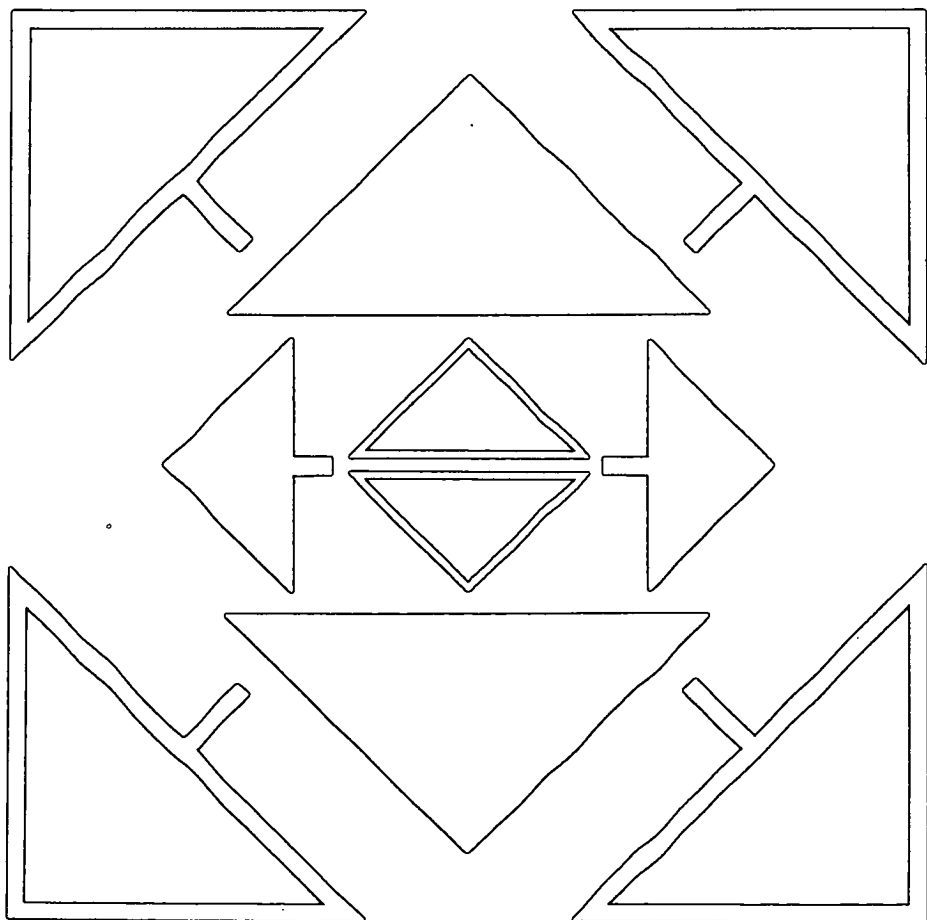


# APPROACHES TO ACTION

*A symposium on services for the  
mentally ill and handicapped*

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## ***Contents***

	<i>List of participants</i>	vii
	<i>Foreword</i>	
	R. H. L. COHEN	ix
1	<i>The psycho-geriatric problem with special reference to the needs of elderly people with progressive mental impairment</i>	
	SIR MARTIN ROTH	1
2	<i>Aspects of the Goodmayes service</i>	
	T. H. D. ARIE	17
3	<i>The Camberwell services</i>	
	LORNA WING	27
4	<i>Some factors affecting the organization and planning of psychiatric care</i>	
	ALEX G. MEZEY	41
5	<i>Mental illness, general practice, and the National Health Service</i>	
	MICHAEL SHEPHERD	57

vi	<i>Contents</i>	
6	<i>Social correlates of psychiatric illness in the community</i>	
	B. COOPER	65
7	<i>Residential provision for mentally handicapped adults</i>	
	ALISON C. ROSEN	71
8	<i>Evaluating residential services for the mentally handicapped</i>	
	ALBERT KUSHLICK	81
9	<i>The future needs for research in mental health</i>	
	JOHN BROTHWOOD	105
	<i>Postscript: a commentary on the discussion</i>	
	THE EDITOR	113

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viii      *List of participants*

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## **Foreword**

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The last few years have seen a rapid development in medical and social research sponsored by the Department of Health and Social Security either alone or in conjunction with the Medical Research Council or other bodies. As experience has been gained in its administration, the need has become clear for having a variety of means for reviewing the strategy of this research in order to assess its relevance to health service problems, to identify gaps and make them known to interested research workers, and to provide opportunities for free and informal exchanges of view between the research workers and those who use their results. In this way it is hoped that gradually a research programme will be built up which has a major influence on the development of policy for which the Department of Health and Social Security is responsible. Furthermore, it is clearly important that information about research under way should be as widely disseminated as possible. For the latter, the ready collaboration of the Nuffield Provincial Hospitals Trust had already been made available to the Department, and had resulted in the publication of the first volume of *Portfolio for Health*.<sup>1</sup> It was natural, therefore, when the Trust offered its help in staging a series of conferences, the purpose of which was to review the strategies of the Department's research programme, that the Department should take up the offer.

It was considered that the mental health research programme lent itself particularly well to this form of discussion, and it was therefore selected as the subject for the first, and it should be admitted to some

1. McLachlan, G. (ed.) (1971). *Portfolio for Health, Problems and Progress in Medical Care*, Sixth Series (Oxford University Press for the Nuffield Provincial Hospitals Trust).

extent experimental, conference. It was decided that the main areas to be covered should be psycho-geriatrics, mental handicap, adult mental illness, and general practice and social work. Other areas of psychiatric research which might have been included, had time permitted, were child and adolescent psychiatry, forensic psychiatry, and problems of addiction. Distinguished workers, supported by the Department (often jointly with another research body) were invited to prepare papers for circulation before the meeting, at which they were asked to introduce them briefly in order to allow as much time as possible for discussion.

Besides the speakers, we were fortunate in having Professor W. H. Trethowan to act as Chairman for the morning session and Dr J. J. A. Reid for the afternoon. In addition senior civil servants from the Department attended as well as representatives from the Medical Research Council. The resulting interchange of ideas between those responsible for formulating policy and those undertaking research was found to be very profitable.

In retrospect, there was general agreement that the conference had been useful. If there was a criticism it was perhaps that the programme had been too ambitious. For example, it became clear during the course of the day that each one of the four areas selected for discussion might have merited a half, if not in some instances a whole, day to itself. There was therefore amongst some of the participants a feeling of frustration that more time was not available for discussion. On the other hand many useful points were made, and we can perhaps look forward to further conferences in collaboration with the Trust covering more circumscribed topics.

Finally, it remains for me to thank the Trust, and particularly its Secretary Mr Gordon McLachlan, for their hospitality but even more for the benefit of their great experience in setting up conferences and publishing the proceedings. We look forward to their willingness for further collaboration in the future.

# ***The psycho-geriatric problem with special reference to the needs of elderly people with progressive mental impairment***

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## **1. The magnitude of the problem**

In considering services for the elderly, the senile and arteriosclerotic dementias (or the 'chronic brain syndromes' as they have come to be called), merit special attention. Patients with these disorders have been found to occupy a high proportion of the beds in every type of long-stay accommodation investigated: geriatric wards, residential homes, and mental hospital wards allocated to long-stay patients alike (1). The success of the plan to phase out mental hospitals of the traditional type within the next few decades will be largely decided by the extent to which alternative forms of care for subjects with cerebral degenerative disease can be provided for aged people with chronic mental disorders.

Those in hospital represent only a fraction of the elderly suffering from mental infirmity and illness. A survey of the elderly living at home in Newcastle upon Tyne (1) revealed a 10 per cent prevalence of organic brain syndromes and about half of these, that is 5 per cent, were 'severe' cases. The findings of different authors working in a variety of cultural settings reflect a wide measure of agreement (Table 1). However, in Newcastle less than one-fifth, even of these severe cases, were being cared for in hospitals or welfare homes.

Moreover, population trends suggest that the demands made by the aged on the health and social services are bound to increase steeply within the next decade. At the present, roughly one out of every eight persons in the population is aged 65 or more. Ten years



Table 1. The prevalence of the main psychiatric syndromes of old age, according to various authors (taken from reference 1) (percentages).

	Sheldon (1948) (N=369)	Bremer (1951) (N=119)	Essen-Möller (1956) (N=443)	Syracuse (1961) (N=1,592)	Primrose (1962) (N=222)	Neilsen (1963) (N=978)	Kay (1964) (N=297)
	65+	60+	60+	65+	65+	65+	65+
Senile and arteriosclerotic psychoses	3.9	2.5	5.0	—	3.6	3.1	4.6
Other organic syndromes	—	—	—	—	0.9	—	1.0
Major functional disorders	—	4.2	1.1	—	1.4	3.7	2.4
Psychoses, all forms	3.97	6.7	6.1	6.8	5.9	6.8	8.0
Mild mental deterioration	11.7	—	10.8	—	—	15.4	5.7
Neuroses and allied disorders	9.4	5.0	1.4	—	10.4	4.0	8.9
(moderate/severe forms)	3.2	12.6	10.6	—	2.2	4.7	3.6
Character disorders							

hence those aged 65 and over will increase by almost 1,000,000 and of these about half a million will be aged 75 or more (2). On 31 December 1967 patients over the age of 65 made up 43 per cent of all residents in psychiatric hospitals (and more than half of the long-stay group). By the end of the next decade, nearly two-thirds of the patients in psychiatric hospitals might be aged 65 or more if existing trends and current patterns of hospitalization continue.

In Sweden it has been estimated that, as a result of ageing of the population alone, the number of places taken up in psychiatric hospitals by elderly people with degenerative cerebral disease will need to be more than doubled between 1960 and 1980 (3). In the Newcastle survey the prevalence of definite cases among those aged 75 and over proved to be 12.5 per cent and within the 65-75 age-group approximately 3 per cent. This suggests that within a decade there will be approximately 80,000 more cases of 'chronic brain syndrome' among the elderly population. What follows will therefore be mainly concerned with the service needs of this group of elderly people.

## **2. Type of mental illness and duration of stay in hospital and residential accommodation**

For the purpose of inquiry into use of beds, subjects in the Newcastle community survey of the elderly were grouped into three broad and mutually exclusive groups: chronic brain syndromes (CBS), functional syndromes (FS) of at least moderate severity, and a group in which no significant psychiatric abnormality was present. The last included life-long personality disorders and those with functional syndromes of only mild severity. Chronic physical illness and handicap were, of course, relatively common in this last 'normal' group. The 1960 sample was followed up four years later and the 1964 sample two and a half to three years later, with about 5 per cent loss by death and removal in both. Admissions to hospitals, to local authority welfare homes, and to private nursing or residential homes, and the total duration of stay in each, were ascertained both for those who had died and those who had survived.

It was found that subjects with dementia, who amounted to 6.2 per cent of the whole cohort of 758 elderly persons, had made demands on hospital and residential accommodation quite out of proportion to their numbers, by comparison with the group suffering from functional illness and the group considered to be normal. This was true both in terms of the numbers admitted and the duration of their stay (4).

Nineteen per cent of the normal group, 23 per cent of the functional group, compared with 61 per cent of the demented, is a proportion of the small group of the last, roughly three times greater than

**Table 2.** 1960 and 1964 samples: matched groups. Numbers admitted and duration of stay in various types of care during period of follow-up (taken from reference 4).

