COMMUNITY CARE IN THE MENTAL HEALTH SERVICES*

By **Kathleen Jones, Ph**

Senior Lecturer in Social Administration, University of Manches

WHEN the National Health Service was created, the advantages and disadvantages of tripartite structure were widely discussed. One of the long-term disadvantages has been the development of tripartite thinking.

LACK OF CO-ORDINATION

Problems of local authority, hospital and practitioner care are considered in isolation from one another. There has been little or no co-ordinated planning at Ministry level. The *Hospital Plan*, published in 1961, deals with developments planned up to 1975. It is concerned almost exclusively with in-patient facilities, and measures expansion in terms of beds per thousand population. Planning is organised on the basis of the regional hospital board areas. *Health and Welfare—The Development of Community Care* came two and a half years later. The target date is not 1975 but 1972. It is concerned only with those community facilities which are the responsibility of local authority health and welfare departments.

Expansion is measured in different ways for different services—in one column, in terms of places to be offered without reference to the number of centres involved; in another, in terms of centres without reference to the number of places. Total numbers of social workers and home helps to be employed are listed without indication of how these workers would be allocated between the needs of the old, the physically handicapped, the mentally disordered and the maternity services, and the areas for planning are those of county and county borough councils. While some attempt has been made to equate these to the regional hospital board areas of the other plan, the result is sometimes misleading. Thus the whole of the West Riding of Yo shire is classified under the Le Regional Hospital Board area. In f one-third of the population of West Riding lives outside the Le R.H.B. area; while half the popula of the North Riding is in fact in Leeds R.H.B. area, though not cla fied as such. About three-quarters million people are thus wrongly c sified.

Both plans have been revised si they were originally published; recent population estimates are divergent from those used in the pl that much of the material in the pl is already out-dated. It is thus imp sible, on the basis of publis material, to find out what is happen in the development of a given ser in a given area.

Health and Welfare is often refer to as "the Community Care Plan"; "community care" is not the name segment of the health and welf services. It is a new view of the wh

FACTS ESSENTIAL

Co-ordinated planning has bec imperative; but it must be based facts rather than on opinions. So the development of community c has been accompanied by controve and generalisation, and facts have b rather scarce. There is now gen agreement that, where possible, m tally ill or subnormal people sho keep in touch with friends and r tives, to preserve their normal pat of living; that, where possible, th should be a wide range of suppor services, medical, social and edu tional. Some of these—social work vices, training centres, hostels, shelte workshops and others—will be p vided by local authorities. Others—o patient clinics and day hospitals—

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be provided by the Hospital Service. General practitioner care will be central to schemes of prevention and early treatment—where possible.

1. Too little knowledge.

The sting, of course, lies in the words "where possible". At present, very little is known of the extent of psychiatric morbidity in the community, and of how many people need help. Whenever extra services are provided, they are used to capacity, and the best efforts to date have not dealt with chronic shortages of staff and money. It is not known what proportion of mentally disordered people benefit from the maintenance of contacts with their normal environment, and what proportion find this an intolerable strain. It is not known what proportion of families can cope with a disordered member—or why—or what proportion themselves break down as a result. It is not known whether community care is less or more expensive than in-patient care, or whether it is less or more effective, and for what types of patient. It is not known what "community care" ought to mean in the rural areas, nor how many of the patients now in the long-stay wards of psychiatric institutions would be capable of a return to the community, or in what circumstances. It is not known how much psychiatric care the average general practitioner ought to be able to provide; and the average general practitioner does not know, either.

In other words, the state of knowledge about mental health work in the community is roughly equivalent to the condition of biology in this country before Darwin. Years of patient classification, years of replacing speculation by exact knowledge, lie ahead.

Until ten or fifteen years ago "research into mental health" meant little more than clinical or scientific research. More recently, studies in psychiatric epidemiology and in the social and administrative aspects of mental health care have begun to make a contribution to understanding.

A survey completed recently by members of the Faculty of Economic and Social Studies in the University of Manchester in association with psychiatrists attached to the Leeds Regional Hospital Board sheds some light on the need for institutional accommodation and the scope of community care.†

2. Psychiatric survey

This study, which covered the psychiatric population of the whole of the Leeds region (nearly ten thousand patients), began from a smaller survey.

When the projected reduction in mental hospital beds was announced in 1961, the Medical Superintendent of Menston Hospital, Dr. C. P. Gore, asked for assistance in surveying the patient-population of his own hospital, and in estimating the probability of discharge for the long-stay group.

The "long-stay" group" was defined as those in hospital continuously for five years or more, and a few fairly simple criteria were taken: how old were these patients? What was the actuarial probability of their survival to or beyond 1975, the date of the Hospital Plan? Had they husbands or wives to care for them? Were they capable of supporting themselves by employment of any kind? Were they mobile? Did they have regular visitors and links with the outside world? What was the prognosis?

The results of this small study were published and are not now worth repeating in detail. It is sufficient to say that it was found that many patients would still be alive in 1975, in a deteriorating condition, without relatives or links with the community, and unable to support themselves.

