and new forms of intervention to sustain the clients. The papers by Don Braisby[3] and John O'Brien[11,12] point towards some strategies which may be appropriate in taking the first steps in this process.

There have been major weaknesses in service planning to date which can be looked at under three separate, though inter-related headings:

a) Organisational

b) Methodological

c) Political

A. In organisational terms planning has often failed to address the total service to a particular client group. The large hospital contribution has been left out or it has been the overwhelming element of service plans. Local agencies have been fragmented and professional leadership has been diffuse and lacking wide agreement, so that the impression received at Authority level has been one of difficulty and ambiguity.

The papers in the pack do not deal with organisational structures in detail but the conclusions of the Nodder report, suitably revised to take account of NHS restructuring, still appear to offer the best available model consistent with the issues raised here. Under the auspices of the Joint Care Planning team, there is a need for a Psychiatric Services Development Group which involves Health Service, Local Authority and Voluntary representation and which ensures that relevant parts of large hospitals participate in the local planning process. Through this group, work on the detail of specific parts of the service will take place.

There may be room here for new approaches to our conception of the overall services, and alternatives to the familiar 'Acute', 'Chronic', 'Psychogeriatric' etc., as headings to sub-divide the tasks. John O'Brien (see Braisby[3]) suggests organising services under 7 headings, selected to correspond with the intended impact on the lives of the individuals they serve:

1. Identification Services - consisting of case finding and screening activities.
2. Crisis Stabilisation - which includes crisis intervention, support and care services.
3. Growth Services - made up of a range of activities aimed at increasing skills and capabilities.
4. Sustenance Services - which maintain functions and skills over time.
5. Case Management services - which link the individual client/patient to the overall system of services and co-ordinate the components. This includes activities such as assessing, monitoring and advocacy.
6. Prevention Services - to reduce the incidence of mental disabilities.
7. Ancillary Services - housekeeping, transport etc. which support the other activities.

These brief headings are in no sense a full description of the system or an argument for its adoption by others, but they illustrate that other ways of organising our thinking about services are possible and that attention to this issue may be important. However the tasks are divided, Authorities will need to ensure that high quality professional leadership is available to carry out the work effectively. In London and elsewhere local services will not be achieved unless Regions also take a very active role in the strategies and co-ordination across Districts, particularly where the relocation of resources from large institutions is at stake.

The task of co-ordinating and energising the major overhaul of Psychiatric Services which is required will not be achieved without full time commitment by skilled key people. The role of central or specialist staff is not however to take responsibility for planning services away from others (or to take the blame for inevitable mistakes), but to provide a constant reference point, and to ensure that the local and smaller scale machinery for planning and implementation is established and supported.

B. In methodological terms a large number of current problems and potential approaches to these are outlined in these papers.

1. Colonising the Future

There is a sense in which we have failed to grasp the fact that our present assumptions and the services we create will shape and limit what is possible in twenty years time. This is particularly true if we invest in expensive buildings whose scope for flexibility and change is very limited. The future is uncertain, demographic changes are uncertain, ideas are uncertain. Plans which commit Authorities to single strategy solutions and tie up large amounts of revenue for all time will be less successful than those that leave future options more open and adaptable.

2. Creating a Network

Planning is about the purposeful development of services. It is not about writing plans and it is not a job just for planners. It is important that we seek multiple perspectives, including those that are critical of what services do at present, to generate alternative visions of what the future might be. This process of building a 'domain' of individuals with different interests will involve:

- linking individuals together
- increasing their investment in the process of change
- sharpening critical abilities
- providing opportunities to discuss and clarify values
- encouraging spin-off activities which can themselves be a major positive outcome of the process.

The paper from Judy Hague on the 'Coalition for Community Care'[7] shows this process in operation in a small way in one part of London and gives one suggestion of how broadening of the planning base might take place.

3. Service Principles

The debate about choices must be in relation to some set of prinicples and criteria for success. In almost all of the papers comprising the pack this is a recurrent theme. Gill Lomas[10] gives an example from Hackney District of how a philosophy of services can be a powerful tool for setting priorities in developing services and guiding decisions about the form these services should take. Chris Heginbotham's[9] paper and the papers from Braisby[3] and O'Brien[11,12] indicate the level of discussion which will be required if the values and assumptions underlying service planning are to be made explicit.

4. Learning from the Experience of Others

O'Brien's paper - 'Designing the Balanced Service System: A Partial Review of the Literature'[12] suggests that psychiatric service planning has failed to make adequate use of available research information. He demonstrates that the process of clarifying values and assumptions is not a purely subjective matter, but is one that can be supported by closer links with research. Both

Judy Hague[8] and Deirdre Cunningham[4a] recognise the important role that the National 'Good Practices in Mental Health' project can play in enriching the service planning in individual Districts, though they also warn us of the dangers of attempting to introduce 'off the shelf' services models which have been successful elsewhere without adaptation to local conditions and needs.

5. Information - Norms, Checklists and Needs

Many different types of information are potentially useful in developing services and monitoring them over time. Deirdre Cunningham's background papers on London Services[4b,4c] raise important questions about which data will be helpful to Authorities and demonstrate some of the difficulties which will be encountered in trying to build up information while our present data collection remains in its present primitive form. The overall message is that collecting information about services will be fraught with disagreement and contradiction. The use of norms or service checklists - such as the very comprehensive list by Donald Dick included in the pack[6] - has a value only in so far as it generates a basis for investigation of options and discussion among planning networks. Used mechanically as a substitute for thought and decision making, those checklists are destructive to real service development.

The 'personalising' of the planning process comes through in Donald Dick's contribution[8] and in his suggestions on service assessment/monitoring.[5] Ultimately services will be concerned with quality of life issues and imaginative ways of seeking client and community views and experiences are essential. A simple but powerful strategy is to arrange for Members and senior officers to spend 24 hours with clients or potential clients learning about their current experience of services (or lack of them) and about what would be needed to lead life in a more effective and humane way. Personalised information is not a substitute for other statistical and clinical data but it is an essential element of the overall information required by those engaged in a process which will determine the quality of other people's lives (Braisby[3]).

6. Planning for Real

Generating ideas and issues needs to be linked to the identification of present and future probable resources, to real finance and manpower constraints and the costing of alternative models. Paper plans which do not take account of real resources, including resources released in due course from existing long stay institutions, are not going to get us very far. It is important though that planning should look at available resources in a more open minded way than has often been the case in the past. A community psychiatric service should be built to avoid duplications and to interlock successfully with the existing strengths and resources outside of the specialist psychiatric provision - including houses and housing management expertise as in Hackney.[10] Costing community care is not a simple matter; it demands imaginative investigation of state benefits systems and local housing, leisure and employment systems if it is to be well informed. As O'Brien[11] and Bennett[2] point out, skillful specialist services are required but it is important that current (and hopefully increased) budgets are spent where they are most needed and most effective.

7. Including People with Severe Mental Disabilities

The tendency for new local psychiatric services to exclude people with long term and major disabilities has been a feature of many services in this country and the U.S.A. Douglas Bennett[2] describes an attempt to change this

pattern from his experience in Camberwell, stressing the need for continuity between services inside and outside the hospital, improved information on the lives of disabled patients with continuing needs and careful goal planning for individuals and for service elements. O'Brien[11] explores the implications of the broad principles of 'normalisation' for these people and spells out some of the things we know about their needs and the difficulties of providing effective services for them. He suggests a framework for approaching the task and a list of practical principles to guide the planning and evaluation of services.

8. Linking Planning and Implementation

We often divorce these two activities and fail to use the potential of those staff who are currently most directly in contact with the users of the services. Partly in consequence we fail to gain their commitment to new developments. We need a much stronger commitment to reciprocal problem solving - senior people actively inviting those down the hierarchy to communicate their current problems and to inform the process of resource allocation, planning and management. Bennett[2] illustrates this theme with reference to the power that exists at 'street level' and the need to ensure that paper planning is acknowledged as a secondary activity to the vital process of engaging providers in innovation. There may be a a gap between planning and powers of resource allocation and it is important to clarify and acknowledge the distinction, but this should not stand in the way of more effective participation systems.

9. Conflict

Given the variety of view points that exist and the size of the changes that are involved, disagreement and conflict are natural and healthy products of the task in hand. 'Mental illness' and 'mental health' are complex concepts which stir deep emotion, and planning will never be really exempt from this influence. The changes involved are radical and resistance to them will be predictable for staff whose working and social lives may be directly affected. If any Authority or planning group believes that there is consensus on the future of the services then they have been misled. The challenge is not to avoid or suppress conflict but to ensure that planning and management systems acknowledge and work with it openly and positively.

10. Monitoring

One of the problems encountered in current plannning is the belief that once you have planned it, it is done. In practice intentions are blown off course too often in this field to make that assumption. In any case the level of unpredicability in the task would suggest that attempts to produce a perfect 10 year plan with a complete service model set out in advance are likely to be unhelpful. At the individual client level we cannot predict how people will function in new service settings from our available measures of dependency or diagnostic tools. Mechanisms for responding to problems and making appropriate service adjustments will be needed. One of the few wholly safe predictions we can make from the experiences in this country and elsewhere is that in designing such a range of new services major mistakes will be made and that some individual lives will be very seriously damaged unless we are able to monitor and respond to problems quickly.

This is not a once a year activity but a continuing process of problem solving involving anyone who interprets needs and allocates resources and requiring a variety of methods and approaches.

Yates[14] describes how routine statistical data can be used to warn of major problems in a hospital service. Dick[5] describes monitoring methods which are less formal but equally powerful. For Authorities the notion of a programme budget may also be useful. This involves a year by year account at constant prices of what is spent in total in the District and the Borough on specialist psychiatric services, including the contribution for the large hospital. This can then be broken down in various creative ways in terms of different sets of clients (chronic patients against acute) or in terms of spending on large scale segregated services against small scale local services, and patterns of spending over time can be compared to stated priorities.

Dick[5] notes that one of the qualities of a good psychiatric service is that it regards itself as continuously engaged in active experiment on service development, with machinery to ensure that it learns from its successes and responds quickly to its mistakes. Monitoring implies not just having sensitivity to events within the service but a management system and a service model capable of rapid adaptation.

C. Finally, planning in this field has also shown typical political weaknesses. There has been weak support for the shifting of resources required to achieve decent psychiatric services locally. Given the range of problems discussed above, it is clear that committed political support is required over a long period rather than spasmodic attention at two or three year intervals.

Judy Allsop[1] explains the problems of establishing a role for Health Authority Members and suggests a strategy of representing local concerns in services, keeping Mental Health high on the Authority agenda, establishing links with sub groups of officers and working constructively with conflicts.

Authority members should be concerned with each of the organisational and methodological issues outlined in the papers. Monitoring will be one major concern but there is room also to consider their place as active individual participants in the 'Network' activities described here.

This list is of course far from exhaustive and readers will find other themes and suggestions for action in the papers which make up this pack. Towell's paper[13] presents, in question form, a shortened review of many of the challenges which have to be met.

CHANGING POLICY FOR THE PSYCHIATRIC SERVICES

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A paper presented at the King's Fund Conference
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services
March 1983

CHANGING POLICY FOR THE SERVICES IN LONDON

I realised soon after agreeing to talk on the role of the member at this seminar that the topic appears to be an obligatory one at meetings of this sort. This leads me to think that perhaps the bafflement I sometimes feel about what I should be doing as a Member of a District Health Authority, may be shared by others, and may indeed be related to the structure of the Health Service and policy making within it, and not just to my 'newness' as a Member. I am going to talk therefore, about some of the difficulties and uncertainties which I see facing members of Health Authorities who must concern themselves with developing policies for those who are mentally ill. I shall go on to say something about ambiguities arising from the structure of the NHS which affect the role of members of Health Authorities. Finally, I will make what I hope are some more positive points, about the part which members can play in changing policy over the next decade.

In beginning with tensions and uncertainties I do not wish to appear gloomy or pessimistic. I think there is some virtue in facing up to conflicts and contradictions. They are part of the landscape for those who are involved in planning for, and providing, district psychiatric services and as such they need to be accepted as obstacles to be negotiated and understood. Conflicts and contradictions are of course perceived differently by different people. I am simply sharing with you my observations as a non-expert lay member of a DHA, based on my own very limited experience.

In many respects I have the impression that the Health Service is still in the eye of the storm following reorganisation. Few Districts can have made much progress as yet, towards tackling the thorny issues of finding extra resources for what used to be called the Cinderella services; services for elderly, mentally ill and handicapped people, though a framework for change may well have been set. In my own Authority new units of management have been established. We have, in fact, a separate unit for the Mental Health Services. Only time will tell whether or not this will help to attract relatively more resources. The Unit administrators are now in post although a few nurse managers remain to be appointed. The financial situation appears not to be too dreadful. We have a set of general objectives for the Authority which include a commitment to develop community services. We have a draft plan for 1983/4 and Joint Care Planning Teams have been established for Mental Illness and Mental Handicap. These include members from the Local Authority Social Services Department and particular voluntary organisations. So for us, the initial turbulances of reorganisation have been navigated. There are new and enthusiastic people in post. Yet we have still to face the major problems. In the case of the mental illness services there are dual tasks of developing a more locally-based psychiatric service while at the same time dealing with the consequences of the planned closure of a large mental illness hospital, Banstead, in 1986.

Both these objectives are in line with what has been the central government policy for developing better services for the mentally ill people for many years. Since the end of the 1950s, the aim has been to 'integrate' those who suffer from mental illness through care and treatment in the community, so that they are not treated as a category of patient, separate and different from the rest of us, isolated from the mainstream of ordinary life, isolated and perhaps forgotten.

Progress towards meeting these objectives, however, has been slow and patchy. It has been much easier to outline policies as statements of intent than to ensure they are actually implemented.

First there is the question of resources. As RGS Brown has pointed out, the culture of the NHS is in the general to do little in response to government cirlcars urging particular courses of action, unless these are accompanied by special allocations to pay for them. Ninety nine per cent of the NHS budget goes towards running existing services. The one per cent of the budget that is left for development has tended to go towards introducing new technologies in the acute sector and towards meeting the revenue costs of capital commitments. For example, a new wing of a hospital planned in the more affluent sixties needs to be opened or a body-scanner purchased from a public donation must be staffed and maintained. In recent years, the London Districts have also had to absorb the consequences of the RAWP allocations to the less-well off Regions as well as their share of efficiency savings. It has been difficult in these circumstances to shift resources from one sector of the Health Services to another; to give priority to the development of services for the mentally ill.

Second, the question of resources and their scarcity raises a series of related dilemmas. How is it possible to move towards closing a large mental hospital, which in our own area would mean taking responsibility of 250 to 300 extra patients without extra resources? It is argued that when a hospital closes, resources will be released. But ways must be found to bridge the gap between having to accommodate patients while waiting to realise the assets. How can we talk about improving the quality of psychiatric services when we must be aware that to close a Banstead or a Horton, Claybury or a Friern means disrupting the lives of thousands of patients, many of whom are frail and confused? Staff too, working in these institutions, will suffer a disruption of their lives. There are families whose members have cared for patients in these communities for over three generations. On the other hand, to maintain these large institutions means, inevitably, a pattern of services for the mentally ill which are determined by the values and methods of treatment of the last century. At the end of the day, long-stay institutions make it formidibly difficult to maintain the quality of care. They tend to reduce the capacity of people to function independently and perhaps to over-protect them from the risks and choices of everyday living. And, of course, they are expensive to maintain and improve. Like other aspects of the Victorian infrastructure inherited from the last century, their fabric is beginning to decay.

I do not have <u>many</u> doubts about aiming to close the large mental hospital although I do not think the task is an easy one. It is one which demands skill and courage particularly if it is not to result in a diminution of care. It seems to me any member of a London Health District in the 1980s must face these difficulties and be prepared to make some fundamental judgements about appropriate patterns of care for their Districts. My own preference would be for a locally-based service with a variety of small scale provision, offering different lengths of stay, which could be used flexibly. In fact a pattern of services which is capable of incorporating a number of approaches to diagnosing and treating mental illness.

A third area of confusion for DHA members is the bewildering variety of approaches toward understanding mental illness. Among health professionals and social workers there are apparently irreconcilable differences. The best way forward is perhaps to accept our own ignorance about the subject. Mental illness as a category covers a range of phenomena. Some aspects are more clearly understood than others. The way of coping with both diversity and lack of knowledge would seem to be to develop flexible forms of therapy, treatment and service, not tied irrevocably to one particular model or large-scale institutional setting.

Having looked at the problems of developing services for the mentally ill, I now want to say something about the limitations on the role of the member. These relate to the ambiguities surrounding their Authority and power which are bound up with the structure of the NHS itself. Looking first at Authority, that is, the right to command or make ultimate decisions which will be obeyed. Members of Health Authorities, and indeed Health Authorities as collectivities, do not make authoritative decisions in the same way as these are made in local government. As everyone here knows, members of Health Authorities are appointed not elected. This weakens their legitimacy. Herbert Morrison argued in the discussions leading up the the 1946 Act that this would make the Health Authorities 'mere creatures of the Minister'. He thought that the Health Services should be part of the local government with democratically elected members. Bevan, on the other hand believed that appointed members could still be said to represent their local communities. It was a matter of finding the 'right men and women' to serve the Authorities. However, the question of the degree of autonomy of the local Health Authorities remains ambiguous and a different emphasis has been struck with each reorganisation. In 1974 there was a shift towards central control, while 'Patients First' in 1979 laid stress on the responsibility of DHAs to make decisions on the basis of their interpretation of local needs, in other words, to use their Authority. This, of course, must be seen in the context of an even tighter grip on the purse strings than ever before by the central government.

The Authority of the Districts has been restated and reaffirmed in the reorganisation of 1982. The legitimacy of that Authority may differ from other major institutions in this country but I do not think that members can escape from the responsibility of attempting to make authoritative decisions, even though these are limited by central government's control over finance on the one hand, and lack of real power to enforce decisions on the other.

It is fairly clear from studies carried out on decision-making in the Health Service during the 1970s, that power lies at the grass roots of the NHS, with the clinicians and other service providers. It is they who determine the use of resources and the quality and quantity of care provided. Both the central government and Health Authorities have lacked the power to influence the development of health policy because the NHS is a 'bottom up' organisation. I do not think the 1982 reorganisation has changed this situation significantly although the attempts to increase accountability through stricter financial control and annual reviews may provide the tools to achieve greater control in the way resources are used.

These developments could enhance the authority of the DHA member to influence the pace of change in services for the mentally ill. I suspect that this will depend upon the extent to which members individually and collectively are prepared to aquire knowledge of the crucial issues. Knowledge has always been one of the vital factors affecting the capacity to exercise power and influence. Also important will be the ability of members to put the issue of the planning and provision of the psychiatric services on the agenda and keep it there.

In conclusion, I should like to argue that members of Health Authorities have an important role to play in the development of services for the mentally ill in the next decade. The task of moving towards less rigid and more flexible patterns of service is a difficult and complicated one. It will not always be possible to predict the outcome of particular initiatives so these will need to be monitored and evaluated. Risks may have to be taken but these may be mitigated by being on a small scale. In the past, the vital change agents in

the psychiatric services have tended to be what Donald Dick calls the 'hero innovators', psychiatrists or other professionals who by the strength of their own conviction and ideas have brought about new patterns of care. I think the change agents of the next decade are much more likely to be groups of people; health and local authority members, service providers and administrators, who will work together to produce changes at the margins through winning resources from other areas of care or who use innovative ways of providing community psychiatry. These groups will need to be ready with schemes to make applications for joint financing or special development funds for mental illness for these may be the only sources of growth money. Much as I deplore this way of funding public services it would be foolish to ignore the possibilities which exist.

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THE PRACTICAL PROBLEMS OF ESTABLISHING A DISTRICT SERVICE

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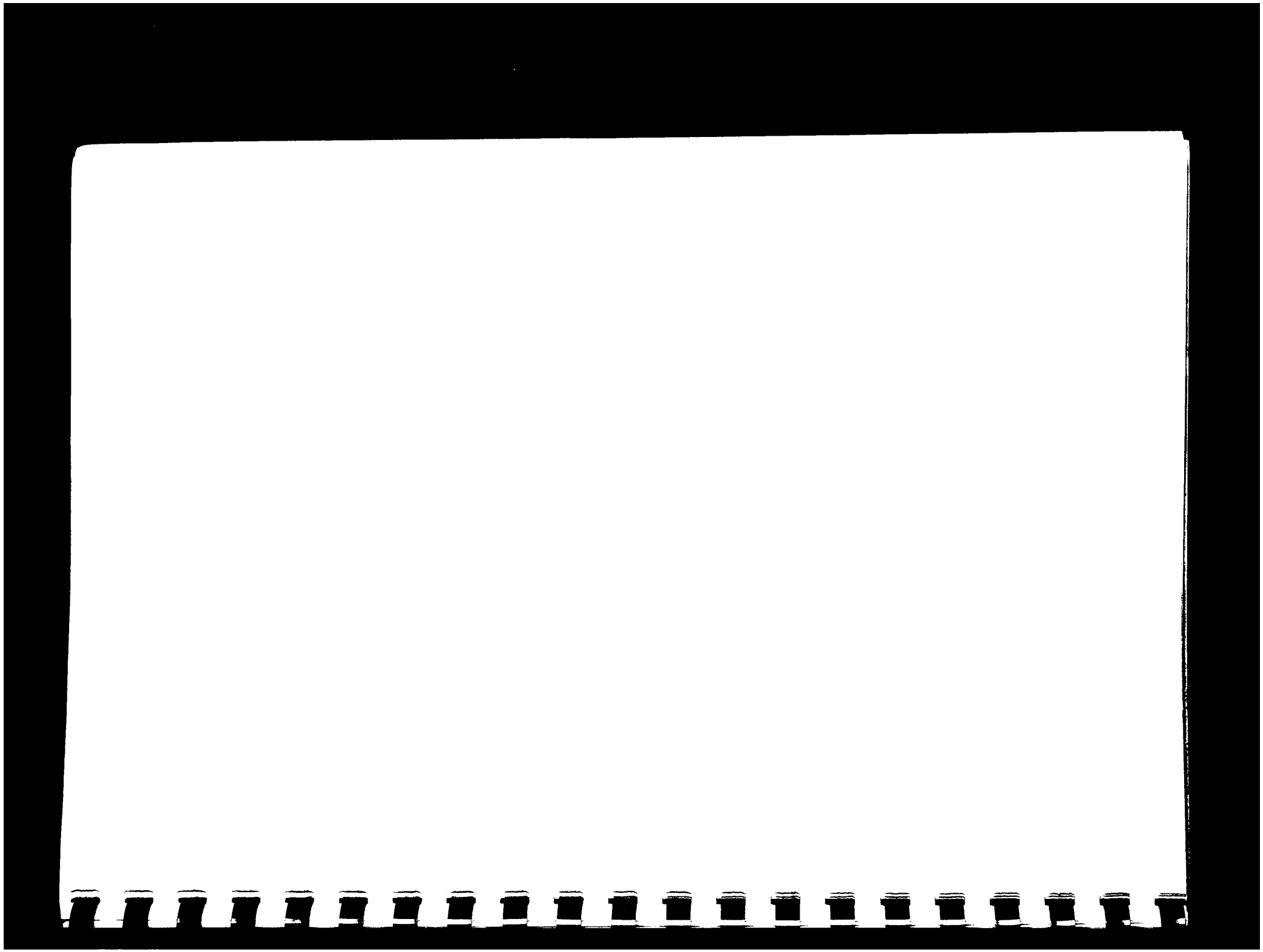
A paper presented at the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983



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THE PRACTICAL PROBLEMS OF ESTABLISHING A DISTRICT SERVICE

While I speak from practical clinical experience, I would emphasise that that experience is limited to a small area of South East London which has some unusual features. When I began to take an interest in the development of community orientated psychiatric service, people told me that it would not be possible to develop a district service around the Maudsley Hospital. Now people are inclined to say that it is the only place with the necessary resources. Of course the Maudsley Hospital and south Southwark have special advantages and special limitations. But so have most areas and most hospitals. So there are no easy answers and there is little place for slavish mimicry. One has to start from first principles. That means that one has to define clearly the aims of a district service.

These aims are frequently misunderstood and are often distorted by pressure for the imminent closure of a mental hospital. The basic aim is not, or should not be, to get people out of the mental hospital or to keep people out of hoispital or to get rid of the mental hospital. The aim is to provide a service which will reduce and minimise psychiatric morbidity, distress and disability not only for the individual patient, but for those with whom he lives and works, and for the wider society.

To achieve this aim will require continuing change in psychiatric services in line with developing knowledge and will never be complete. Of course, one must aim for completion and for comprehensiveness but I suspect that it is an unachievable aim. The service will always be at some stage of incompleteness.

There is, of course, a general strategy within which one has to work. But it is also necessary to set very definite and very limited goals. Grand goals, like comprehensiveness, are what Albert Kushlik always referred to as 'fuzzies'. Words like 'rehabilitation', 'prevention' or even 'least restrictive environments' are 'fuzzies'. Such aims have to be broken down into smaller more definite goals related to individuals or small groups. The achievement of these goals depends very much on people working close to the individual's needs rather than shuffling papers at some distance.

I know that all this is obvious, but it is not always understood. It is often assumed too that when care has been moved from the mental hospital to the wider society, all will be well. At best such a movement is only a precondition for the beginning of more sensible care. At worst it could be a retrograde step, or even a defeat in the long campaign which I visualise.

The analogy of a military campaign, it not entirely appropriate, is useful in that it suggests the mobile use of resources, advances and retreats, victories and defeats. The analogy is not appropriate in the sense that there is not an enemy, unless it be human frailty, prejudice and vested interest. One has to take account of pockets of resistance and one has to penetrate areas of sloth and reaction, establish bridgeheads and secure key objectives. There is also the great need for improvisation and a skilled deployment of resources as well as for combined operations. Structural planning with its tidy blueprints assumes the construction of a whole and complete 'building'. In practice the resources for the second floor are often available before the ground floor is built. Then people will try to arrest further advance before the ground floor is finished. By the time those resources are there the ground floor plan has changed shape or shrunk. Planners who consider the structure, its spaces and especially its beds, may not consider the manpower at hand, the difficulties of shifting the people, and whether there will be battle-seasoned veterans or new recruits to do the job. The trouble is that battle-seasoned veteran staff have

usually been trained for static rather than mobile warfare. Re-training is possible for some and some will courageously face up to the challenge and strengthen the morale of the new recruits. Some however fall by the wayside. But even so it is they and not the planners or the general staff who determine what can and cannot be achieved in action.

So while there is need for an overall plan there is also a need to take account of tactical contingencies. By this I mean that in the provision of a district psychiatric service there are large areas of ignorance and even larger areas of uncertainty. There are unforeseen delays, budgetary difficulties and a failure to coordinate the plans of different organisations. There are other changes which are as unpredictable as they are inevitable. In my own experience there have been reorganisations of the National Health Service and other reorganisations in Local Government and social work. Psychiatric social workers have disappeared, hospital social workers have disappeared; Camberwell which was a London Borough when we started out has now re-emerged as a new Health District comprising the old borough and the east half of Lambeth. These changes affect the work of the practitioners for they have to make new personal contacts if they are to effect or to sustain the necessary collaboration. Through all these changes of plan those involved must have some idea of what their patients need, so that they can persuade other organisations to change their plans. Alternatively they have to change their own plans if they are to provide combined or integrated services. This approach to change has been dsescribed by Lipsky as 'street level bureaucracy'. The street level workers are not the passive agents of top-down management.

Let me illustrate some of the problems I have been discussing as well as some other problems by describing one aspect of change in our district service. One of the problems which will affect all services and one of the most difficult is that of the severely psychiatrically disabled; the often difficult and seemingly unrewarding chronic patients.

To its credit the mental hospital always dealt with these patients whom society and the other services tended to reject. But in future we cannot improve services for the vast majority of our patients by making those services accessible and acceptable and yet still preserve the distant mental hospital for the decreasing numbers of chronic patients. If we are going to replace the mental hospital we have to provide local services for the chronic patients. For descriptive purposes there are five main groups of chronic and difficult patients.

1 The 'old' long-stay - those who have spent long years in mental hospitals and are still there.

2 The 'new' long-stay - those 'new' patients who in spite of therapeutic advances and changes in care cannot live in the community. Their behaviour is too difficult and embarrassing or they are too incompetent; or there is no available supportive situation which can or will accept them. Although they have a long stay, that stay is rarely permanent. Many of these patients improve slowly over the years.

3 The 'new' long-term - these are patients with mild behaviour problems, and difficulties in coping. They are very vulnerable to social stresses. They usually have limited support because they have been unable to construct their own families or negotiate for their own social needs. The members of the family of origin are either old or retired or dead.

4 The mentally disordered offenders - those who show or have shown aggressive or criminal behaviour in association with their mental illness and need secure provision and special nursing.

5 Overlapping with the first three groups are the elderly mentally infirm who are mostly demented patients over the age of 65 years. There are some aged patients too with other diagnoses.

Now provision has to be made for all these groups at the same time as new services are provided for alcoholics and drug addicts and adolescents. At the same time people want to provide more sex clinics and all the useful help for the large numbers of the 'worried well'.

Let me tell you briefly what we have tried to do. First of all from the Maudsley base we have provided services in the last 16-20 years so that people living in the old Borough of Camberwell (South Southwark) do not have to go into the mental hospital. Most new district services try to get people out of hospital. That is the main difference between our service and other services. At first 'new' long-stay patients built up in the wards of St Francis Hospital (the old observation ward) and Cane Hill Hospital (the mental hospital). Then five years ago we moved half of the 'new' long stay under the age of 65 to the Maudsley Hospital. Now we have closed the wards at St Francis as well as our wards for those under 65 at Cane Hill. We are looking after one half of these 'new' long-stay patients in a house in the hospital grounds. I want to emphasise that it is not only the house that matters. It is the programmes worked out for every individual patient and the ways in which the staff work. What matters is this new way of working and a reasonably generous number of nursing staff. You need staff if you are going to do away with the mental hospital back ward. We have a part-time psychologist working with the nursing staff daily, devising and revising these individual programmes. There is also a group psychotherapist who comes for a staff group once a week and we also have an ethical committee.

While some of these patients may improve one has to accept that they may not and that not all psychiatric patients are curable. It does not seem easy for people to grasp and accept this in an age of space travel or in a time when people still have high hopes of community care. Secondly, you have to accept that most chronic patients in future will be the elderly, severely mentally infirm. We have accumulated 96 'new' long stay patients for a population of 130,000 since 1970. Thirty are under the age of 65 and 66 are over the age of 65 of which number 33 are over the age of 80. So you can see that two thirds of our long stay patients are psychogeriatric and that most of them are demented. Thirdly, you have to accept that personal social services and general practitioners provide a very different type of care from the specialist psychiatric services based in the hospital. Ninety five per cent of people with psychiatric symptomatology are treated in the community by general practitioners, social workers, clergymen and voluntary helpers and so on. Those 5 per cent who have always been treated in hospital have quite different needs and they will continue to have quite different needs when they move to the community. They are more seriously ill, more seriously disabled and more difficult to help or even control. If we take a physical illness analogy, the difference is between someone who has a bad headache and someone who has had a cerebral catastrophe, perhaps a stroke. Therefore there is a difference between the appropriateness of a visiting advice and emotional support service on the one hand and structured care and support services on the other. Structured services have a very different time scale of care in terms of the duration of their help and support. To paraphrase Dr Kushlik, people can need direct care for the whole 24 hours, for a few hours a day, as in day care, for a few minutes a day, or only for a quarter of an hour a month.