	Normal controls ( <i>N</i> = 73)			CBS subjects ( <i>N</i> = 47)		
	<i>N</i>	Total duration (and mean) in weeks	Total stay <i>N</i>	<i>N</i>	Total duration (and mean) in weeks	Total stay <i>N</i>
Acute	15	95	1.4	8	43	8.3
Geriatric	2	7		19	298	
Mental	—	—		5	49	
LA homes	—	—	0.8	4	288	12.7
Private homes	3	59		5	205	
Total	17*	161 (9.5)	2.2	28*	986 (35.2)	21.0

\* Some patients admitted to more than one type of care.

that of either of the two other groups, had been admitted to some kind of institution.

In the second sample of 449 subjects taken in 1964, the demented accounted for between 37 per cent (in homes) and 54 per cent (in geriatric wards) of the *time* spent in institutional accommodation by the whole sample. This group of 26 subjects had, for example, spent 360 weeks in welfare homes accounting for 57 per cent of the 630 weeks spent there by the whole sample.

These differences were not connected with the age or sex of the subjects as, although the demented on the whole were slightly older than the others, it was found in a comparison of groups of normal subjects and demented *matched* for age and sex, the latter were two and a half times as likely to be admitted to hospitals or homes, where they spent in all six times as long. In spite of their markedly abridged life-expectation, the demented subjects had spent four times as long in hospital and ten times as long in homes as the controls; 47 subjects with CBS in the 'matched' group occupied beds in hospital for 390 weeks and in homes for 596 weeks or 11½ years (Table 2).

Detailed information was available about the home circumstances of each subject and no evidence came to light that institutional forms of care were being over-used. Newcastle was relatively deficient in beds and residential places for the aged. More CBS subjects might, therefore, have been admitted and some might have been admitted earlier but for a shortage of 200 places compared with national standards. However, it is possible that the provision of more extensive domiciliary services and alternative forms of care could have postponed admission in some subjects, or, in a proportion, possibly averted it altogether.

### **3. Limits of safety**

But precise information is needed about the feasibility of the alternatives for this specific group of disabilities. There is a precarious equilibrium between the large morbidity in the community and the small proportion of it that flows, ever so slowly, into institutional accommodation. The vacation of places by death and discharge, and the provision of services in the form of domiciliary care, out-patients' clinics, and day-hospitals have somehow kept the system going. But it is astonishing that the service can continue to function even at its present level of efficiency.

With improved care the mortality of demented will slowly but surely decline to a limited extent with a consequent increase in demand for accommodation. Townsend (5) found that relatives bore the main brunt of the burden of sickness in old age and a recent survey (6) has shown that local authority home-helps provide less than one-twentieth of the help given to pensioners with preparation of meals and with shopping, and less than a sixth of the help given with housework. It is this very saving clause, the aid given by relatives, that is now imperilled by the increasing mobility of young adults in search of employment, the population shifts caused by industrial changes, by the closure of mines and shipyards, and by the improved opportunities for women in full-time employment. Moreover, precise information about the social effects of such changes on old people is lacking.

At the present time, only 5 per cent of people aged 65 and over are resident in some form of institutional accommodation and the pressure on this accommodation is so intense that an increase of 1 per cent might give rise to serious embarrassment. In the light of these facts, the estimate made some years ago, that approximately 75-80 per cent of aged people in this and other countries (7) live with others and often in close contact with children or other relatives, no longer justifies unalloyed satisfaction. A number of imponderable factors are impinging on the precarious balance that somehow continues between family support, on the one hand, and the care provided by the health and welfare services, on the other. In such a situation one should perhaps hesitate to introduce major over-all changes in patterns of care until their effects on a system in a state of uncertain equilibrium are assessed by carefully designed experiments.

### **4. Factors influencing admission**

In this context, a number of questions arise in relation to hospital usage by subjects with different types of disorder. If subjects with

CBS make such heavy demands on institutional places, and if the number of severely demented living in the community far exceeds those who have had to be admitted, what factors determine viability in the community? This would call for careful comparisons between those in and outside institutions and these comparisons have yet to be made.

Information is available only about over-all differences between institutionalized persons of every kind, on the one hand, and the general population of comparable age, on the other. Surveys in different parts of the world have shown that the single, widowed, and divorced make disproportionate demands. Townsend and Wedderburn (8) found that among old people living in institutions (1) more are unmarried than married, 30 per cent as against 10 per cent; (2) more of the married or widowed lack children, 26 per cent as against 16 per cent; (3) more lack brothers and sisters, 40 per cent as against 22 per cent; (4) more of those with children have only one, 39 per cent as against 26 per cent, and they have sons rather than daughters. It is not known whether subjects with CBS living in and out of institutions, differ in respect of such familial features, but it would be interesting to find out. A high proportion of those in long-term geriatric wards suffer from dementia as well as chronic physical disability, but if it were not for the psychiatric disorder many would be at home. Community studies have repeatedly paid implicit tribute to the fact that families continue to bear great hardships and burdens as a result of physical disablement and long-term emotional disturbance among their elderly relatives.

As far as features relating to admission among those with dementia are concerned, there is little precise information. Those liable to disturbed, aggressive, and persistently confused behaviour, to dangerous conduct within the home and to persistent incontinence figure prominently. Urinary incontinence is a major problem, particularly in households with limited resources and few families in ordinary homes can cope with it. Admission is often needed as the result of an exacerbation that follows the death of a spouse or complication by some acute physical illness but such disturbances may be transient. There are also step-like changes in the progress of dementia about which little is known. Systematic observations would be of value in paving the way for the development of more clear and consistent criteria for the admission of those with cerebral degenerative disease to institutions for long-term care. The places are few and precious and the establishment of such criteria is an urgent necessity.

## **5. Preventive measures and the concept of 'lines of defence'**

It will be plain that illness, disablement, and infirmity is so common among elderly people in the community of modern affluent societies that the only realistic approach is one that devotes substantial resources to facilitating life within the community for all but the most severely infirm and demented aged individuals. Such an approach conforms to the wishes of the great majority of the aged and to a large extent their families also. And the alternative would imply increasing reductions in the resources made available to the remainder of the population, on a scale that is unacceptable.

It is salutary to return to the philosophy expounded within the Sixth Report of the Expert Committee on Mental Health of WHO 1959 (9):

... the size of the problem of mental health among the aged and the rate at which it is growing make it impracticable to consider in terms of hospital beds the care of even the small fraction of cases who become infirm or sick or who belong to the marginal group that hovers between sickness and health. But, even if there were an abundance of places, the old person is, as a rule, better off in his own home, unless illness or serious infirmity afflict him. It is both expedient and humane to maintain the aged person in the community or, if he breaks down, to treat him promptly and return him there before his social roots have been finally severed. The emphasis on social environment as a factor in mental health is growing, and so is the realization that uprooting an individual may be as important as illness in the long run, in impeding his return to the community.

The policies envisaged in this statement and described in more detail in the Report imply action along three broad lines: (1) political and social reform in an attempt to mitigate the unhappy plight of many old people in modern industrial communities; (2) medical and social measures to reduce the frequency with which aged people are uprooted; (3) the 'lines of defence' concept, or the development of a range of services within the community that make for greater flexibility and freedom of choice in selecting a way of life or planning long-term management for aged people. An examination of these recommendations in the light of the developments of the past fifty years is of interest.

### **a. POLITICAL AND SOCIAL ACTION**

The literature that deals with the social aspects of gerontology has during the past few decades brought to light an impressive body of evidence testifying to the under-privileged status of the aged in modern industrial societies. That they are economically deprived is well established (8); they constitute an impoverished leisured class. They suffer more from social isolation (10) and the effects of this are

frequently compounded by the desolation that follows bereavement. They frequently complain of loneliness (1). And in modern industrial communities they are deprived of the privilege and dignity which was their lot in civilizations that placed less emphasis on vigour, enterprise, and youth. Townsend (5) has given a vivid description of the decline in dignity and self-respect that follows, particularly in working-class men, when they cease to be the breadwinners of the family; women are, in contrast, sustained by their role as managers of the household and the influence for cohesion and unity they exert within the family round which daughters and grandchildren tend to cluster.

The case for social reform to mitigate the plight of aged people in contemporary society does not need to be argued; it is widely accepted that radical measures aimed at enhancing the quality of life in old age are an urgent necessity. However, systematic observations have failed to bring to light any clear or convincing evidence of a relationship between the indices of under-privilege that have been touched upon and the causation of mental disorder in old age. There is no evidence that retirement exerts an adverse effect upon mental health (11) but much to indicate that those in manual occupations are in ill health at pensionable age and glad to retire. Isolation has proved in a number of rigorous inquiries (12, 7, 13) to be more a consequence than a cause of mental disorder in old age. Loneliness proves to have little relationship with measures of isolation; it is most conspicuous in those with a long history of emotional instability and life-long difficulties in relating to others (14). Bereavement has been shown (15) to have a clear association with admission to hospital for psychiatric disorder when all stages of the life span are taken together. But recent widowhood has proved to have no clear association with psychiatric illness in old age, either in the Newcastle or in American surveys (12, 13) although more detailed inquiries are called for. The same statement has to be made in relation to social class and income; no clear correlation with functional or organic mental disorder has emerged (13).

Social reform is not, therefore, likely to make much impression on existing prevalence rates. The health and welfare services seem to have accepted that the geriatric problem has a hard refractory core and that social provision has to be made for a high proportion of elderly people unable to sustain an independent life. In Denmark, for example, there are plans for the provision of residential and nursing-home accommodation for 4 per cent of the population aged 65 and over. An additional bed per 100 is intended for elderly people with mental disorder who are to be accommodated outside psychiatric hospitals. Units are to be small and home-like and a large part of the

accommodation is to be in single and double rooms and small dormitories. Ample facilities for occupational therapy and social activity will be provided and the units are to be within easy reach of the communities from which the disabled people have been drawn. Moreover, provision on this scale is for the immediate future; it is recognized that, within large cities such as Copenhagen, up to 10 per cent may need to be accommodated in the foreseeable future (16).

Even if the enormous cost of provision on this scale were disregarded, the question arises as to whether geriatric services within which institutional care, albeit of high quality, figures so prominently conforms with the aspirations of old people or their relations. In their important Chichester survey, Grad and Sainsbury (17) found that families with elderly relatives being cared for at home, in the community-orientated services, suffered considerable hardship, some 63 per cent ascribing symptoms of emotional disturbance to the burdens imposed by elderly relatives. Yet many families preferred to have their aged at home. There are two other points that are germane in this context. The first is that although social influences have not, so far, proved to have a clear relationship to the causation of mental disorders in the aged, their influence on the likelihood that they will have to enter an institution for long-term care is indubitable and the evidence bearing on this has already been discussed. Secondly, the effect of community care, including the network of well-developed domiciliary services, on the prolongation of independent social life and the avoidance of institutionalization is in danger of being underestimated. In Chichester, domiciliary services were less well developed than in some other areas in England and Wales.

#### *b. THE AVOIDANCE OF UPROOTING*

As the pressure exerted by the geriatric problem increases, the need to deploy scant resources in the most efficient manner possible will grow more urgent. The warning against the dangers of uprooting, implicit in the WHO statement quoted above, continues to be timely. Those responsible for admitting elderly people to residential homes exhibit a distinct preference for well-behaved, well-preserved, and continent old people. Yet, with some measure of support, most of such elderly people should be capable of maintaining a life in the community. As a matter of policy they should be protected from the hazards of entry to Part III accommodation, for, as Townsend (18) pointed out, discharge from Part III accommodation is very uncommon. According to a recent estimate (19) sheltered housing would have been a satisfactory alternative for at least one in five persons admitted to residential homes. Some ten years ago, Town-



send showed social factors to have been decisive in the admission of a substantially higher proportion.