It was recognised that it is sometimes possible to rehabilitate even the most unpromising patient, and that a number of local authorities can quote with pride individual instances of this kind; but such work consumes a great deal of time and energy on the part of the over-loaded workers. It puts such a strain on the supportive services that

† C. P. Gore, K. Jones, W. Taylor and B. Ward, *Lancet*, August 28th, 1964.

the conclusion was that it was not possible for it to be copied on a large scale with the resources likely to be available by the early 1970s. Another conclusion was that further investigations were necessary before the policy of mass discharge envisaged by the Ministry was embarked upon.

Even this modest conclusion was criticised on the grounds that the population was too small, the hospital atypical, and the methodology not sufficiently rigorous. A much larger survey was therefore set on foot with the co-operation of the Leeds Regional Hospital Board. The Board had been told in 1961 to make plans for reducing the psychiatric beds in its area to the regulation of 1·8 per 1,000 by 1975. This would have meant a reduction of about 5,800 beds; and since geriatric beds in the region were also to be reduced in proportion to the expected population, the Board was seriously concerned about the level of provision.

This time a larger research team was organised, including a social statistician and a psychiatrist with planning experience; and a bigger task was attempted: that of estimating the need for psychiatric beds in the region in 1975. Forecasts are very difficult to make for more than a year or so ahead, because of the variety of factors affecting bed-demand. The operation of such factors as the possibility of biochemical or pharmacological advances, the employment situation, a shortage of nursing staff in the hospitals or social work staff in the community services, and changes in public opinion and Government policy, cannot be assessed with any degree of accuracy.

At the same time, some fresh sources of information were available. The Registrar General's population forecasts had changed appreciably since the publication of the official policy. The plans of local authority health and welfare departments were available. Since the survey was to be organised on a regional basis, very strict checks could be kept on the accuracy of the data, and not only a pilot study but also a validating study were carried out, in which 5% of all patients in the sample were examined by one of t psychiatrists, and the informati checked against records.

On the basis of the census of nea 10,000 patients and an analysis regional trends over the past ten yea the research team has advised t Leeds Regional Hospital Board th the demand for hospital beds for t mentally ill in 1975 will probably between 9,000 and 10,000: that is, th any further reduction in beds is u likely to occur. The main reasons f this estimate are:

(i) The increase now forecast in t population at risk. The Health a Welfare plan was constructed the estimate of a 3·3% increase 1972. The Registrar Genera Office now estimates that popul tion will rise much more steeply the population increasing by 12 by 1977 and the over-65 populati by 27%. This must affect both lo authority services and hospital p vision.

(ii) The confirmation of the findings the smaller Menston survey. Ma long-stay patients would be e tremely difficult to rehabilitate, a are likely to require continuo care for many years.

(iii) The continued pile-up of chron patients in mental hospitals. Pr files of treatment for the three ma diagnostic categories (the affecti disorders, the senile psychoses a schizophrenia) indicated that t optimism of 1961 was not ful justified. The effects of new metho of treatment were marked in t case of the affective disorders, b senile patients and schizophreni were still being added to the lon stay group in appreciable numbe

Statistics for the Leeds Region we checked wherever possible again national figures for the mentally ill hospital. These comparisons did n reveal any significant regional bias. the conclusions from this survey c be applied nationally, the need f psychiatric beds in 1975 may be so 50,000 or more higher than the estima used for the *Hospital Plan*. Provisio on this scale is not merely a matter f argument between those who work the mental health field, but a matt

national economic and fiscal policy. ven if the health and welfare plans of cal authorities are fulfilled, a huge ogramme of capital expenditure will e required.

Problem of the single

The survey indicates that there are any patients in mental hospitals who o not need the full range of hospital are; but it is merely facile to argue at they can therefore live in the com- unity and return to family life. The ajority of them are in institutional are precisely because they have no milies. Over half the patients in the eeds Regional Hospital Board survey ere unmarried, and the proportion ingle rose steadily with the length of ay to 71·5% for those who had been hospital for more than 20 years. he peak admission rates for long-stay are tend to be in the middle years of fe, when parental care fails, and there no comparable form of care to re- lace it.

Some of these patients could be dis- harged to local authority care if the cal authorities were willing and able o provide suitable accommodation and are for them. In most cases, this would ave to be permanent care. Hostels ould "silt-up" with patients likely to emain there for 20 or 30 years or onger, and fresh hostels would have to e set up year by year for a consider- ble time—with all the attendant prob- lems of securing capital appropriations, sites and staff. It would have to be fairly intensive care, providing a structured social environment for people who cannot organise their own lives; and, to economise the use of the necessary specialised staff, it would have to be comparatively large-scale care, either in large units, taking 100 patients or more, or in small units grouped round a centre.

Are local health authorities ready to take on responsibilities of this kind? Even if they were, the heavy financial burdens involved might be too great for local financing; and it may be necessary that the responsibility should remain with the Hospital Service, which is financed out of general taxation, if only for this reason.

CONCLUSION

To sum up, much of the optimism about the development of community care in the Mental Health Services springs from wishful thinking rather than from a knowledge of the facts. The community care services must be developed as well, and as rapidly, as possible; but the problems of long-stay patients in two kinds of institutions investigated have been shown to be severe. Many such patients require a permanent sheltered environment of a type which it may be beyond the resources of local authorities to provide.

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