I emphasise this distinction only because well-intentioned people seem to believe that they are going to be able to deal with severely psychotic or massively disabled patients with a counselling, advice or crisis intervention service, where much more structured services are essential. To return to the military analogy, it is like Dad's Army facing up to tanks. Dad's Army has its place but it cannot stand up to the immovable or irresistible forces of psychosis. You not only need a large range of services, but services which are geared to the special needs of these patients. It is equally important therefore by analogy that you do not provide a steam hammer to crack a nut. This principle has been formulated by Dr Birley as that of the 'minimum therapeutic dose'. You only expect to do those things for the patient he cannot do for himself. To make sure that this happens it is wise in the first instance to provide services for minimal support. Then as a last resort, more supportive services can be provided for those individuals who really cannot manage without them. If provision is not ordered in this way, there is a risk of offering too much support to those who do not need it; and that was what the mental hospital did.

I come therefore to the provision that we at the Maudsley, have made for the long term district patients in South Southwark or, as they are called by the M.R.C. Social Psychiatry Unit, the 'high contact' patients. These patients since they are chronic have a continuing high rate of contact with the services. In this district they make up many hundreds of psychiatrically disabled people. They do not need 24 hour support or help except for short periods of time. What they do need is some support and some shelter. For them we have built a District Services Centre which is a large day hospital with beds organised around three teams. There are 80 day places and 34 beds but no wards. In this way we have demonstrated our view of the primacy of day treatment. This is the medical part of the support services. It is the medical hub of a large social wheel of families, day centres, lodgings, bedsitting rooms, council flats, a sheltered workshop, a walk-in clinic, domiciliary service, joint appointment social workers, medical consultation to social services and many other services. The patient needs help to integrate these services and support in his negotiations with them. Whether patients are dealing with general practitioners, the social services department, housing, employment or social security they will find that their needs are given less priority than those of children, the elderly and so on. Neither is there much evidence to support the view of government that much of the work of psychiatric services will be taken over either by the social services department or by the general practitioner and his primary care team.

The District Services Centre as I have said, has three clinical teams. These teams, as well as being multi-disciplinary, could be called 'unified clinical teams'. They are unified teams because they continue to take responsibility for a set of patients whether they move from inpatient to outpatient to day patient or other transitional forms of care. This service is for hospital and community, not hospital or community patients. Wherever these patients are living or whatever service they are attending they receive continuity of care from the same social and medical team.

I must not forget to mention briefly that at Bethlem Hospital there is a medium secure unit which not only cares for mentally disordered offenders in the South Southwark service but also for similar offenders in other services within the South East Metropolitan Hospital Region. There are doubtless services for other patient categories which will have to serve regions rather than districts.

I want to re-emphasise the need to plan for continual change. Our Maudsley plans in 1968 took little or no account of the impending 'geriatric crisis' although warnings had been sounded. As I said earlier and repeat, of the 96

new long stay hospital patients accumulated since 1964, 66 are over the age of 65 and 33 of those are over the age of 80. They are the problems of the future. I have not been much involved with these services since they are the responsibility of colleagues. But I am aware that in providing these services there is again no place for mimicry, for there is nothing to mimic. There is however plenty of room for imaginative experiment.

To know about all these needs, to know how many people have different types of needs you require an intelligence service. I am not sure what to advise. I have been particularly fortunate to have been able to draw on the findings of the Camberwell Register which notes the contacts of all Camberwell patients with a wide range of psychiatric services. Thus I have always had the advantage of an up-to-date view of the disposition of patients whether in the mental hospital or district general hospital unit, the day hospital, outpatients and so on. The Register also provides a perspective of change in the use of services, whether expressed in the run-down of the long stay populations, or the accumulation of long term patients in the community. The Register, like any other statistical device, says something about the numerical needs and will indicate too the effect of service changes on those needs. But it will not tell one what to do. No research will do that. One has to look at research results, interpret them intuitively and undertake some limited experiments. Success or failure leads to further adjustments in pursuit of new hunches. Trial and error is the only way forward when one is confronted with those large areas of ignorance, to which I have referred. Common sense is not enough. Nor, in my view, are simple popular but vague ideas of normalisation or anti-institutionalism or stopping the cycle of re-admission. We need reliable observations.

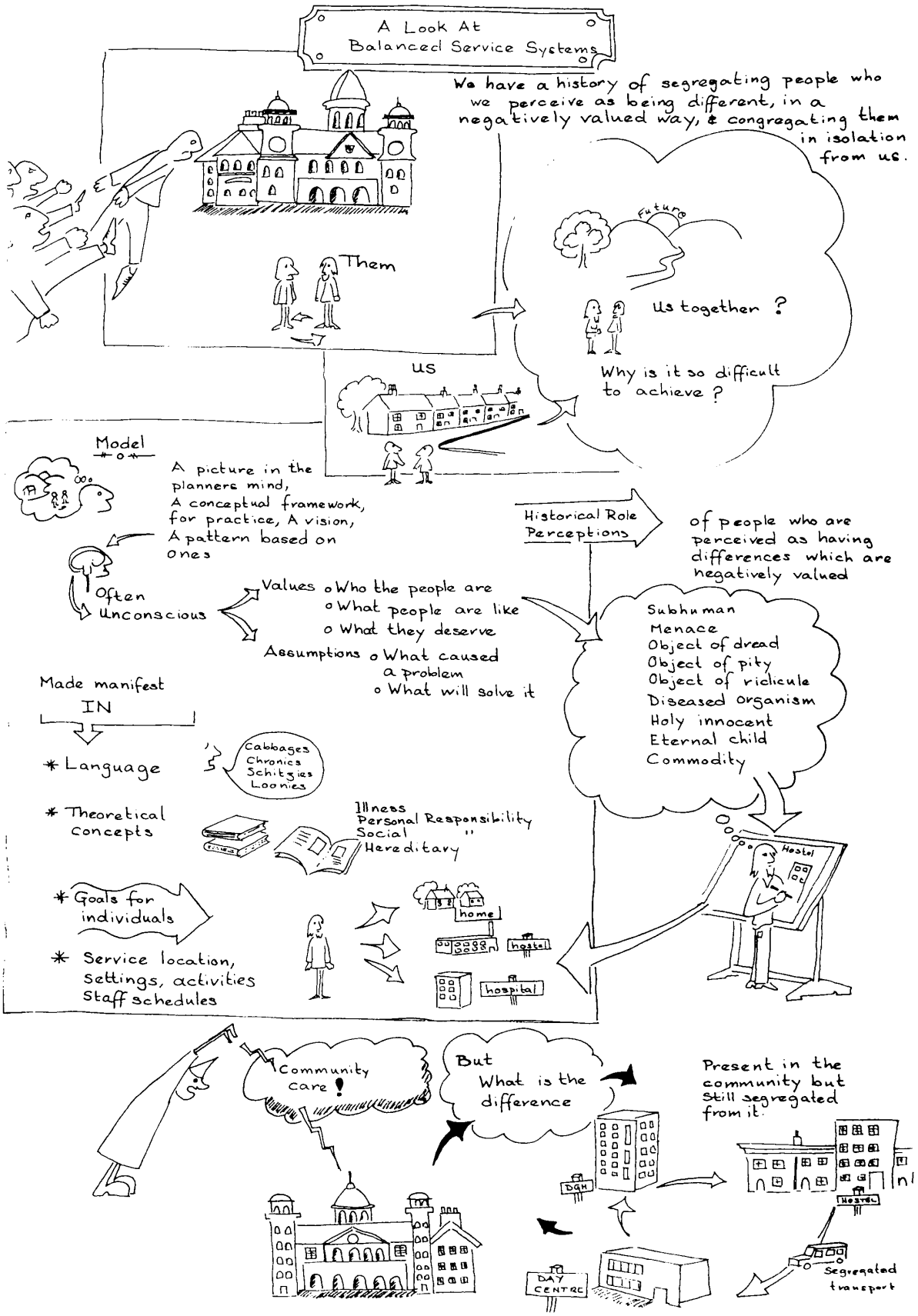
In many London Boroughs the immediate aim will be to establish services which will replace those provided at present in the mental hospital. In making this replacement it is easier to provide alternatives than substitutes or functional equivalents. It is possible to discharge very disabled and new long stay patients - for example those who have been in our new long stay hospital unit - to a house outside the hospital. This house is a kind of group home but for patients who are much more disabled than traditional group home residents from the mental hospital. The house is provided by a Housing Association. It is run by a small charity which has been set up by hospital staff members. The patients are visited daily by ward nurses from the Maudsley. Those patients who need day centre attendance go either to Local Authority Day Centres or to the Maudsley day hospital provision. Here you see two charities, the Local Authority and two parts of the hospital combining in a number of ways to serve the severely disabled patients and in doing so, offering them something that neither Cane Hill Mental Hospital nor the Maudsley or a day centre or community nursing services could ever offer.

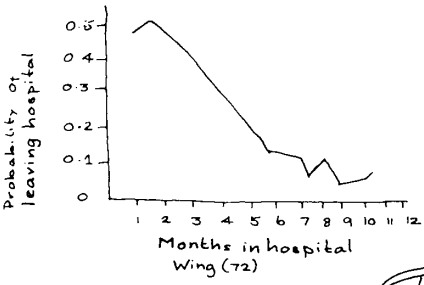
In the developing services replacement of the mental hospital is only a small first step. But it is a step whose practical and theoretical consequences are essential for the development of the psychiatric service which is not only available and accessible but acceptable to the public.

A LOOK AT BALANCED SERVICE SYSTEMS

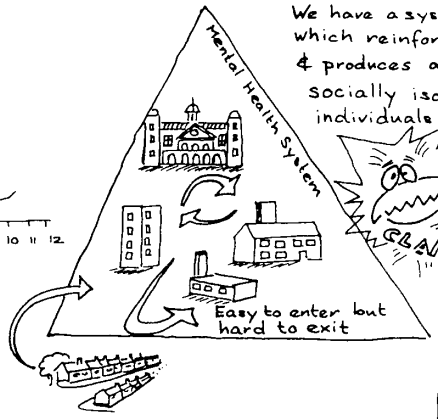
Don Braisby
Development Officer
Camden Social Services

A presentation at the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983


A Look At
Balanced Service Systems
We have a history of segregating people who we perceive as being different, in a negatively valued way, & congregating them in isolation from us.
Them
us
Future
Us together ?
Why is it so difficult to achieve ?
Model
A picture in the planners mind, A conceptual framework, for practice, A vision, A pattern based on ones
Often Unconscious
Values
o Who the people are
o What people are like
o What they deserve
Assumptions
o What caused a problem
o What will solve it
Historical Role Perceptions
of people who are perceived as having differences which are negatively valued
Subhuman
Menace
Object of dread
Object of pity
Object of ridicule
Diseased organism
Holy innocent
Eternal child
Commodity
Made manifest IN
* Language
Cabbages
Chronics
Schitzies
Loonies
* Theoretical concepts
Illness
Personal Responsibility
Social "
Hereditary
* Goals for individuals
* Service location, settings, activities Staff schedules
home
hostel
hospital
Hostel
Community care !
But What is the difference
Present in the community but Still segregated from it.
DGH
Hostel
DAY CENTRE
Segregated transport



* Discharge or death



We have a system which reinforces dysfunctioning & produces a population of socially isolated totally dependent individuals

Commonly Stated Service Goals

PLANS

- To increase the capacity of people with mental disorders to function as independently as possible.
- To improve the quality of life for people with a mental disorder

WHAT

Statements about peoples needs

Can get mixed up with

HOW Statements about ways to respond to peoples needs:

- Assessment
- Group home
- Hostel
- Day care

Services are seen as a professional enterprise without a place for a real partnership that includes people identified as patients/clients & their families

- Support defined by professionals in packages
- Tensions between bureaucratic response to peoples needs & ordinary community response
- A variety of responses to peoples needs are broadly & inventively practised through out communities
- It defines the problem in terms of quantity of resources

Critique of Shopping list approach

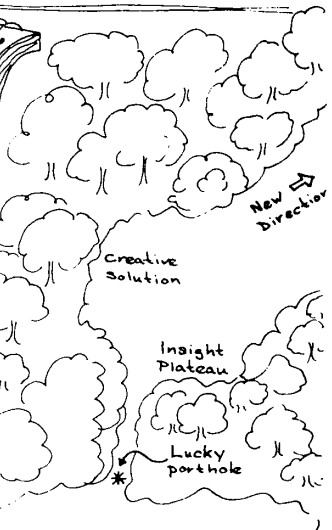
no one organisation is responsible for responding to all the needs

↓

it isolates service elements as parts of organisations

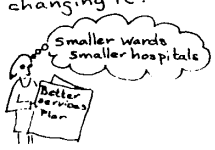
Leads to Shopping List Approach to Planning

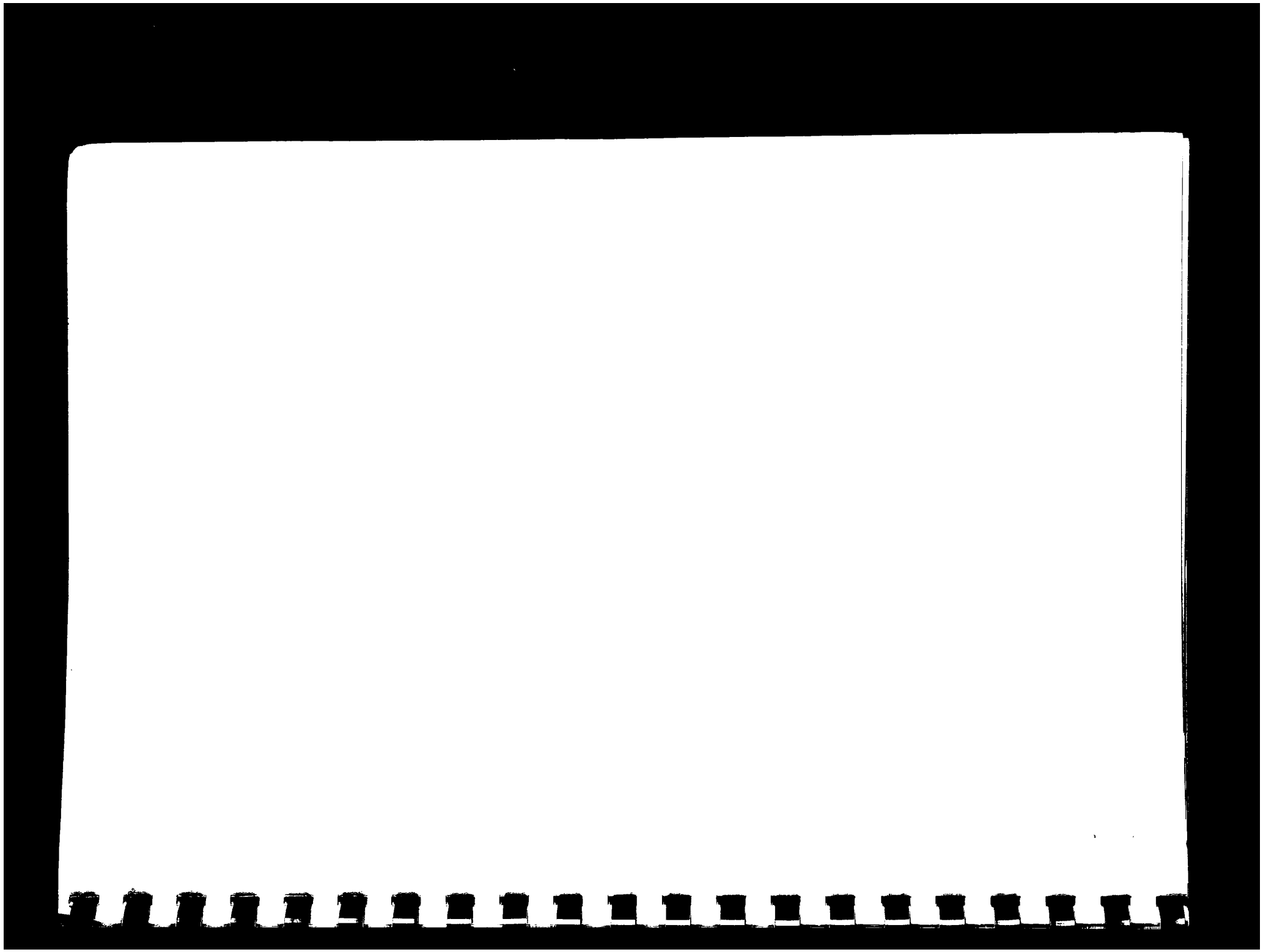
- List services
- Survey access of population to current services
- Identify the gaps
- Recommend ways to close gaps
- Develop new services



Most of our efforts at improvement have been aimed at cleaning up our act not changing it.

Where to now?



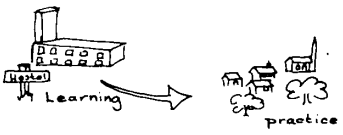


* A service which concentrates solely on such concepts as periods of illness & cure is not consonant with our knowledge of mental health needs

To improve the quality of life for the mentally disabled through personal & social integration

* The major disabilities, while almost always readily stabilized continue with indefinite perhaps permanent impairment

* Because of the problems associated with the transfer of learning from one situation to another services should be provided, whenever possible, in the setting in which the newly acquired behaviour is to be applied



* A service must build on the assets of its consumers & their natural support systems by increasing their collective capacity to eliminate, cope with, & tolerate disability

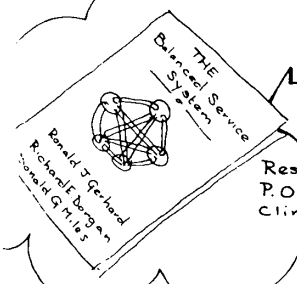
* The types of service to be provided should be based on a continuing analysis of need & be designed to correct deficiencies in out comes of existing systems.

* New systems seldom evolve naturally from existing & established systems.

* Values of the system must be stated

The B.S.S. outlines

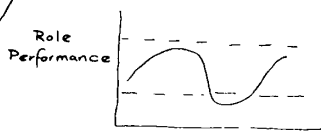
Seven Major Strategies for achieving service goals & the social integration of its consumers

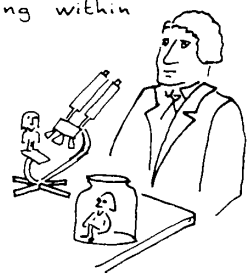


For a full description of implications

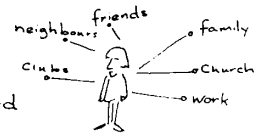
Responsive Systems Assoc
P.O. Box 846
Clinton, Oklahoma 73601

Strategy One: the focus of service must shift from individual pathology to individual functioning within a social environment.



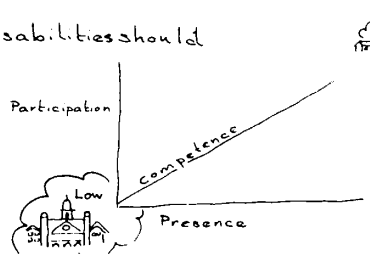


Strategy Two: the capacity of the community networks to support the individual is the prime determinant of service location.



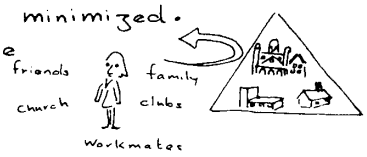
- Selecting the location of service based on the capacity of the community occurs during ⅓ screening for making admission decisions & ⅔ during planning & linking conferences for making transfer & discharge decisions

Strategy Three: individuals with mental disabilities should be integrated into community networks.



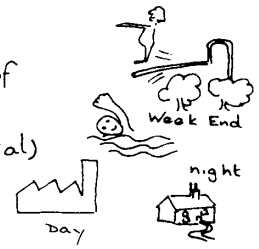
Strategy Four:

The individual's degree & duration of penetration into the system should be minimized. In order to reduce the degree of penetration the service will rely heavily on the capacity of the individuals community network to support him.



Strategy Five:

Services should follow the natural rhythm of the day & week, that is, day, evening & leisure time and overnight (residential) modules should structure the type & location of services offered This implies that distinction should be maintained between residential & non-residential services



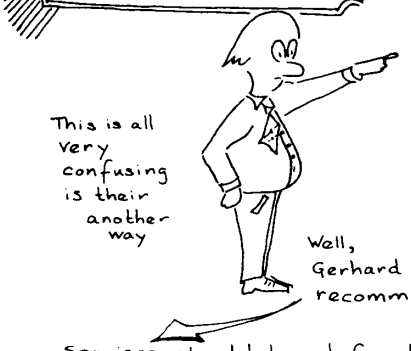
Strategy Six:

The service system should support age appropriate roles of consumers
- The Balanced Service System produces a variety of roles by providing services which enable individuals to organise their capacities into useful social roles. Services such as "subsidized work" & "sheltered work" create jobs for people who would otherwise not have employment options. These services promote the rights & responsibilities of individuals & make possible the needed additional social alternatives & self images required by people functioning with a minimum of service provider contact.
- Other roles are created when consumers are placed together in small residential settings which foster peer support.

Strategy Seven:

There should be a full range of interconnected services to meet the expressed need of the population without overutilization of protective environments or exporting people outside the area for service. Considering the scarcity of resources, this would suggest giving priority to severly disabled people.

Service Functions Responsive to a Range of Human Need



Currently, some services are defined in terms of activities performed, such as rehabilitation; others in terms of their facility type, such as inpatient or out patient; others are defined in terms of the time of day provided, such as day treatment; while still others are defined on the age or disability characteristics of the client, such as childrens service or drug service

Services should be defined in terms of their own distinguishing characteristics. The most important attribute to any service is the purpose for which it is employed

The B.S.S. classifies service functions in terms of their intended impact on the lives of the individuals they serve

The terms used to identify the seven service functions were selected because they describe their purpose

1 Identification - Services aimed at determining the need for, or the establishment of, services relationships between consumer & provider

2 Crisis Stabilisation - Services aimed at the reduction of acute mental disabilities & their social & physical manifestations to ensure the safety of an individual & society

3 Growth - Services aimed at enhancing intrapersonal, interpersonal & instrumental skills.

4 Supportive - Services aimed at maintaining intrapersonal interpersonal & instrumental skills

5 Case management - Services aimed at linking the service system to a consumer and at co-ordinating the various system components to achieve a successful out come

6 Prevention - Services aimed at reducing the incidence of mental disability resulting from spiritual social & emotional, intellectual or biological affliction

7 Ancillary - Services which compliment the provision of other services.

The mission

To improve the quality of life for people with mental disabilities through personal & social integration

can be sub divided into goals which establish divisions of labour.

See over for the five goals

The five goals are:

1. Service goal – To eliminate or reduce mental disabilities and their adverse effects for a defined population and to encourage social integration.

2. Administrative goal – To organise, finance, facilitate, execute and control the delivery of mental health services

3. Citizen Participation goal – To facilitate the system's responsiveness to consumers & other citizens.

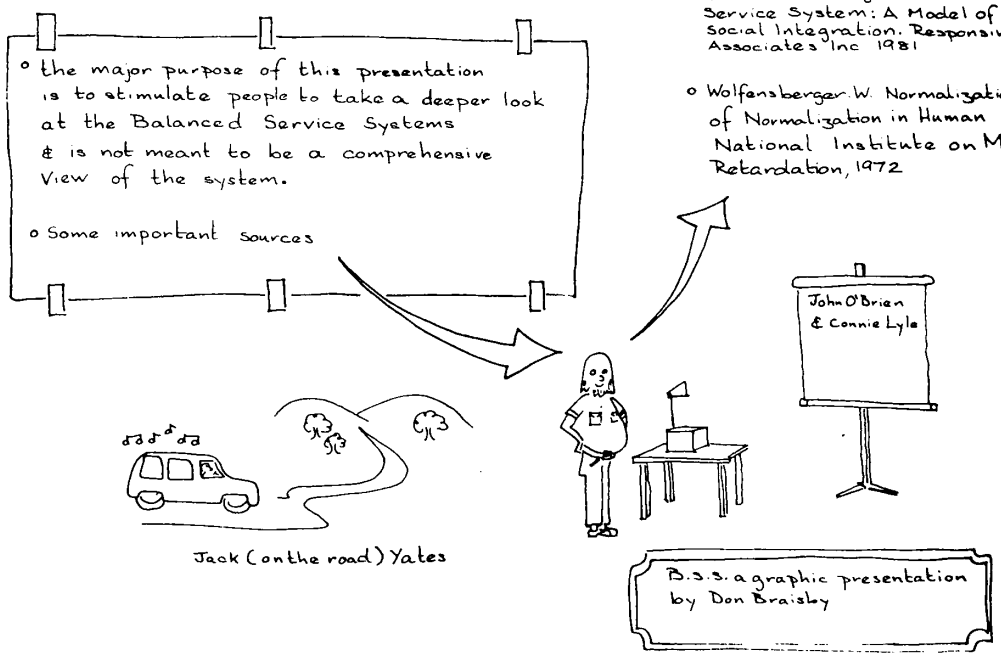
4. Research & Evaluation goal – To continually improve the systems level of quality & capacity to detect deviation fom objectives.

5. Staff Development goal – To make maximum use of peoples potential as a resource

The following table illustrates functional areas & functions.

Service	Administration	Citizen Participation	Research & Evaluation	Staff Development
1. Identification	1 Plan	1 Community Development	1. Research	1 Career Development
2. Stabilization	2. Manage	2. Community Planning	2. Evaluation	2. Education & Training
3. Growth	3. Control			
4 Support				
5 Case management				
6 Prevention				
7 Ancillary				

The advantage of identifying & developing goals & functional areas simultaneously is that objectives & activities tend to be complementary An important example of this is the planning process which translates information from the evaluation process & ideas from the citizen participation functions into plans which are operationalized through the management function.



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DISTRICT NEEDS FOR PSYCHIATRIC SERVICES

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Background paper for the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

DISTRICT NEEDS FOR PSYCHIATRIC SERVICES

Recent publications on aspects of psychiatric services have included reports dealing with services for problem drug users[1] and with services for the elderly mentally ill.[2] Doubtless DHA members, given the current initiatives, will wish to look at their own district services with a view to planning adequate levels of provision. How can such planning be done in a rational manner?

Norms (Government and other) can be used as rough guidelines as to what average levels of provision are indicated for a health district. Usually these can be taken to be minimum acceptable levels but norms for different types of provision are closely interconnected and depend on the balance of care between all parts of a service, including both National Health Service and Social Services' provision. A shortfall in one type of provision may increase the need for another. Levels of provision calculated according to norms must be interpreted and modified to take account of a district's special circumstances. To do this it is necessary to come to grips with the concept of need.

THE MEANING OF NEED FOR PSYCHIATRIC SERVICES

Various definitions of need have been put forward.

1. Matthew (1971)[3] defines in terms of an individual's impairment, for which there exists 'effective treatment'.

2. Glass (1976)[4] uses a similar definition but suggests that the treatment must alter the prognosis of the disease 'in some favourable way at reasonable cost'. He states that need should not be used for planning unless it can 'be determined by measurable qualities against agreed standards' and implies that the establishment of these standards is not the responsibility of any single professional or group.

3. Bradshaw (1972)[5] uses a taxonomy of need, dividing need into the following categories:

   - Normative Need ie. what is a professional (eg. a doctor) defines as a need in any given situation.

   - Felt Need which is limited by the perceptions of the individual patient

   - Expressed Need ie. felt need turned into the action of asking for a service

   - Comparative Need where a measure is made of certain characteristics or conditions in a particular area or group who are receiving a service. If people with similar characteristics in another area or group are not receiving that service, then there is a comparative need.

CHOICE OF A WORKING DEFINITION OF NEED

Use of the first definition (Mathew) involves knowledge of treatment and assessment of the impairment of individuals. This can be problematic, even for those actually working with the mentally ill. Assessment by members of different disciplines can produce different rating of impairments and is also a time-consuming task.

The second definition (Glass) may be a more useful one in that it recognises both financial constraints and a multi-disciplinary approach. However, as yet there appear to be no generally agreed standards of psychiatric care held by multi-disciplinary groups, despite the exhortations of the DHSS.

At this time, probably the most useful categorisation for DHA members is the third (Brandshaw's taxonomy) as used by Forster in the Brotherson Report (1978)[6]. The taxonomy may be less accurate in terms of the assessment of indvidual patients' needs but can be used to indicate broadly the needs of a District. It has the advantage of taking into account the views of the consumers as well as those working in the field. Unfortunately, although theortetically much of the information required may be obtained from routinely available data sources, in practice this may not be the case. The role of the DHA member may be in the first instance to ensure that information systems for planning and monitoring mental health services are improved.

THE USE OF BRADSHAW'S TAXONOMY TO ESTIMATE A DISTRICT'S NEEDS

The simplest estimation of need is that of:

a) Normative need

What a district needs according to norms can be calculated by applying the currently accepted norms (see paper on Model District) to the working district population figures. However, the resulting normative need figures are merely a starting point and must be modified according to the special characteristics of the district.

Accurate modification may be impossible because of the difficulties in the collection of necessary information and the problem of determining the importance to attach to each of the four categories of need. The following categories of need can be appraised by asking certain questions:

b) Felt need

Has a study of individual patients' needs and their relatives' needs been undertaken in the District? In fact, is there a register of psychiatric patients in the District?

c) Expressed need

What views to key groups and workers in the mental health field hold regarding District needs? Consideration should be given to the views of the Community Health Council and voluntary bodies such as MIND, Social Services, General Practitioners and health professionals concerned with psychiatric care. However, although the importance of a common philosophy to the implementation of Community Care has been stressed by many concerned with the topic, it is surprising to note the range of differing views which can be expressed by individuals and organiations within a district. The case-study of Hammersmith and Fulham exemplifies this.

d) Comparative need

How does your District compare with other similar districts? It may sound simple to compare a particular district's provision and usage of mental health services with those of other similar districts, but such comparison in turn raises further questions:

i) Which other districts are similar and why?
ii) What services do they have and how do they use them?

The lack of 'routinely available' data with which to answer these questions is discussed in a further paper which makes an attempt to compare London Health Districts using varoius parameters ie. social and demographic factors and provision and usage of psychiatric services.

A quicker if less exact approach would be to pick other broadly similar districts who have published a Good Practices in Mental Health guide. If services are provided in those districts but not in yours then you may have identified a need.