In the Newcastle survey, the estimated total prevalence for elderly persons with psychiatric disorder within institutions was 17.1 per 1,000 and of this almost a quarter was made up by people with manic-depressive disorder, paraphrenia, neuroses, and character disorders. With the addition of mild forms of dementia these groups accounted for 9.3 persons per 1,000, that is, more than half the total prevalence of institutional cases. The possibility of alternative forms of provision within the community for these groups of cases needs to be carefully studied.

But in the near future, decisions relating to long-term care should be governed by a carefully worked out system of priorities. For this purpose medical and social indices, validated by operational research, will be needed. They will have to be applied with stringency, if limited resources are to be deployed in the most effective manner possible.

#### C. 'LINES OF DEFENCE' WITHIN THE COMMUNITY

In the Report of the WHO Sixth Expert Committee on Mental Health (9) the main components of the psycho-geriatric preventive services outlined were:

1. A number of medical and social arrangements in the community comprising a network of domiciliary services, out-patient clinics designed to provide for the special problems of aged people, day-hospitals, clubs offering facilities for people with differing needs, and aid to encourage the growth of voluntary organizations or, in the words of the Report, 'the spontaneous association of citizens for the purpose of bringing relief to those of their fellows in need'. The domiciliary services for the aged were conceived as providing meals-on-wheels, home visiting and nursing, transport to hospitals and clinics, laundry facilities, and mobile physiotherapy services.

2. An administrative structure that would eliminate wasteful overlap, inefficiency and inflexibility by facilitating the integration of services of local health authorities, family doctors, and hospitals.

3. 'Guidance centres' which would provide facilities for multi-disciplinary investigation of the early phases of mental disorder, as well as counselling. These centres were therefore the progenitors of present-day psycho-geriatric assessment units. They were to be located at the general hospital and be closely linked with the long-stay in-patient unit.

Recent years have seen a certain amount of development along these lines. Thus day-hospital attendances by aged people doubled

between 1964 and 1968; changes in out-patient tendencies have been on a similar scale (20) although it would appear that out-patient services tend to be under-used by the aged. Psycho-geriatric assessment units have been developed in several centres either within general or psychiatric hospitals. However, on the whole the development of community services for the aged is patchy and inadequate. Thus in 1968, only 13 per cent of local health authorities in England and Wales had established day-centres for mentally infirm old people (21). With the exception of a few examples, based on local initiative, integration is a remote prospect. However, the reorganization of the National Health Service provides fresh opportunities for establishing an integrated administration for geriatric services at district, area, and regional levels.

## **6. Needs in the immediate future**

In summary, therefore, the main ingredients of the present situation as far as the long-term care of geriatric patients is concerned, are:

1. An anticipated rise in the decade 1971–81 of almost a million in the number of those aged 65 and over in the general population with a disproportionate increase in the number of the very aged who make the greatest demands on the health and social services.

2. A disproportionate increase in those forms of mental disorder in old age that have far more need for long-term institutional care than any other kind of geriatric disablement.

3. Scarcity of accommodation within every type of institution that provides long-term care against a background of rapid social change that may slowly erode the support and services that at present enable the majority of aged people to live out their days in their own homes.

4. Health and social services that function within narrow margins of safety and which show signs of strain at the seams when there are only 5 per cent of people aged 65 and over within institutions.

5. A policy that is intended within a few decades gradually to eliminate the forms of care for psycho-geriatric patients provided by the traditional type of mental hospital.

This situation calls for certain measures in the immediate future. First, facilities for community care for the aged, and the domiciliary services in particular, require immediate expansion if institutions are not to become gravely over-burdened and serious encroachment upon the services available to the remainder of the population is to be avoided. Secondly, the projected phasing out of traditional mental hospitals cannot be proceeded with until alternative residential accommodation has been provided within the community; here the

main need is for a network of small home-like units that are capable of providing satisfactory care for confused, wandering, intermittently disturbed, demented subjects who frequently suffer from incontinence.

Thirdly, further provision should be made of *psycho-geriatric assessment units* which can be rapidly established at relatively small cost and, in the present situation, make a contribution of particular value in a number of ways. When adequately staffed so that psychiatrists and geriatricians can combine their efforts with those of social workers, psychologists, occupational therapists, and physiotherapists, they are able to undertake the kind of multidisciplinary assessment that has formerly been lacking and that is essential for the planning of a programme of long-term management, tailored to individual needs. In carrying out these tasks, the units already established have exerted a valuable integrative influence in bringing together representatives of local authority services, family doctors, with psychiatrists, geriatricians, social workers, psychologists, and other members of the therapeutic team.

When established in a setting free from the stigmas of under-privilege and hopelessness that attach to many long-term units, they have been able to attract referrals at an early stage in the development of disability. This is of great importance for a number of reasons. There have, in the past, been very few opportunities for studying in the early stages of their development disorders that culminate in severe dementia. However, there are compelling reasons for focusing attention on this stage of dementing processes. Although the evidence is not conclusive, it strongly suggests that the main forms of dementia represent a quantitative exaggeration or parody of the ordinary process of ageing. There are, however, threshold effects. The progressive and irreversible phase in the evolution of dementia commences when the aggregate of the damage passes beyond a certain threshold point (22, 23).

Accounts given in textbooks of medicine suggest that the states of dementia sometimes found in association with pernicious anaemia and myxoedema, among other causes, are reversed when metabolic defect is corrected. In practice, mental deterioration is little affected, yet it might have responded at an earlier stage. Early assessment and intervention is also likely to reduce the proportion of 'crisis' admissions which preclude flexibility in making decisions about the long-term care of elderly people. It also reduces the risk that families who care for elderly unmanageable and incontinent patients reach such a pitch of strain, before such patients are admitted to hospital, that they are unwilling to contemplate having the old persons back. Finally, careful screening procedures are essential to ensure that

scarce hospital or sheltered accommodation is not taken up by those for whom home-care, backed by community services, would suffice. This is particularly important in cases for whom a place in a long-term unit is being considered. Although the staff of psycho-geriatric units will not be able to assess and plan disposal in every case, they can, through their many contacts with local authorities and welfare departments (24), define the criteria to be applied in disposal and disseminate the pattern among their colleagues. It is relevant in this connection to draw attention to the large error that has emerged from previous surveys that have attempted to identify senile and arteriosclerotic dementia in their early stages. Experience should make it possible to reduce this error in future; the subject has important practical implications. In a follow-up of 760 people aged 65 years and over, in Newcastle (25), 30 were found to have developed chronic brain syndromes 2-4 years after the initial interviews. In only 6 of these 30 subjects had a chronic brain syndrome been originally suspected. However, in 14 others not included in the 30, initial low intelligence combined with a poor educational standard and long-standing personality difficulties had led to the original, probably erroneous, suspicion of an early dementia.

## **7. Inquiries needed for the planning and development of psycho-geriatric services**

It is unlikely that any of the measures outlined will be put into effect at more than a moderate pace. In the meantime, it is essential to provide answers, derived from systematic investigation, to certain crucial questions. The results of screening programmes of elderly people and of early ascertainment require to be evaluated. Do they succeed, in the way suggested, in bringing to light disabilities in an early, treatable phase, and in this way reduce the burdens of chronic disablement and long-term institutionalization? Domiciliary services and the other components of 'lines of defence' within the community absorb a vast effort and the results of this demand investigation. It should prove possible, by making appropriate comparisons, to determine how far they succeed in their objectives, of prolonging the period in which disabled old people (and those with dementia in particular) are able to remain in the community and in averting institutionalization.

Finally, the optimum size and placement within the community of residential units for psycho-geriatric patients needs investigation. Most of those who have written on the subject have expressed themselves unequivocally in favour of the small home-like residence for 40-50 people. The advantages are many and obvious but the prob-

lems experienced by isolated small units have received too little attention. Diversification is difficult in a small unit, so that those who are quiet and relatively well for much of the time are constantly exposed to the most disturbed and sick. A small unit is unable to mount an adequate range of occupational and other facilities, sickness and absence among a limited staff is liable to precipitate crises and morale is prone to falter for other reasons. So joint staffing arrangements with neighbouring units may prove to be desirable. The problems entailed in organizing a large network of small units are likely to prove formidable; the resources needed, staffing problems and the results achieved need to be compared with those of larger *subdivided* units capable of providing for up to about a hundred persons. It is accepted that, as far as possible, homes should be located within the community; the advantages of some association with a nearby hospital service as well as practitioners tend to be ignored. Yet such an association makes possible more flexible staffing arrangements, crises are more readily dealt with, specialized investigations can be more easily arranged and temporary transfer to an acute unit may present fewer problems. The possibility of involving voluntary helpers in an active way in the work of the different kinds of units also needs to be investigated.

Such inquiries would be expensive but it is no exaggeration to say that there is a dire need for them; disablement in old age represents the largest single problem faced by the health and welfare services in affluent societies everywhere.

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## ***Aspects of the Goodmayes service***

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I should like to discuss three related topics: (1) developments in the psychiatric service for old people at Goodmayes Hospital; (2) some of the issues of morale and job satisfaction, and (3) some ideas about the future of psychiatric services for old people, as these have grown from our experience with the service, and from the exploratory phase of our research.

### **1. The Goodmayes service**

I have described the service elsewhere (1) and will here discuss only those aspects and recent developments which make a background to the issues which I want to raise. There have been two closely interconnected aspects of the unit's life over these first three years: attempts to develop more effective patterns of care and of collaboration with related services and to show that a psycho-geriatric service can be run as a lively psychiatric unit, setting itself high standards and attracting able staff.

Goodmayes Hospital has a catchment area of some 370,000 people of whom about 43,000 are over 65, including about 15,000 over 75. Three local authorities are at present involved though from next year there will be only two, but there will then be a net increase in population of some 60,000 as a result of the rearrangement of psychiatric catchment areas in East London. The unit takes almost all psychiatric referrals of persons over 65, and in 1970 took nearly 90 per cent of elderly patients admitted to Goodmayes. Our hospital base is 6 wards which now include a mixed admission unit of 30 beds and we are about to open a second mixed unit; these are the first mixed wards in the hospital, though others are soon to be opened. Day-patients come



to all the wards. Very nearly all referrals of old people now come direct to me and if they do not, are redirected to me by my colleagues. Nearly all patients are first seen at home, and in 1970 I myself did 317 such visits to old people; of 392 referred patients 88 per cent were first seen at home, or wherever else they might be, whilst of the 343 actually referred from home, 95 per cent had first been seen there. Such a high rate of home assessment may not be possible in large rural catchment areas, but it is 13 dense London miles, and up to an hour's drive to the edge of my area. Whilst we try to prevent unnecessary admissions, and admitted patients from becoming unnecessarily long-term admissions, we very much encourage admission where early assessment or treatment can prevent deterioration.

By 1 January 1971, 106 beds occupied by old people had been emptied despite an increase in admissions and a decrease in deaths, and this has enabled us to begin to reduce crowding and to reduce the complement of the new wards from 50 and 55 to 30 beds each. We need to be sure that we are not leaving undue burdens in the hands of relatives, but all patients are followed up and we take pains to make known our availability, to the extent that our 'on line' exposure can make for problems in the routine of the unit; we therefore doubt whether large burdens are being left, at least among those who have been referred to us, but we propose now to attempt to measure the extent of unrelieved burden and other consequences following our interventions.

A registrar was assigned to me from the existing staff of the hospital, but he was near the end of his two years at the hospital and I had to start looking for a successor for him. I need not emphasize that mental hospitals, even in London, do not find it easy to attract good junior staff and it seemed likely that recruiting staff of ability for work with old people would pose enormous problems. It has; but happily we managed to find as our registrar an able young doctor working in a local general hospital. When after two years she had got her DPM and the time came for her to leave, it was a test of our viability to find a successor of comparable ability. Fortunately, we managed to do so. Apart from the full-time registrar our medical staff have been young married women working part-time, all training as psychiatrists, and occupying both established clinical assistant posts and additional posts which the Regional Board has made available. These doctors are learning not only psychiatry, but the business of planning, delivering, and attempting to evaluate a medical service; an aspect of social medicine which I sometimes find myself better placed to teach both to my doctors and to medical students in the context of my service than in my other job as a teacher of social

medicine, where I have no service responsibility. The fact that we have been able to maintain the quality of the medical team into what is now entirely a second generation, has been one of the most gratifying aspects of the unit.

The hospital runs chronically far below its establishment of nurses, and as regards occupational therapists we were unable to attract a single one; and we are still without a physiotherapist. The occupational therapy problem has been solved by recruiting untrained local housewives to work on the wards. These women have transformed the atmosphere of those wards on which they work, though, alas, I am still having to press for funds to enable one to be allotted to each ward. Last month a long-stay ward from which virtually no one will now be discharged won five prizes at the local Old People's Welfare Association's exhibition of work. If one of the roles of long-term care is to retrieve and preserve function, then these untrained workers are proving brilliantly successful.

Dr T. B. Dunn, the Ilford geriatrician and I have recently opened a joint assessment unit of only four beds, in the geriatric hospital across the road. These beds will serve that part of our catchment area which is common to both Dr Dunn and myself, some 170,000 people, and will also be available for transfers of patients for joint care if the need develops after admission to either of our units. We are monitoring the functioning of these beds very carefully.

For social work we have been dependent upon our local authorities. Until 'Seebohm' our two main authorities had each attached a welfare and a mental health social worker to our unit, who took all our referrals and attended our meetings, becoming effectively members of our team; with the Borough of Redbridge the hospital also had a long-standing 'joint-user' arrangement in regard to five mental health social workers. The reorganization of social services threw all this into uncertainty and we have been going through a difficult period. However, there are signs that things may be looking up, and we have negotiated with the Director of Social Services in Redbridge an arrangement whereby a social worker will be based in my unit, and will take all in-patient referrals from the unit regardless of area of origin, and most of my Redbridge non-hospital patients; the hospital will pay half her salary. Again, we mean to try to evaluate very carefully this pattern of collaboration; indeed, the consequences for hospital services of the Seebohm changes, and the assumptions from which they derive, are subjects about which we have needed to think very closely.<sup>1</sup>

1. The author has since joined the Social Services Sub-committee of the Government's Working Party on Collaboration between Local Authorities and the Unified Health Service.

In short, then, we have a lively unit which is beginning to solve some of its organizational problems. Indications are that it is functioning well and giving a good service, though its shortcomings are still enormous. Of 238 admissions in 1970 (comprising 203 persons), 57 per cent (113 discharges and 23 deaths) had left within six weeks, whilst by 30 June 1971 there had been a further 44 discharges and 29 deaths, leaving of the original 238 admissions only 26 still in the hospital. Looking at it another way, in round figures, up till now of the admissions in any one quarter, about 10 per cent are still in the hospital at the end of the corresponding quarter of the following year whilst 6 months after that the figure falls to about 5 per cent. In other words, the accumulation of long-stay patients is relatively small, though the long-term caring role is a very real part of the unit's work; and it is the problems inherent in a service which is part preventive, part acute therapeutic, and part long-term caring that leads to my second theme, that of morale and job satisfaction.

## **2. Morale and job satisfaction**

Very early in the history of the unit it became clear that things were happening which needed objective study. For a start my hunch that this work could be lively, could engage the enthusiasm of able staff, seemed to be being borne out. I had taken pains to try to make the unit a team, all members of the staff if not actually participating in the different types of work, at any rate sharing in the exchange of information and the feeling of a joint enterprise. When nearly all the recoverable patients had been got out of the long-stay wards, and the admission wards had been upgraded, the acute and chronic functions of the unit began, in the eyes of the nursing staff especially, to become more sharply distinguished from each other. The staff of the long-stay wards had to find ways to come to terms with the disparity between these functions, which was felt to be growing greater and greater despite the fact that beds were coming down on the long-stay wards, occupational therapy was being introduced and long-stay wards were objectively getting much more support from doctors, and from able and lively doctors. We could see various strategies being adopted by the personnel of different long-stay wards for coping with the divergence of the long-term caring role from the acute investigative and therapeutic role of the admission ward and extramural activities: and I became more aware of the problems of embracing these heterogeneous functions under the umbrella of a single unit ideology.

It was against this background that we were able to secure the support of the DHSS for the appointment of a research worker to

look at these and related matters. After a long search for the right person we found May Clarke, a young sociologist who joined us in January 1971. It was agreed that she would begin with an exploratory period during which she would take stock of the issues, and define with greater precision the lines of her research. Her university base is Margot Jefferys' unit at Bedford College and I would like to record my gratitude both to the Department for their support and to Professor Jefferys for hers. With the completion of the exploratory phase, the Department is reviewing the future of this work and it is about research issues only, rather than results, that I can speak at this stage.

During these six months Miss Clarke closely observed the work of the unit in all its aspects, including routine ward activities, clinics, ward rounds, professional meetings, and domiciliary visits. She interviewed in detail 51 people concerned in the work, including hospital doctors, general practitioners, and the clerk of the Executive Council, nurses of all grades, social workers, occupational therapy helpers, the staff of old people's homes in the area, and a group of recently discharged patients and their relatives, and she has also been analysing routine data of the unit's work.

It soon became clear that a definition of morale could not be simple. Miss Clarke concluded from reviewing related work and observing the unit, that morale must be regarded as deriving from a variety of components: for instance, favourable attitudes towards the organization, and identification with the organization's goals; favourable attitudes towards the peer group and identification with its goals; involvement with and commitment to the work; adjustment to the job and satisfaction with the work; a feeling that goals are capable of being achieved; hopefulness and enthusiasm about the work. Similarly, work satisfaction could be measured in a number of dimensions: for example, satisfaction with the intrinsic nature of the job; satisfaction with the goals of the job and the opportunity to realize them; satisfaction with the status of the job; satisfaction with the degree of personal control over the work situation; satisfaction with career prospects; satisfaction with work conditions, eg the physical environment and the hours; satisfaction with the rewards: the pay and less tangible rewards such as feelings of achievement and gratitude of patients; satisfaction with relationships with colleagues. It followed that in heterogeneous work such as that encompassed by our unit the nature and sources both of morale and of work satisfaction were likely to vary between different individuals and different groups.

May Clarke has formulated a series of working hypotheses which we now mean to test both by study within the unit and by comparative studies with another psychiatric hospital which is without an

equivalent geriatric unit, and of staff working in old people's homes. Broadly, the hypotheses are:

1. That in a unit specifically directed towards active treatment of geriatric patients, and where the staff are involved in decision-making and teaching, work is likely to be more satisfying than where the similar work is undertaken outside a structured unit specifically directed towards these ends.

2. That even for staff who say that they prefer work with younger patients, such a unit may be more attractive despite the fact that it is geriatric work that is being done, than a unit for young patients which does not have these characteristics.

3. That whereas a high level of satisfaction for staff on the admission wards will be the result of activating the conventional treatment orientation, on the long-stay wards where these goals cannot be achieved, nurses will develop new goals; and where the achievement of these is frustrated by lack of facilities or interest from the doctors, satisfaction will be low.

4. Much of the work done by nurses on the long-stay wards is similar to that done by untrained attendants in old people's homes; it both under-uses their skills as trained nurses, and frustrates the traditional curing orientation of trained staff. Therefore untrained staff working in old people's homes are likely to be more satisfied with their work than trained nurses working in the long-stay wards of hospitals; and even trained staff in old people's homes, where a caring rather than a curing role is predefined for them, will be more satisfied than trained staff in long-stay hospital wards.

It is proposed to test these hypotheses by interview and observation and by comparative studies. Staff attitudes will be correlated with objective differences in the work situation: such as staff-patient ratios, numbers of incontinent patients, constancy of ward complements and staff, frequency of contact with other members of staff, opportunities to participate in decision-making and to form social relationships with colleagues. The background of staff members in terms of age, sex, marital status, education, previous occupation, length of service at the hospital, membership of trade union and professional organizations, will be related to their work satisfaction whilst similar studies will be made of the staff in old people's homes. In addition, staff turnover, sickness rates, and the deployment of nurses between different parts of the hospital will be studied. Concurrently we are studying patterns of referral to the service and of the flow of patients through it, and the results of our intervention, whether involving admission or not.

### 3. Future pattern of psychiatric care of the elderly

The fruits of these studies should have practical implications for patterns of service for old people. I have discussed elsewhere (2) some of the issues as I see them at this relatively early stage of our work, or rather as I saw them at an even earlier stage, and there has been a lively correspondence over recent months in the *British Medical Journal*. I would like here also to consider what ought to be the place of a 'psychiatrist with a special interest in old people' in the future pattern of services; I particularly want to discuss this inasmuch as it is often suggested that against the background of what appears to be the prevailing view that 'psycho-geriatrics' should become the responsibility of geriatricians, there is unlikely to be a place for psychiatrists taking a special interest in this work. It seems to me that there is no conflict at all between a service in which the long-term care of those demented patients who need hospitalization will be the responsibility of geriatricians, and the continuing necessity for particular psychiatrists in each area to take a special interest in the psychiatry of old age.

I have argued that the need of long-stay *ambulant* demented patients is almost wholly for residential care rather than hospital care and May Clarke's early observations seem to begin to support the hypothesis that if this work can be done away from the hospital with its 'medical model' of investigation, treatment, and discharge, then staff will be more content. I am impressed with the results of the work of Dr Wilson and his colleagues at Redruth (3, 4) where these patients have been shown to be both appropriately and effectively cared for in residential accommodation staffed by people without nursing qualifications.

Those who doubt, or even reject, this view sometimes seem to do so not because they think residential care is inappropriate for these old people, but because of the difficulty in the present administrative structure of including local authority-based residential services in a single pool of available facilities for old people (5). This emphasizes the urgent need recently underlined by Professor Wing (6, 7) for a base in the formal structure of the new health service for collaborative planning and deployment of resources, embracing residential and sheltered accommodation in the community, mental hospital and geriatric hospital places, day-care of different types, and community supportive services. At the moment there is no hint of how this will be achieved in the reconstructed health service, but one has terrible fears that there will be exhortations to local collaboration, which is indeed vital, without the necessary mandatory structure to enable this collaborative deployment to become a reality throughout the health

service. It follows also that if there is to be a shift from long-stay hospital care for ambulant demented to residential care then residential facilities will need to be greatly expanded.

It is sometimes pertinently argued that the shifting of patients from one amenity to another results simply in the redeployment of the same stage-army of women in caring professions, rather than in expansion of the available personnel. I do not think this view can be sustained where it can be shown that untrained staff can do the work of trained staff, or parts of trained staff's work: another instance would be untrained ward clerks relieving nurses, social workers, doctors, and secretaries. I have already described how we have been able to remedy our failure to recruit occupational therapists by recruiting untrained housewives. Of course, things differ from one part of the country to another, but there surely can be no doubt that the pool of staff available for caring for can be expanded by bringing in untrained (and if necessary part-time) personnel who would not otherwise belong to the pool. In some instances untrained staff may be not only acceptable substitutes, but may even at times for reasons some of which I have already touched on, be better suited to particular jobs than professionals.