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CASE STUDY OF HAMMERSMITH AND FULHAM

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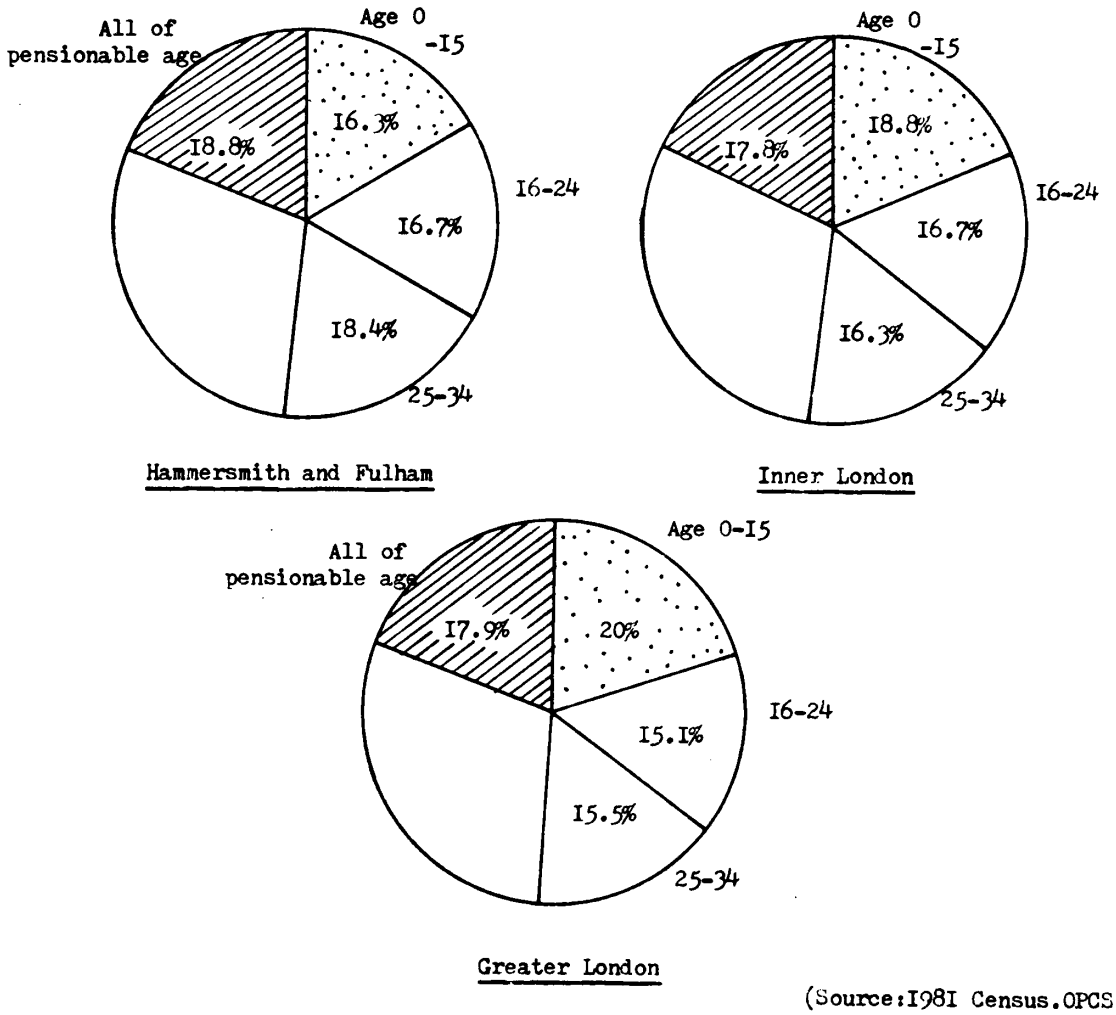
Background paper for the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

CASE STUDY OF HAMMERSMITH AND FULHAM

Hammersmith and Fulham borough is an Inner London borough in the West of London. Its population composition by age group is shown in Fig.I.



(Source:1981 Census.OPCS)

Fig.I

Whilst in many ways the borough is typical of Inner London, its particular social and demographic characteristics are portrayed in Fig.2.

Social and Demographic characteristics of Hammersmith and Fulham compared with Inner London and Greater London

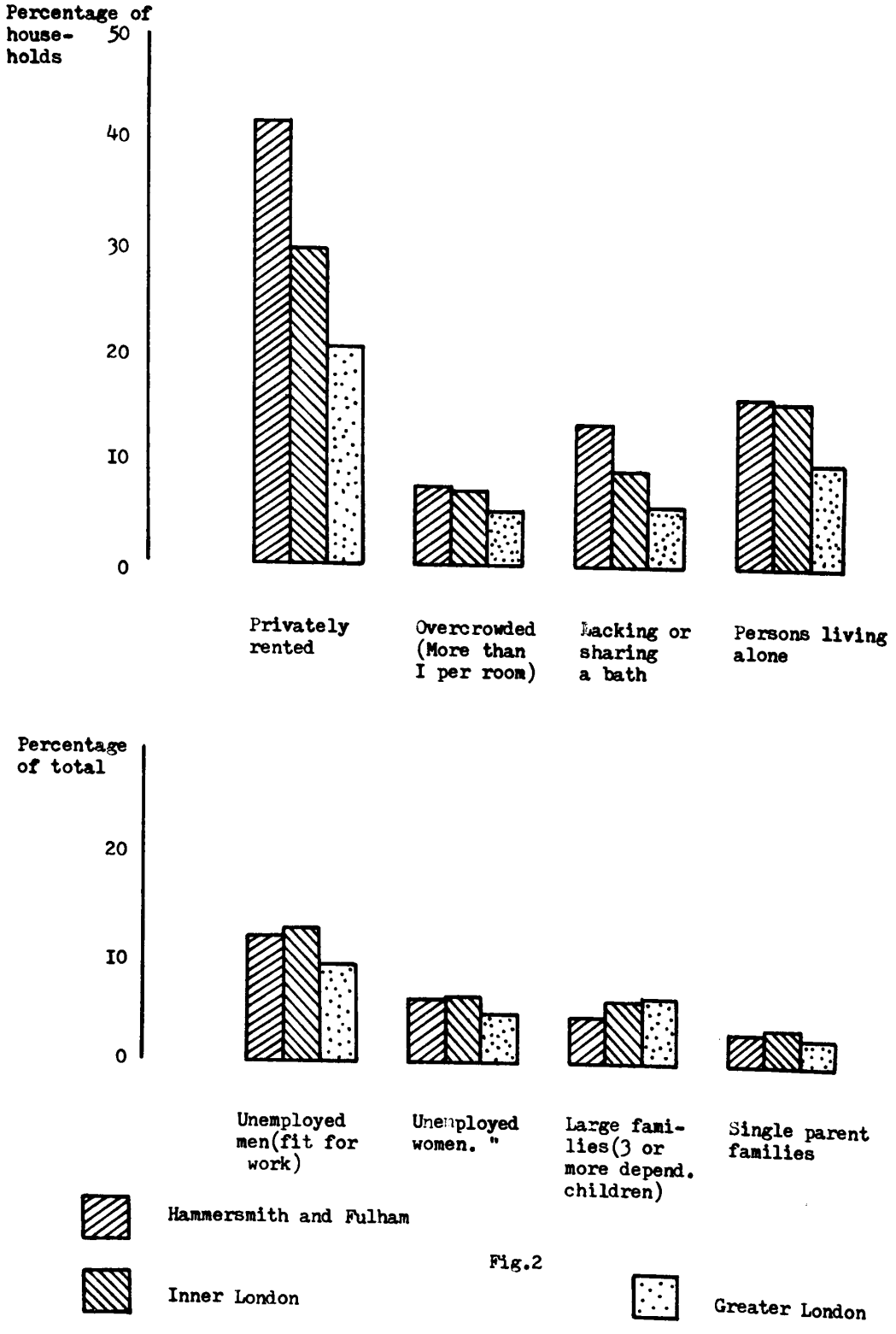
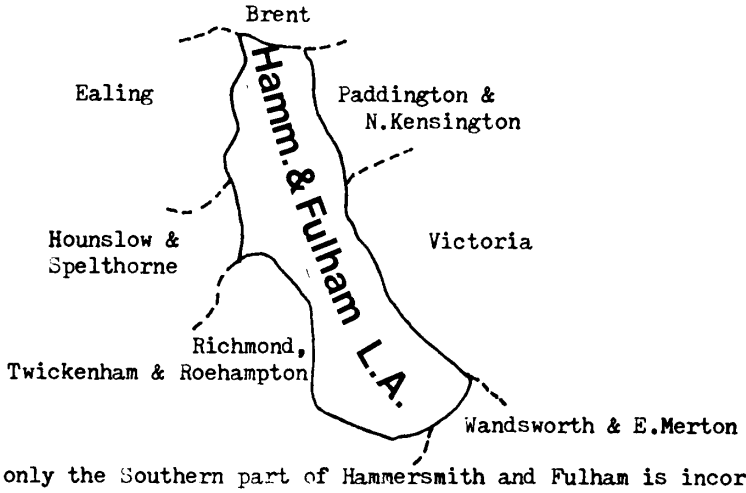


Fig.2

Hammersmith and Fulham District Health Authority

Fig.3



Currently only the Southern part of Hammersmith and Fulham is incorporated into the District Health Authority. Although this may change from April Ist when the district and borough may become coterminous, this paper will examine only the psychiatric services provided for residents of South Hammersmith. The population of South Hammersmith at the I98I census was 73,984.

Psychiatric Services for South Hammersmith Residents

Provision and Usage figures are shown in the following tables.

A. Hospital-based Services

Site	Type of provision	Provision	Usage
Charing Cross Hospital	Acute beds	40	28 *
	Psychogeriatric beds	0	
Cassel Hospital (in Ham, Richmond. Administered by District)	Psychotherapeutic beds		virtually nil
Banstead Hospital (I5 miles away in S.London)	Short stay beds(Under I yr.)	40	56 (I7.6.'82)
	"New" and "Old" longstay		I00 "
Included in the above	Short stay, elderly M.I.		38
	Longstay, elderly M.I.		63
It is not possible to distinguish which of these patients are functionally mentally ill and which are demented.			

* Use by academic patients from outside S.Hammersmith not included in usage figures.

A.Hospital-based Services(contd.)

Site	Type of Provision	Provision	Usage
Charing Cross Hospital	Day places -adult mentally ill	40-45	20 (I used by inpatients)
	Day places -psychogeriatric	0	
Charing Cross Hospital	Outpatient Sessions	26/wk.	I7/wk.
" "	Drug dependance clinic appointments	204/yr.	I00/yr.
	Psychiatrists	6	3.5 *
	Community Psychiatric Nurses (Hospital-based since '74)	7	5

B.Community-based Services

Local Authority Social Services within borough	Places in hostels(2) (serving MI adults in whole borough)		22
Wimbledon -outside borough	Places for elderly MI (Home opened I8 momths ago)	30	disappointing (staffing probs).

Voluntary Agencies' Provision

Agency/site	Type of Provision	Provision	Usage
ROMA(run by Turning Point). Hostel	Drug rehabilitation places	I5	max. 3
ACCEPT. Disused hosp. buildings	Problem-oriented approach -places for alcohol misusers	?	? (used by people from far afield)
MIND. Buildings in S.Hammersmith	Psychotherapy(individual)		50pers. at any time
	Group Home places	6	4 (2 residents now inpatients)
	Places in houses for MI (4 houses)	32	? (some not M.I.)
	Health Education courses	3/yr ('82)	?26 pers per sess.

Comparison of what South Hammersmith has with what it appears to Need

Bradshaw's taxonomy(1) is used to categorise need.

I. Normative Need

The extent to which services as used meet the guidelines is shown in Fig.4

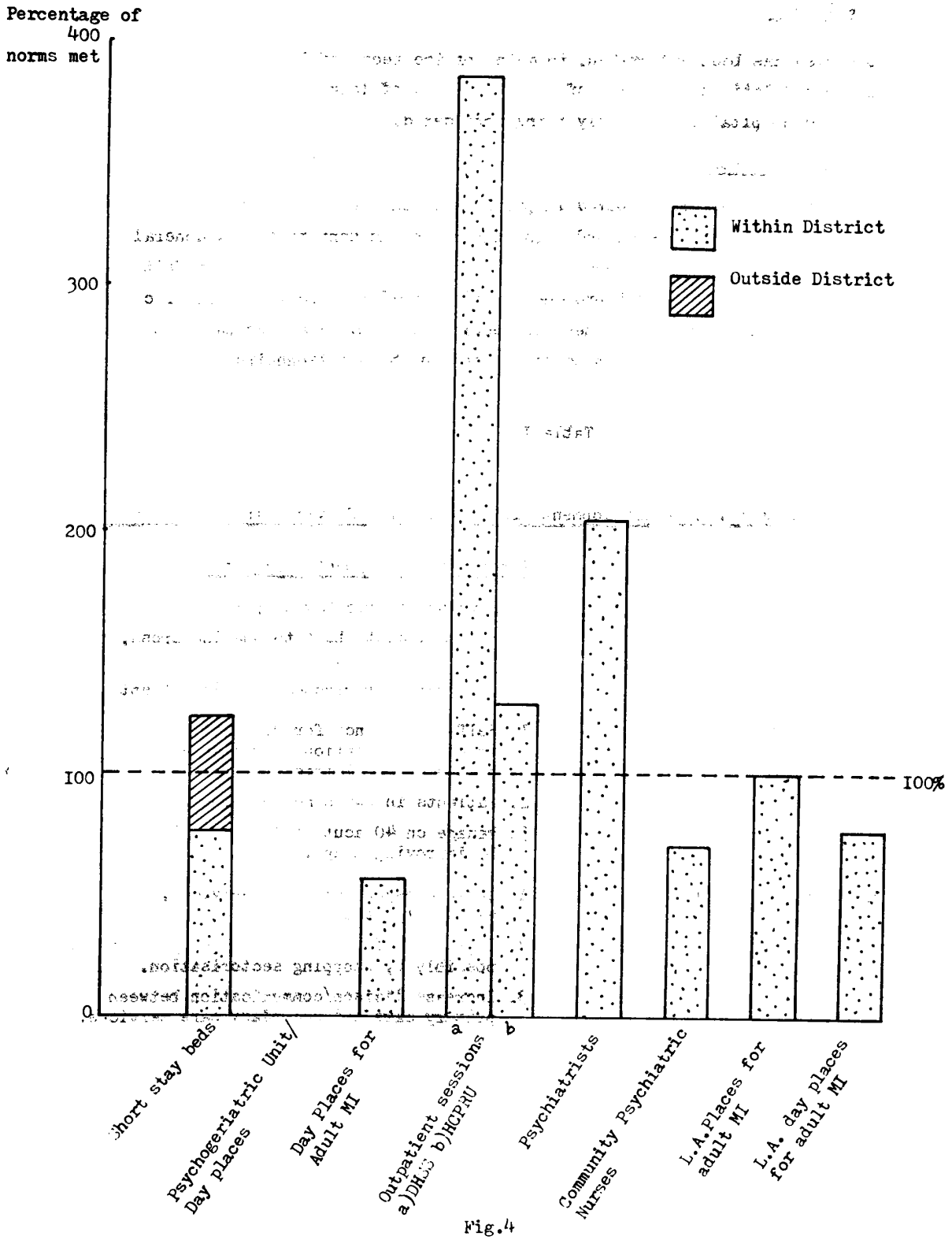


Fig.4

HCPRU = Hackney Community Psychiatry Research Unit

2. Felt Need

No survey has been undertaken, to date, of the needs of individual patients or their relatives. A survey of the dependancy of longstay petients at Banstead Hospital is currently being considered.

3. Expressed Need

Key people and groups involved in psychiatric care of South Hammersmith residents were interviewed and a questionnaire was sent to all 8I General Practitioners(GPs). All groups and individuals were asked what they felt to be the most important improvements which could be made to psychiatric services. Their priority issues are recorded in Table I and compared in Table 2. Half of all GPs contacted replied to the questionnaire.

Table I

Most Important Future Developments for Psychiatric Services in South Hammersmith

People/Group	Important Developments Suggested
Psychiatrists	I. Psychogeriatric Day Hospital
	2. Move all acute beds to Charing Cross, together with staff
	3. Beds/Unit for psychogeriatric patients
Social Services	I. Self-sufficiency for District.ie. immediate cessation of reliance on beds outside district
	2. Patients in own homes or Group Homes
	3. Manage on 40 acute beds at Charing Cross by improving usage.
General Practitioners	I. Improve psychogeriatric services, especially beds
	2. Improve performance of emergency services, possibly by stopping sectorisation.
	3. Increase liaison/communication between primary care and secondary care services.

Table I(contd.)

People/Group	Important Development Suggested
Community Psychiatric Nurses	I. Involvement of Community Psychiatric Nurses(CPNs) in more preventive work. 2. Increase number of CPNs. 3. Closer liaison b etween primary care and secondary care services: would be assisted if CPNs were once again based in the Community.
Community Health Council	I. Psychogeriatric beds in the District 2. Plan a complete psychogeriatric service 3. Multi-disciplinary Drop-In Centre.
MIND	I. Develop Preventive Services 2. Less reliance on drug treatment 3. More housing options for patients

4. Comparative Need

For comparison of Hammersmith and Fulham (S.Hammersmith) with other London Districts, see paper on Overview of Psychiatric Services in London. Some aspects of comparative need have been included in Table 3.

Comparison of Normative Needs with other categories of Need

Table 3 attempts to explain South Hammersmith's apparent departures from norms in terms of the other categories of need. Conclusions are put forward.

Table 2

Priority Issues for Future Developments	Psychiatrists	Social Servs.	GPs	CPNs	CHC	MIND
A. Psychogeriatric Services in District						
a) Opening a psychogeriatric Day Hospital	+++				++	
b) Psychogeriatric beds in District	+		+++		+++	
B. Movement of Beds to Within District						
a) All acute beds	++					
b) Acute and "New" longstay (Under 5 yrs)						
c) "Old" longstay(Over 5 yrs)					0	
C. Discharge of "New" and "Old" longstay to own homes/group homes		+++				++
D. Build-up of Community Support Services						
a) Increase No; of CPNs				++		
b) Improve liaison between Primary/Secondary Care		++	+	+		
E. Emphasis on Prevention				+++	+	+++
F. Improve Emergency Services			++			

+++ = Top priority issue
++ = second priority issue
+ = an issue of some priority
0 = possible objections

Table 3

Normative Need Apparent departures from norms	Expressed Need Endorsed? By Whom?	Comparative Need Endorsed? Why?	CONCLUSIONS
A. PSYCHOGERIATRIC PROVISION			
(i) No psychogeriatric beds in District (shortage of 21-26 beds) *	Yes Psychiatrists Yes 8 GPs Yes CHC	Yes S.Hamm. one of 3 London Dists. with no such beds	(i) A unit of 21-26 psychogeriatric beds needed in District
(ii) No Day Hosp. (shortage of 26 places)		Yes S.Hamm. one of 6 London Dists. with no EMI day hosp.	(ii) A Day Hospital for the elderly mentally infirm is needed in the District: 26 places
B. EXCESS HOSPITAL PROVISION			
(i) Too many psychiatrists (105% or 1.7 psychs. excess)	Yes Social Servs. No GPs (2 want more)	Yes bar Hampstead, S.Hamm. has most of 20 London health districts	(i) There is overprovision of psychiatrists
(ii) Too many outpatient sessions (286% excess: DHSS guidelines 29% excess: HCPRU guidelines)	No 6 GPs (want quicker OP appointments)	No -if district were self-sufficient Yes -if it is not	(ii) The No; of outpatient sessions can only be supported if District self-suff.' is planned
C. INSUFFICIENT COMMUNITY SUPPORT			
(i) Too few CPNs (3 too few: CPNA guidelines)	Yes CPNs Yes 3 GPs	No S.Hamm. has one of the two best CPN:pop. ratios of 20 London Districts	(i) The No: of CPNs is reasonable if all are actually working
(ii) Too few L.A. day places (21 short, for borough)	Yes Social Servs.	?	(ii) It would help if there were more L.A. day places
(iii) Too little liaison/communication between all levels of servs.	Yes CHC Yes MIND Yes CPNs Yes 8 GPs	?	(iii) Information/liaison/communication could be improved
(iv) Too few housing options as alternatives to hospitals	Yes everybody	?	(iv) Housing options for "old" longstay and to prevent accumulation of "new" longstay must be sought.

* N.B. A 21 bedded unit failed to open this year because of financial constraints

Plans for Future Services

District strategic psychiatric plans are currently being reviewed in the light of certain forthcoming changes. In I986 Banstead hospital is scheduled for closure. It is proposed to transfer many longstay South Hammersmith patients from Banstead to another large mental hospital in South London: Horton ,but there will be insufficient beds for them.

Who will have responsibilty for residents of North Hammersmith, currently the responsibility of a Special Health Authority, after April Ist, has yet to be announced.

Reference

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Deirdre Cunningham. February I983

AN OVERVIEW OF PSYCHIATRIC SERVICES IN LONDON HEALTH DISTRICTS

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Dept. of Community Medicine
West Lambeth Health Authority

Background paper for the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

INTRODUCTION

General Points Which Emerge

Although the methodology of this study was designed to overcome some of the current problems of obtaining and using unsatisfactory routinely-available data, it has raised further problems:

1. Most districts appear to have found great difficulty in providing information, in particular about personnel employed and beds/dayplaces used by residents.

2. Whereas virtually all districts said that psychiatric services took a 'high' priority, it did not appear that this priority was being supported by resource or revenue allocation. In particular, psychogeriatric services seemed generally undeveloped.

What This Might Mean for You as a District Health Authority Member

You might consider raising the following issues:

i) Information Is the information available to your district as up-to-date as possible and relevant to planning services for residents?

ii) Psychogeriatric Services Should psychogeriatric services be a priority in your district?

iii) District Priorities: Overt and Covert Does district resource allocation match the ranking of stated priorities?

iv) Range of Staff Employed 'Community Care' involves staff in the community. What is your district's current level of staffing in the community? eg. Community Psychiatric Nurses, psychologists, psychotherapists. Is the level of staffing adequate for the level of Community Care envisaged?

OVERVIEW OF PSYCHIATRIC SERVICES IN LONDON HEALTH DISTRICTS

In order to compare psychiatric services for London Health Districts, the following questions must be answered:

i) What services does each district have for its residents?

ii) How are they used?

iii) Does the district have any special needs?

It is difficult to answer these questions from routinely available information sources. Since reorganisation in April 1982 it has been unclear even to many District Health Authorities exactly what psychiatric services are offered to residents. Usage figures obtainable from hospital returns (SH3 forms) and collated in the Mental Health Enquiry can only be obtained from the DHSS for the period up to and including 1981 and from two Thames Regions only up to 1980. These usage figures relate to pre-reorganisation services. Moreover, the data is presented in an indigestible form, is in many aspects relatively inaccurate and it is difficult to establish from it usage figures for district residents rather than all those treated within the district.

Questions tackled by this paper: Methods

i) What service does each district have?

A questionnaire was sent to the District Medical Officer of each of the 31 London Health Districts. Twenty two replies have been received from districts (71%) in all four Thames Regions as follows:

NW Thames RHA	NE Thames RHA	SW Thames RHA	SE Thames RHA
89% (8)	55% (6)	80% (4)	66.66% (4)

ii) What special needs has each district?

Social and demographic data for each district have been obtained from the 1981 census. All London districts have been divided into groups and exceptional districts have been listed to provide a guide for District Health Authority members as to special characteristics of districts.

RESULTS

NB. Not all districts had all information available.

PERSONNEL

PSYCHIATRISTS

Ratio of no. of Psychiatrists to population

1:2,000 to 1:35,000	1:42,000 to 1:58,000	1:64,000 to 1:110,000
Hampstead (NE)	Harrow (NW)	Enfield (NE)
*Victoria (NW)	Brent (NW)	*Newham (NE)
*Wandsworth (SW)	Richmond, Twickenham & Roehampton (SW)	Hounslow & Spelthorne (NW)
*Hammersmith & Fulham(S) (NW)	Hillingdon (NW)	*Haringey (NE)
Bexley		Ealing (NW)
*Tower Hamlets		Merton & Sutton (SW)
*City & Hackney		Greenwich (SE)
Waltham Forest		
Bromley (SE)		

Note: Royal College of Psychiatrists recommends 1 psychiatrist per 40,000 residents (1:40,000) * = Inner London District

CHILD PSYCHIATRISTS

1:7,000 to 1,184,000	1:216,000 to 1:406,000
Hampstead (NE)	Harrow (NW)
*Victoria (NW)	Ealing (NW)
*Wandsworth (SW)	Bromley (SE)

*Tower Hamlets (NE)	Merton & Sutton (SW)
*Haringey (NE)	
Richmond, Twickenham & Roehampton (SW)	
Hillingdon (NW)	Nil
Hounslow & Spelthorne (NW)	
Greenwich (SE)	Brent (SW)
*City & Hackney	Bexley (SE)

Note: Royal College of Psychiatrists recommends 1 child psychiatrist per 200,000 residents (1:200,000)

Hampstead is outstandingly well provided with psychiatrists. It apparently has 55 working for 528 sessions with 20 child psychiatrists working for 179 sessions. If these really are all serving Hampstead residents then Hampstead has one psychiatrist for every 2,000 residents. East London and Inner London districts seem to be particularly well endowed.

PSYCHOGERIATRICIANS

Specific Psychogeriatricians	None
*Hammersmith & Fulham (NW)	Brent (NW)
*City & Hackney (NE)	Hillingdon (NW)
Hampstead (NE)	Hounslow & Spelthorne (NW)
*Newham (NE)	*Victoria (NW)
*Tower Hamlets (NE)	Enfield (NE)
Merton & Sutton (SW)	Waltham Forest (NE)
Richmond, Twickenham & Roehampton (SW)	Bromley (SE)
*Wandsworth & East Merton (SW)	Greenwich (SE)

* = Inner London District

PSYCHOLOGISTS

Ratio of no. of Psychologists to population

High	Average	Low
1:5,045 to 1:18,000	1:22,024 to 1:47,000	1:65,000 to 1:202,000
Hampstead (NE)	*Hammersmith & Fulham (NW)	Harrow (NW)
*Victoria (NW)	*Newham (NE)#	Hounslow & Spelthorne (NW)
Brent (NW)	Richmond, Twickenham & Roehampton (SW)	Greenwich (SE)
*Wandsworth (SW)	Bromley (SE)	Hillingdon (NW)
Bexley (SE)	Waltham Forest (NE)	*Haringey (NE)
	*Tower Hamlets (NE)	Nil
		Enfield (NE)
		Merton & Sutton (SW)

= Psychologists employed by Local Authority

PSYCHOTHERAPISTS

Ratio of no. of Psychotherapists to population

Relatively High	Some Psychotherapists	No Psychotherapists
Psychotherapist Complement		
1:5,000 to 1:67,000	1:98,000 to 1:653,000	
Hampstead (NE)	Richmond, Twickenham & Roehampton (SW)	Brent (NW)
*Wandsworth & East Merton (SW)	*Victoria (NW)	Hillingdon (NW)
*Tower Hamlets (NE)	*Hammersmith & Fulham (NW)	Harrow (NW)
*Haringey (NE)	Greenwich (SE)	*City & Hackney (NE)
	Hounslow & Spelthorne (NW)	Enfield (NE)
		Waltham Forest (NE)
		Merton & Sutton (SW)
		Bexley (SE)
		Bromley (SE)

* = Inner London Districts

COMMUNITY PSYCHIATRIC NURSES

Ratio of CPNs to population

High	Average	Low
1:5,700 to 1:14,000	1:18,500 to 1:28,950	1:32,000 to 1:64,000
*Victoria (NW)	Hampstead (NE)	Hillingdon (NW)
*Tower Hamlets (NE)	Waltham Forest (NE)	Harrow (NW)
*Hammersmith & Fulham (NW)	Hounslow & Spelthorne (NW)	Greenwich (SE)
*Wandsworth & East Merton (SW)	Bromley (SE)	Merton & Sutton (SW)
Richmond, Twickenham & Roehampton (SW)	*Newham (NE)	Brent (NW)
*City & Hackney	Bexley (SE)	Enfield (NE)
	*Paddington & North Kensington (NW)	
	*Haringey (NE)	

Note: Community Psychiatric Nursing Association (CPNA) recommends one CPN per 7,500 population. South East Thames Regional Health Authority recommends one CPN per 10,000 population.

In 1981 in England and Wales there was an average of one CPN per 20,000 population.

FACILITIES FOR THE ADULT MENTALLY ILL

BEDS (Adult Mentally Ill) per 1,000 population

High	Medium	Low
2.6 per 1,000 to 2.0	1:51 to 1.03 per 1,000	0.8 to 0.22 per 1,000
*Hammersmith & Fulham (NW)	Richmond, Twickenham & Roehampton (SW)	*Lewisham & North Southwark (SE)
Harrow (NW)	Bexley (SE)	*City & Hackney (NE)
*Newham (NE)	Merton & Sutton (SW)	*Tower Hamlets (NE)
	Greenwich (SE)	Enfield (NE)
	Bromley (SE)	Hounslow & Spelthorne (NW)
		Haringey (NE)
		Hillingdon (NW)
		Ealing (NW)

Note: DHSS recommend 0.5 short stay beds per 1,000 population and 0.17 'new' longstay, ie. 0.67 beds per 1,000 population.

* = Inner London District

BEDS (Adult Mentally Ill) percentage within District

100%	34% - 69%	11% - 21%
Bromley (SE)	*Haringey (NE)	Richmond, Twickenham & Roehampton (SW)
Bexley (SE)	*Lewisham & N Southwark (SE)	Harrow (NW)
Enfield (NE)	Hounslow & Spelthorne (NW)	Greenwich (SE)
Ealing (NW)		*Hammersmith & Fulham (NW)
Brent (NW)		Merton & Sutton (SW)
*Tower Hamlets (NE)		
*City & Hackney (NE)		Nil
		*Newham (NE)

DAY PLACES FOR MENTALLY ILL ADULTS

Districts with Day Hospitals	Districts which have a DGH Unit
*Hammersmith & Fulham (NW)	*Paddington & N Kensington (NW)
*City & Hackney (NE)	Hillingdon (NW)
*Lewisham & North Southwark (SE)	Harrow (NW)
Ealing (NW)	Hounslow & Spelthorne (NW)
Merton & Sutton (SW)	Enfield (NE)
Richmond, Twickenham & Roehampton (SW)	Kingston & Esher (SW)
Bexley (SE)	Merton & Sutton (SW)
Bromley (SE)	Richmond, Twickenham & Roehampton (SW)
Greenwich (SE)	Greenwich (SE)

Districts with both

*Victoria (NW)

Ratio of day places for adult mentally ill to population

Medium	Moderately Low	Very Low
49-54 places per 100,000	18-42 places per 100,000	11-14 places per 100,000
*Hammersmith & Fulham (NW)	*Victoria (NW)	Bromley (SE)
*City & Hackney (NE)	*Wandsworth (SW)	Hillingdon (NW)
*Paddington & N Kensington(NW)	Enfield (NE)	Ealing (NW)
	Merton & Sutton (SW)	Hillingdon (NW)
	Hounslow & Spelthorne (NW)	Ealing (NW)
	Richmond, Twickenham & Roehampton	Bexley (SE)
	Greenwich (SE)	Nil
		*Tower Hamlets (NE)
		Brent (NW)
		Waltham Forest (NE)

Note: DHSS recommends 65 places per 100,000 population
Two Districts, Newham and Hillingdon, mix adult mentally ill with elderly mentally ill patients (demented).

FACILITIES FOR THE ELDERLY MENTALLY INFIRM (Psychogeriatrics)

London districts virtually all appear to have poor services for their psychogeriatric patients and for many districts the information is incomplete.

Beds Only 7 of the responding 22 districts appear to have specific psychogeriatric assessment beds. These districts are:

*Newham	*Lewisham & North Southwark	*Wandsworth & East Merton
*Tower Hamlets	Brent	Merton & Sutton
		Bromley

Numbers of beds for the elderly confused (mentally infirm) range from 20 per 100,000 population to 250 per 100,000 population in those districts where there are beds actually designated as such. However, the figures are so difficult to interpret that they are not given here.

Day Places Ratio of day places for the elderly mentally infirm to population

High	Medium	Low
30 to 43 per 100,000	18-19 per 100,000	13 to 5 per 100,000
*Tower Hamlets (NE)	Waltham Forest (NE)	*Wandsworth (SW)//
*City & Hackney (NE)	Harrow (NW)	Merton & Sutton (SW)//
		Lewisham & N Southwark (SE)
		Richmond, Twickenham & Roehampton (SW)
		+Enfield (NE)
		Bromley (SE)

Remaining respondents: nil + = places about to open // = some shared facilities

PRIORITY GIVEN BY DISTRICTS TO DEVELOPMENT OF A COMPREHENSIVE DISTRICT PSYCHIATRIC SERVICE

Inner London	
Hammersmith & Fulham	'High' - particularly psychogeriatrics. Uncertainties re. District boundaries.
Paddington & N Kensington	'Very high' - especially elderly mentally infirm. Deadline for self-sufficiency: 1985.
Victoria	'High' - closure of a large, out-of-District mental hospital (Banstead) imminent.
City & Hackney	Not known
Haringey	'High' - for psychogeriatrics. Other psychiatric priorities not established yet.
Newham	'High'
Tower Hamlets	'High' - in accord with North East Thames Regional guidelines.
Wandsworth	'Great concern' - comprehensive service has almost been achieved.
Lewisham & N Southwark	'Highest priority' - proposed redirection of resources from acute services to priority care group.
Outer London	
Brent	'Great' - District General Hospital Unit/Day places proposed by 1985.
Ealing	'Great' - proposal to cut down services currently provided for other Districts.
Hillingdon	'High' - but resources scarce and other services must not suffer.
Harrow	Not known
Hounslow & Spelthorne	'High' - priorities are (a) psychogeriatric beds (b) Day Hospital for elderly mentally ill.
Enfield	'Top' - especially deveopment of long-stay and psychogeriatric services.
Waltham Forest	'High' - Closure of Claybury Hospital will necessitate Community-based service within 10 years.
Kingston & Esher	'High' - but only within existing budget for psychiatry. Reallocations necessary.
Merton & Sutton	Not known
Richmond, Twickenham & Roehampton	'Very high' - rationalisation of catchments, Day Hosp. provision, especially more CPNs.
Bexley	Not known
Bromley	'High'
Greenwich	'Top' - especially Unit for elderly severely mentally ill (by 1983/4), additional child psych. (by 84/85).

SPECIAL NEEDS OF DISTRICTS

a) Children

Districts with large proportion of children (21.4%-23.1& population)	Districts with small proportion of children (10.8%-16.3% population)
*Newham	*Bloomsbury
Bexley	*Paddington & N Kensington
Greenwich	*Victoria
*City & Hackney	Hampstead
Waltham Forest	*Hammersmith & Fulham
Croydon	

Note: Hampstead, with the smallest proportion of children, appears to have the highest complement of child psychiatrists.

b) Persons of Pensionable Age

Districts with largest percentages of pensioners (19.5-20.5% pop.)	Districts with smallest percentages of pensioners (15.9-16.9% pop.)
Richmond, Twickenham & Roehampton	Brent
Bromley	*Haringey
Hampstead	*Newham
Kingston & Esher	Croydon
Merton & Sutton	Bexley
Waltham Forest	Ealing
Barnet	Hounslow & Spelthorne
	*City & Hackney
	*Bloomsbury
	Hillingdon

c) Overcrowding ie. more than one person per room

Districts with most over-crowding (8.5-10.0% households)	Districts with least over-crowding (2.4-3.8% households)
*Tower Hamlets	Bromley
*City & Hackney	Kingston & Esher
Brent	Bexley
*Newham	Merton & Sutton
	Redbridge
	Richmond, Twickenham & Roehampton
	Enfield
	Hillingdon
	Harrow
	Croydon

* = Inner London Districts

d) Unemployment: High unemployment may increase psychiatric morbidity

Men

Districts with high unemployment rate (14.1-17.4% of fit men)	Districts with low unemployment rate (5.3-6.0% of fit men)
*City & Hackney	Kingston & Esher
*Tower Hamlets	Harrow
*Camberwell	Bromley
*West Lambeth	Merton & Sutton
*Islington	Hillingdon

Women

Districts with high unemployment rate (11.6-8.1% of women seeking work)	Districts with low unemployment rate (2.6-3.2% of women seeking work)
*City & Hackney	Bromley
*Camberwell	Bexley
*West Lambeth	Kingston & Esher
*Wandsworth	Merton & Sutton
	Enfield
	Hillingdon
	Harrow
	Croydon

e) Large Families: a family with 3 or more children may increase the risk of depression in the mother (ie. dependent children)

Districts with high percentages of families with 3 or more dependent children	Districts with low percentages of families with 3 or more dependent children
*Newham	Bloomsbury
*City & Hackney	*Paddington
Ealing	*Victoria
Brent	Hampstead

* = Inner London Districts

THE PROOF OF THE PRODUCT

Dr Donald Dick
formerly Director, Health Advisory Service

A paper presented at the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

THE PROOF OF THE PRODUCT

I was Director of the Health Advisory Service for four years and when I started, I found a headline in The Guardian which said 'He did not find knowledge, he modestly avers, he rearranged his ignorance'.

In the last four years, I've been trying to devise better ways of evaluating services for the mentally ill and the elderly, the mentally handicapped in Wales, and children who spend long periods in hospital. I've certainly rearranged my ignorance but I'm quite sure you will recognise that neither I nor anyone else has found perfect knowledge.

We have not been inspecting because an inspection needs stability - you have to have an agreed way of doing something before you can accurately inspect it. Mental health services are not in a phase of stability, they are in a phase of great change and if we are in the eye of the storm there are probably further storms later on. Evaluation of services is an issue that therefore requires us to regard each Health District and the service it provides as a form of experiment. Each Health District is a laboratory, and the reason for that is broadly that every District has got a different geography, a different history, a different set of resources, a different set of people and ever changing boundaries, and is ever reorganising itself with 'minimum turbulance'.

Districts differ so very much, that there is no way you can compare the middle of Wales to the middle of Birmingham. You drive through the middle of Wales and think that the main problem must be a nasty attack of shepherd's delight, or in Birmingham your worst problem is avoiding motor cars and staying conscious enough to do so.

The way to judge a service is to try to determine whether it is a good learning system or not, whether it can work out what it is doing and what it needs to do to correct what it is doing, towards a vision of what it ought to be.

I have called this paper 'The Proof of the Product' because what we have to keep in mind all the time is the question 'What are we doing when we are trying to run a mental health service (and as part of that a psychiatric service)?'

I believe that whilst the specialist mental health professionals in a health district, and its associated social services, are providing a specialist form of treatment they also have an obligation to provide services for other agencies also concerned with Mental Health. That means Social Work Services; voluntary organisations, informal care within the community of all kinds; and the ever growing movement towards self help and self support groups. So there are two major tasks for any psychiatric service - one within its own specialism and one with the assisting of other agencies concerned with the Mental Health of the community.

We are in the process of a revolution and you are revolutionaries whether you know it or not. What we <u>thought</u> we were doing, was trying to provide a modicum of decency to the mentally ill and a better quality of life than they have already, struggling with old buildings which are often in a disgraceful state of neglect and poor maintenance, struggling with trying to find somewhere to put day hospitals and day centres and staff them, struggling with consultants who will not together give us a common policy, struggling with a Regional Health Authority which will not part with the necessary capital to make bridging loan so that we can begin to pursue the ideas that

we have, struggling with a government that seems unable to fit priorities which have been declared by successive governments of different colours into any kind of reality. The truth is unhappily that mental health is still losing compared with acute services despite years of priorities being assigned to what are called the Cinderella Services. There is a struggle too to persuade local Authorities and Social Services to provide more complementary services and to follow the vision of sharing the care of the mentally ill. And all this has to be balanced against the ever increasing demands of high technology, and the ever increasing demands of an ageing population. In the next century 25 per cent of Western Europe will be of retirement age and over, 7 per cent of the rest of the World will be of retirement age or over. We will be ancient nations and they will be young.

What we are <u>really</u> trying to do in this long drawn out process of revolution, is to find a better way of dealing with the people we decide to call mentally ill than the option chosen in the last century - which was to say 'because they are being neglected in the community therefore we must provide them with asylum'. There seems no doubt at all that it was a humane and proper and right solution at the time to offer safety, warmth and shelter in asylums. But the reason asylums had to be offered was that there was no alternative way of stopping the neglect. In 1830 John Conolly wrote a charter for lunatics - it has seven or eight points and it actually reads a bit like a District Health Authority plan for 1982. It suggests that while certain people do need to be in a asylum, alternatives should be provided outside the asylum, that the attendants and the alienists (the doctors) working within the system, should assess people before they come into hospital and should try to maintain them in their own homes, their own communities if possible. We are 153 years on and John Conolly still hasn't arrived.

The history of the early part of the last century was a revolution that took some 60 years. I'd like to suggest that the present revolution that we are in really began in the middle of the 1950s - one might say November 1954 when the great debates about the hospitals started. If we are nearly 30 years on and have another 30 to go, then officers of Health Authorities have the task of seeing through the revolution to the end. What are we trying to do that is different in the future? If it is not to isolate, if it is not to put people who disturb us or upset us into hospital, it is surely to find some way to share that problem between ourselves and the communities in which we work. People who are more severely sick clearly do need specialist services. Those that are less sick and can manage at home need their support.

I'd just like to show if I can, three points of view of looking at the mentally ill which appeal to me in trying to evaluate services.

1. Stand in the dormitory of the back ward of the large mental hospital which is your responsibility - look across the room and see a patient who has been there for 40 years. If he gives you permission, have a look in his locker and discover what possessions he has accumulated in 40 years, and, whether he has privacy, whether he has dignity, whether he has a choice of what he does, where he is, who he talks to, what he wears, where he goes for his occupation and how the hell can he get out.

2. The second place to look at services is in the High Street; stand and look at the passing population and imagine what will happen to individuals across the road if they should fall mentally ill and require services. That means looking at a whole range of people - the muddled old lady, the young mother who may after childbirth have a puerperal illness, the man who is hell bent on killing himself by drinking, the disturbed schizophrenic youth who may become emmeshed in the system of mental health care for 40 or 50 years - the range of people for whom one should provide a service.

3. A third place to look at services is actually in the living-room - look within a family and say, 'What will happen if the young son who is beginning to act in an odd way should develop schizophrenic illness? What will be available by way of support to the family? What will happen to his chances of employment? Where will he go if he should need hospital treatment? Will it be miles away? Will there be people to assist that person not to become a career mental hospital person or a career mentally ill person? What services are going to support and endeavour to keep that person in the right place, in the destiny of his life?'

If you look at those three places you begin to see the magnitude of the task. Yet if you do not have an all embracing aim, it seems that all that will happen is that people will go on repeating the activities that have been their practice for years.

It is curious that this movement towards a different way of dealing with the mentally ill is almost universal. I find a great deal of pleasure in thinking of the different political stances that are taken by people in trying to explain what they are doing.

1. People should be enabled to determine their own lives with as little State interference as possible and should pay for it if they can.

2. Vulnerable people should be supported by society so that they reach the maximum potential of which they are capable and contribute what they can.

3. Society should tolerate deviant behaviour unless the individual asks for help.

4. The proletariat should by revolution, help the worker/patient to cast off the chains wrapped around him by the capitalist medical system and find his place as a productive member of society.

5. Love thy neighbour or if you cannot love him tolerate him.

Those stances all to me seem to emerge with the same intention in the end which is a way of saying that the mentally ill must have a different deal. We thought we were responsible for deploying the resources to provide comprehensive mental health services as part of the total health care system, whereas in fact what we are trying to do is to work something out which is more humane and that suits the ideas of our time.

The trouble is translating those ideas into practice - what do you actually do in order to achieve some of those aims?

It seems to me that the most important function of a Health Authority is to set the objectives of a mental health service, to declare what it is that has to be done. A Health Authority can not do that on its own, what it has to do is to interpret what is generated on its behalf by the people who are working within it and providing the service. When the Authority has determined what needs to be done against a general policy or philosophy then it can be broken down into the bricks for which the architectural plan has already been made. Then we go round again because the service providers will suggest alterations and shifts and the need to think again.

When we are talking about the change of the site of care from large mental hospitals nobody should use that phrase 'the run down of mental hospitals'. It is very demoralising to everybody who has devoted their life to looking after some extremely difficult problems. In a hospital the major functions which

are provided are those of assessment, diagnosis and treatment, especially where there is the need for the concentration of professional expertise and technology. Most of the other functions that are carried out by psychiatric hospitals are those that can probably be done elsewhere, be it in an attenuated form of ward or hostel or home or sheltered accommodation. What a hospital is providing is a safe place, a place for people to live when they don't have anywhere else in which they can manage, a place for rehabilitation, a place to be tolerated and understood, a place for social contact, for leisure, for occupation and employment, and a place to try to maintain some form of realistic daily contact which might otherwise not be possible. The latter functions of the hospitals can all be put on wheels, and certainly we don't seem to need the large villages or small towns out amongst the bad lands, the golf courses and the cemeteries where they were put 80 to 90 years ago. Of course a hospital has important functions for staff. St Teresa said 'If you want bees to make honey you must provide them with a hive'. What we must not do in changing the site of care is to destroy the important body of knowledge and toleration and wisdom about the mentally ill that we have built up so far.

I've tried to describe the bricks of what, on reflection, seemed to be the component parts of a mental health service in the paper 'The Components of a Comprehensive Psychiatric Service'. When you look at a service - a comprehensive service - look for its gaps, for its deficiencies, look at what it doesn't do rather than what it does, excellently, alone. The way to look at a District Health Service is to go into every building that serves the mentally ill in that District and ask the question, 'Who is not allowed in here?' not 'Who is allowed in here?' or 'What do you do well?' because at the end of such an exercise you have a sum of all the deficiences in service that need some attention.

I'd also like to suggest you look at those particular problems of the elderly. We have recently tried to summarise from the Health Advisory Service our experience over the years in providing services for the elderly mentally ill in a document called 'The Rising Tide'. The 'Rising Tide' being the outcome of all the successes of better feeding, better drains, and better medical care in children and the middle aged.

I am a great optimist about what is happening - I believe that despite some of the awful things that I have seen in touring around 160 Health Districts in England and Wales - in spite of some dreadful wards, some ill thought out services - in amongst this one has seen many, many growing points, many of the laboratory models, the design shops for the future, the translation of excellent practice that really needs to be put into the production line. In 1954, at the height of the mental hospital population in this country there were over 150,000 residents in mental hospitals - is it now down to 60,000 or just above. It is going down, it has gone down. We are a very successful organisation and we are going to be more successful.

THE COMPONENTS OF A COMPREHENSIVE PSYCHIATRIC SERVICE

Dr Donald Dick
Formerly Director Health Advisory Service

Background paper for the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

THE COMPONENTS OF A COMPREHENSIVE PSYCHIATRIC SERVICE

PAPER BY

DR D H DICK, MA MB FRCPsych DPM, CONSULTANT PSYCHIATRIST AND

DIRECTOR OF THE NHS HEALTH ADVISORY SERVICE.

INTRODUCTION

1. If a community is to claim that it has a comprehensive psychiatric service to meet the needs of the mentally ill in its midst, it must be sure that services are available for the whole range of people suffering from mental disorder wherever they are to be found in the community and at all stages of their illness or disorder.

The definition of the term mental illness gives rise to immediate difficulty since its embraces, at one end of the continum, the formal diagnosis of severe mental illness and, at the other, forms of psychological distress. The severe end includes organic psychosis, the functional psychoses and the clearer forms of psychoneurotic disorder, psychological manifestations of physical disease, through to the effects of stress, despair and adversity and then to the interaction of personality, environment and society at the other end.

2. Many agencies are concerned in the response to the departure from full mental health. For present purposes a psychiatric service is defined as the organised contribution made by the mental health professions to the specialist treatment of the mentally ill on the one hand and the contribution of specialist skills to the work of the other agencies on the other. For example, the great majority of people suffering from psychological disturbance are treated by general practitioners. A minority are referred on for specialist treatment and to a further group the specialist service provides consultation, support, advice on management, occasional intervention at times of crisis and the use of special facilities. There is a similar partnership with other specialist hospital services, social services, voluntary organisations, and the variety of counselling and support groups that are to be found in any community.

3. A comprehensive service can be described in a number of ways, as its component buildings, as its staff groups, as specialist departments or as separate functions for categories of patient.

The description chosen here is based on groupings of patients who need separated services, although there is always overlap and joint usage. The test of comprehensiveness is what is left out rather than the enumeration of what is available.

4. Some general statements of objectives and measurement are also necessary as is an account of how the service is to be planned, managed and developed, which will follow at the end.

OBJECTIVES

5. The objective of a comprehensive community psychiatric service should be "to contain and eventually reduce the psychiatric morbidity of the community".

6. Most contemporary services aim to provide care in a domestic setting as far as possible and to disrupt the personal, social and occupational lives of those who become mentally ill as little as possible. It is national policy to work towards the establishment of locally based services which are self-contained within each health care district.

7. Services also aim to be sensitive to community needs, to be open to community scrutiny and to preserve the rights, dignity and the exercise of choice of all patients in their care.

8. A complete service is also concerned with the recruitment of good staff and their career development, professional training, research, public education and health education. Research and training is a particular aim of services associated with a teaching department or training schools. It is a complex organisation which takes up just short of a fifth of the resources of the health service. It needs to be described and planned most carefully.

9. The description of the service is divided into sections. Part One concerns the grouping of patients who appear to need separated services. Part Two is about the links with other agencies that provide services for the mentally ill. Part Three describes the organisational arrangements for planning and managing the service, the organisational links and how is to be monitored.

10. PART I

GENERAL PSYCHIATRY

PSYCHIATRY OF CHRONIC MENTAL ILLNESS

PSYCHIATRY OF OLD AGE

ALCOHOLISM

DRUG DEPENDENCY

FORENSIC PSYCHIATRY

PSYCHIATRY OF DISTURBED BEHAVIOUR

PSYCHIATRY OF ADOLESCENCE

PSYCHIATRY OF CHILDHOOD

PART II

PSYCHIATRY IN PRIMARY HEALTH CARE

PSYCHIATRY WITHIN SOCIAL SERVICES

PSYCHIATRY IN HOUSING

PSYCHIATRY IN VOLUNTARY ORGANISATIONS

PSYCHIATRY IN SELF HELP AND INFORMAL CARE

PART III

ORGANISATIONAL ARRANGEMENTS FOR:

- STRATEGIC DEVELOPMENT
- POLICY OBJECTIVE SETTING
- FINANCING
- PLANNING
- MANAGEMENT
- CO-ORDINATION WITH OTHER SERVICES
- INFORMATION
- MONITORING

11. The normal requirements for beds, day places and staffing, that is, the numbers required are not given here. Each District has a balance between the different elements and has to determine its own needs within the guidelines suggested by the DHSS and the RHA. What is required is that the balance of care is served.

12. GENERAL PSYCHIATRY

Inpatient beds

locally based in DGH or general hospital with access to whole range of general medical services and investigation (especially special neurological and neurosurgical investigation).

Outpatient clinics

within reasonable travelling distance of community served.

Walk-in or emergency clinics

daily, if not at night and weekends.

Psychiatric service for A & E Departments

Liaison psychiatry

for the other departments including self injury and self poisoning.

Day hospital places:

i) in association with the main inpatient unit,

ii) peripheral day hospital units within reasonable travelling distance of community served,

iii) intermittent day hospital places for small or scattered population,

iv) specialist day hospital places

eg for alcoholism, elderly mentally infirm, children, adolescents and etc.

Community Psychiatric Teams

Consultant led multidisciplinary teams responsible for an agreed catchment area.

Domiciliary consultation

24 hour availability. This also requires adequate numbers of doctors approved under Section 28 (England) of the Mental Health Act.

Domiciliary assessment

Availability of all disciplines to visit at home whether at time of crisis or to plan future management.

Community Psychiatric Nursing Service

i) attached to general psychiatric teams

ii) specialising in the psychiatry of old age

iii) nurse therapists and counsellors

iv) attached to general practice

v) in rehabilitation and resettlement

Crisis intervention or community intervention teams

Jointly between health and social services. Usually needs a local base in a day hospital, community mental health centre or a simple local base.

Psychotherapy Department

Advisory, teaching and assessment service and availability for full range of treatment techniques; individual, group, family and behaviour modification.

District psychology services

With an agreed contribution to psychiatric services but also available to other departments and to primary health care and social services.

District occupational therapy services

Working within hospital and community psychiatric services.

District physiotherapy services

Working within hospital and community services but especially for the elderly frail and mentally infirm.

Secure accommodation

i) within the general psychiatric service

ii) access to medium secure accommodation (see also FORENSIC)

Non acute hospital services

Continuing care wards (residential, long stay, slow stream rehabilibation)

Rehabilitation places

Intensive care unit - disturbed ward, behaviour modification ward, token economy ward.

Mother and baby unit

(May be within psychiatric unit) or a unit for mothers and young children.

13. PSYCHIATRY OF OLD AGE

- A Department of Psychogeriatrics, Mental Health Care of the Elderly, Department of Old Age Psychiatry, Department for Mental Illness in Old Age.

- Psychogeriatric assessment unit

  Access to geriatric and general hospital departments. Sited in general hospital if possible.

- Unit for treatment of functional psychiatric illness.

- Joint assessment between psychiatry and geriatric departments.

  A ward or shared beds, in association with the geriatric department.

- Fast stream rehabilitation beds.

  Special contribution from OT, physiotherapy, psychology and social workers.

- Slow stream rehabilitation beds.

  Special contribution from community psychiatric nurses, social workers and voluntary organisations.

- Continuing care beds.

  Sick ward and nursing of infirmity.

- Holiday relief beds

- Intermittent care beds

  Care sharing "10 in a bed". Special contact with relative support groups and general practitioners.

- Crisis and emergency beds

- Day hospital places for elderly mentally infirm, especially for assessment and relief of supporters.

- Out patient clinics

  Referrals other than in crisis. General practitioners seek advice.

- Domiciliary consultation and assessment

  In crisis and to plan management

- Consultation, advisory and support services for general practice, residential homes and social workers on elderly mental infirm

- Day centres for elderly mentally ill.

- Specialist community team for elderly mentally ill especially specialist CPNs

- Relative support groups

- Retired Person's Advisory Group

  Network for information and counselling.

- Home help services
- Community Nursing Services

- Health Visitors

- Home meals

- Street wardens and neighbourhood schemes

- Home care assistants

- Augmented home care ('flying squad')

  The response to improved communication systems, such as radio links (Piper communication system)

- Elderly Persons Homes

  i) Special EMI homes

  ii) EMI Wings in ordinary homes

  iii) Group living ordinary homes

- The Private sector for old people

  i) Rest homes

  ii) Nursing homes

  iii) Housing associations

14. PSYCHIATRY OF CHRONIC MENTAL ILLNESS

- Hospital rehabilitation unit or wards
- Rehabilitation and resettlement team
- Progressive hospital accommodation

  cubicles, single rooms, group living, flats, rehabilitation homes within hospitals
- Occupational therapy department with ADL
- Industrial therapy (graded work)
- Social rehabilitation groups

  literacy, social skills, domestic management
- Joint health and social services resettlement scheme.
- Local authority Old Persons' Homes
- Mental illness hostels

  i) residential
  ii) assessment and crisis
  iii) rehabilitation
- Hospital hostels.

  the experimental schemes
- Sheltered lodging scheme

  landlady groups
- Supervised accommodation

  jointly with housing department
  housing allocation for mentally ill
- Staffed group homes
- Group homes

  i) District Council

  ii) Voluntary Associations

  eg MIND, Housing Associations
- Rehabilitation houses

- Halfway homes eg Richmond Fellowships etc

- Special Hostels

  eg St Dismas, Cyrenian

- Sheltered housing

  (Warden supervised)

- Very sheltered housing

  (Warden supervised and augmented home care services) Managed jointly by social services and housing departments.

- Independent housing

  Special housing schemes and Housing Associations

- Day Hospitals

  Special arrangements for chronic mental illness

- Day Centres

  Provided by local authority

- Occupation and activities centres

  Provided by voluntary bodies eg MIND

- Luncheon and social clubs

  Provided by local authority

- Sheltered work

  i) Local authority
  ii) Voluntary bodies eg PRA
  iii) Department of Employment
  iv) IRUs
  v) Industrial Therapy Organisations
  vi) Enclave working

- Social Services Area Teams

  either generic social work for a defined popupation ("patch") or specialist social work arranged in client groups.

15. ALCOHOLISM

- A consultant with special responsibility for alcoholism. Staff of all disciplines with responsibility for alcoholism.

- Alcoholism unit, outpatients and day hospital.

- Detoxification beds or arrangements for detoxification.

- Access to Regional Unit for Alcoholism.

- Information and counselling service (preferably through a Council for Alcoholism).

- A forum for interested agencies: Health, Social Services, Probation, Police, Magistrates, Prisons, Industry, GPs, Church, Hostels etc.

- Self Help Groups

  AA, AL-Anon, Al-ateens, ACCEPT, Libra Project, etc.

- Half Way House

  Recovering alcoholics

- Hostels for persistent drinkers

  eg St Dismas, Cyrenians, etc.

- Service to Hostels

  Church Army, Reception Centres, etc.

- Information and advice service to other agencies.

- Public and health education.

16. PSYCHIATRY OF DRUG ADDICTION

- Consultant with special responsibility for drug addiction and "substance abuse".
- Other professional staff in support:

  nurses, social workers, psychologists and voluntary workers.
- Inpatient facilities
- Outpatient clinics
- Outpatient or day hospital

  premises for community management of drug addiction.
- Advisory Services for other agencies.
- Advisory services for families, education and prevention.

17. FORENSIC PSYCHIATRY

- Consultant with responsibility for forensic psychiatry
- Other professional staff in support:

  nurses, social workers, remedial therapists, psychologists and voluntary workers, together making specialist team.
- Medium secure unit or access to a Regional Unit
- A unit within the psychiatric hospital
- Outpatient clinics
- Access to day hospital care
- Half Way Houses
- Supervised accommodation
- Sheltered or supervised employment
- Access to services for chronic mental illness
- Contact with special hospitals, prisons, remand centres, probation centres etc.

18. PSYCHIATRY OF DISTURBED BEHAVIOUR
(Other than forensic services)

- Consultant with responsibility within the District, for non-forensic patients with persistenly disturbed behaviour.
- Associated staff such as nurses, psychologists, occupational therapists, social workers
- Unit for behaviour disturbance, such as behaviour modification unit, intensive care ward, disturbed ward, token economy ward, etc.
- Access to forensic and psychology services.
- Access to social services managing disturbed behaviour.
- Access to probation and prison services.

19. PSYCHIATRY OF ADOLESCENCE

- Consultant with responsibility for psychiatry of adolescence.
- Staff associated with department of adolescent psychiatry:

  nurses, social workers, occupational therapists, and other therapists, psychotherapists, psychologists and teachers.
- Inpatient unit, regional or local.
- Outpatient clinics.
- Day hospital and assessment places.
- Family support services.
- Services to other agencies.
- Court and probation links.
- Support for general practice.
- Education and preventive services.

20. CHILD PSYCHIATRY AND CHILD GUIDANCE SERVICES

SERVICES - STAFF:

- Consultant psychiatrist with responsibility
- Psychiatric social workers
- Educational psychologist
- Child psychotherapists
- Nursing Staff
- Teachers

SERVICES TO:

a) General practice

Specialist services

b) Social services

Probation services

Education authority

Community services

c) Assessment centres

Courts

Residential homes

PREMISES:

Inpatient unit

Outpatient clinics

Assessment centres

PART II

21. PSYCHIATRY IN PRIMARY HEALTH CARE

- Consultation in surgery or health centres
- Outpatient clinics
- Domiciliary consultatation
- Domiciliary assessment
- Access to psychiatric community teams, such as community psychiatric nurses, psychiatric social workers, occupational therapists
- Referral to clinical psychologists
- Contact between primary health care personnel and specialist team
- Crisis and community intervention services (see also GENERAL PSYCHIATRY)

22. PSYCHIATRY WITHIN SOCIAL SERVICES

- Joint strategic planning (JCC and JCPT)
- Joint management of shared facilities (Management of joint finance and shared premises)
- Joint working of specialist staff.
- Available specialist advice for crises
    - i) Mental Health Act
    - ii) Section 28
    - iii) Monitoring of compulsory admission
        - a) Section 29
        - b) Section 25
        - c) Section 26
        - d) Section 136, with police
- Hospital social work departments: staffing and responsibilities
- Assessment for residential care
- Joint assessment with health and housing departments

- Family management and treatment

- Contribution of health services to advice on management of shared problems

- Support and advice for treatment of the mentally ill in social services care.

- Contribution of health services to education and training on mental health

23. PSYCHIATRY IN HOUSING

- Joint assessment of the mentally ill for housing needs

- Joint supervision, with social services

- Access to day care, employment, social activities and leisure for the mentally ill

- Development of housing component of the range of accommodation for the mentally ill

- Financial issues in housing for the mentally ill

- Housing Associations

- Group Homes

24. PSYCHIATRY IN VOLUNTARY ORGANISATIONS

- Support and advice for committee structure and organisation

- Assistance with education

- Support for projects

- Support for development of premises

- Advice for counselling groups

- Support groups

- Self help groups

- Advice for advocacy

- Information services

- Access to statutory services

- Housing Associations

- Group Homes

- Private Hostels and Homes

- Day Centres

- Employment and Occupation Centres

25. PSYCHIATRY IN SELF HELP AND INFORMAL CARE

- Support for self help groups, for example, Alcoholics Anonymous, AL-ALCOL, AL-Ateen, ACCEPT, Libra, Anorexics Aid, Depressives Associated, branches of the National Schizophrenia Fellowship, Open Door, relative support groups for the elderly mentally ill, etc.

- Advice for Citizens Advice Bureaux, Legal Aid Centres etc.

- Informal advice services.

PART III

26. STRATEGIC DEVELOPMENT

A group to plan a comprehensive service, derived from all contributing bodies having an interest in mental health, both statutory and voluntary groups.

POLICY OBJECTIVE SETTING

The recommendations of the strategic development group, set in priority by district and social services officers for confirmation by health and social services authorities as policy objectives.

FINANCING

Finding the resources to implement the agreed objectives

a) new money

b) joint finance

c) better use of present resources

PLANNING

- The interpretation of objectives following assignment of resources as detailed plans for action

- As Health Care Planning Team

MANAGEMENT

- The implementation of policies with agreed resources towards the objectives of policy.

- Requires a group of staff from each discipline which has the power to dispose resources to combine as an exective body:

i) Psychiatric Services Management or Unit Management Team

ii) Hospital Management Teams

iii) Departmental Teams

iv) Psychiatric Multidisciplinary Teams

CO-ORDINATION WITH OTHER SERVICES

- Within Joint Planning Teams

- In contribution to joint strategy generation

- In implementation of policies and consequent plans

- In joint working, especially where there are differences between disciplines, defining roles and common working.

- Generating proposals for joint funding because of jointly perceived problems.

INFORMATION

A regular service to all service providers that is designed to show how they are performing against agreed policy objectives. This should include trends reflecting admission patterns and length of stay for different categories of diagnosis, age and sex and the performance of individual teams and for the organisation as a whole.

MONITORING

The relation between the outcome described by the information service and the policy objectives declared by the authorities either as separate plans or jointly with other authorities.

COALITION FOR COMMUNITY CARE

Judy Hague
Secretary, Victoria CHC,
on behalf of the CCC Steering Group

Notes of a seminar from the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

COALITION FOR COMMUNITY CARE

Four members of the steering group of the recently formed Coalition for Community Care were present. They described the Coalitions's background, its achievements to date and the obstacles encountered in getting this new organisation off the ground.

The catalyst to its formation had been the plans to run down and eventually close Banstead Hospital in Surrey; one of two major mental illness hospitals serving the boroughs of Westminster, Kensington and Chelsea. The boroughs were served by three district health authorities (Victoria, Paddington and North Kensington and Bloomsbury) none of which were co-terminous with a single local authority. In addition, the borough of Westminster related to two different Joint Consultative Committees and, to confuse matters further, Bloomsbury Health Authority was in a different region from its two neighbouring DHAs.

The three CHCs and two Mental Health Associations serving the boroughs had always cooperated and worked closely together. Whilst supporting the Banstead and Horton strategy, they were also convinced of the need to plan and develop a comprehensive community based psychiatric service in advance of the closure of Banstead Hospital. In examining current district services, fragmentation and marked disparities between the three Health Authorities and the two Local Authorities, and even, in some instances, between different parts of the same District emerged. The creation of the District Health Authorities under the reorganised NHS looked set to increase fragmentation and to make successful joint planning an even more remote possibility. It was against this background that the idea of the Coalition was born and it was decided to launch the new organisation at a workshop, held in July 1982.