The acute service must be based on the district general hospital, inasmuch as the resources of a general hospital are arguably even more necessary for elderly patients than for young psychiatric patients. Our experience suggests that about 30 acute beds will be needed for a typical population of a quarter of a million, or about 1 bed for 1,000 over 65s. Whether these beds should be part of the general psychiatric ward or separate, is a matter for experiment and evaluation, but a particular psychiatrist must take a special interest in the elderly, and be the man to develop links with relevant 'community'<sup>1</sup> services, to be adviser to other related bodies, such as the Housing Department with its responsibility for sheltered housing, and to non-statutory bodies, and to participate in collaborative assessment and selection of patients for different types of care and services.

The extent of need for an actual joint assessment unit depends very much on local patterns of services and of collaboration between individuals. I suspect that fewer of these beds are needed than is generally advocated, and we mean to try to test this by very careful definition of our criteria for our use of the small unit we have now set up, and of monitoring how it is actually used. However, there is little doubt that *some* joint assessment beds are valuable, and again the psychiatrist 'with a special interest in the elderly' would be the

1. The place of the concept of 'community' in current caring ideologies, and its semantic plasticity, deserves study in its own right, which in a small way we are attempting using a semantic differential technique.

man who would service these beds jointly with the geriatrician. He would also be in charge of those few long-stay psychiatric beds that might be needed for old people with severe behaviour problems which would be either in the district general hospital or in 'community hospitals'; and he would be the consultant whom GPs would normally call in to see old people at home and in residential accommodation. Finally, he would share in the general psychiatric work of the area. May I emphasize how much this 'job description' differs from the more common usage of designating one doctor (not even always a consultant) to interest himself in a group of long-stay wards, which are designated 'psycho-geriatric unit', the work of assessment and admission policy being outside his control.

Two last points: the evidence is now surely compelling that in those few centres where particular individuals have taken a special interest in this work useful results have accrued; and there is no doubt that a psychiatrist who is especially concerned with this work, and who has a personal network of relationships with related services, can be a uniquely economical and at the same time effective instrument for the work. The Department's excellent memorandum on psycho-geriatric assessment units (8) suggests that assessment visits 'to all elderly patients who are mentally disturbed' should always be done jointly by psychiatrists and geriatricians, with GPs and social workers; this is impossibly expensive or resources, even were it possible to envisage a state of affairs where, on the well-over-300 such visits which I did in 1970 (to say nothing of the non-geriatric visits) only by managing to fit them flexibly into a very personal timetable, I should have been accompanied by three other professionals; imagine the logistics of co-ordinating such visits in the busy programmes of each participant and the daunting procession into patients' homes. And is there evidence that the results would be better? By contrast, a psychiatrist with a special interest in old people, in addition to his psychiatric skills, even if he has no claim to being a first-class general physician, is after all a doctor, and should be capable of detecting the presence of significant physical illness; he can wield an ophthalmoscope and a thermometer, he can take blood samples; he is capable of making a practical social assessment; and the fact that he is a psychiatrist results very often in him being able to identify and often to deal with related need for his help in other members of the family. Finally, as a 'specialist' he can deploy the non-specific therapeutic powers of the specialist intervention, which are often so skilfully invoked for their own sake by canny GPs.

Joint home assessment is rarely necessary provided that psychiatrist and geriatrician have across-the-board access to each other's and to joint, and to other relevant facilities. Thus, for instance, in 11 per



cent of my visits in 1970 I redirected the patient into general medical, surgical, or geriatric services. (Incidentally, there is little information on how often GPs accompany consultants on domiciliary visits; some, of course, come always, but only on 15 per cent of visits in 1970 was I accompanied by the GP.)

Surely then there is everything to be said for at least one psychiatrist in each area taking a special interest in this work. We can claim to have shown that it is possible to engage the interest of able young doctors in it and there should be few problems of recruitment if decent facilities are ensured, and if academic departments take an interest both in research in this field, and in ensuring that the medicine of old age gets a place in the mainstream of teaching. But to follow that theme would be to dive into the deep pool of medical education, and to consider the often inappropriate models of practice and expectations which are still being presented to our students. The answers to many of the problems of the care of the elderly surely lie in new patterns of medical education at least as much as in new patterns of services.

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## ***The Camberwell services***

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### **1. Description of the area<sup>1</sup>**

Camberwell is one of the inner ring of London's industrial working-class suburbs. It was formerly an LCC borough and now forms part (together with Bermondsey and Southwark) of the Greater London Borough of Southwark. The population of Camberwell built up rapidly during the period 1861-91 and reached its peak of 260,000 in 1911. Since then it has been slowly declining. In 1961 the total population was 175,304. In the 1966 sample census the figure had dropped to approximately 172,000 (after correction for under-enumeration).

In Scott's pilot analysis of enumeration district data from the 1961 census (Centre for Urban Studies, unpublished) Camberwell was homogeneous on most variables (for example, the proportion of dwellings with shared households). On the six-fold classification of the Centre for Urban Studies, 44.6 per cent of EDs are grouped as 'stable working class', 28.3 per cent as 'almost suburban', 22.5 per cent as 'local authority housing', and 4.6 per cent as 'poor'. The other two categories ('bedsitter' and 'upper class') are not used. However, although the bulk of the area is still composed of Victorian terraces, Camberwell also contains the Dulwich College estate. This covers a fairly large area, but its population of upper middle class and professional people represents only a small percentage of the total Camberwell population.

The 1966 10 per cent sample census, shows that Southwark men are predominantly manual workers (71 per cent). The area is rather below average on amenities (parks, hot water, etc.), but Camberwell is better off than the rest of Southwark in this respect. Sainsbury

1. This description is based on extracts from reference 1.

found that Camberwell was fairly high on indices such as unemployment, poverty, and overcrowding which are correlated with delinquency but not with suicide rates. On the other hand, it was fairly low on the number of persons living alone or in hotels, divorce and daily movements into and out of the area which were correlated with suicide rates (2). The suicide rate was low in Sainsbury's study and remains low in the latest statistics.

Camberwell also ranks low on geographical mobility (21st out of 29 London boroughs). According to the 1961 census 6.1 per cent of Camberwell residents had moved into the area during the preceding year.

## **2. The Camberwell Register**

The MRC Social Psychiatry Unit has set up a case-register for Camberwell (financed jointly by the Department of Health and Social Security and by the Medical Research Council). The Register began on 31 December 1964 with a census of all patients, adults and children, with home addresses in Camberwell, who were currently in contact with psychiatric or mental retardation services, whether as in-, day-, out-, domiciliary, or ward-referred patients. Basic identifying, social, and diagnostic data were collected for each patient, entered on the patient's Register card and also, in coded form, on Atlas computer magnetic tape.

All patients contacting the services since the initial census day have been added to the Register. The basic information for each person is updated and the dates of each contact with in-, day-, or out-patient, domiciliary or ward-referral services are recorded in chronological order on the Register cards and on the magnetic tape. Details of deaths in Camberwell are obtained from the environmental health department of the local authority each week and matched with names on the Register, so that the relevant dates can be entered. A library of computer programs is being built up for the extraction of tables from the stored data. They are written so that they can be used for routine output and also adapted for special analyses.

The essential characteristics of the Camberwell Psychiatric Case Register are as follows:

1. It is a linked record system, collating information from the in-, day-, and out-patient, domiciliary, and ward-referral services of the relevant psychiatric agencies, for each individual patient.
2. It is based on a defined population and attempts complete coverage of that population.
3. It is cumulative over time.

The Register was set up for three main purposes. Firstly, it provides information for routine statistics; secondly, it is used to monitor the changes taking place as the Camberwell services develop; thirdly, it acts as a sampling frame for research studies, especially those which evaluate psychiatric services. The rest of this paper will contain examples of all three uses.

### **3. The Camberwell services**

During the course of one year approximately 2.0 per cent of the Camberwell population aged 15 and over makes contact with a psychiatric service. This figure is very similar to the one-year prevalence rates obtained by other comparable registers (eg Aberdeen City, 1.8 per cent; Baltimore City, 2.0 per cent (3); Nottingham, 2.2 per cent (including the local authority services) (4). In Monroe County, New York, Gardner *et al.* (5) reported a one-year prevalence of 2.3 per cent for the population aged 18 and over).

Before 1967, psychiatric patients from Camberwell contacted a variety of psychiatric hospitals, clinics, and psychiatric departments of teaching and general hospitals. Camberwell represented about one-quarter of the total catchment area of Cane Hill Psychiatric Hospital, but, apart from this, no agency was specifically responsible for providing services for the area. The distribution of patients between different agencies in 1965 is shown in Tables 1 and 2.

During 1967, the joint Bethlem and Maudsley Hospital began to implement a plan for accepting Camberwell as its special catchment area and a number of beds were set aside for Camberwell patients. The psychiatric unit of St Francis's Hospital had always been staffed by the joint hospital, but until 1967 had been used as an observation ward for acute admissions from all over London. During 1967 the unit was closed for three months, the staff given a special reorientation and retraining course and the wards were then reopened for short- and medium-stay in-patients. The majority of beds were reserved for patients from Camberwell. In-, day-, and out-patient and rehabilitation facilities are now also being developed at the same hospital.

The local authority health department and the newly formed social services department are developing close contacts with the hospitals concerned with Camberwell. Developments initiated by the local authority include a short-stay hostel for psycho-geriatric patients and an increase in the numbers of day centre places for acute and chronic psychiatric and psycho-geriatric patients.

A joint committee on which both hospital and local authority staff are represented has been set up to co-ordinate future developments in the area.

**Table 1.** Camberwell Register: One-day prevalence by agency and service (absolute numbers and age-specific rates per 100,000 population aged 15+).

	31 December 1965		31 December 1970	
	No.	Rate	No.	Rate
<b>1. OUT-PATIENTS</b>				
Bethlem/Maudsley	322	241	368	275
St Francis	0	0	24	18
KCH and Guy's	68	51	62	46
Cane Hill (St Giles)	136	102	100	75
Other	12	9	0	0
Total	538	403	554	415
<b>2. IN-PATIENTS (short and medium-stay)</b>				
Bethlem/Maudsley	29	22	82	61
St Francis	2	1	43	32
KCH and Guy's	3	2	3	2
Cane Hill	68	51	34	25
Other	23	17	8	6
Total	125	94	170	127
<b>3. IN-PATIENTS (long-stay)</b>				
Bethlem/Maudsley	0	0	3	2
St Francis	0	0	1	1
Cane Hill	250	187	182	136
Other	167	125	120	90
Total	417	312	306	229
<b>4. DAY-PATIENTS</b>				
Bethlem/Maudsley	21	16	22	16
St Francis	0	0	18	13
Other	2	1	1	1
Total	23	17	41	31
<b>5. DAY-CENTRES, ETC.</b>				
Local authority	22	16	58	43
Voluntary	9	7	11	8
Maudsley Rehabilitation Unit	0	0	15	11
Total	31	23	84	63
<b>6. HOMES AND HOSTELS</b>				
Geriatric	0	0	2	1
Other (voluntary, local authorities other than Southwark)	6	4	10	7
Total	6	4	12	9
Total one-day prevalence	1,140	853	1,167*	873

\* Excluding patients with no settled address.

**Table 2.** Camberwell Register: One-year prevalence by agency and service (number of patients and number of contacts).\*

	1965		1970	
	<i>Patients</i>	<i>Contacts</i>	<i>Patients</i>	<i>Contacts</i>
1. OUT-PATIENTS				
Bethlem/Maudsley	1,061	5,183	1,498	7,680
St Francis	—	—	63	334
KCH and Guy's	421	1,346	316	1,305
Cane Hill (St Giles)	447	1,841	276	1,081
Other	47	153	14	61
Total		8,523		10,461
2. IN-PATIENTS				
Bethlem/Maudsley	175	197	351	412
St Francis	93	101	189	256
KCH and Guy's	6	6	40	44
Cane Hill	280	342	88	100
Other	66	81	39	44
Total		727		856
3. DAY-PATIENTS				
Bethlem/Maudsley	52	64	65	83
St Francis	—	—	44	57
Other	12	18	15	18
Total		82		158
	<i>Admissions in 1965</i>		<i>Admissions in 1970</i>	
	<i>(unduplicated)</i>		<i>(unduplicated)</i>	
4. DAY-CENTRES, ETC.				
Local authority		24		34
Voluntary		5		—
Maudsley Rehabilitation Unit		—		21
Total		29		55
5. HOMES AND HOSTELS				
Geriatric		—		9
Other		3		2
Total		3		11
	<i>N</i>	<i>1965</i> <i>Rate</i>	<i>N</i>	<i>1970</i> <i>Rate</i>
Total one-year prevalence (unduplicated count of patients) per 100,000 aged 15+	2,514†	1,881	2,925†	2,189

\* Patients are duplicated between agencies and services in 1, 2, and 3 so the numbers cannot be added.

† Excluding patients with no settled address.

A private housing association has just opened a local hostel for chronically handicapped psychiatric patients who need minimal supervision and who can look after themselves in bed-sitting rooms. No hostel places for this type of patient are provided by the local authority.

Tables 1 and 2 show the changes in the numbers of patients catered for by the different agencies in 1970 as compared with 1965. The reduction in the numbers of short- and medium-stay patients in the area psychiatric hospital and the increase in the number admitted to the joint hospital and St Francis's can be seen. Although the numbers are gradually decreasing, there are still many long-stay patients in area psychiatric hospitals. Anthea Hailey (6) has shown that, although run-down occurs at a faster rate than build-up, there are nevertheless some patients who become long-stay during the course of each year.

Tables 1 and 2 also show the very small proportion of patients who attend day-hospitals, or day-centres, or who live in hostels. The joint hospital runs a rehabilitation unit, but there is no sheltered factory in the Camberwell area. Occasionally a patient has a course at an industrial rehabilitation unit, or is placed in a Remploy factory, but the nearest of these are some way from Camberwell and places are hard to obtain. The local authority day-centres provide work, but it is not as organized or as productive as it would be in a sheltered workshop or factory.

#### **4. Evaluation of services**

The preceding section gave a very brief review of the changes taking place in the Camberwell services and some statistics to show the redistribution of patients. It should be pointed out that changes in services do not necessarily produce benefits for patients, and that statistics describing a current situation are not blueprints for future improvements. To quote J. K. Wing *et al.* (7): 'It is important to emphasize a danger in these purely descriptive statistics, which is that the mere statement of a trend will be taken to mean that this trend is worthwhile.'

For this reason, the MRC Social Psychiatry Unit has undertaken a number of detailed studies of the way in which psychiatric services are working and the effect upon individual patients and their families. These special studies include: an investigation of the increase in admissions from 1965 to 1968 (Dr Colin Godber); the reasons why patients are admitted (Dr John Gleisner and Dr Sheila Hewitt); the clinical condition and intensity of out-patient contacts in patients previously suffering from psychoses (Dr Julian Leff and Miss

Christine Vaughan); the reasons why patients are certified (Dr Harold Dawson); and the characteristics of patients becoming long-stay (Dr Sheila Mann).

One of the studies which is of particular relevance to the changes occurring in the Camberwell services is that concerning the employment problems of chronic psychotic patients in the community. In the present transition period during which the Maudsley Hospital is building up its services for Camberwell patients, it has been arranged that 45 patients can be admitted to Cane Hill each year. The eventual aim is for all in-patients, whether long-, medium-, or short-stay, to be admitted to the local Camberwell services. However, the developing local services have little experience in caring for chronic psychotic patients. Furthermore, Camberwell has no sheltered factories and no hostels for these patients (apart from the one recently opened by a voluntary association). It was, therefore, considered important to investigate the services which might be called upon to cater for patients of this kind who are currently living in the community, but who, in the past, would probably have been long-stay hospital patients. In this paper I shall describe one study carried out on this group.

## **5. Employment problems of chronic psychotic patients**

The aim of this study was to establish the prevalence of chronic psychotic patients who were unemployed or who had difficulties at work and then to do an experimental assessment of the effects of planned rehabilitation. (For a fuller account see reference 8.)

### **a. THE SAMPLE**

It was decided to limit the sample to people aged 18-54 inclusive. Camberwell patients in this age-group, in contact with psychiatric services in 1968, who were not long-stay in-patients by the end of 1968 and who had been diagnosed as suffering for one year or more from a functional or organic psychosis or epilepsy were identified from the Camberwell Register (a total of 380 people). The case-notes of these patients were examined. Fifty-six were excluded because there was no evidence of a psychotic illness, despite the diagnoses assigned to them. A total of 170 were employed during 1968, 75 were fully occupied as housewives, 2 were unemployed only when acutely ill, and 2 were too physically ill to work. This left 75 who were eligible for the study. One of these died and 2 left the country in 1969 before they could be interviewed. In 4 cases the consultant refused to allow the patient to be seen.



The rest (68) were contacted and asked to attend for interview. Fourteen patients refused to come, leaving 54 who were seen. Of these 11 would not take part in the study, 9 had been in the rehabilitation unit in 1968 so were not eligible and 6 were too seriously ill and disturbed to be included. That left 28 who were willing to take part. They were divided at random into an experimental group (14) and a control group (14). The former were admitted to the Maudsley Day-Hospital and later to the rehabilitation unit for as long as the consultant considered necessary. The latter were not admitted, but their consultants could arrange any other rehabilitation programme they wished.

#### *b. FOLLOW-UP OF PATIENTS IN THE SAMPLE*

The experimental group were interviewed at the beginning of the study, at least once during their time in the day-hospital and rehabilitation unit and on discharge. A final check was made on their social and employment status through their case-notes, at least two years after their first service contact in 1968.

The control group was interviewed at the beginning of the study and again at least one year later. The final case-note check was also made as for the experimental group.

The other patients were interviewed at the beginning of the study and again at least one year later if they were willing to co-operate. Information was obtained from case-notes for the patients who refused to be seen and the final case-note check was made as for the rest of the group.

#### *c. INFORMATION COLLECTED AND METHODS OF ASSESSMENT*

For all patients, basic information was collected, including sex, age, diagnosis, occupational, social, and marital status, history of the illness and service contacts, and family history.

Those who were interviewed were seen by a psychiatrist and a psychologist. The former used the Psychiatric State Examination (9) to make a diagnosis and completed a role performance schedule concerning relationships with spouse or relative, sociability, and leisure activities. The psychologist gave intelligence and aptitude tests and assessed the patient's confidence concerning his ability to obtain and hold a job, his attitude to work, and his attitude to unemployment. A sociologist interviewed the patient's relatives where possible and rated the relatives' account of the patient's role performance (as above), the problems presented by living with the patient and the attitude of the relative to the patient. These measurements and ratings were all repeated in the follow-up interviews.

*d. CHARACTERISTICS OF THE WHOLE GROUP*

Fifty-five per cent of the whole group of 75 patients could be definitely diagnosed as suffering from schizophrenia on the history and present state examination. Only 9 per cent had an affective psychosis.

Their occupational, social, and marital achievements were considerably below average and many showed a deterioration from a previously higher level. Only 36 per cent had ever had a stable marriage, or cohabiting partner and by the time of interview only 11 per cent were still married or cohabiting. Fifty-one per cent lived with their parents or other relatives.

All but 2 had at some time been in-patients: three-quarters of them more than once. Twenty-three (31 per cent) had had at least one spell of in-patient care lasting one year or more.

Using criteria described by Wing (10) 65 per cent of the 54 patients who were interviewed were moderately ill and 35 per cent were severely ill, the latter having marked delusions, hallucinations, or incoherence of speech, or poverty of speech or muteness.

The measures of role performance showed that most of the patients interviewed had virtually no social life or leisure activities. By and large they had no complaints about their relationship with the relatives with whom they lived (if any). The relatives themselves, on the other hand, tended to describe more difficulties, though most, on balance, wanted the patient to continue to live at home.

*e. INITIAL COMPARISON OF THE EXPERIMENTAL AND CONTROL GROUPS*

The patients were randomly assigned to the experimental and control groups and comparison on the variables that were measured showed little initial difference between the groups. They were compared on all the items of basic information mentioned above and on the measurement of attitudes. There were no significant differences apart from an even poorer rating on leisure activities for the control as compared to the experimental group.

*f. RESULTS*

*i. Epidemiology*

The one-year prevalence of chronic psychotic patients with employment problems (as defined) and in the 18-54 age-group was 75, or 44 per 100,000 total population.

Eight of the group had been unemployed for only one year and 19 for two years. The average annual incidence probably lies somewhere between these two figures. (For a fuller discussion see reference 11.)

*ii. Effect of the rehabilitation procedure*

By the time of the final follow-up (at least two years after the first contact in 1968) 4 patients in the experimental and 4 patients in the control group were working. Three in the former group and 4 in the latter had tried work but had not been able to stay in employment. When over-all change in social and occupational pattern instead of employment at the end of the study was rated, again no difference between the two groups could be seen. There were also no significant differences in the attitude and role performance ratings of the two groups at the final interview.

*iii. Correlates of improvement*

Examining the whole group of patients (72 people, excluding the 3 who died or left the country before they could be included in the study) 29 patients showed some improvement in their social and occupational patterns as compared with the beginning of the study. Thirty-six did not improve (5 of these showed some deterioration), 2 had died, and 5 could not be contacted.

When those who improved and those who did not were compared some correlates of improvement were found, such as a history of a stable marriage at some time in the past and a positive score on the psychologist's ratings of drive and realism in relation to work. Perhaps the most interesting was the correlation of willingness to co-operate with improvement. The patients who refused interview or refused to take part in the study did significantly less well than those who agreed to co-operate ( $p < 0.01$ ).

*g. DISCUSSION OF THE FINDINGS*

The first point to make is that this study is *not* a trial of the day-hospital and rehabilitation unit. This unit provides a valuable service for a variety of different kinds of patients, but until the present study chronically handicapped psychotic patients formed only a very small minority of the patients who were admitted. This study was an attempt to assess the usefulness of the rehabilitation procedure for a special group of patients and it is only fair to emphasize that the day-hospital and rehabilitation unit were not designed to cope with patients of this kind. Those involved in the experiment felt that it was worth while because the policy of reducing psychiatric hospital beds must mean that more chronic psychotic patients will have to be cared for in the community. A start had to be made to assess what the existing services could offer to these patients.

The results show that the arrangements made for rehabilitation did not materially influence the social and occupational patterns of the

patients in the study. This did not seem to be due to any other arrangements for rehabilitation being made by the control group's consultants. Two of the control patients entered a local authority day-centre, one tried a day-centre but failed. None of these three was working by the final follow-up.

The results of this study can be compared with those of a previous experiment (12) in which 45 moderately ill schizophrenic patients (residents of two psychiatric hospitals) were sent on an eight week's course at an industrial rehabilitation unit. Of these, 30 per cent were working a year after discharge and 22 per cent were in sheltered employment (52 per cent altogether).