A planning group was set up and fifty people were invited to the workshop from the health and local authorities, the voluntary sector and the CHCs. Our aims were two-fold: firstly, to initiate further discussion on what the essential components of a comprehensive community based service were and, secondly, to unite organisations and individuals in a campaign for community mental health resources to be known as the 'Coalition for Community Care' or CCC The workshop was judged a success, the Coalition was born and the attached position paper was adopted. A steering group was entrusted with the task of putting the Coalition on a more formal basis.

Our next event, in the Autumn of last year, was a seminar entitled 'Where are the funds for community mental health facilities?' Our speakers were David Knowles, District Administrator, Victoria Health Authority, responsible for the Banstead and Horton strategy, and Ms Gillian Lomas of the Community Psychiatry Research Unit, Hackney Hospital. Their talks pointed to the same road ahead for the Coalition - to be really effective it would have to be more than a loose federation of individuals and organisations concerned about the provision of community mental health facilities. It would need to become an active body employing its own worker in order to be in a position to make a detailed enough assessment of need to influence service development and to attract resources in to the district. The steering group was encouraged by the high level of interest in its venture and the calibre of those attending the events organised.

In less than a year, the Coalition had made several positive steps forward. For our inaugural workshop, a description of existing facilities had been prepared including the NHS, Local Authority and voluntary organisation provision, preventive and rehabilitative facilities including housing and employment. This exercise had highlighted gaps and differences between the

three DHAs. A preliminary list of the elements in an ideal service had been drawn up in the form of a position paper. Attendance at our two workshops had been good. In fact, we had to turn people away through limitations of space. These two events had provided a forum in which people who do not usually meet had come together and new contacts had been made. For example, a GP who attended our workshop had met the CHCs Secretary for his locality who had been able to provide him with much needed information about community facilities - particularly for the elderly.

We stressed the importance of the Coalition as a mechanism for cutting across false boundaries. We saw the Coalition as an education forum by passing geographical, political and professional boundaries and providing a venue for an exchange of views outside official settings.

The group had debated the merits of different working models - one possibility was to use a pressure group model, another was to adopt a collaborative approach and to seek to disseminate good practice through education and research. Each member of the steering group had to examine their own relationship to the group and question whether they spoke within it as an individual or as a representative of their organisation. These were among the issues that the steering group had to debate and to clarify.

The group is in the process of defining its aims, establishing a constitution, putting together a job description and drawing up funding applications. An annual grant over three years has already been obtained.

Finally, the value of establishing a separate organisation. It was felt that the complexities of Kensington, Chelsea and Westminster demanded a single unified organisaton with an overview of the needs of the two boroughs. This theme was picked up in questions from the audience and subsequent discussions. Some of the audience felt that a comparable organisation would be unnecessary in a district with co-terminous local and health authority boundaries. Another member of the audience felt that a similar consortium of alcoholism agencies in South East London had proved the value of such a forum. A CHC Chairman asked in what way the Coalition could have an input beyond that of the existing CHCs and mental health associations. We stressed the importance of an overview and added that a full time officer, if appointed, would be able to carry out research which the CHCs and mental health associations would not have the time or the resources to undertake. The Coalition would not seek to provide services but rather to act as catalyst in the identification of need and the highlighting of good practices. A theme which had run through the whole conference, and was stressed by the DHA member who spoke, was the need for informal discussion forums involving authority members, practitioners and planners. The Coalition was seen as one mechanism for achieving this aim. A GP member of a health authority was disappointed that the presentation had not given a detailed assessment of the elements of a community based service. It was agreed that this was a major task to which the Coalition would give priority when formally constituted.

For further information about the Coalition for Community Care, please contact Judy Hague, Victoria CHC, Tufton Street, London SW1 (tel. 222 6957)

COALITION FOR COMMUNITY CARE POSITION PAPER FOR ADOPTION AT JULY WORKSHOP

The closure of Banstead or Horton hospital is a considerable challenge to the newly created district health authorities. The Victoria Health Authority has the forbidding task of implementing the Banstead and Horton strategy, and together with its neighbouring Paddington and North Kensington and Bloomsbury Health Authorities, simultaneously developing locally based psychiatric facilities within the Inner city including those for the different categories of patients returning to the community from these two large Surrey based institutions.

The three CHCs and two Mental Health Associations in Westminster, Kensington and Chelsea unanimously agree that, if Banstead and Horton hospitals are to merge, and one of them is to close, it must be clearly demonstrated in advance of the closure that a planned community care programme, including the promotion of positive mental health, has not only been drawn up but has received adequate funding to allow it to be put into operation.

Facilities in the community at the moment do not meet the needs of an often transient population with a high psychiatric morbidity. Services are fragmented and there appears to be a lack of coordinated planning with little involvement of the voluntary sector.

In addition to the necessary acute and long term in-patient provision, based locally, we consider that a range of community services should be made available so that people suffering from mental illness can have access to facilities flexible enough to cater for their individual needs.

The following elements are essential in any community based service:

1. Community Staff

   - Community pychiatric Nurses (including attachment or outposting with GP practices)
   - Social workers
   - Development of community intervention teams
   - Community OTs
   - GPs properly informed about and integrated with psychiatric services

2. Community Facilities

   - Open access centres
   - Drop-in centres (advisory/treatment perhaps associated with a health centre)
   - 24 hour advice service for relatives
   - Emergency overnight accommodation
   - Services for alcohol and drug dependents

3. Prior to Discharge

   - Provision of welfare rights and housing advice
   - Information on support services
   - Liaison with families

4. Rehabilitation

- Preparation for discharge in Occupational or Industrial Therapy Units
- Day Centres
- Day Hospitals
- Work experience in sheltered workshops
- Opportunities to volunteer
- Disablement Resettlement Officers
- ILEA classes

5. Accommodation

- Therapeutic communities
- Hostels
- Half way houses
- Group homes
- Public sector housing

6. Social Facilities

- Evening, weekend and lunch clubs
- Befriending schemes

7. Voluntary organisations

- Liaison with and involvement of voluntary organisations in the planning and provision of services

8. Other Activities

- Transport
- Home helps
- Meals on wheels
- Locally based out-patient facilities

9. Provision for Elderly Mentally Confused Patients

- Community psychogeriatric staff
- Day care facilities
- Relief and support for families caring for a confused relative.

In addition, we would emphasise the fact that the vast majority of people medically treated for mental illness never use hospital psychiatric facilities. Local services have to be able to help this group, and liaise with the many voluntary organisations who offer supportive help in times of stress. Ways of preventing breakdown at a time of crisis need to be explored.

We propose that interested bodies and individuals come together to monitor the implementation of the Banstead and Horton strategy, to press for the community care programme outlined above and to ensure that existing resources are used effectively, resources released by the rundown of the Surrey based institutions are put into locally based services and all possible sources of funding including revenue, capital, joint finance, DHSS and charitable monies and urban aid programme monies are explored. Coordinated planning between the health districts, local authorities, CHCs and voluntary organisations is essential and we would argue that some form of working party involving all four parties in equal measure should be established.

We recommend the formation of a COALITION FOR COMMUNITY CARE which would fight to ensure that these objectives are achieved.

THOUGHTS ON PSYCHIATRIC SERVICE DEVELOPMENT

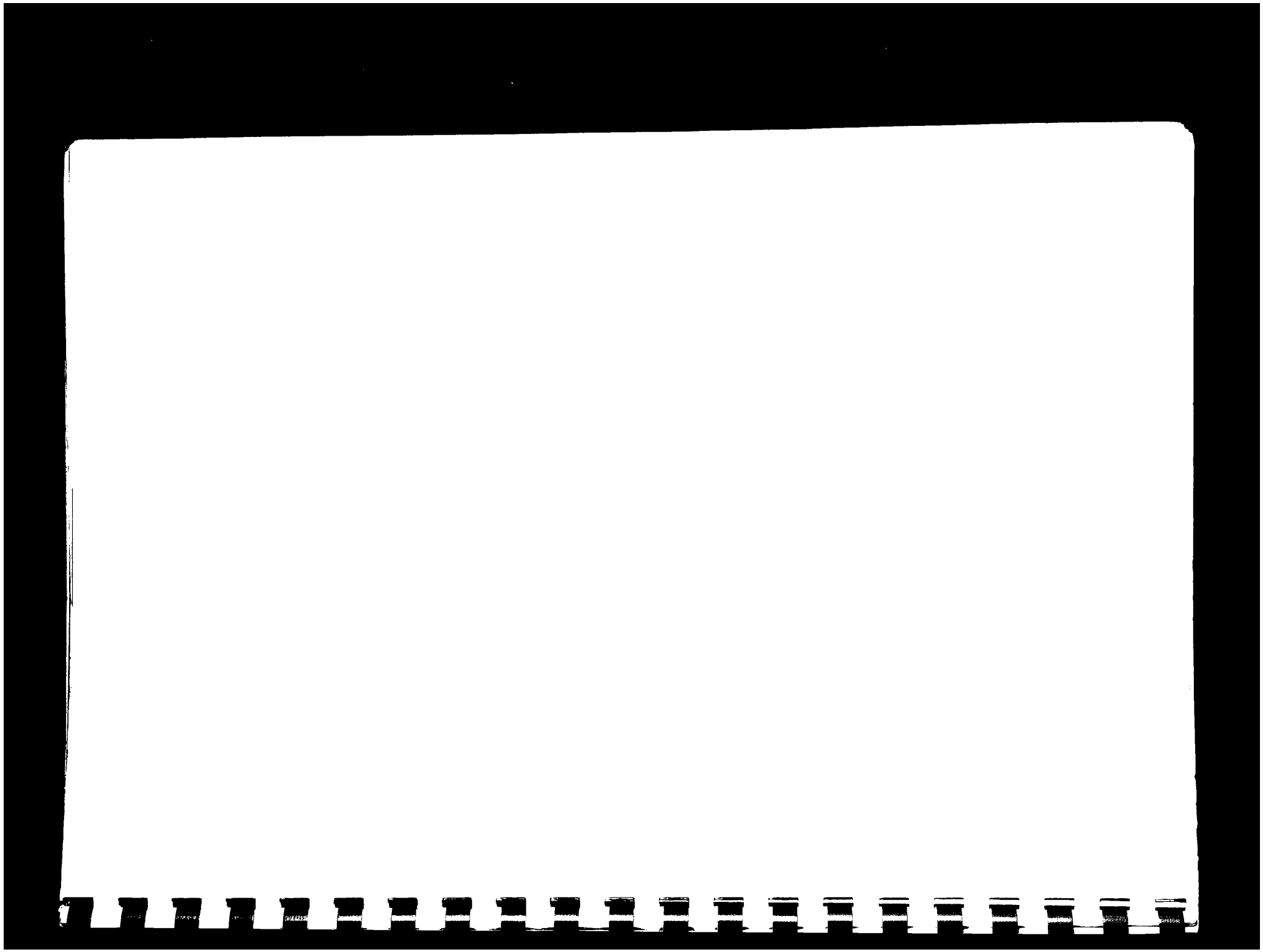
Judy Hague
Secretary, Victoria CHC

Donald Dick
Former Director, Health Advisory Service

Chris Heginbotham
Director, MIND

Douglas Bennett
Formerly Consultant Psychiatrist, Maudsley Hospital

Notes of a panel presentation from the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983



THOUGHTS ON PSYCHIATRIC SERVICE DEVELOPMENT

The notes that follow outline key issues, questions and fragments of advice on the development of services which the speakers have identified from their own experience. They are introduced as a trigger for discussion and thought rather than rounded proposals or policy.

Judy Hague

1. Does a good description exist on what is already available in your District? - If it doesn't, make sure someone takes responsibility for doing one and that it covers the whole spectrum not just the Health Service.

2. Do you know already where the good practice is? If you don't go and find it. Beware of trying to transplant good practices from outside in the belief that they will necessarily work in your District. If you find your good practices, set about spreading them throughout your District, and see if they can be replicated in areas where they are not already being done.

3. Has a description already been drawn up of what your District will need in terms of a comprehensive service? If it has not, who is going to take responsibility for doing that?

4. This next point comes from the experience of the Coalition for Community Care (see relevant paper). I would stress the usefulness of creating informal forums for discussion, where nobody is there 'wearing their hat' and having to make decisions, but where you can mix representatives of the Health and local Authorities with GPs, with practitioners, with voluntary organisations, with volunteers, with CHCs, with users, with the housing department, with people in employment, with education. That is the type of thing which we have been trying to achieve in Kensington, Chelsea and Westminster and which I think has been proving enormously helpful.

5. One point for DHA members is that when you are looking at the plans presented to you, look at them in terms of their flexibility for future use since conditions are always changing. Think also, in terms of not only bricks and mortar but in terms of personnel and working methods.

6. Finally, if, as our own Health Authority is doing, you are embarking on a long term strategy to close an out of town hospital encourage your Health Authority to think also in parallel of planning what is going to replace those out of town hospitals and don't wait until the closure eventually comes.

Donald Dick

1. I think a Health Authority should demand of its service providers an account of what it is doing and what it intends to do. I think incidentally that this is a demand that might be made of each of the component services of any Health District in turn. Ask the service providers what they are doing and out of that what they need to do it better. That is like an annual account of what is happening within a comprehensive mental health service.

2. Secondly, it seems immensely important to realise that work is not done unless it is assigned and I believe that we should be absolutely certain that the work of the mental health service should actually be given to named individuals. The thing that would please me most to see in a Health District, I think, would be something like the distribution of business that one sees in

government departments and civil service departments. It is one of the better aspects of bureaucracy. Who is responsible for what? Not which group but which person. Certainly not just a translation of philosophy into a general intention.

3. Experience of good services around the country always seems to show the immense importance of a core group of people working together with a common objective in mind. I think that the advantages of developing core groups of people to perform certain parts of the task which together make up the jigsaw puzzle is not emphasized enough. We plan buildings, we plan staffing, we plan training, we plan equipment, paying awfully little attention to the factors which make for a highly effective group. We are nothing like as good at that as any ordinary shoe sale company.

4. And fourth, a very important part is that no service can really work properly without a decent information service. A service that enables it to know whether or not is has met the policy objectives set by the Health Authority, whether it is doing well or badly, whether it is being efficient or otherwise. And it is embarrassing to see how very little information can be routinely obtained from mental health services, geriatric services and, I suspect, any other kinds of services around the country. Where is your statistical bulletin? We used to have one but we stopped it in 1975 because nobody ever read it.

Chris Heginbotham

1. My feeling is that one of the lessons we have learnt is that simply closing hospitals without having some form of service for people in that area is not the right way round. What we have got to do is to develop comprehensive local mental health services with the consequence being the closure of some of the very large hospitals. I hope the consequence would be closure, but if we are concerned about individual users we should concentrate on developing a comprehensive service first.

2. My second point is that I believe that staff at all levels must be involved in all stages in the planning of the service. I think what tends to happen is that some consultants are involved, some individuals who are very keen get involved, but the staff throughout the hospital from those working in catering and ancillary services right through to the medical services don't get involved. I think we must make every effort to involve staff. We must consider training, retraining, removal allowances, or whatever it happens to be which is crucial to the needs of those staff.

3. Thirdly, I believe that 'Community Care' is not a cheap option - it never has been and it shouldn't be allowed to become a cheap option. We should become more conscious of where we are spending our money and the relative spending on different types of services. We are putting the little money bags into Community Care and large amounts of money are still going into the hospitals.

4. That brings me to the fourth point - in a sense all the work which we are involved in now is because of underfunded services. It is not because of bad staff or poor services given by those staff but because the hospitals are under funded, under resourced and with staff who are not given proper training. If we are going to do something about that, and to try to get more money into the service, let us do it in far more appropriate settings rather than put money into the existing big institutions.

Douglas Bennett

1. When we are talking about comprehensive services, I suppose that I believe basically that there are only two kinds of comprehensive services. Those services for people who are personally agreeable and rewarding patients and those services which are for people nobody wants to treat. Whether you go down through 'alcoholics' or 'schizophrenics', or whatever, you always divide up in this way. The word in America was YAVIS patients - Young, Attractive, Verbal, Intelligent and Social - those are the patients that people want to treat and then there are the rest. If we do look carefully at where resources have been allocated within Psychiatric Services, we can interpret it as giving money, as the King's Fund does, to chronic patients. Where the money has gone to distant large institutions it is because that is where these patients are. Health Authorities and the King's Fund would be justified in not giving money to the community until people are prepared to provide services in the community for chronic patients. I think one of the greatest things in this period of change is for Health Authorities to ensure that services are provided for people nobody wants to provide for.

2. The second point is that none of the numbers given in the statistical guidance is God given. Those figures are perfectly alterable by doing different things. For example, the number of new long-stay patients in a service reflects both the work which is being done to rehabilitate those patients and the alternative services that are available. Some people talk as if this were a fixed thing and as if you had to provide for a set number of new long-stay patients. This is not the case. What we should do is to treat these figures simply as indicators of 'how things are' in a service.

3. The third thing is that I think the task is to encourage hospitals to change. When we are talking about taking money from the 'Mental Hospital' to this place called the 'Community', it is very difficult to picture what the community really is. It is not enough to move the 'Hopsital' into the 'Community'. Psychiatric services and hospital services have to change and we have to look for a new model. We must now think carefully about what is needed for the medical part of these services. The borderline between medical services and non-medical services is changing all the time and we must decide whether to cross that boundary - for example, to have a unified clinical team which treats all kinds of people including in-patients, day-patients, out-patients, and so on - or to maintain a barrier between health services and other services.

PRINCIPLES OF MENTAL HEALTH SERVICE DEVELOPMENT
DISCUSSION DOCUMENT

Chris Heginbotham,
Director, MIND, (the National Association for Mental Health)

A seminar paper at the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

PRINCIPLES OF MENTAL HEALTH SERVICE DEVELOPMENT: DISCUSSION DOCUMENT

1. Introduction

Any discussion of the principles which should inform a local comprehensive mental health service must return to certain fundamental and basic issues. These concern the reasons for the service; the needs and rights of individuals; the social, environmental and political context of expressed need; and the widely varying models of treatment and care available or appropriate to differing perceptions of need. It is not sufficient to make assumptions on priciples without consideration of the wider philosophical dimensions of models of treatment and their purpose. This paper is an introduction to that discussion but does not attempt a deeper analysis.

2. Some Questions

Any proper discussion of principles must provide an answer to some of the following questions:

- Why is there a desire to move beyond the hospital?
- What is 'Community Care'?
- Are there illnesses which are specific to certain social or environmental situations?
- What are the rights of the individual to appropriate treatments? Or the rights to refuse treatments?
- What are the limits society puts on the freedom of a person who is or may be a danger to himself or others, and what if no treatment is available?
- What should society do about the person who would appear to others to require care, and for whom treatment might well be efficacious, but refuses treatment (especially if not dangerous to self or others)?
- Finally, at what point is the line drawn in providing secure provision for the non-offender to effect that treatment?

Related to these more philosophical questions are the practical problems of costs in human and financial terms.

Any serious and coherent philosophy of care must try to address all these questions.

3. Hospitals

There are conflicting views of hospitals as institutions and as places for treatment and understanding. Firstly, there must be a clear decision as to the need for asylum, which must be seen as an important part of any comprehensive service. Secondly, a misleading analogy must be dealt with - that large institutions equate to bad practice and therefore hospitalisation per se is bad. Thirdly, there is the bandwagon effect of saying 'community care' over and over again which has a soporific and entrancing effect such that its chanters seem to become oblivious to its imperfections. Fourthly, the message about mental health or mental illness services is different to the message for mental handicap services. The message in mental handicap is relatively simple - provide ordinary housing and an ordinary life with care and support appropriate to the needs and wishes of the individual. For mental health services that message is too simple - it is part of the total - but the

qualifications and amendments produce a different message. They must not be confused. Mental handicap hospitals are simply large, albeit uncomfortable, hotels. Mental illness hospitals may have much wrong with them, may be under-funded and under-staffed, contain bad practice, be overly custodial, have a large proportion of 'hotel only' clients, far removed from the communities served, but contain, in part, treatment services for clients suffering illness. That is not to say the treatment cannot be provided in a different setting - it is to say it must not be forgotten.

Community care must be seen as a 'humanising trend to reintegrate a person into society' - not as a cheap option, or as anti-psychiatry, or anti-treatment or anti-hospital. But, if we base the service on the principles set out below, the service becomes related to the individual's needs for care, support and reintegration appropriate to the person's needs; and questions as to whether the service design is a cheap option, or anti-hospital, or anti-treatment are sterile debates which can be avoided.

It is important to start with perceptions of the needs of individuals within the 'community' to develop a description of service needs in that community and strategies for implementation on that base, and not to start with the hospital and try to determine which bits of the hospital service should be or could be moved into or nearer the community.

4. First Principles

Over the last twenty or thirty years a steady shifting has occurred in Western thought from a utilitarian ethic of welfare to a much stronger rights orientated approach. This has been manifest in the rights approach to social work, to housing benefits, in the work of NCCL and the approach of MIND to treatments and consent, especially in the drafting of the Mental Health (Amendment) Act 1982.

The trend to rights as opposed to utility is not complete and it is as yet difficult to see the likely final (if there ever is a final) position. Already the 'rights' arguments have thrown up totally competing philosophical positions - in particular those of Rawls[1], Nozick[2] and Dworkin[3]. In order to develop a clear set of principles for a local psychiatric service a primary task is to decide on a theoretical starting point and a practical base level for a service. To this end the new Amendment Act should help in developing the practical strategy towards improved service provision.

Underpinning this discussion is the concept of individual freedom or liberty. The starting point should be as defined by Dworkin - that the central concept is of equality, not liberty. He presumes that 'government must treat those whom it governs with concern, that is, as human beings who are capable of suffering frustration, and with respect, that is, as human beings who are capable of forming and acting on intelligent conceptions of how their lives should be lived. Government should not only treat people with respect but with equal concern and respect. It must not distribute goods or opportunities on the ground that some citizens are entitled to more because they are worthy of more concern'. This is linked to his view of a 'strong right' defined by saying that if - 'someone has a right to something, then it is wrong for the government to deny it to him even though it (may) be in the general interest to do so.' This is important in defining our view of the services mentally ill people are entitled to - but should not be confused with positive liberty. Such a statement is not in contention with bounded negative freedoms, that is, the rights to freedom of action within agreed parameters or liberty as licence. 'Liberalism based on equality... rests on a positive commitment to an egalitarian morality'.

This starting point allows us to develop the notion that the individual has a right to whatever help or support that individual requires in time of crises. On the utilitarian model this would not be so - by locking up 50,000 mentally ill people it might be possible to show that total happiness of the population is marginally increased, at the expense of considerable misery to the minority.

It is also important to distinguish liberty as 'licence' from the above definition of liberty as equality. Liberty as licence is the freedom of individuals to do or not to do certain things. Certain clear rules can be formulated in our existing society. For example, everyone (on a trivial level) has the right to their own toothbrush, but not to kill another person. Society makes laws for the general good of all - and these clearly reduce freedom (as licence) but are accepted as necessary compromises to ensure that one person's freedom is not a severe constraint on that of another. This distinction is needed so as to avoid confusion between equality of service as of right to the mentally ill person; and the right of society to constrain the violent or dangerous person. The main difficulty, of course, arises when society has to decide if a person is capable of making rational choices, and this is what all the argument over consent to treatment has been about, and why the new legal framework in the Mental Health (Amendment) Act is so important.

5. Assumptions

On the basis of the foregoing discussion it should be possible to develop assumptions on which to build principles of a service. The following are suggested. These, to some extent, follow work by John O'Brien[4] and others - but have been modified to try to accord with the basic philosophy set out above and to turn 'Teutonic American' into something vaguely understandable.

The assumptions are:

a) A service should not be based solely on concepts of 'illness' but a much wider understanding of the individual's equal status as a citizen, and therefore -

b) Any discussion/decisions should involve the consumer and should include the consumer's ability to obtain help from society at large. The 'consumer' may be an individual but may include an individual's family, or maybe a family or group.

c) A service can therefore draw on resources within the consumer's natural environment - friends and family networks, leisure contacts, employment etc; yet offering an individual the opportunity to spend time out of usual environment if therapeutically indicated.

d) A service should then facilitate a collective capacity of society (community) to eliminate or cope with disability, whenever possible, whilst accepting that specialist treatment role is still required.

e) Mental disability can be improved, reduced or stabilised, and although continuous, does not render a person unable to live an independent life, given certain support.

6. Principles of a Service

From these assumptions, seven principles emerge. A local comprehensive service is one which:

a) Values the consumer as a full citizen with rights and responsibilities entitled to an active opportunity to shape and influence relevant services no matter how severe his or her disability;

b) aims to promote the greatest independence of the individual;

c) aims to provide and evaluate a programme of treatment, care and support based on the needs of the individual regardless of age or severity of disability;

d) aims to help the consumer (client) to as ordinary or normal a life as possible;

e) aims to meet special needs arising from disability through a locally accessible fully co-ordinated multi-disciplinary service given by appropriately trained staff;

f) is delivered wherever possible to the client's normal (usual) social environment;

g) plans actively for reintegration into society of individuals in institutions if they so wish.

7. Bases of Service Implementation

Such principles lead us on to certain planks of service implementation. In short these are:

a) There must be a wide definition of mental health problems, with no single model of 'illness', and hence a service must offer a wide range of care or treatment modes.

b) Services should take full account of the resources within the consumer's 'natural environment'.

c) Services should seek to enhance a consumer's own network; or focus on developing networks necessary to improve integration into society; and consequently -

d) Services should aim to minimise the dependence of the consumer on professional services.

e) Services should relate to the normal patterns of the consumer's life and not expect non-normal patterns to be forced on the consumer. This, for example, means that day and residential services would be separate in the 'norm', though this may not always be the case for certain individuals.

f) The service should maintain acute provision whilst improving support to people with chronic problems.

g) Admission to and discharge from a service should be 'neutral' events, available without prejudice to those requiring the service. Services should not be measured by admission rates, discharge rates, bed occupancy etc., but by clients' perceived ability to reconstruct/reactivate normal social networks.

h) Goals should be set for a service and should relate to natural evolution of the service on the basis of changing needs perceived by individuals and the service.

i) The values of the service should be clearly stated, including the value of normalisation. Normalisation is, itself, a difficult concept, especially as the 'norm' is constantly changing and the development of a value system is like trying to hit a moving target.

(Note: this does not tackle secure provision which must be part of a comprehensive service but requires further detailed consideration).

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SOME KEY ISSUES FOR DISTRICT PSYCHIATRIC SERVICES IN LONDON

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Background paper for the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983

INTRODUCTION

This briefing paper was prepared for a one day conference which is part of the King's Fund programme of consultation and discussion with District Health Authority members in London, concerning the planning and continuing development of comprehensive psychiatric services in all Districts.

The tenor of the King's Fund programme, and hence of this paper, is one of accord with national and regional policy in supporting the run-down and eventual closure of large mental hospitals which do not fit into a pattern of local service provision, along with the development of a full range of hospital and community facilities to serve the needs of local people.

London is an area which, even within most of its 31 Districts, encompasses services at widely different stages of conception and implementation. Nevertheless, despite the 'negative growth' regime, energetic plans are underway and there is confidence that, after years of procrastination, some progress is to be made. The challenge and opportunities are being met with excitement, with some interesting schemes for collaboration which seem bound to influence for the good the chances of achieving an effective service for people with mental disturbance or disability.

The paper is divided into three sections: it is intended as a reference to the main issues, together with guidance as to where to seek more detailed information and discussion:

1. Summary of national policies.
2. The pattern of in-patient services at present.
3. Key issues in the development of comprehensive District services.

SECTION 1

National Policy

1.1 The basis of the present move towards District-based services is the oft-quoted 'Better Services' White Paper of 1975[1] which envisaged a 'local district network' as the new pattern of services. In this pattern, the DGH psychiatric unit was meant to serve not only as an in-patient department, but 'as a centre providing facilities for treatment on both a day and in-patient basis, and as the base from which the specialist therapeutic team provide advice and consultation outside the hospital' (p 29). At that time, the guidance relating to joint health and local authority planning was consigned to four paragraphs on the penultimate page of the text, and discussion of the role of the mental hospitals in the transition period to an apendix! These two main issues are the ones which have proved to be the greatest stumbling blocks in developing a full range of local services for mental illness.

1.2 Since then, the DHSS has produced several papers: in 1976 came 'Priorities for Health and Personal Social Services in England',[2] which reiterated the 'Better Services' strategy, suggesting priorities for a capital programme of £25 million annually to make progress in developing district-based services (pp 54-61).

1.3 Further discussion, based on 'Priorities' was produced in 1977: 'The Way Forward'.[3] By this time there was a distinctly wary attitude to the strategy: 'Progress (towards community care) will vary from place to place depending on economic constraints, local choice and differences in the existing levels of provision' (p 9). Dilatory Districts were given solace: 'Where the pace is slow, the hospital service should continue to make adequate provision' (p 9) - hardly words to incite adverturous planning.

The practicalities of joint planning and finance were still problematic, and were not recognised to be essential elements of progress.

1.4 Subsequently, DHSS papers have promoted a more optimistic view. 'Care in Action'[4] (1981) identified mentally ill people as one of four priority collaboration: 'Health and local authorities have a statutory duty to cooperate to secure the health and welfare of the population' (p 22), dating from the National Health Service Act of 1977. Three urgent tasks were suggested:

i) create local services (following the Norder report);

ii) provide a full range of services for the elderly severely mentally infirm;

iii) make arrangements, over the next ten years, for the closure of mental hospitals not well placed to fit into a district service.

1.5 Attention was paid to the need for resources to create the new pattern of services, and a consultative document, 'Care in the Community'[5] explored a number of ways in which patients and resources might be transferred from the NHS to the personal social services. But despite a host of ideas, joint planning and joint finance is still fraught with problems. In an article reviewing the eight years of statutory collaboration, Howard Glennerster[6] indicates only limited success, at the expense of considerable time. "Local authority officers are grateful for the extra funds joint finance may have brought, but are none too happy with the form it takes or its long-term implications for their budgets, while health officers are none too sure about the value for money they are getting'. Different means of allocation - top-slicing - are tried in order to adhere to the priorities of different interest groups, but there remain three reasons for disappointment, identified by Howard Glennerster:

i) the absence of a long-term review of future resource levels and service development objectives;

ii) the new joint planning machinery has been asked to do the impossible - to make up for legislators' inadequacies;

iii) the whole perception of the way in which organisations and professional people work together was naive.

The article also suggests methods of improving things at a practical level.

1.6 The other issue, that of the closure of poorly located mental hospitals, is largely one with which the Regional Health Authorities must grapple. The record of experience is not encouraging - only 3 hospitals closed in 21 years. The expensive 'Worcester' project for instance, has still not managed to run down its mental institution (Powick Hospital) to a point where it can be closed, despite many years of active development work, well funded by the DHSS.

1.7 Ten years ago the DHSS sponsored a symposium on 'Comprehensive District Psychiatric Services'[7] at which most questions were thoroughly aired and which prepared the way - inevitably lengthy - for the stand which DHSS and the RHAs seem now prepared to make. In 1982 a similar conference was organised by the Community Psychiatry Research Unit at St Bartholomew's Hospital Medical College.[8] At this conference, Lord Trefgarne, Parliamentary Under-Secretary at DHSS, re-affirmed the policy of creating local psychiatric services and doing away with those mental illness hospitals which are not well placed to provide a local service. He enumerated ways in which government could help to ensure that psychiatric services received a fair share of resources:

i) mental illness as a ministerial priority;

ii) annual reviews with RHAs as an opportunity for monitoring progress;

iii) action on the 'Care of Community' initiative - joint finance to include education and housing;

iv) guidance on day care;

v) Mental Health (Amendment) Act.

The feeling from the whole conference, noted from the chair by Dr Douglas Bennett, an eminent proponent of locally-based services, was that the debate is now finally over and the need for a new pattern of service accepted. The issues now are not whether, but how best, to make the change. This is the point from which strategies can be implemented.

1.8 The Mental Health (Amendment) Act (1982) also contributes to the activation of community-based services in accepting the principles of providing care in the least restrictive conditions possible. It provides for the appointment of a guardian - usually, but not necessarily, the local authority - who will have power to ensure that a patient, who is required to live in a specified place, and attend places for medical treatment, occupation or training, is seen by a doctor, social worker or other appropriate person, at home. This arrangement will allow patients who might otherwise have been compulsorily detained in hospital, to remain in the community. It will only be effective if there are worthwhile alternatives to hospital care. The proposed amendment to place a specific duty on the DHA/LA to provide aftercare for anyone detained under S.26 or S.60 of the 1959 Act was initially resisted. It was later felt that such an amendment should strengthen the case for receiving a larger share of available resources.

1.9 The key role of the social worker in effecting a compulsory admission is recognised and measures are proposed to improve training and levels of practice and to ensure that, in two years' time, only approved social workers will be able to enact the statutory functions.[9]

1.10 The responsibility for mental health policy and services in the NHS rests with the Secretary of State for Social Services exercising authority through DHSS. If present policies are to be effective, other government departments will have an increasing role to play.

1.11 In particular the Department of Employment could, through its policies, co-ordinate with NHS day-care and voluntary occupational schemes to increase training opportunities and chances of undertaking some form of paid work for mentally ill people. The problems of finance and benefits should be solved by collaboration at national level.

1.12 As more patients are living outside institutions, the part played by housing policies of the Department of the Environment will become increasingly relevant. At present the concept of 'caring' homes and hostels is rather rigid, and little financial latitude is offered to an authority who wishes to use some of its property for special purposes. There is scope, with pressure from Health Authorities, for a greater degree of collaboration on means of using buildings in a more flexible manner. If the Department of the Environment espouse the policy of care in the community, then there is scope for more explicit recognition, in national housing policy, that many patients will live in 'ordinary' - eg. council homes. If an element of care can be introduced, without all the trappings of a 'special project', or relinquishing property to other agencies, this would greatly enhance the chances of getting a satisfactory home for many mentally ill people.

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5. Circular HC(81)9/LAC(81)5, Care in the Community. A consultative document on moving resources for care in England. July 1981.

6. Howard Glennerster, Barter and Bargains, Health and Social Service Journal. June 24, 1982. pp 771-773.

7. See Cawley R. and McLachlan G. eds. Policy for Action. A symposium on the planning of a comprehensive district psychiatric service. OUP, 1973.

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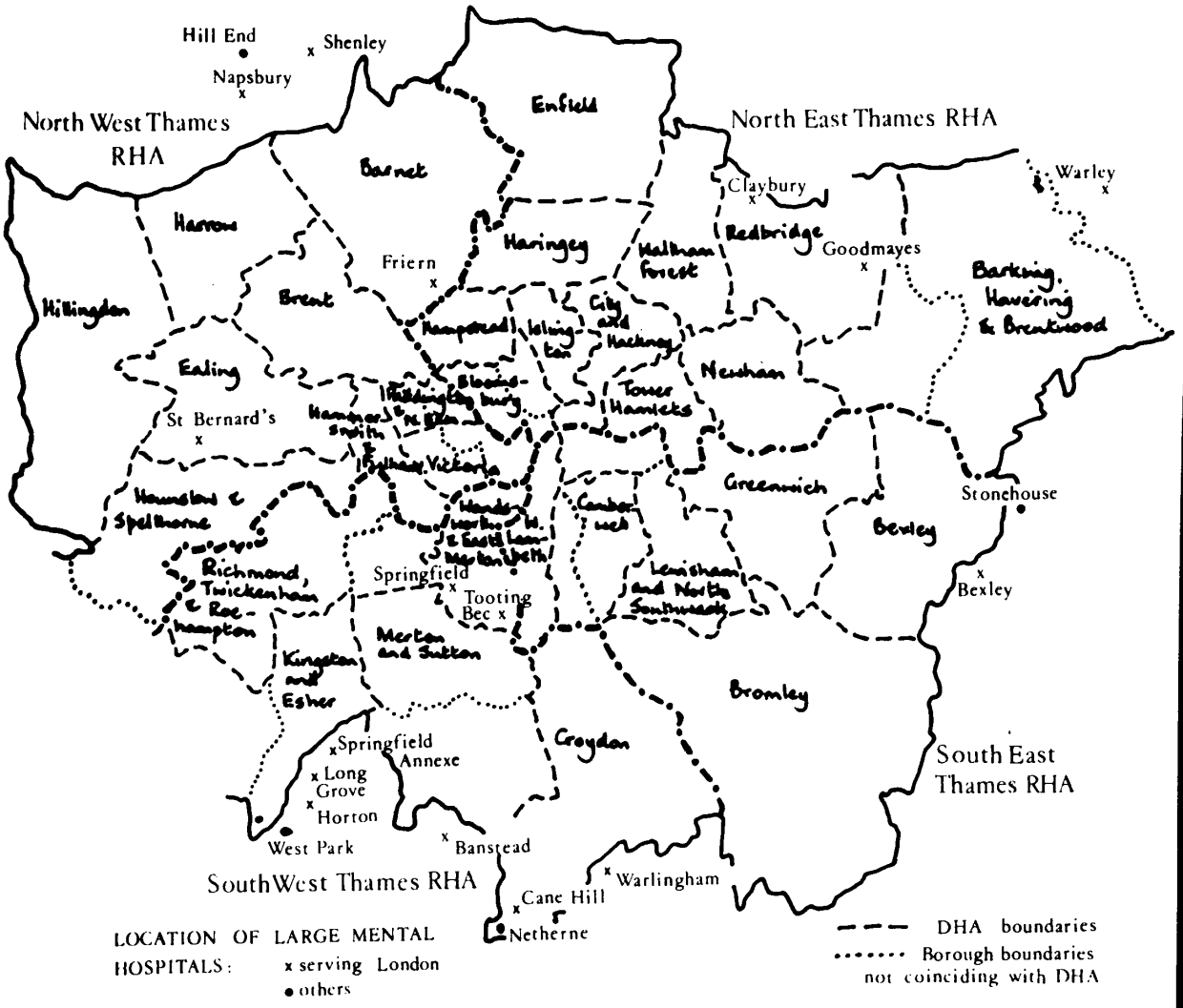

LONDON'S DISTRICT HEALTH AUTHORITIES

SECTION 2

The pattern of in-patient services at present

2.1 The main problem with psychiatric hospital beds in London, as with other facilities - housing is a good example - is not actual shortage, but that many are in the wrong place and are performing the wrong function in relation to present day demand.

2.2 There are 15 large mental hospitals which draw their patients mainly from London and are managed by London Health Authorities. As the map shows, eight are sited outside London, well away from their catchment populations. Eleven hospitals are managed by an authority different from the one in which they are sited, and most take patients from more than one district.

2.3 During the last 10-15 years a number of units in DGHs have been opened but still only 7% of London's psychiatric beds are in general hospitals, and several Districts have no local psychiatric beds. Over 85% are in the 15 large hospitals. Understandably the flow of patients through DGH units is far greater than through the mental hospitals, and 75% of out-patients are seen in DGH units.

2.4 The numbers of beds and residents in large mental hospitals in all four regions continues to decline. In South East Thames RHA 9.8% of beds are in DGH units, but three Districts still have no local beds and a number of Districts have few local community facilities. South West Thames RHA is particularly short of day hospital provision although only one District has no local provision at all. North West Thames RHA is fortunate in having long established and active voluntary associations running a wide range of community facilities. A major issue is supported housing when new DGH beds are opened. In North East Thames RHA there are DGH acute services in seven Districts, but the service is dominated by the 5,000 beds in six large hospitals, which account for 85% of provision.

In all regions, services for the elderly mentally ill are far from ideal. In North East Thames RHA, for instance, only three of eleven London Districts have any local psychogeriatric beds, and those fall far short of norms.

SECTION 3

Key issues in the Development of District Services

Issues can be grouped under three headings corresponding to stages in the development of comprehensive district psychiatric services:

i) principles and objectives
ii) planning and implementation
iii) operation and review

3.1 Principles and Objectives

3.1.1 Before any discussion about the details of a service it is important for all agencies to be in agreement about the principles on which the service is based. The seven principles were put forward at the CPRU conference 'Cinderella No More' by C J Heginbotham, Director of MIND, with the suggestion that they form the basis of debate:

A comprehensive local service

1. Values the consumer as a full citizen with rights and responsibilities entitled to an active opportunity to shape and influence relevant services no matter how severe his or her disability.
2. Aims to promote the greatest independence of the individual.
3. Aims to provide and evaluate a programme of treatment, care and support based on the needs of the individual regardless of age or severity of disability.
4. Aims to help the consumer (client) to as ordinary or normal a life as possible.
5. Aims to meet special needs arising from disability through a locally accessible, fully co-ordinated, multi-disciplinary service given by appropriately trained staff.
6. Is delivered wherever possible to the client's normal (usual) social environment.

7. Plans actively for reintegration into society of individuals in institutions, if they so wish.

A copy of a paper developing these ideas is included in the pack.

3.1.2 With these principles in mind, schedules of objectives - in the form of elements of a service - can be determined. Dr Donald Dick, Director of the NHS Health Advisory Service has compiled an invaluable check list of some 160 components of an idealised service. The list is arranged in sections, corresponding to groups of patients who appear to need separated services, though with some overlap and joint use. The headings within sections refer to structural components (beds, day places, workshops): to services (psychiatric teams, CPNs, rehabilitation teams): and to organisational arrangements for planning and managing the complete system.

A copy of this paper is included in the pack.

3.1.3 An additional necessary objective is the establishing of a proper information system and data base.

Nationally and regionally, only the Mental Health Enquiry has a computerised data base and this is restricted to admissions and discharges. Its accessibility at Regional level has improved, but at local level, where most of the data collection effort is made, the system is of little practical value.

Other information systems are based on annual or quarterly returns, largely related to hospital based or hospital orientated activities. There are some doubts about the accuracy of these systems, and their relevance to the management of the service.

The availability of information in the area of community activity is very limited, and misleading, since voluntary facilities - often numerically important - are rarely recorded. The other main problem is the time-lag before information is available.

For many years there have been psychiatric case registers - Camberwell and Salford are the best known - in some Districts, but many areas, including most of the large psychiatric hospitals serving London do not have easily accessible, computerised records for planning purposes. Nor do many DGH units have computerised systems for use as a service base to provide staff with regular information about caseloads, patients missing appointments and medication, transfers between parts of the service or to help identify a likely demand for a new facility or service. The cost of such a system would not be great in terms of its potential usefulness in research, planning and co-ordinating services.

Ref: NHS, Medical Informaton Systems Notes on Good Practices 15. 1979.

3.1.4 The run down of large mental hospitals which will no longer be needed as part of local services is an objective agreed by Regional Health Authorities. Around the country there are schemes at various stages of implementation to move long-stay patients out of large hospitals into small community-orientated facilities. In London those hospitals most actively involved are Banstead and Horton (NWTRHA) and Friern and Claybury (NETRHA). Many districts are involved, often not co-terminous with local authority areas, and the planning and implementation processes concern many agencies; again housing departments and Housing Associations may be only peripherally aware of plans until rather late in the day.

The traditional order of events, once needs are assessed, is for the more able patients to be moved out first, into other accommodation, gradually leaving a residue of very incapacitated people in large, underoccupied buldings. There is no intrinsic reason against, and a good many arguements for, reversing this process. The group of patients needing full nursing care and 'asylum' could, in principle, be moved, along with staff, into smaller premises, suitably converted and renovated. Remaining patients, most of whom would eventually live with support in the community, could move out at an increasing rate (rather than the traditional decreasing one) - slowly at first, but more speedily after patients and staff have been properly prepared for alternative work and life-styles in carefully planned community facilities.

3.2 Planning and implementation

The issues under this heading concern the questions of what facilities to provide? What principles should be borne in mind during detailed planning? What links are important? What combination of elements?

3.2.1 Researchers (and others) have spent many fruitless hours searching for the elusive 'pot of gold' - the concise description (in words, pictures or equations) of a service and the inter-relationships between its elements. Various assessments have been made of different parts of services. For instance: Professor Hirsch and his colleagues found that a patient's stay on the ward could be shortened without harm provided there were follow-up day care facilities. It is also clear, empirically, that over-provision of one element (say, day hospital places) will not compensate for under provision of another element (in-patient beds). Equally, unless the whole range of facilities is available to some degree it is likely that a patient may simply cease to make progress. An example of this is in the relatively larger number of hospital readmissions with a 'social' component in Districts where there is very little by way of specially supported housing.

A study of long-term patients in Hackney in 1978 showed that it was possible to classify patients according to types of accommodation (corresponding roughly to levels of care input) and thus estimate the numbers of places needed for that population. A similar exercise is being undertaken for long-stay patients of Friern and Claybury as part of NETRHAs planning for the run down of these hospitals.

A proper data base/informatoin register and research study will enhance the chances of having robust estimates of the level and size of needs, and will assist understanding of the ways in which different parts of the service affect each other.

3.2.2 What principles underly the provision of services?

The following is a list which has been drawn up (often with the benefit of hindsight) from experiences in City and Hackney Health District, where there has been no access to long-stay beds since 1974.

- All schemes should be 'real-life' rather than research constructs. Research should aim to serve the patients and not inhibit any chance of progress, and Schemes should be planned to have 'permanent' benefits rather than simply for the duration of a research study.

- Existing premises, facilities staff, should be used rather than creating 'special' (ie. divisive) services'.

Many 'special' projects are, on closer examination, devised more for the convenience of the organisers than that of the consumers, eg. sheltered workshops, enclave schemes, special hostels may be unnecessarily divisive for

some and will reinforce the 'disabled' status, making full recovery more difficult.

- Infrastructure should be divided from service agents for greater flexibility and efficiency.

Following the principle above, support - with occupational stresses and in everyday life - can often be supplied independently of an actual building. A peripatetic, multi-disciplinary team can give intensive or occasional support and practical help as required by an individual in 'ordinary' accommodation or place of work, rather than having each project/scheme individually staffed and managed. This methods and obviates the necessity for a proliferation of 'management committees' by using housing department, Housing Association, or employer as manager.

- 'Travelling' by patient/client should be reduced and the service should aim to adapt to client's needs rather vice versa; stresing continuity for the user.

This principle avoids both the paradox of 'punishing' a patient - eg. requiring him to move home - for making progress, and also the disruption to progress which may occur in the course of transfer from one element of a service to another. Multi-disciplinary teams and good co-ordination between hospital and community, with overlap of personnel, mean that the difficulties which often arise at the 'interfaces' are experienced and handled by professionals rather than the patient.

- Services should follow hierarchy of psychological need, aim to anticipate difficulties and concentreate on crisis prevention rather than intervention.

Experience in Hackney (and doubtless elsewhere) has shown the pointlessness of trying to provide for sophisticated needs before simple, basic ones are properly met. Patients are unlikely to take advantage of an activity which improves their social life or esteem unless their needs for home, food and personal security are met satisfactorily.

- Unnecessary bureaucracy and fixed capital investment should be avoided.

3.2.3 Several elements of a comprehensive service are subjects of particular discussion at the moment:

a) 'New' Long-stay Patients.

Statistical convention groups together all patients who have been in hospital continuously for one to ten years under the title 'new' long-stay. Psychiatric staff tend to think of the term as meaning patients with illnesses such as schizophrenia (for younger patients) or dementia (in the case of elderly patients). For planning purposes this distinction is important since many patients who may, in the past have become long-stay in terms of continuity of in-patient treatment may, under a new pattern of care, remain long-term (their illness will be protracted and may leave substantial disability) but will not need long-stay care on a hospital ward. In districts where there are no long-stay beds, patients with illnesses which, in other places, might entail a lengthy hospital stay, are treated, by and large, on an out-patient basis, with occasional short periods in hospital. Such a pattern is more effective when a range of supported accommodation and facilities for day-time activity is closely linked with the psychiatric service.

b) Crisis Intervention

Again, the terminology does the concept a dis-service. It is argued that an ideal service should rely on prevention rather than intervention, and often a crisis team is seen as an alternative to standard domiciliary visit procedure.

A number of CITs operate in London. One of the most recently formed (in 1979) is based at Lewisham's Mental Health Advice Centre, where the local DGH has no emergency service for psychiatry, where the catchment area's psychiatric team is based in a hospital 12 miles away, and where there are no day hospital facilities. A recent report of the CIT concludes that it has been able to develop a system of community care not only for people 'in crisis' but also for people with acute mental illness, notably psychosis. The CIT has improved its links with other professionals in the community, leading to an increase in informal consultations, especially with non-medical colleagues, and a reduction in the number of formal referrals. This indicates the broad interpretation which must be put on the concept, and a realisation that 'crisis intervention' may be a fairly small part of the total impact of such a team.

In Districts where there are well-developed emergency services, day care, social work and CPN follow-up, it may be that crisis work can be handled by teams of existing staff, able to go to a patients's home, and continue treatment on an intensive basis when necessary.

Ref. Bouras, N. and Tufnell, G. Mental Health Advice Centre. The Crisis Intervention Team, Research Report No 2. Lewisham & North Southwark Health Authority.

c) Provision for mentally ill offenders.

In 1974 the Butler Committee highlighted the need for a special service for mentally ill offenders so that they might be suitably treated rather than detained unncesessarily and ineffectively in prisons or special hospitals. A belated response to this, in some parts of London, is the planning of Psychiatric Intensive Care Units (PICUs). These units are akin to, but more appropriately named than, Medium Secure Units. The PICU will take any patient who needs intensive care, with high staff/patient ratios, specialised treatment and careful observation of patients at all times. Day care will be an integral part of the PICU, but as the patient improves he will transfer to the more general care of an ordinary psychiatric ward and local day care. One of the problems with planning a facility such as this is the dearth of information about offenders in need of treatment for psychiatric problems. Present plans contain a research element which will acquire information crucial to the future development of facilities to help mentally ill offenders.

d) Services for the elderly mentally ill

During the past few years there has been a rapid expansion in specialist services for the psychiatry of old age, but in most Districts provision is still developing, possibly at a rate slower than the increase in demand. Ten per cent of people aged 65 and over, and 20 per cent of those over 80 show symptoms of dementia.

The Government is preparing to allocate large sums of money to Districts whose plans show comprehensive coverage and effective collaboration between

statutory and voluntary agencies. But many districts will not qualify for extra financial help though the needs of residents may be very great. The NHS Health Advisory Service, directed by Dr Donald Dick has very recently released a paper which will be a godsend in many places. The paper covers all conceivable aspects of a service using material collected over many years of experience and three and half years of particular attention to the subject by HAS staff and visiting teams. The report is arranged in sections to give a series of questions which, taken in sequence, form a checklist of the tasks which those responsible for establishing the service need to tackle in order to maintain continuing growth.

Ref: NHS Health Advisory Service, The Rising Tide, Developing Service's for Mental Illness in Old Age., HAS, November 1982.

3.2.4 Services provided through Community Mental Health Centres

In places where a whole new pattern of psychiatric service is feasible the idea of Community Mental Health Centres as the primary resource for each catchment area is attractive. It offers flexibility of use and management and the opportunity - perhaps necessity - of comprehensive co-ordinated care between health and local authorities and voluntary agencies.

Torbay, in South Devon, is one Health District which sees CMHCs as a key primary resource in a fully developed community psychiatric service. They propose forming CMHCs each

- jointly financed and managed through a special Management Committee;
- with multi-disciplinary team of staff;
- providing a range of services to a designated geographical area;
- easily accessible to clients.

The CMHCs would offer certain services themselves:

- 'walk-in' on formal referral;
- crisis intervention;
- mental health counselling;
- clinics;
- after care; the co-ordination of treatment and support at primary level;
- education and consultation.

Additionally, the CMHCs would refer to specialist services covering the District on wider area:

- in-patient care (DGH unit in preparation);
- hospital day places;
- care for elderly mentally ill;
- child psychiatry;
- psychological services (possibly sessions at CMHC);
- alcohol services;
- psychotherapy.

The organisation, finance and other aspects of the Torbay plans, many of which would be applicable in a London setting are documented in a paper 'The Way Forward - Community Mental Health Centres', published by Torbay Health Authority and South Devon Social Services. Available from Peter Colclough, Exminster Hospital, Exeter.

3.2.5 Primary care

Except for the (relatively) few people who seek help directly from specialist service or a Community Mental Health/Advice Centre, the GP is the first point of contact for those with mental or psychological problems. About 95% of such people are treated by GPs, although there is wide variation in the levels of psychiatric illness reported - averaging 10-15% of patients. The primary care team, sometimes collaborating with community psychiatric nurses is also the main agent of follow-up after a patient is discharged from hospital.

With the advent of the new pattern of care primary care teams should be closely linked to other elements in order to provide continuity of care for patients and ensure the best combination of elements for each individual.

The primary care team, wherever sited, will remain the first stage of assessment for patients. This problem of recognising psychiatric illness is one of the most important issues among the many which have featured in a number of conferences on psychiatry and general practice in recent years. Other issues, according to Dr John Fry, a GP for over 30 years, are:

- what is the natural history of psychiatric illness? What happens without the effects of specific therapies?
- who should carry out care - where, when how and why? There is a wide socio-medical spectrum of people who may contribute to care. The GP has to decide who should be involved;
- what treatments are useful; what are not? More constructive criticism of present trends may be needed;
- whose responsibility? Remember that the patient is also responsible for co-operating with professionals.

1. Fry, J. Psychiatric Illness in General Practice, in Clare and Lader (eds) Psychiatry in General Practice. Academic Press, 1982. pp 43-47.

3.2.6 The 'social' component of mental illness.

Research studies have noted that 'social disintegration' is conducive to psychiatric disorder. Staff of hospitals and day centres know only too well the reluctance of many patients to leave their care once the psychiatric symptoms have cleared up because clients have few personal friends and little capacity for organising a social life. Many hospital beds are occupied, from time to time, by people whose main problems are social rather than clinical. The lack of people to talk to, friends and acquaintances, other than professional carers is one of the biggest barriers to full recovery from mental illness.

Yet the majority of activities and schemes for mental illness are concerned with repairing the damage, reconstituting social skills and helping people make new friends. Relatively little is done to preserve contact with relatives and friends or enlist their active involvement even during acute illness.

Community-based services should be far better able than the large hospitals, to reduce the levels of loneliness and social need. Exactly what happens, especially for patients who are likely to have a prolonged illness, is not clear. If we can understand this and devise ways for social disintegration to be halted or reduced, this may go some way to preventing unnecessary accretion of 'new' long-stay patients in future.

3.2.7 Finance and costs

Finance is a complex matter, especially in relation to the run down of the large hospitals and the replacement of many of the services and facilities they offer, currently paid for by the NHS, by community services, largely the responsibility of the local authority Social Services Department and to be paid for through Joint Finance arrangements, or, in some parts of London, with funds from Inner City Partnership.

Three types of issues are important:

a) The amount of money available for mental illness services.

At present most financial summaries omit items such as special schemes operated, with public and charitable funds, by voluntary organisations and also the contributions of accommodation and management services by local housing departments and Housing Associations.

b) The process by which money is allocated and spent.

For a psychiatric service to be able to undertake long or medium-term planning it is essential to have control of its own budget and the ability to transfer funds from one element to another according to savings and priorities.

c) Knowledge of comparative costs of alternative forms of care.

Nobody, by now, considers 'community care' a cheap option. Equally, it is not necessarily expensive. So far there has been no systematic analysis of the alternative patterns of care over the whole period of chronic illness, so we do not know the relative costs to the community of, say, several short admissions and many community facilities, community nursing etc. versus a stay of several years in hospital, for someone who develops schizophrenia.

3.3 Operation and Review

3.3.1 Organisation of district services

The main alternatives are to organise facilities and services according to which agency is providing them or to organise multi-disciplinary services for a given geographical area.

In the first model there would be:

- NHS facilities - in-patient beds, out-patient beds, Day Hospital etc.
- Social Services provision - field work, special accommodation, Day centres etc.
- contributions from voluntary agencies (Drop-In Centres, befriending schemes, housing and occupation projects) and Housing (LA and Associations)

These would be linked by a Health Care Planning/Strategy Team and informal meetings with transfer of patient care between agencies as appropriate.

3.3.2 In the second model, the central provision would be through Community Mental Health Centres providing a range of services convering the majority of psychiatric needs for a given (sub-District) catchment population with access to some service (in-patient care, specialised therapies, intensive care etc.) on a District, or sub-regional basis.

3.3.3 Monitoring and review

Given current proposals to accelerate the move to community care, there will be a Regional requirement to monitor these changes and a District requirement for management information.

It is easy to add a sentence about monitoring to the end of the description of any proposed project or a service element. It is much less easy to carry out that monitoring. Methodologically, an evaluative study is complex, and results are generally questionable in a situation where change is some intangible like 'satisfaction' or is one of the 'quality of life' objectives. Rarely are personnel employed to undertake monitoring; existing staff are meant to fit it in as best they can. However, the best means of ensuring a regular feedback and supply of information (not just statistics) is, firstly, to invest in an information register, and secondly, cultivate the District Information Officer's interest in psychiatric services. An enthusiastic DHA will soon stimulate the production of regular progress reports, for discussion, with more useful outcome than formal evaluation.

COMMUNITY SUPPORT SYSTEMS FOR PEOPLE WITH SEVERE MENTAL DISABILITIES

A FRAMEWORK FOR DEFINITION

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A background paper for the King's Fund Workshop:
'Planning Local Psychiatric Services'
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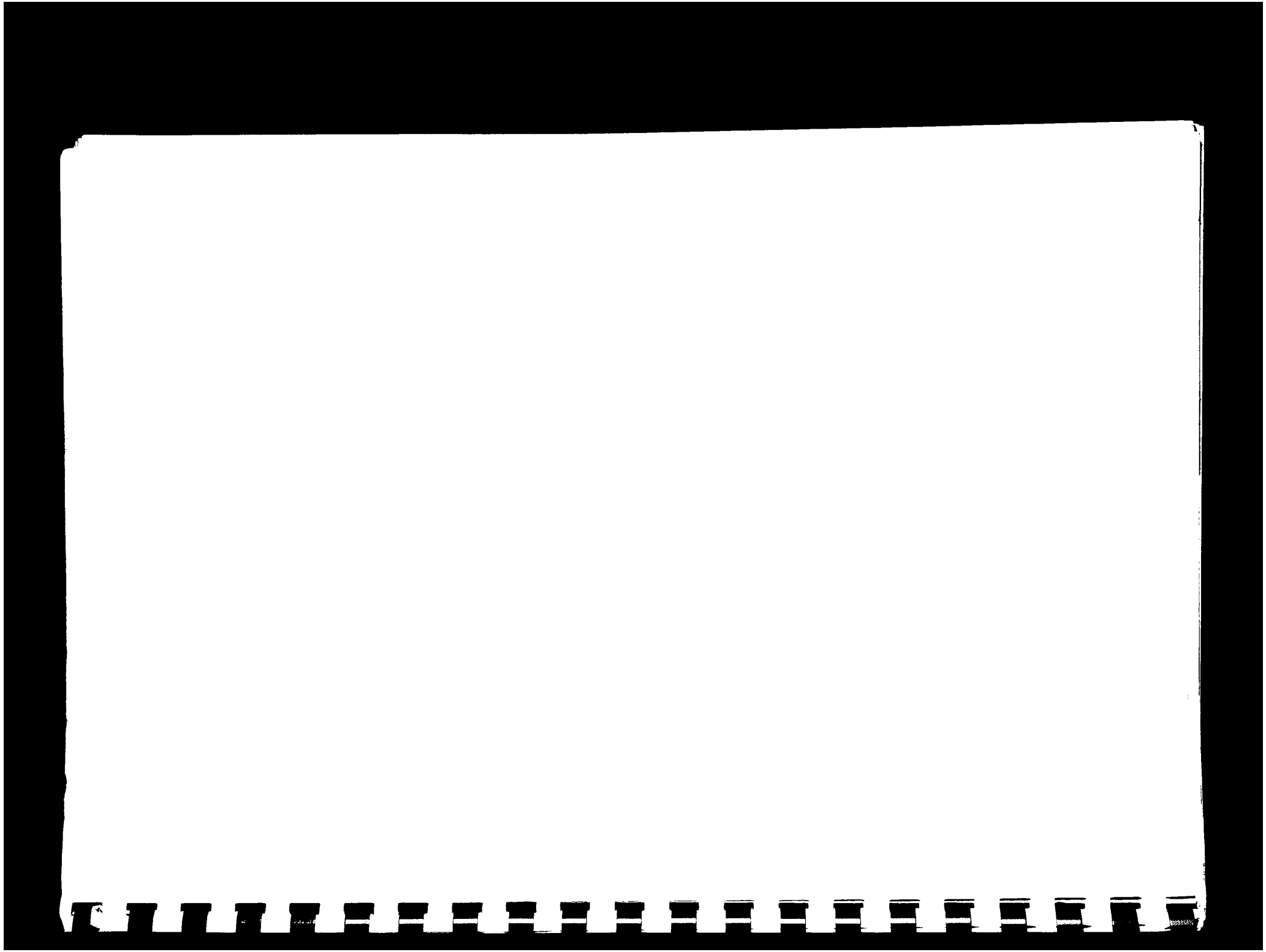

CONTENTS

NOTE

An earlier draft of this paper was written for and reviewed by a task force which assisted the National Institute on Mental Health in the development of its Community Support Projects initiative. I benefited greatly from the thoughts of the other members of that task force; its present content and structure is my responsibility.

References to support this paper will be found in:

R. Gerhard, et al. The Balanced Service System. Atlanta: Responsive Systems Associates, 1981.

J. O'Brien. The Balanced Service System: A Partial Review of the Literature. Atlanta: Responsive Systems Associates, 1979. Reprinted with permission in this pack.

THE PEOPLE

A substantial number of adults experience severe, usually life long disability in social functioning which is labelled as chronic mental illness and results in extended contact with the mental health service system. These people are impaired in their ability to make and keep mutually satisfying and productive relationships with other people - families, friends, neighbours, employers, and human service workers. Relationships with them are strained by what others experience as extreme dependency and strong, sustained demands for tolerance of odd behaviours and idiosyncratic interests and concerns. Their difficulty in maintaining a variety of everyday relationships results in social disfunction and often in considerable personal suffering. They often experience depressed ability to perform the tasks of everyday living and working and seem to have more difficulty than most of us in acquiring new skills. In particular, people with severe mental disabilities will have more difficulty structuring their time around activities which most of people in a community would see as worthwhile. They find it extremely hard:

- To maintain regular employment or otherwise fill a role which permits them to be economically self-sufficient and have a reliable source of food, clothing, and shelter;

- To participate in the range of leisure time investments which provide most members of a community with a sense of personal meaning and enjoyment (for instance, church membership, shared hobbies and recreational activities, civic groups, and social action groups); and

- To utilise the services typically provided by helping agencies in a manner that helpers can agree is appropriate.

Their social isolation and marginal economic position results in periodic strain on their ability to adapt to adverse conditions. To compound this, people with severe mental disabilities seem to be characterised by a special vulnerability to stress. As stress increases, so does the likelihood that the person with a severe mental disability will have atypical experiences which are difficult to control and will display behaviour that is increasingly unacceptable and disturbing to others.