Taking the 17 moderately ill patients in the present study who attended the rehabilitation unit (not all of whom could be called schizophrenic on strict criteria, but who would probably have been given this diagnosis in the psychiatric hospitals concerned), 3 of these were working at the end of the study, 1 was doing voluntary work and 1 was in sheltered employment (29 per cent altogether).

Further work would be needed to establish the reasons for the difference in these results, but some suggestions can be made. One important point is that the patients living at home can more easily refuse to co-operate than those in hospital. Five of those in the experimental group left at their own insistence within a few days or weeks of admission. The patients in hospital had a long period of preparation before attending the industrial rehabilitation unit. Those who came from the hospital with the longest and best preparation less often showed a temporary exacerbation of their symptoms than patients from the other hospital.

Patients in hospital are supervised during non-working hours, whereas patients living at home (some by themselves) are not looked after in the same way. Skilled and tactful supervision might anticipate and prevent adverse reactions and provide support for the patients who suffer some anxiety when starting work. If there had been a hostel associated with the day-hospital this might have improved the results, although the problem of persuading some of the patients to accept this form of accommodation would remain.

Finally, it is possible that better employment conditions in 1960 when the hospital experiment was carried out might have influenced the results.

#### *h. IMPLICATIONS OF THE FINDINGS*

The group of chronic psychotic patients studied were severely handicapped with regard to social achievement and occupation. They appeared to be worse off in these respects than patients resident in a good psychiatric hospital which can offer a wide range of work

suitable for all levels of skill and an active social and recreational programme outside working hours. In some cases, a hospital can offer a more comfortable standard of living than that available to the patient outside.

In theory, a reasonable answer to the problems presented by this group is the provision of residential hostels and sheltered work in both day-centres and in factories. This is the responsibility of the local authorities, but unfortunately they do not have a background of experience of these types of services. The people who do have the appropriate traditions are the staff of some of the large area psychiatric hospitals in which sheltered workshops were pioneered and the system of housing patients in villas away from the main hospital, equivalent to self-care hostels, has long been in use. The differences between community and hospital management of chronic psychotic patients was underlined by the present study. The 75 patients were, between them, receiving very little help with work or accommodation. Fourteen were in day-centres when first interviewed. Nine had been in the Maudsley Day-Hospital and Rehabilitation Unit in 1968 and of these one eventually found work in a Remploi factory outside the area. Five were living in hostels (run by various voluntary bodies) which were not primarily for psychiatric patients and 2 of which were felt to be extremely unsuitable for the patients concerned. It was felt that a further 22 of the patients needed good hostel accommodation, either immediately or when their elderly relatives could no longer support them.

In practice, even those patients in the sample who agreed to accept the rehabilitation service offered by the Maudsley were not able to benefit to the full, partly because of lack of continual help and supervision during the phase of anxiety at first entry and partly because no suitable sheltered factories or workshops were available after the rehabilitation course. It is not possible to say how many would agree to live in hostels or attend sheltered factories even if these were provided. It is obvious from the present study that a number would not be willing to co-operate.

It is possible to argue that early treatment and early rehabilitation would allow the development of a good relationship with a patient and thus improve the chances of his future co-operation. Time spent in hospital could be used to prepare him for eventual rehabilitation in the community. For this to work successfully, it is essential that the staff of the community services and of the hospital should work as a team, so that the former as well as the latter are familiar to the patient and are accepted and trusted by him. Otherwise transition from hospital to community will remain the severe problem which it is at present.

The situation uncovered by this study clearly poses the problem as to whether chronically handicapped psychotic patients are best cared for in hospital or in the community. The great majority of those in the present sample said they preferred to be at home and did not want to return to hospital. In fact, one of the reasons for lack of co-operation was a refusal to have anything more to do with hospitals. Only a few felt they could not manage in the outside world. One in particular enjoyed the hospital's social life and was an active member of the cricket team. At home he had no comparable leisure activities. The relatives, while expressing more problems than the patients, on the whole did not feel that they had a severe burden to bear and preferred to have the patient with them at home.

On the other hand, Wing and Brown (7) in their study of long-stay patients in hospital found that the people they interviewed tended to want to stay in hospital and were reluctant to be discharged. All human beings have a tendency to become habituated to their environment, but the chronic psychotic patient is especially vulnerable to this process which is the basis of 'institutionalism'.

In this situation it is difficult to decide what is best for the patient and for his family. However, if the decision is taken to reduce the numbers of psychiatric beds it is clear that the community services will have to cope with many more chronically handicapped patients. They will not start to lead normal lives simply because they are discharged from hospital. A whole range of hostels, day-centres, sheltered factories, and clubs providing facilities for recreation and leisure activities are needed if these patients are to lead any semblance of a normal life. Some will refuse to avail themselves of these services, but others will join in and show by their regular attendance, if not by any outward show of enthusiasm, that they find the activities and the possibility of earning money preferable to sitting at home doing nothing.

From the objective point of view there is evidence that schizophrenic patients (who form the majority of the chronically handicapped unemployed psychotic patients) show fewest symptoms in an environment where there is an optimum amount of social stimulation including occupation. If there is too little stimulation, then symptoms of withdrawal occur, if too much, florid symptoms of delusions, hallucinations, and incoherence of speech are seen (7). The community services will need to develop expertise in this field so that they can provide the most suitable environment for these patients with the appropriate level of stimulation: not too much, not too little, but just right.

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## ***Some factors affecting the organization and planning of psychiatric care***

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The following is an account of a series of studies into psychiatric services and the problems arising from the integration of psychiatry into the work of general hospitals.

The area investigated is in the north-east of London and comprises the three former boroughs of Edmonton, Enfield, and Tottenham; they were until 1 April 1965 part of the county of Middlesex, but since then Edmonton and Enfield have been incorporated in the new London Borough of Enfield, while Tottenham is now part of the London Borough of Haringey. Part of the work was concerned with the whole area, while others deal only with Edmonton, which occupies an intermediate position both in the geographic and in the demographic sense. At the 1961 census the population of Edmonton was 92,000, and the three boroughs together had a population of 315,000 (1). The area was served by Claybury Hospital, Essex, and the local general hospitals. During the last decade the centre of gravity of the service was gradually shifting to the local general hospitals, particularly the North Middlesex Hospital in Edmonton, where practically all the out-patient work, and an increasing proportion of the in-patient work, was carried out.

### **1. Admissions (1)**

What is the relationship between demographic characteristics and hospital admissions? To answer this question it is necessary to examine it in a situation where the organization of the service (in terms of admission policy, availability of beds, out-patient, and community facilities) is a constant, but the area examined offers a variety



**Table 1.** Admission rates per 1,000 population for the three boroughs, in 1963-4.

	Total population			Adults (aged 15 and over)		
	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>
Edmonton	2.56	2.12	3.00	3.22	2.64	3.68
Enfield	1.93	1.37	2.45	2.45	1.70	3.07
Tottenham	3.13	3.03	3.25	3.90	3.82	3.97

of demographic and socio-economic conditions. This criterion was met in the three boroughs of Edmonton, Enfield, and Tottenham. There was a consistent correlation between the differential admission rates from the three boroughs and a number of demographic and ecological characteristics of the three urban areas. The admission rates were highest for Tottenham, followed by Edmonton, and the lowest rates were recorded from Enfield (Table 1). The differences in the crude over-all rates between the boroughs are highly significant ( $p < 0.001$ ). The sex-specific rates for adults differed considerably and here again the significance was  $p < 0.001$  for men, while for women it just fell short of statistical significance at the 5 per cent level.

These differences were not only statistically significant but very considerable in absolute terms: thus the number of admissions from Tottenham were two-thirds as high as those from Enfield, though the two boroughs had an almost identical number of residents. The same gradient was found when analysing the populations of the three boroughs: Tottenham had the highest percentage of the elderly, of the single, of those previously but no longer married, of low socio-economic groups, of population mobility, of those born outside the United Kingdom, of people living alone, and of poor housing conditions. The rank order for hospital admission rates and these demographic factors were the same for the three boroughs.

Fig. 1 illustrates the three boroughs' recent fortunes. Tottenham, already a community of some importance at the turn of the century, continued to grow and its population was highest at the 1931 census. Its decline, possibly started by the economic depression of the 1930s, is still going on. The growth of the initially much less populated boroughs of Edmonton and Enfield was parallel at the beginning of the century, but between 1931 and 1951 Enfield caught up with Edmonton, whose population started to diminish rather rapidly after the mid-century.

A community in decline such as Tottenham probably retains a higher proportion of its more vulnerable, and maybe also of its less enterprising members. It is likely to attract, or perhaps to tolerate more readily, those unstable in emotional state or behaviour. In such a disintegrating urban community the incidence of mental disorder is

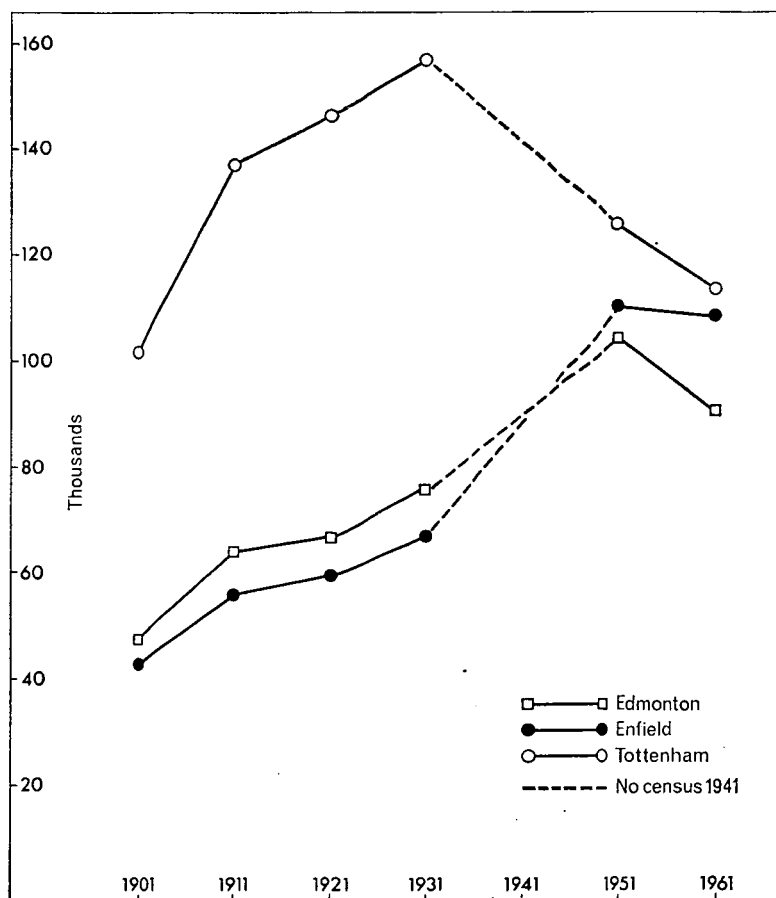


Figure 1. Total population of the three boroughs in successive census returns.

expected to be high. Conversely, rapidly developing new towns have a low psychiatric hospital admission rate. We concluded that the differences for hospital admission rates for the three boroughs represented a medico-social reality, and not an artefact produced by the hospital and community services. By population alone Tottenham would need almost identical facilities with those of Enfield; in fact psychiatric hospital admissions from Tottenham were 67 per cent higher than from Enfield. The size of the population in a given area is therefore too crude a guide to the number of beds, staff, and other psychiatric facilities needed, even if account is taken of age and sex distribution. As long as the psychiatric service was carried out from

large mental hospitals for a population of half a million or more, differences in the prevalence of mental disorder between different areas were obscured and could be ignored. With decentralized arrangements as it is envisaged in the transfer of psychiatric work to district general hospitals we need more refinement in planning.