From the point of view of the human service system, people with severe mental disability are defined by their lack of response to commonly available mental health service processes and by the puzzlement they cause people who want to explain their behaviour. A person with a severe mental disability can be reliably identified and labelled - most of them are diagnosed as 'schizophrenic'. But available diagnoses do not establish a chain of causation for the person's condition nor do they lead clearly to the design of valid interventions. Genetic, biochemical, physiological, and social levels of explanation each provide useful information. But, taken alone or in combination, available explanations don't adequately explain.

People with severe mental disabilities may be similar in their social functioning and in the generalised social response to their disability, but they are far from a homogeneous group in their interests and abilities. In fact, people with severe mental disabilities appear to respond less to community norms than the rest of us. And each person seems to choose his own pattern of non-response resulting in highly individualised patterns of attention, motivation and concern.

People with severe mental disabilities experience significant problems in living. The level and power of social support with which they are able to maintain contact over time is a critical determinant of the quality of their lives.

THE PROBLEMS

One social consequence of severe mental disability is a heightened risk of devaluation and avoidance by more typical community members.

- Their odd behaviours and unusual preoccupations are disturbing to others. In many of us they create the sense that they are 'not right' and we should keep our distance. Coupled with the fact that that some people who are also seen as 'mentally ill' commit inexplicable acts of violence, this often results in rejection of the person as unpredictable and dangerous.

- The fact that most people with severe mental disabilities do not work can lead to a perception of the person as trivial, worthless, or a burden on community charity.

- In recent history, people with severe mental disability have been managed in mental hospitals under medical leadership. This contributes to a social perception of them as having a sickness which exempts them from expectations of typical role performance, demands hospital treatment until cured, and, for some of us, raises the threat of contagion.

- People with severe mental disabilities are, as a group, responsive to medical stabilisation of periodic crisis situations. However, hospitalisation beyond a brief period of time does not seem to improve social functioning and often leads to an actual decline in competence. They are usually uninterested in verbal therapies regardless of setting and often don't comply with a prescribed regimen of activity and medications. Unresponsiveness to traditional mental health interventions can lead others to conclude that the person with a severe mental disability is suffering from chronic, incurable disease. Many of us - including many people with severe mental disabilities - are confounded by this failure and confused about whether and when a person should be held responsible for lack of enduring change.

- People with severe mental disabilities have difficulty establishing good relationships with mental health workers. Their idiosyncratic preferences for the type, timing, and extent of influence they want another person to exercise over them leaves many helpers frustrated and confused. The helper who expects early, steady, significant progress toward wellness and independence will be doubly frustrated. The helper who expects such progress in response to traditional mental health processes will have no refuge but to judge them unmotivated, unsuited, and undeserving of service, avoid any personal engagement with them by declaring them some other agency's responsibility, and sanction their long term segregation in mental hospitals.

Traditional human service patterns have failed people with severe mental disabilities by embodying one or another of these common devaluing social perceptions and providing either too little social support or too much social control and segregation. These failures have become more clear and more perplexing with an increasing concern for the civil rights of people with severe mental disabilities and a declining social consenus on the desirability of isolating people on the basis of differences.

- Traditional mental institutions provided some severely mentally disabled residents with sufficient structure to establish their ability to work and to relate. However, these settings have been extremely difficult to manage in a humane, cost-effective way over long periods of time. The best of them seem to have been gripped by cycles of reform and deterioration into human abuse. And even in the best of times many people with severe mental disabilities were likely to experience a lower quality of service than other

residents who were seen as more able or more responsive to help. In any event, such settings almost certainly provide people with more shelter, control, and segregation from community life than they need all the time.

- Most community placement schemes have achieved physical movement out of hospitals but have seldom provided adequate social, fiscal, or programmatic support to allow people with severe mental disabilities to support more than a very isolated and marginal community role. Many people have found their way only as far as a single room occupancy, an isolated 'foster care' placement, or a boarding house with few characteristics to distinguish it from the hospital.

- The shape of the services and support available has been determined less by a sense of the needs and capabilities of people with severe mental disabilities than by the interaction of one or more of the common socially devaluing perceptions with a funding pattern. For example, in the USA, as people with severe mental disabilities became eligible for federal funding in nursing homes, large numbers of people were defined as needing such service. In this context, 'movement' reflects a shift in sources of revenue and not necessarily concern for a fuller measure of citizenship.

- Severe mental disability is not 'curable', but people with severe mental disabilities can develop their skills and many of them can work productively at least part of the time. Rehabilitation services - such as sheltered workshops, could make an important contribution to improving people's quality of life. But many rehabilitation agencies judge their success in terms of movement to 'independence' within reasonably short time limits. Such agencies frequently select out people who will not realistically be ready to 'graduate' soon. Services based on the expectation of rapid transition deny the reality of many people's disability and thus exclude them from realistic opportunities for skill development.

- Many community mental health services define their responsibility for people with severe mental disabilities narrowly. Mental health services which define themselves as primarily concerned with 'treatment' in the form of verbal therapies and medications for cooperative people relegate people with severe mental disabilities to unspecified or unwilling community agencies or to institutionalisation.

A FRAMEWORK FOR SOLUTION

There are a number of well established interventions which support an improved quality of life for people with severe mental disabilities and decrease the social and fiscal costs of their disabilities. Many of these interventions have been small scale, time limited experimental and demonstration projects. Seldom have there been opportunities to test the synergy among a variety of these approaches in the same area. So the extent to which it is possible to create a genuine alternative to institutionalisation which is based on the best available practice on a large scale over time is unknown.

What is needed is a pattern of human service responsibility based on principles consistent with the state of the art. The notion of a community support system defines such a pattern:

A community support system is a network of responsible people and coordinated resources within a defined area. This network is commited to assisting people who are vulnerable to personal suffering, social dysfunction,

and community exclusion because of severe mental disability. The network measures its success by its increasing ability to improve their capacity to meet their needs for a reasonable quality of life and participate as much as possible as valued members of natural communities.

Such a community support system should insure each person with a severe mental disability access to:

1. Direct Service Activities

- Someone who is responsible to be concerned with his personal welfare throughout the time he chooses to live in the area regardless of whether or not he uses other services. This person fills the role of adviser, assistant, and broker between the person and the community's organised service and social control agencies as well as between the person and the community's naturally occuring social systems. She sets the high expectations for a reasonable quality of life and community participation which are essential, helps the person establish and maintain some role in the world of work, helps him gain entry into a supporting social system, uses personal influence to get as much cooperation as possible in taking appropriately prescribed drugs and treatments, and is readily available in times of stress.

- The active opportunity for work to support the person's self image and reputation with others, to maintain and increase competence, to reduce the amount of time the person must structure for himself, and to provide at least some money for self-support.

- A range of choices for investment of leisure time in educational, civic, religious, and recreational activities which will provide a diversity of potential social contacts and opportunities for meaningful activity.

- Housing of good quality which provides the potential for community contacts, privacy, and a setting for a reasonable standard of living.

- An opportunity to develop functional life skills in a structured and well organised programme.

- The full range of entitlements to assistance with income support, housing, general health care, etc. which are his by virtue of citizenship, residency and disability.

- Proper use of psychotropic drugs. While drugs do not, at this stage of development, 'cure' severe mental disabilities they can help a person control many experiences and behaviours which cause him personal suffering and which stigmatise him in his community. Proper drug use includes effort to teach people as much control over their own drug regimen as feasible.

- Reliable, immediately available crisis assistance, oriented to maintaining and improving social linkages. Crisis services should, as much as possible, be delivered in the settings and interpersonal circumstances where problems occur and use sheltered environments - such as hospital places - only when less restrictive environments cannot be arranged.

- Provision of opportunities for necessary practical and emotional support to those who live and work with the person with severe mental disability.

2. Enabling Activities (to guarantee availability of adequate support)

- Means to identify those people within an area who need organised support to maintain community membership because of severe mental disability. This should include people currently institutionalised in hospitals and nursing homes who come from the area.

- Ways to form an initial relationship within which a person with a severe mental disability and other people who are concered with him can decide the pattern of support he needs and the terms on which he will accept it. In the event that a person's choices appear to conflict with legitimately established social control functions of the mental health service system, the community support system must observe due process to protect the person's civil rights. If a person appears legally incompetent to make decisions, guardianship proceedings should be initiated.

- Specification of the resources which will enable the delivery of the required pattern of support - including organised services, entitlements and volunteer resources - and the agreements and follow up arrangements which will coordinate support.

RESPONSIBILITY

The statutory mental health system is the most reasonable focus of responsiblity for developing and guaranteeing the community support system for people with severe mental disabilities. However, this responsibility cannot be discharged effectively by providing a total system of services that duplicates services which are more generically available in an area.

Most communities have dealt with people with severe mental disabilities by isolating them in large and small institutions or abandoning them to marginal social roles in urban areas. Most organised community services - including even community mental health agencies - have mirrored this pattern of abandonment. Thus the mental health system in an area must develop a long term strategy to reverse these patterns of exclusion and organise a network of community support. In the meantime, the mental health system needs the flexibility to provide essential supports - such as housing or access to work - in ways which meet the dual objectives of providing adequate support and increasing the responsiveness of other community resources.

In building a network of community support, the mental health system will confront two major internal issues:

- The tradition of dual public health systems, one system based in hospital services to the more severely impaired and the other based on community services to people who are less impaired. This dual system needs to be unified within an area and moved toward a unified system.

- The fact that without very substantial (and very unlikely) increases in funding, service and spending priorities in communities must shift systematically in favour of providing community based services to the most severely disabled and away from services to people with less disabling conditions and services provided in total institutions.

POTENTIAL PROBLEMS AND NECESSARY SAFEGUARDS

A community support system for people with severe mental disabilities will be difficult to convene and maintain.

The collaboration across agencies and jurisdictions implied by the definition of a community support system is far easier to think about than it is to achieve. Agencies vary widely in how they define human problems, their sense of who can be helped and how, and their priorities for allocating service. People with severe mental disabilities are likely to fall just outside the definitional boundaries of most human services.

People with severe mental disabilities are seldom seen by their helpers as people who are rewarding to work with. There is little professional status in working directly with them and in providing the kinds of services that structure meaningful social roles. People who arrange for decent housing or provide necessary work supervision or teach functional daily living skills are not as highly regarded among human service workers as people who provide verbal therapies.

The people who make up a community support network are not immune to the devaluing perceptions of people with severe mental disability common to the rest of us. They are the inheritors of buildings, traditions, language, and symbols which support isolation and segregation.

The essential challenge to the people who make up a community support system defines its mission:

> The mission of a community support system is to provide people who have major difficulty in making and keeping productive relationships and who are consequently at risk of being excluded from the life and services of a typical community with a source of reliable personal contact and a coordinated programme of services to support as many positive relationships as possible.

Committed leadership, careful management control against clearly stated principles, and carefully considered strategies for self-renewal are critical to maintaining focus on this mission and preventing services from drifting toward service forms which traditionally enjoy higher levels of professional involvement and thus away from contact with people with severe mental disabilities.

At the minimum, the leaders of a community support system need to initiate two types of safeguards. Firstly, they must clearly state the network's basic principles and clarify its commitment to them by monitoring and modifying actual practice. Secondly, they must design, operate, and manage in terms of an information system which will track the pattern of service it provides in terms of the changing needs of people with severe mental disabilities.

PRINCIPLES

The community support system should design, manage, and monitor its activities in terms of these principles.

- The aim of the network should be to increase the level of participation of people with severe mental disabilities in as many spheres of community life as possible. As used here, 'as much as possible' means that

effort on the part of the community support network is not limited by negative expectations but only by the personal choice of a legally competent consumer and by the knowledge limits of the field as a whole, given effort to discover and utilize available knowledge.

- Support should be accessible to those people in an area who have severe mental disabilities and who need it to maintain community membership. This implies:

  i) support will be actively offered in the natural settings and situations where those served live and spend their time;

  ii) to a far greater degree than has been typical in human services, basic relationship to the community support system accommodates the personal relationships and service preferences of the people it supports;

  iii) support will be offered in ways that provide as much as possible for continuity of personal relationships between representatives of the community support system and each person supported.

- Support should be sufficient to offer people with severe mental disabilities a range of options in the services which structure and support enduring social roles in three major spheres of community life: daytime, (particularly full-time and part-time work opportunities); evening and leisure time opportunities; and housing.

- Services should be provided as economically as possible in as socially integrative a setting as possible. This implies:

  i) each person should be assisted to fully utilize the entitlements of citizenship and residency;

  ii) no more service should be offered than is sufficient to maintain community membership;

  iii) services, especially those that structure people's community roles (occupation and housing arrangements), should make as much use possible of opportunities and organized services used by typical community members, with extra help as needed to support participation;

  iv) when a person is unable to find the support needed from typical community resources, the community support system should:

  - utilize or organise mutual self help efforts;

  - provide an individualized brokerage and skill training programme when there is a reasonable possibility that the barriers to serving a person in a more typical setting can be overcome by influencing the person and the environment he seeks to enter;

  - collaborate with an existing community setting when extra help or resources in that setting will permit people with severe mental disabilities to participate;

- provide a system of service when the above strategies are carefully considered and found impractical.

- Service structures, methods, and settings should be consciously designed to be familiar and valued by a significant number of typical community members and should provide settings, activities, routines, and rhythms of the day, week, and year which are appropriate to the age of the person served.

- Service structures, methods, and settings should consciously avoid stigmatizing people by association with locations, practices, and symbols which signal dangerousness, sickness, triviality, pity or charity.

- Services should assume no more control of a person's life than is necessary consistence with due process protections available to each citizen.

- There should be a functional grievance management process including openness to outside monitoring by citizen groups and access to legal counsel.

- When necessary, people should be provided with guardians.

- It should be unusual for a person to spend more than brief periods of time in a setting which structures and controls all 24 hours of his day. Generally, when a person is in structured programmes, his daytime occupation should be in a setting which is separate in location and management from the place he lives.

- Services should promote increasing acceptance of people with severe mental disabilities by typical citizens by:

  i) dispersing services settings across an area rather than concentrating them in one or two places;

  ii) avoiding congregation of excessively large number of people with severe mental disabilities in any particular geo-political area;

  iii) avoiding groupings of people with severe mental disabilities which are larger than groupings of typical citizens in comparable settings;

  iv) locating services in buildings and neighbourhoods which are consistent with the function they are intended to serve;

  v) providing and supporting a broad range of well timed challenges to involvement of typical citizens in a variety of interactions with people who have severe mental disabilities.

DESIGNING THE BALANCED SERVICE SYSTEM

A PARTIAL REVIEW OF THE LITERATURE

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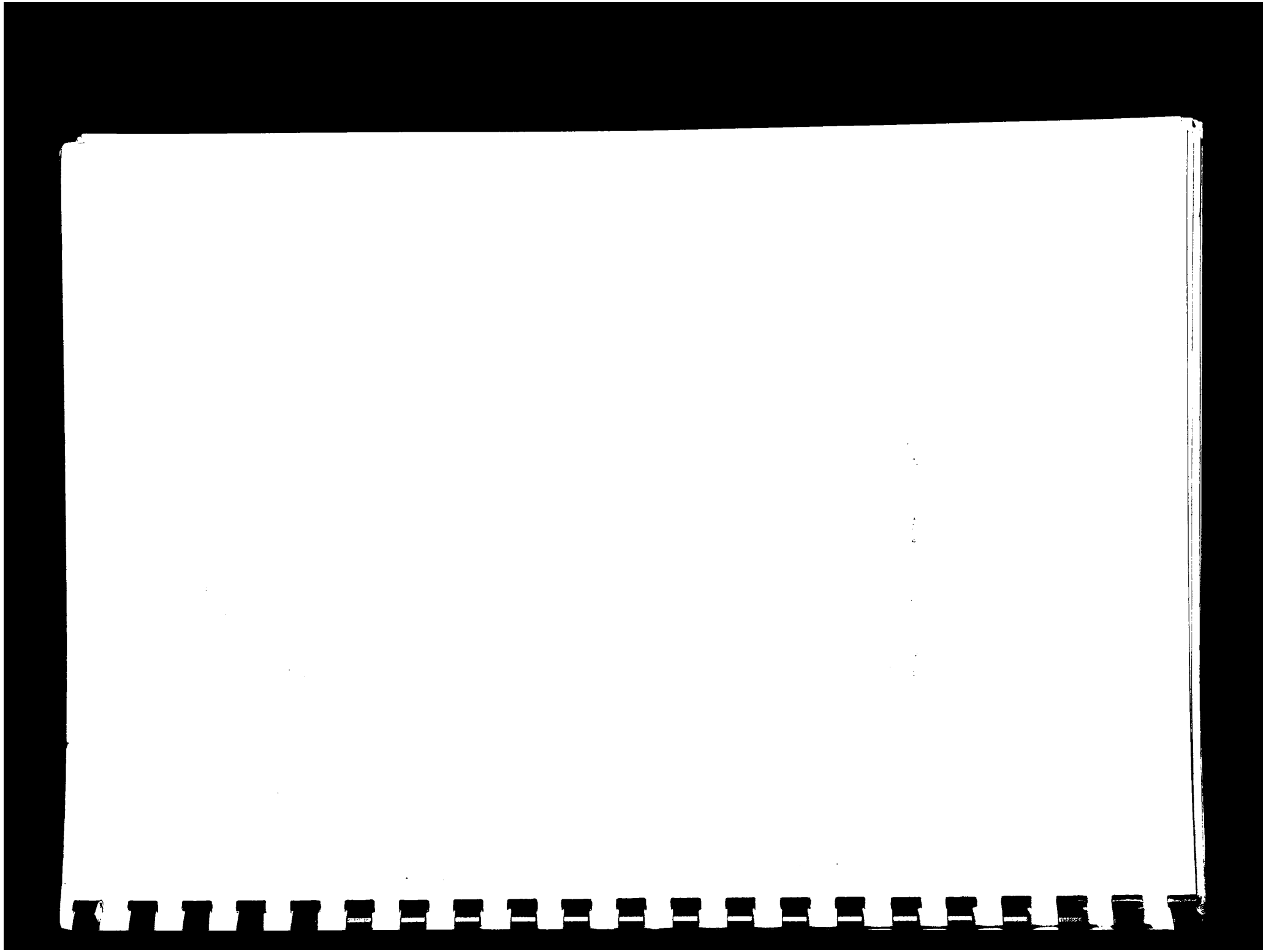

INTRODUCTION

The 'Balanced Service System' of psychiatric service development, introduced in an accompanying paper by Don Braisby, is one which was designed to change in response to feed back from the results of its own operations and in response to the changing knowledge available from the mental health field as a whole. As part of the process the designers of the system have been engaged in an ongoing review of the literature and in a search for 'well conducted studies demonstrating differential effectiveness of various service methods'. The results of this work are used to determine the nature of effective professional practices and service components within the system and also to critically examine the overall model.

John O'Brien suggests that complete empirical documentation of any mental health system is not possible for two reasons:

'Firstly, because once the vast literature of the mental health field screened against even modest standards of evidence there are broad areas of practice in which we lack reliable information guide our decisions. (However, we can't wait until all the evidence is in to decide how we will use our resources).'

Secondly, because every model of services expresses values - which must be chosen rather than proven. (Though they can be chosen to be consistent with empirical findings).

This implies:

Firstly, that a system of services needs to have the capacity to incorporate new knowledge and convert it into revisions of concepts and practice.

Secondly, that a system of services should clearly state its values and that it should provide a planning and evaluation process which allows those participating in the system to clarify and make conscious choices about these base values.

In this case the set of 'Assumptions' which form the basis of the model are:

1. A system which depends soley on such concepts as 'episode of illness', 'cure' and 'discharge' is not consonant with the current state of knowledge. The major disabilities, while almost always easily stabilized, continue with indefinite, perhaps permanent, impairment.

2. A responsive system should provide the service, whenever possible, in the exact setting in which new learned behaviour must be applied.

3. A service system must build on the assets of its consumers and their support systems, by increasing their collective capacity to eliminate, cope with and tolerate disability.

4. The type of services provided by the mental health system should be based on a continuing analysis of needs and be designed to correct outcomes of the existing service. Whenever one type of service is under utilized or over utilized, a method should exist to shift resources into another type of service.

5. New responsive systems seldom evolve naturally from existing and established systems.

John O'Brien points out that:

a) The statements of findings and the references chosen to support each assumption are representative, not exhaustive.

b) References were selected which would be readily available in most libraries (in the United States) and wherever possible literature reviews - marked with a '*' - are cited in preference to single studies.

c) The implications drawn are not the only ones which could be supported.

d) The collection of implications do not touch all of the implications for practice contained in the Balanced Service System model.

There are differences in style, vocabulary and (to some extent) access to academic sources between this country and the United States, but for the purposes of this publication no significant changes have been made and there has been no attempt to fully update the sources cited. However, as John O'Brien indicates, this document is written to be rewritten as additional evidence becomes available, and it can be thought of as a framework within which other information can be incorporated or disputed.

The material is presented here both as a useful guide to the literature in its own right and as a demonstration of the vital process of examining relationships between:

a) the basic assumptions underlying a service;
b) evidence from research; and,
c) implications for practice.

Tom McAusland
September 1983

This Basic Assumption

A system of service which depends solely on such concepts as episode of illness, cure, and discharge is not consonant with the current state of knowledge. The major disabilities, while almost always easily stabilized, continue with indefinite, perhaps permanent impairment.

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Is supported by these results of mental health research and leads to---

People with major mental disabilities account for a major proportion of total available mental health resources (federal, state, and local) over time (Babigian, 1975*; Lee, 1973*; Smith, 1974; Davis, 1974; Kraft, 1967).

▶ *---these implications for practice.*

▷ Priority on service to people with major disabilities.

▷ Service patterns which stress

--linkage of the severely disabled to the widest possible range of generic human services and entitlements.

--collaboration with generic human service agencies in program development and operation.

---these results of mental health research lead to---	---these implications for practice.
In the absence of substantial community support, people with major mental disabilities have a high probability of remaining in a hospital or a hospital-like environment or experiencing repeated readmission to hospital services (Kohen and Paul, 1977*; Rachlin, 1976; Erickson,1975*; Anthony, 1972*; Davis, 1974; Mandelbrote and Trick, 1972; Lamb and Goertzel, 1972).	Planning for some group of people served to have indefinite membership in the system which does not require indefinite residence in a hospital.
	Providing case managers who offer continuity of personal relationship and insure that people have access to needed services in the most natural environment possible.
	Insuring that all services in whatever environment are provided utilizing the most culturally normative and valued settings, processes and methods possible
People with major mental disabilities can be reliably assisted to stabilization during recurring crisis episodes with a combination of appropriate medications, in situ instrumental support, focus on reactivation of linkages to relevant social resources, and ready availability of protective environments for shelter if and when necessary and only for as long as necessary (Hansel, 1976*; May, 1975*; Polak, 1976; Stein, 1975; Grinspoon, 1972, Langsley and Kaplan, 1968; Pasamanic, 1967)	Making available immediately responsive stabilization services focused on --provision of sufficient medication; --in situ intervention; --screening-linking-planning process; --a range of supportive and protective sheltered environments which can provide sanctuary.

---these results of mental health research lead to---	---these implications for practice.
People with major mental disabilities are at risk of experiencing progressive deterioration of social functioning which can be prevented, to some degree, by structured opportunities for meaningful, responsible activity (Murphy, 1975; Davis, 1974; Strauss and Carpenter, 1972, 1973; Christensen, 1974).	Use of methods which develop competent social functioning.
	Use of service environments and processes which demand exercise of social competency.
People with major mental disabilities have a low probability of maintaining consistent employment in the open market (Erickson, 1975*; Anthony, 1972*; Davis, 1974; Pasamanic, 1967; J. Cumming, 1963).	Insuring availability of a range of sustenance services which provide age appropriate, productive social roles (e.g. long term sheltered work).
	Insuring availability of adequate housing.

This Basic Assumption

A responsive system should provide service whenever possible in the exact setting in which newly learned behavior must be applied.

Is supported by these results of mental health research and leads to---	*---these implications for practice*
Programs which deliver services in consumers' natural settings are more effective in reducing the use of hospital services than programs which rely on services in hospitals or in professional (supportive) environments (May, 1975*; Stein, 1975; Redding, 1973; Rubenskin, 1972; Langsley and Kaplan, 1968; Pasamanic, 1967).	<u>Priority</u> on developing the capacity to rapidly and consistently deliver services in natural environments (e.g. home visiting; in-school or at work interventions).
	Management <u>control</u> of drift toward provision of services in professional (supportive) environments.
Post-hospital functioning cannot be reliably predicted from in-hospital behavior (Ellsworth, 1975*; Guerl, 1972; Ellsworth, 1968; Ludwig, 1968; Fairweather, 1960).	The case management function of <u>screening-linking-planning</u> which --is programatically distinct from other service programs and is empowered to control their utilization; --convenes and involves consumers and their significant others in program planning and evaluation.
Goals and purposes for hospitalization are discordant between hospital staff and consumers with their families (Pollak, 1976; Ellsworth, 1968).	Both individual program planning and program outcome evaluations focus on information about functioning in natural environments.

---these results of mental health research and leads to---	---these implications for practice
The more differences there are between the setting in which a skill is learned and the setting in which it is to be applied the more difficulty a person will have actually performing the skill and the more necessary it becomes to invest resources in transfer training (Gagne, 1968*; Goldstein, 1974*).	As much as possible, develop environments to support people in community role performance and living arrangements rather than attempting to "rehabilitate" people as a precondition of movement.
For people with servere mental disabilities, social skills are highly situation specific; there is low transfer of acquired social skills across environments (Mariotto and Paul, 1975).	As much as possible, deliver a variety of skill training approaches within the exact environment in which skills are to be exercised.
There is an insignificant difference in community functioning between severely disabled people who receive extensive training before being resettled in community placements and those who are resettled without such training (Linn, 1977).	When it is necessary to provide skill training outside of a person's natural environment, design training approaches explicitly for transfer and evaluate them in terms of their effect on community role performance over time.

This Basic Assumption

A service system must build on the assets of its consumers and their folk support systems by increasing their collective capacity to eliminate, cope with and tolerate disability.

Is supported by these results of mental health research and leads to---	*----these implications for practice.*
The responses of family members to a person with a mental disability are a significant determinate of the nature and extent of the services the person needs.	Service should not replace any more support functions provided by a person's social network than absolutely necessary to meet the person's needs.
--The level of social support available to mildly and moderately mentally disabled people relates directly to the phenomenon of "spontaneous improvement" without service (Walker, 1977*; Rachman, 1971*).	Services should not remove a person any further from expectation and opportunity for performance of existing social roles and contact with existing social resources than is absolutely required by the level of social support available.
--The nature of family response to a member who has been institutionalized for a severe mental disability is directly related to the continuing need for institutionalization (Kreisman, 1974*; Brown, 1972).	
--The nature and extent of a family's social network is directly related to its capacity to manage changes in individual member's functioning (Sarason, 1977*; Bott, 1972).	Service planning strategies should separately assess a person's need for service and the resources of his family and social network.

---these results of mental health research lead to---	---these implications for practice.
People with mental disabilities who live outside of natural family unit - even those often perceived as isolated - typically have significant social network resources which can assist them in managing their life problems (Ferleger, 1977*; Collins, 1976; Weisman, 1974).	Service planning and case management functions should be organized to detect and convene existing social supports for all consumers.
A mentally disabled member can burden the resources of a family and social network and the level of perceived burden is related to the rate of service utilization (Kreisman, 1974*).	Insure that services are accessible and intelligible in terms of cultural norms.
Service practices which families and social networks perceive as reducing this burden are positively related to the mentally disabled person's ability to avoid institutionalization and maintain social functioning in community life (Davis, 1974; Langsley, 1968; Pasamanic, 1967; Laquer, 1964).	Discover and minimize service practices perceived to increase family burden.
Members of a mentally disabled person's naturally occurring social network can be trained to effectively influence social functioning (Carkhuff, 1976; Patterson, 1976* O'Leary, 1976*; Wahler, 1971*; Prowa, 1972*).	Before directly providing services, systematically explore all possible means to augment the skills and resources of the naturally occurring social network.

---these results of mental health research and lead to---	---these implications for practice.
Many people who are isolated from natural community social networks by reason of institutionalization or other long term separation can be assisted to form networks of support --by systematically involving them with each other with the explicit purpose of developing support groups (Bell, 1977; Hansell, 1976*; Katz, 1976; Fairweather, 1968, 1964). --by systematically involving them with typical community members who will relate to and represent their interests voluntarily (Wolfensberger, 1973).	Case management and service developing functions should place a higher priority on <u>devising</u> networks of social support than on direct provision of services whenever an ongoing community support network can be created by the service system's action.

This Basic Assumption

The types of service provided by the mental health system should be based on a continuing analysis of needs and be designed to correct outcome of the existing system. Whenever one type of service is underutilized or over-utilized a method should exist to shift resources into another indicated type of service.

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Is supported by these results of mental health research and leads to---	▶	*---these implications for practice.*
Reorganization of service patterns to stress continuity of service reduces the frequency of deteriorated social functioning among the severely disabled (Gruenberg, 1974*; Macmillan, 1957).	▷	Unification, as much as possible, of all available mental health resources within a region into a single system of service which offers a case management function which actively promotes service continuity.
The full range of needs of all the mentally disabled people in a large natural population can be met without reliance on a centralized institutional facility (Herjanic, 1968; Fakhruddin, 1972). --This requires an array of community based services which can successfully be developed by the planned reallocation of resources from the traditional state hospital to combine with community resources (Lafave, 1976). --the resulting system is less costly, overall, than major reliance on institutional services (Cassel, 1972).	▷	Unified management of the public mental health resources within a region permitting jointly planned resource sharing in terms of changing needs.

---these results of mental health research lead to---	---these implications for practice.
Hospitalization is an over-utilized mental health resource in terms of its outcome compared to less restrictive, less costly programs: --use of hospital services can, for most people, be avoided by in-community programs which are as effective as hospitalization in stabilizing crisis situations and tend to be more effective in terms of community functioning (Hansel, 1976*; Langsley and Kaplan, 1969; Pasamanic, 1967; Sainsbury and Grad, 1966; Carse, 1958). --all but the most seriously acutely disturbed people who cannot be managed in their natural environment can be served by partial day programs which are as effective in stabilizing crisis situations as hospital services and are more effective in maintaining social functioning (Herz, 1975a*; J. Cumming, 1973*; Herz, 1971). --community programs offering work roles and adequate housing are more effective in sustaining social competence than hospitalization and substantially less costly (Beard, 1976; May, 1975*; Fairweather, 1969; Paul, 1969).	Control of hospital utilization by organized review and empowered case management. Availability of crisis intervention and services which work in natural environments. Availability of crisis support in part-day programs with priority on utilizing part day program over hospitalization or returning people from hospital to part day programs as soon as possible. Availability of a wide range of sustenance services offering work roles and residences maintaining, as much as possible, programatic separation between day, evening and overnight programs.

---these results of mental health research lead to---	---these implications for practice.
Hospitalization is an over-utilized mental health resource in that those who must be hospitalized tend to remain in hospitals longer than is differentially beneficial given the availability of some community based services: --early hospital release is not associated with a higher rate of readmission than longer stays in the hospital (Herz, 1975b; Caffey, 1971; Burhan, 1967). --brief hospitalization (average 12 days) is as good as longer hospitalization (average 60 days) in terms of resolutions of acute symptomology and rate of readmission and is superior in terms of maintaining role performance and time spent in the community (Herz, 1977, 1975b). --brief hospitalization does not impose any more family burden than longer hospitalization (Herz,1976). --failure to differentiate consumer needs for stabilization of acute crisis state from needs for growth and sustenance services can result in overutilization of hospitalization and can be detrimental to some consumers well being (Goldberg, 1977; Van Putten, 1976*).	Specification of the mission, goals, manpower and procedures of hospital units in terms of providing only these stabilization services necessary to permit a person to function in the next least restrictive available environment. Deliniation of the role of hospital services in relationship to community programs: community programs, through the case management function, maintain accountability for providing service.

---these results of mental health research lead to---	---these implications for practice.
Psychotherapy is an over-utilized mental health resource in terms of its outcome with moderately and severely disabled people relative to other, often less costly, approaches: --Psychotherapy contributes minimally, if at all, to the improvement of social functioning for the moderately and severely disabled (Goldstein and Stein, 1976*; May, 1975*; Luborsky, 1975*; Truax, 1971*; Luborsky, 1971*; Bergin, 1971*; Rogers, 1967). --Psychotherapy appears to be differentially effective across social classes, with people of lower socioeconomic status less likely to benefit than people of higher status (Goldstein, 1974*; Garfield, 1971*). --Psychotherapy and psychosocial approaches are less effective than psychotropic drugs for stabilizing moderately and severely disabled people (May, 1975*; May, 1971; Luborsky, 1975*; Grinspoon, 1972; May, 1968). --Social and instrumental skill development through structured training programs is more effective than psychotherapy in promoting the social competence of the moderately and severely disabled (Goldstein, 1976*; Carkhuff, 1976; Goldstein, 1974).	Specification of service mission, goals, programs and staffing patterns to permit a range of stabilization, growth, and sustenance services rather than a focus on psychotherapy. Organized review of individual service plans to insure appropriate utilization of psychotherapy. Service focus on skill training approaches to growth services.

---these results of mental health research lead to---	*---these implications for practice.*
When psychotherapy is an indicated growth service, individual psychotherapy tends to be overutilized in contrast to group psychotherapy which is usually less costly, and --is as effective, in general, as individual approaches; (Luborsky, 1975*). --for severely disabled people tend to be more effective than traditional approaches (Claghorn, 1974; Herz, 1974; O'Brien, 1972).	Growth services utilizing psychotherapeutic approaches should in general be delivered in group settings.

---these results of mental health research lead to	---these implications for practice.
Primary prevention activities tend to be utilized imprecisely with uncertain or predictably low benefit relative to cost: --A clearly established casual relationship is necessary for the design of intervention which will impact on incidence of mental disabilities --Somatic interventions are effective in reducing incidence of mental disability where a clear model of causality exists (e.g. prevention of some types of severe mental retardation; syphilis) (Fotheringham, 1977*; Zusman, 1975*). --Environmental intervention of sufficient intensity and comprehensiveness are effective in reducing some mental disability (e.g. mild mental retardation) which is clearly related to depressed parental social functioning (Heber, 1972). --Environmental intervention often rest on confused or implicit models of causality and have no reliable effect on the incidence of mental disability (Cowen, 1977*; Kessler, 1975*; Munoz, 1975*).	Review of all primary prevention activities to insure that each either arises from an empirically supported model of cause and means of intervention or is conducted as a well designed, carefully controlled pilot-study with sufficient time allotted to reflect impact on the incidence of disability in a well defined target population. Insure that all empirically supportive prevention efforts are implemented by appropriate area human services.

This Basic Assumption

New, responsive systems seldom evolve naturally from existing and established systems.

Is supported by these results of mental health research and leads to---	*---these implications for practice*
Innovations in service programs based on utilization of research knowledge occur relatively infrequently, even in the presence of active dissemination efforts (Davis, 1974; Fairweather, 1974; Glaser, 1974).	Provide resources and sanction to a research investigation and utilization function and make use of its work in administration and service related decision making.
Attempts to modify the mission of a service system are difficult when the modification involves change --in the professional ethos and hierarchy of the service. (Fairweather, 1974). --in the management practice of the service system and its supporting social institutions (GAO, 1977). --in the economic structure and outputs of the service system (GAO, 1977; Bachrach 1976*).	Insure the effectiveness of a planning process which includes the perspective of each system constituent (consumers; providers; sponsoring social institutions) in clear specification of mission, a <u>management</u> function which operationalizes the mission and a <u>control</u> function which systematically tracks performance toward objectives. Assign staff to provide class specific advocacy. Document deficiencies in the system's operation and modify services in terms of this feedback.

References

Notes:

-Whenever possible the reader is referred to literature reviews which summarize the state of the field on the issue presented. These reviews are marked with an "*" in the display above and in the reference list.

-Although much of the documentation of the BSS lies in presently unpublished material or in internal agency reports and studies which are difficult to retrieve, this list cites sources which should be easily available. In the few cases where unpublished material provides the best review of evidence, it is cited and the material has been deposited at the Georgia Mental Health Institute Library where it is available for loan.

-For added convenience, as many citations as possible have been made from two commonly available reference books:

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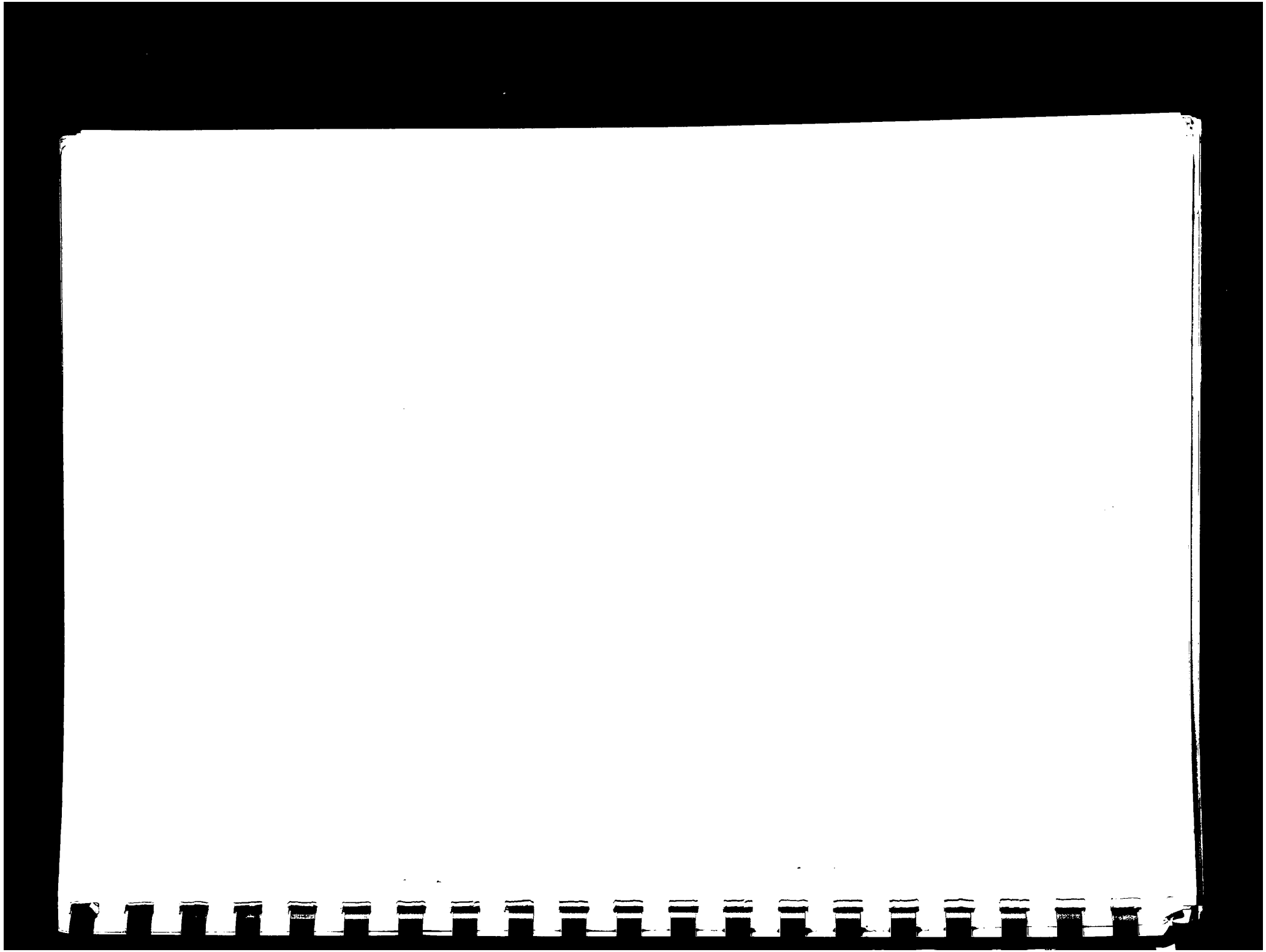

ACHIEVING MAJOR CHANGE IN THE PATTERN OF PSYCHIATRIC SERVICES

A CHECKLIST OF 20 KEY QUESTIONS

David Towell
Assistant Director,
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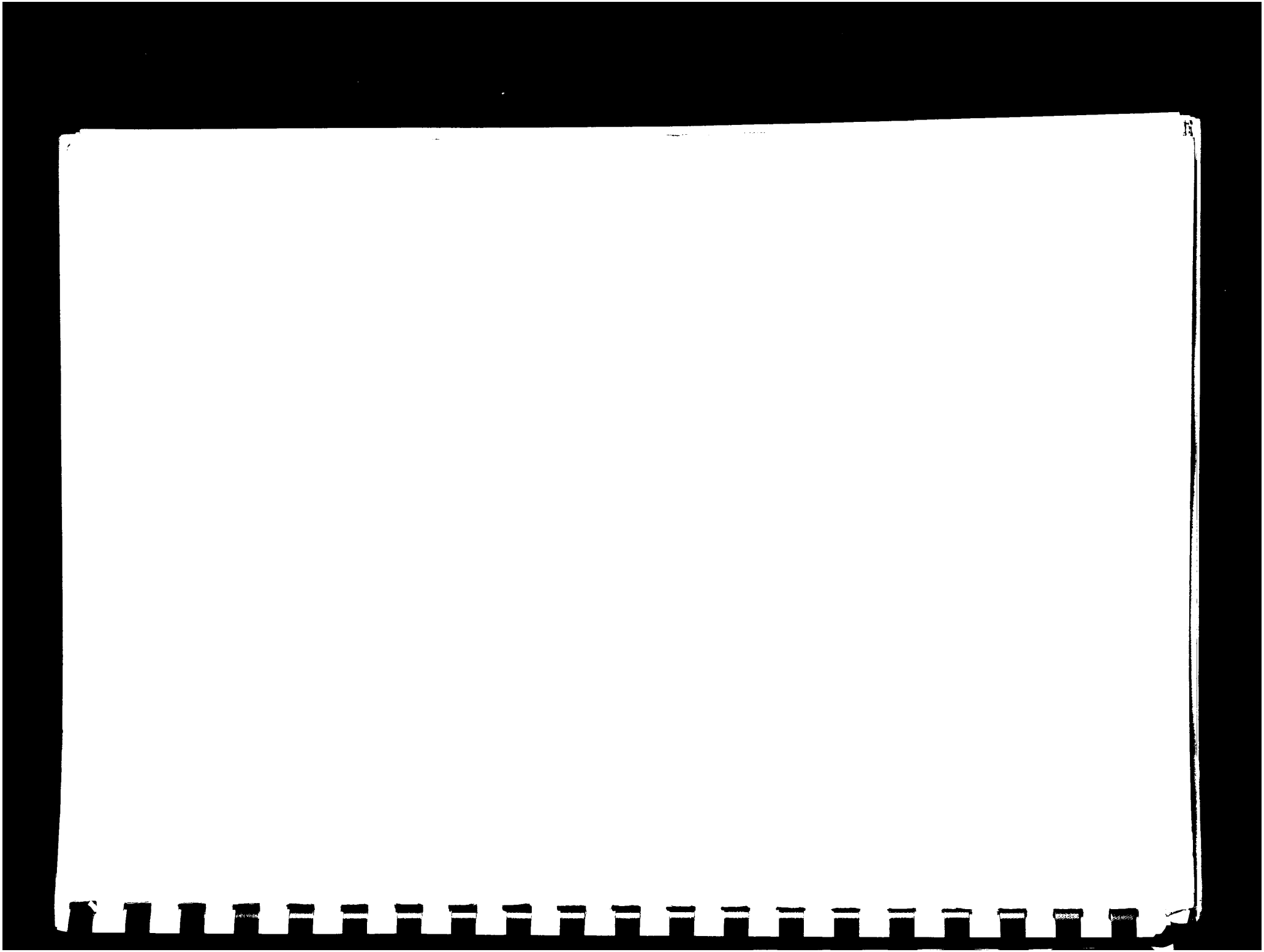
August 1983



ACHIEVING MAJOR CHANGE IN THE PATTERN OF PSYCHIATRIC SERVICES

CHECKLIST OF 20 KEY QUESTIONS:

At Regional Level

1. Have planners and providers established a guiding vision of the future pattern of services, based on an explicit statement of philosophy/principles?

2. Is there political backing for this vision at Authority level and the commitment to making resources available for the development of priority services?

3. Where large hospitals are concerned, has Region established appropriate cross-District mechanisms to co-ordinate the reallocation of resources over a lengthy period of transition? Are incentives available to promote development of local services?

4. Is responsibility for managing redeployment of staff clearly defined?

5. Has a coalition of influential staff come together to provide visible leadership for efforts to achieve change? Is there adequate investment in the skills necessary for planning and implementing new services?

6. Despite the hierarchial organisation of the NHS, have close links been established between policy-making and implementation in the service development process? How far is there a real dialogue between planners and providers about opporunitites and problems in achieving progress?

At District/Local Authority Level

Most of the first six questions are equally important locally. In addition:

7. In each District is there a planning and development forum concerned with the total psychiatric services (including the large hospital contribution)? Are the Local Authority and Voluntary Sector contributions to future services adequately represented in this forum?

8. Is planning for real, in the sense of being closely linked to well-grounded finance and manpower assumptions? Is it well informed by systematic data on likely future needs and demands for services?

9. Is the planning process actively seeking and incorporating client and community views about current and future services? Are opportunities created for users to shape developments in provision?

10. Rather than being constrained by the assumptions implicit in existing services, is planning innovative in the sense of involving the exploration of alternative forms of provision for the future?

11. Are planners and managers trying to work through (rather than avoid) the conflicts in professional expectations and other views which arise in introducing significant changes?

12. Are planning and development informed by explicit evaluation exercises? Are local efforts informed by comparison with how similar client needs are being met elsewhere?

13. Are relevant development and training opportunities being provided on the scale necessary to prepare staff to exercise new roles and skills? Is the potential contribution of staff being fully realised through investment in participation?

14. Are management monitoring systems being established to ensure that service objectives, client needs and resources are carefully related? Is management concerned not only with developing, but also maintaining, good practices 'when the novelty wears off'?

And specifically in relation to the management of contracting institutions:

15. Are arrangements established to ensure that relevant parts of the large hospital operate as part of total services to each catchment District during the period of transition to local provision?

16. Is the investment in communication and participation adequate to ensure staff fully understand the plan for change and themselves contribute to shaping the future?

17. Are appropriate personnel policies established to promote a smooth transition?

18. Does financial planning make allowance for any 'hump' in resource requirements and foster improvements in the quality of institutional provision as well as relocation of services?

19. Do admission and retrenchment policies give institutional staff the chance to achieve such improvements?

20. Is careful attention being given to safeguarding the interests and ensuring fair treatment for existing hospital patients, particularly those who through lengthy stay may be deeply 'attached' to the institution?

Note: This checklist is drawn in slightly revised form from David Towell's 'Introduction' to the report of a national conference on Bringing about change in the provision of long-stay services held in Birmingham, March 1983. As well as discussion at this conference, it reflects earlier experience in a study of Winwick Hospital (Towell, D. 'Developing better services for the mentally ill: an exploration of learning and change in complex agency networks' in Barrett, S. and Fudge, C. (eds) Policy and Action Methuen, 1981) and more limited discussions with officers involved in the Worcester Development Project, the relocation of services based on Darenth Park Hospital, and the rationalisation of services in the catchment areas of Banstead and Horton Hospitals.

MENTAL ILLNESS HOSPITALS SERVING GREATER LONDON

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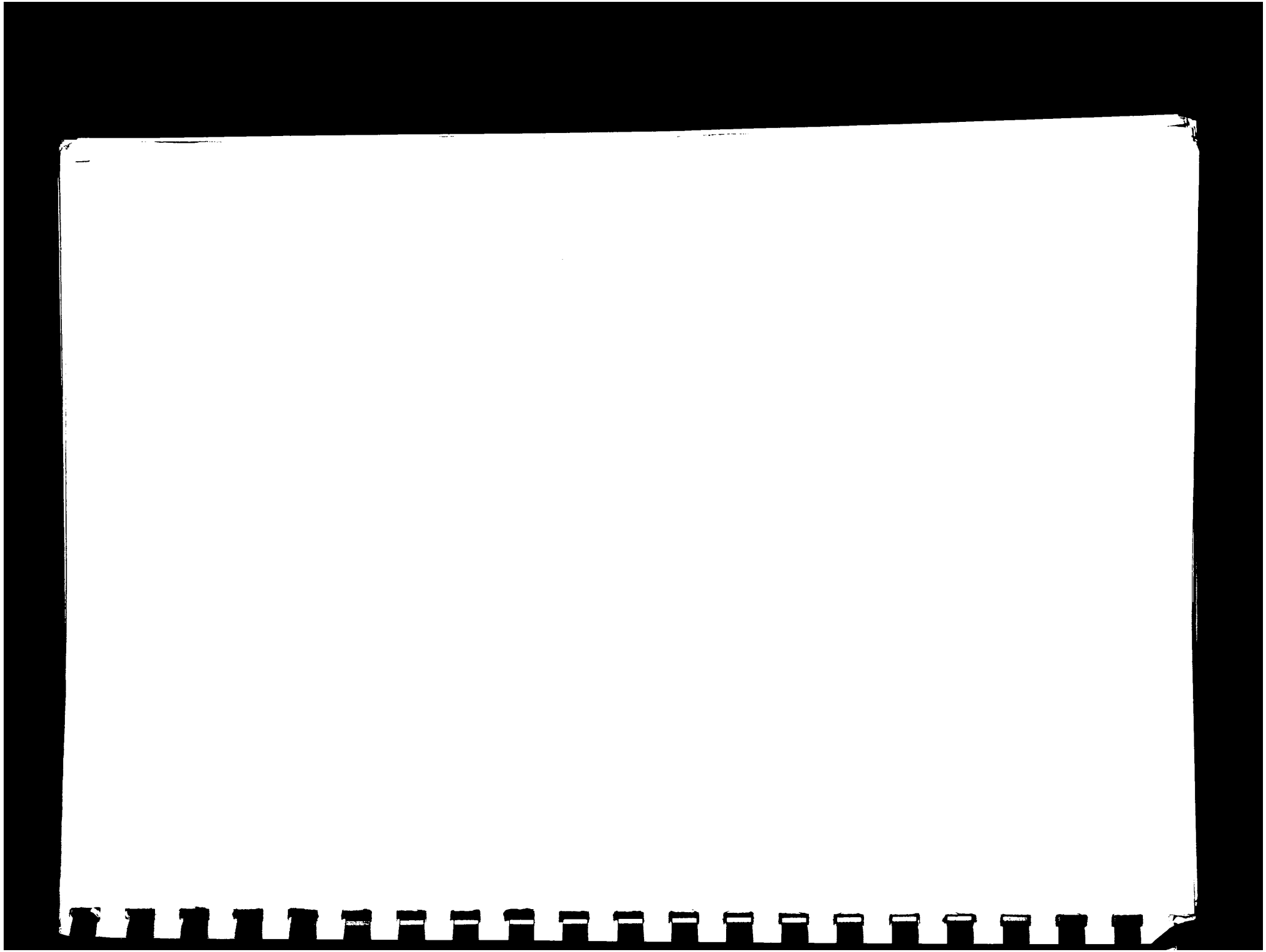
Background paper for the King's Fund Conference:
'Issues for London District Health Authorities:
The Development of Comprehensive Psychiatric Services'
March 1983



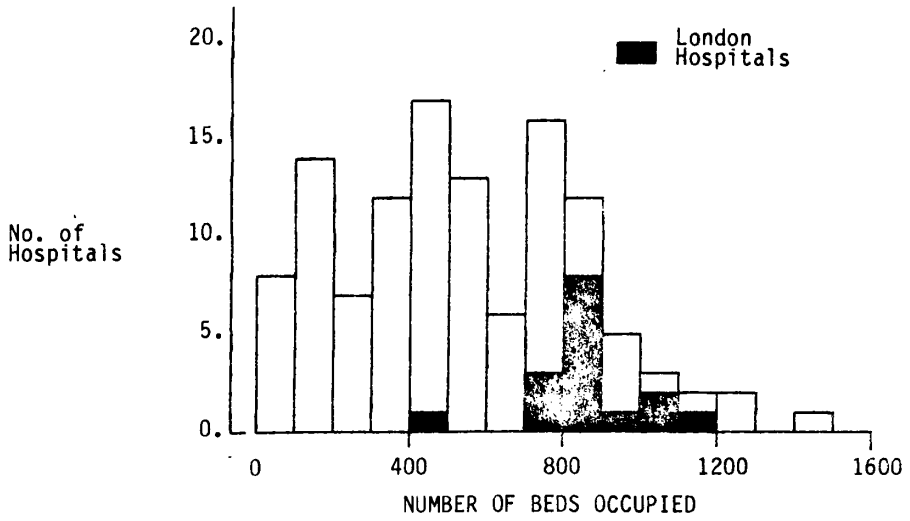
MENTAL ILLNESS HOSPITALS SERVING GREATER LONDON

There are sixteen large mental illness hospitals that are managed by health districts within the Greater London Council area, although some of the hospitals are physically situated outside the GLC area. These sixteen hospitals do not constitute the only hospital care for psychiatric patients, but do represent a very significant element of the psychiatric hospital services for London. Figure 1 shows that London's large mental illness hospitals form a significant proportion of the larger hospitals in England. Of the twenty five English hospitals with more than 800 patients, twelve of them are in London.

FIGURE 1

SIZE OF HOSPITAL DISTRIBUTION

For 116 Mental Illness Hospitals in England in 1981



It might be argued that the large size of these hospitals simply reflects the very large populations which they have to serve, but there are those however who feel that larger hospitals quite often suffer from difficulty in communications and personal relationships simply because of their size.

Those who support Schumacher's notion that "small is beautiful" are concerned that the sheer size of such institutions makes personal care and attention difficult, and would argue that London's health districts have a formidable problem on their hands. The fact that in many cases the longer stay patients were originally admitted from locations no longer served by the hospital only hightens the problem.

INTER-HOSPITAL COMPARISONS

Over the past two years The Health Services Management Centre at the University of Birmingham has been attempting to provide comparisons of resources and performance for English mental illness and mental handicap hospitals. The remainder of this report provides a glimpse of the sort of analyses that are available. The results presented here are for the sixteen London hospitals, but information can be made available on an individual hospital basis to consultants, senior nurses, and administrators working at hospital and district level. In the case of these sixteen hospitals, information has already been requested for seven of them at hospital or district level, and thirteen of them by regional health authority officers. Should any health authority members wish to avail themselves of such information, it is suggested that they ask their district administrator to approach HSMC.

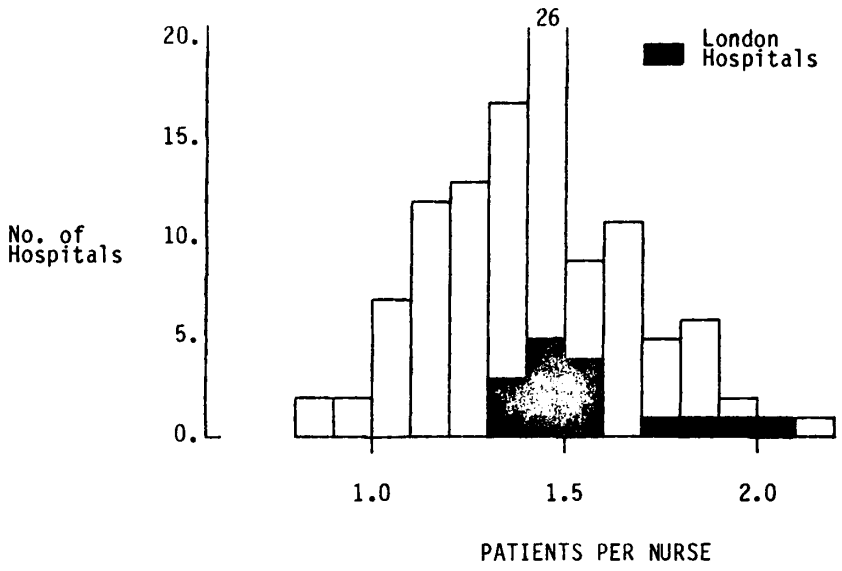
SOME COMPARISONS

One crude indicator of resources allocation is to compare the number of nurses with the number of in-patients. Clearly such an input measurement gives no guarantee of standards of care. Having said that, as one of the functions of a hospital is to provide nursing care, it is perhaps surprising to see that there is almost a threefold variation in nurse staffing figures across England. Figure 2 shows that provision in London does not vary so widely.

Figure 2

PATIENTS PER NURSE DISTRIBUTION

For 116 Mental Illness Hospitals in England in 1981



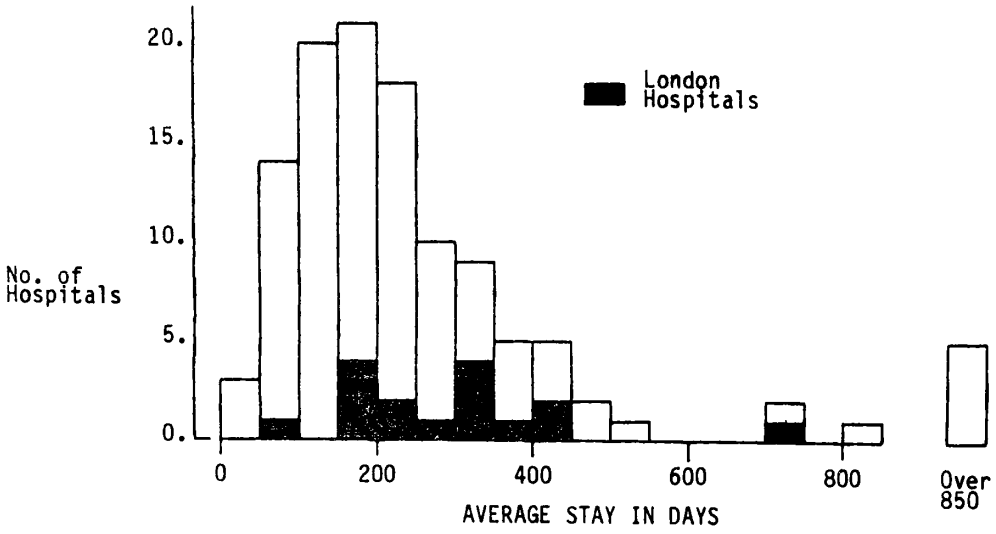
All the sixteen hospitals are either near the English average, or much worse than it. In view of the fact that many London districts are classified under the RAWP formula as being relatively "well off", some hospitals appear to be surprisingly badly staffed.

If one proceeds to seek for measures of process or outcome, then indicators are even more difficult to come by. One crude attempt to look at process is to examine the proportion of long stay patients within a hospital. Much has been written in the past twenty years about the danger of spending long periods in institutions and thus an examination of a crude length of stay pattern may give some idea of the extent to which hospitals are successful in rehabilitating and discharging patients. Figure 3 shows the average length of stay of patients in English hospitals. The five hospitals where length of stay is shown as over one thousand days are all psycho-geriatric hospitals. If those five hospitals are excluded from the distribution, it can be seen that London has eight of the twenty five hospitals where average patient stay is over three hundred days.

Figure 3

LENGTH OF STAY DISTRIBUTION

For 116 Mental Illness Hospitals in England in 1981.



This very crude indicator of performance has in the past been surprisingly sensitive to performance failure. Quite a large number of "enquiry" hospitals of the last twenty years, in both mental illness and mental handicap have had a high proportion of long stay patients.

ACCIDENTS CAN HAPPEN ANYWHERE, BUT DISASTERS ARE PLANNED

When people study performance failures such as Aberfan, Hixon train disaster etc., they quite often find that a large number of problems exist. It is unusual for one small event to cause a major disaster. If one takes that analogy and applies it to mental illness hospitals, it is possible to analyse some, but not all, of the factors that relate in some way to performance. In an attempt to test this idea we have taken six indicators of performance, and looked at these for all hospitals in England over the last sixteen years. The resulting analysis does not provide a precisely accurate diagnostic tool for identifying enquiry hospitals before they happen, but it does tend to confirm that enquiry hospitals have a number of problems and that some of them are measurable. Displaying these six indicators on the same diagram (see Figure 4), enables one to make a crude comparison of any individual hospital against all others in England. Hospitals which frequently appear towards the right hand side of the diagram are ones which might suggest cause for concern, particularly if the positions on the right hand side included patient nurse ratio, and/or length of stay.

Excluding psycho-geriatric units, there are 10 hospitals which appear to display a large number of 'risk' factors. It is these hospitals which we suggest might be at risk of performance failure. Four of them are in London!

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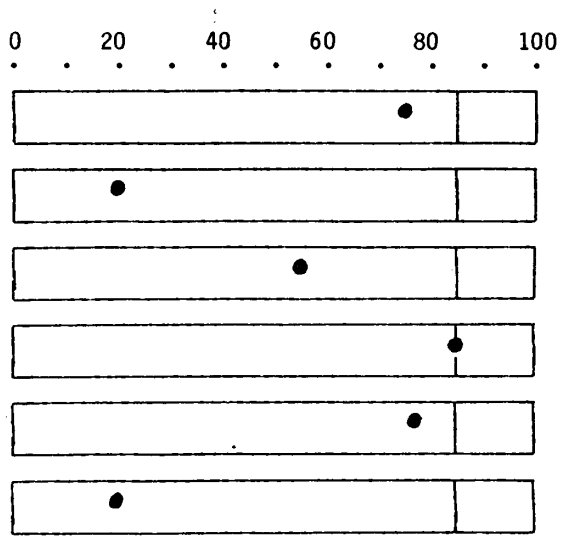
4 February 1983

Figure 4

MENTAL ILLNESS HOSPITALS' PROFILE (for 1981)

INDICATOR*	RANGE FOR ALL HOSPITALS	FIGURE FOR SAMPLE LONDON HOSPITAL	POSITION RELATIVE TO OTHER HOSPITALS (Expressed as a percentile)
SIZE OF HOSPITAL	38-1401	+	
PATIENTS OVER 65	13%-99%	49.7%	
PATIENTS PER CONSULTANT	10-1255	99	
PATIENTS PER NURSE	0.8-2.2	1.70	
PATIENTS PER THERAPIST	8-438	35	
LENGTH OF STAY	34-4318	224	



+ Omitted to preserve anonymity

COMMENTARY

This profile shows the position of the hospital in relation to 115 other hospitals in England. It appears to be relatively large in size and has staffing levels that are generally worse than most other hospitals. The length of stay indicator gives an idea of the amount of movement of in-patients through the hospital and in this case shows a low proportion of short-stay patients.

Our analysis is primarily concerned with identifying potential risk factors in hospital performance and we have concentrated on six indicators which appear to be more sensitive than others. If we examine the tail 15% of the distributions this hospital along with 30 others displays only one major risk factor - the patient nurse ratio. A high number of patients per nurse will make nursing care, treatment and attention difficult. This hospital has considerably less nurses per patient than many other hospitals in England. Is this because the type of patients in the hospital do not require high numbers, or is it seriously short-staffed?