## **2. Out-patients (2)**

Relatively little is known about psychiatric out-patient work, and even less about the relationship between in-patient and out-patient psychiatric facilities in service requirements for a given population. The growth of out-patient psychiatric work is relatively recent, and its existence outside teaching hospitals is largely a National Health Service development. With in-patients concentrated in large mental hospitals serving an extensive area the psychiatrist's connection with any individual general hospital was necessarily limited, and the out-patients a small and peripheral part of his work. Also there is a considerable difficulty in collecting reliable out-patient statistics; the definition of what constitutes a new patient often varies from hospital to hospital, and the amount of clinical and administrative information available is usually incomplete (3). These reasons go some way to explain why, at least until very recently (4) we have not had data comparing these two aspects of clinical work on a national or local scale. We have therefore set out to examine the relationship between in-patient and out-patient work, and particularly the extent they substitute for, or complement, each other.

The study showed that in-patient and out-patient clientele remained distinct streams in certain respects. In Edmonton the out-patient referral rate was very low, and the hospital admission rate very high for elderly patients of both sexes. The ratio of rate per 1,000 for the over-65s, and the 15-45 group, differed significantly ( $p < 0.01$ ) between in-patients and out-patients, both for males and for females.

Forsyth and Logan (5) already found a low out-patient referral rate for the elderly in all specialties, and speculated that the generation now over 65 may have a lower expectation from the medical services, may exert less pressure on GPs, and there may be a tacit understanding among the medical profession that elderly chronics are not 'suitable' subjects for consultation. Another, more specifically medical, explanation is that about half of the elderly patients are physically ill or disabled (7), and many are severely demented, so that they are more likely to be seen on a domiciliary visit rather than in the out-patient department, or transferred to a psychiatric bed from a medical one. Not unexpectedly, the diagnostic composition of the in-patient and out-patient groups was very different, as was

**Table 2.** Age and sex specific rates of psychiatric patients in Edmonton per 1,000 population.

	In-patients		Out-patients	
	M	F	M	F
15-44	2.73	3.19	3.93	4.47
45-64	1.69	3.49	2.57	3.98
>65	5.46	4.57	1.24	1.82

the way they reached the two branches of the hospital service. Other groups under-represented among Edmonton out-patients were the single and the 'previously married' (widowed, separated, divorced). It seems that the two upper social classes were using much less, and the two lowest social classes were using much more, both aspects of the local psychiatric hospital service than expected from their respective share in the population of the borough (1). Social differences between in-patients and out-patients were much less marked, but a predominantly working and lower middle class borough is probably not suitable to test social class polarization between in-patients and out-patients, or the existence of disparities in treatment opportunities similar to those reported for educational opportunities. Our impression was that people living alone, and also immigrants, were less commonly seen among out-patients than among hospital admissions. It seemed that out-patient referral is more likely to be arranged for those integrated in the protective matrix of society than for those living on its margins. The two facets of the hospital service performed, therefore, functions which to a large extent are complementary.

In Edmonton there was within the span of three years a 34 per cent increase of referrals to the psychiatric out-patient clinic, but virtually no change in admissions at a time when national figures of hospital admissions were still rising. This suggests that an increase in new out-patient referrals, ie, for diagnosis and treatment, can prevent admission or prove an alternative to it. Thus, among medical hospital admissions Forsyth and Logan (6) found that 25 per cent of males and 42 per cent of females were not, on clinical grounds alone, in need of in-patient care; in Aberdeen (3) hospitalization rates for psychiatric patients varied inversely with the amount of extramural service offered by the unit to which the patient was referred.

The substitution of out-patient for in-patient treatment is already taking place, but our results seem to indicate that too many among the socially under-protected are not yet reached by the out-patient services. The possibility of substituting out-patient for in-patient care for at least some patients is one of the factors to be considered in the apportionment of medical manpower between the two facets of the

Table 3. Number of Edmonton, Enfield, and Tottenham patients remaining continuously in hospital after admission in 1960-1 and 1963-4 cohorts.

	1960-1	1963-4
All admissions	606	609
At 6 months	104	82
At 1 year	72	56
At 2 years	48	30
At 5 years	19	9
At 6 years	13	7
At 7 years	11	7
At 8 years	10	—
At 9 years	7	—
At 10 years	7	—

hospital service. With a steady fall in the number of patients in psychiatric beds, and the gradual transfer of clinical work from the often remote mental hospital to the local district general hospital, a larger part of the psychiatrist's time may need to be devoted to out-patients.

### 3. The chronic sick (8, 9)

The number of patients remaining in hospital after a given lapse of time is one of the indices of the severity of the illness as well as a guide for administrative planning. We have used this measure to assess the size and the nature of the problem which confronts the hospital services. Patients remaining in hospital from two admission cohorts were followed up for, respectively, ten and seven years.

At all stages of the follow-up fewer patients remained in hospital from the 1963-4 than from the 1960-1 admissions. By the end of the follow-up period just over 1 per cent of the original cohorts was still in hospital. It is likely that this is the 'hard core', ie, those who will require permanent residential care, as in our sample no patient was discharged from hospital after ten years' continuous residence.

We have examined the residue of the original cohorts at various stages, and a brief summary of the follow-up findings will be given. The patient who stays in hospital for *six months* is generally not middle-aged; for both sexes the peak age periods are before 45 or after 65 years. The over-65s, who constituted a quarter or less of the original admission cohorts, represented a third of men and half of all women patients at the six months stage. At this point in time, the typical male patient is an unmarried schizophrenic labourer of about 30, with two or more previous admissions to hospital, and his counterpart is a widow of 75 suffering from senile dementia and with no

**Table 4.** Separations from hospital of Edmonton patients between 1966 and 1970, by length of stay.

<i>Years in hospital</i>	<i>Death</i>	<i>Discharge</i>
2-5	14	8
5-10	5	2
>10	14	—

previous admission. Approximately one-quarter of patients in hospital at this stage were in the group of personality/neurotic disorders. In the vast majority of cases the reason for prolonged stay was genuinely psychiatric, ie, the severity of the mental disorder whether complicated or not by physical illness, inadequate social support, or low intelligence.

The reduction in numbers after the six months stage resulted from discharges more or less uniformly distributed over the various diagnostic categories, and the death of a large number of elderly demented women. Table 5 shows the characteristics of the residue of the 1963-4 cohort *two years* after the original admission.

Only a small number of patients remain in hospital at the end of the follow-up period when the curve of the rundown is flattening out. Table 6 shows the composition of the two groups: in both there are more females than males, a considerable proportion is in the higher age groups, and the largest diagnostic categories are schizophrenia and organic mental states.

#### 4. The elderly sick (7, 10, 11)

It is a truism that the care of this increasing section of the population is the greatest challenge facing the health services. We felt that the whole geriatric problem needs re-examination and we analysed hospital admissions of all elderly patients in this area. The following is a summary of our findings.

**Table 5.** Age on admission, diagnosis on admission, and the reason for hospital care after two years continuous residence (30 patients admitted in 1963-4).

<i>Age</i>	<i>No.</i>	<i>Diagnosis</i>	<i>Reason for hospital care</i>
<45	11	Affective	6 Psychiatric
45-64	4	Schizophrenic	9 Psychiatric and other factors
>65	15	Organic	11 Special treatment
		Personality/neurotic disorders	4 Non-psychiatric

**Table 6.** Sex, age, and diagnosis after ten, respectively seven, years continuous stay in hospital of Edmonton, Enfield, and Tottenham patients.

	1960-1 cohort (N=606) 10 years later (N=7)	1963-4 cohort (N=609) 7 years later (N=7)
SEX		
Male	2	3
Female	5	4
AGE		
30-39	—	2
40-49	2	1
50-59	—	1
60-69	1	1
>70	4	2
DIAGNOSIS		
Affective	—	1
Schizophrenic	3	4
Organic	3	2
Personality/neurotic disorder	1	—

1. Most patients over the age of 65 are not admitted either to a geriatric or to a psychiatric bed but to another department of the general hospital.

**Table 7.** Annual admission rates per 1,000 population aged 65 and over.

Department	Rate
Geriatric	36
Psychiatric	5
Other	50

2. The over-all admission rate increases rapidly with age.

**Table 8.** Annual admission rates per 1,000 population by age-group.

Age-group	Rate
65-74	65
>75	143

3. In the 65-74 age-group three-quarters of the patients go to a non-geriatric ward of the general hospital, but the majority of

patients over 75 are admitted to the geriatric unit. The clinical picture also changes around the age of 75 with a marked increase in multiple physical disease and mental deterioration, often complicated by sensory defect.

4. Seventy per cent of misplacements, ie, of admissions to the inappropriate part of the hospital service, occurred in the over 75s. At this age it seems that 'physical and mental illness are inextricably intertwined' (12).

5. So-called misplacement did not worsen the prognosis either in terms of survival or in terms of length of stay in hospital. These remained primarily a function of the nature and severity of the illness that led to admission.

**Table 9.** Survival at six months after admission, expressed as percentage of patients admitted.

	<i>Geriatric unit</i>	<i>Psychiatric unit</i>
1. Mental	80.0	80.7
2. Mental-physical	50.0	75.5
3. Physical-mental	42.0	72.7
4. Physical	51.8	12.5
All groups	50.2	73.8

6. The patient most likely to be misplaced in a geriatric bed was a spinster, often living on her own supported by social agencies, and whose history went back to two years or more. The patient misplaced in a psychiatric bed was frequently a man who has had an episode of mental illness in the past and who was admitted after a fairly short illness.

7. The rate of discharge followed a different pattern, with an early peak in the geriatric unit as compared with a peak between the fourth and eighth weeks for the psychiatric unit. In both units the discharge peak for patients with both physical and mental disability was about one week later than for patients with mental or physical disability alone.

We concluded that the separation of medical geriatrics from psycho-geriatrics is not in agreement with clinical reality. As an attempt to bridge the gap in the existing services, the concept of the psycho-geriatric assessment unit is undoubtedly a step in the right direction. We felt that it is necessary to go further and create a comprehensive service for the elderly sick, operationally defined as patients aged 75 and over. The geriatrician, whose training should



include both the medicine and psychiatry of old age, would be in charge of this comprehensive service embracing both hospital and community care.

## 5. Attitudes (13, 14, 15)

The integration of psychiatry into the work of general hospitals is a radical departure from past practice. The transfer of this hitherto isolated branch of medicine cannot go smoothly if the new milieu does not prove receptive to our approach and tolerant to our patients.

The attitudes to psychiatrists and psychiatric patients of the consultant staff of six large general hospitals were explored by means of a questionnaire. The results showed that psychological factors were accepted as important in a variety of medical conditions. Consultants in surgical specialties showed a somewhat less tolerant attitude to neurotic patients and were less certain that psychiatrists should also deal with neurosis, but otherwise there was little difference in expressed attitudes. In general, younger consultants tended to be more critical.

**Table 10.** Variations in attitudes between physicians, surgeons, and gynaecologists.

<i>Statement</i>	<i>Consultants</i>	<i>Mean</i>	<i>p</i>
'Neurotic patients are difficult'	Physicians	0.97	<0.01
	Surgeons	1.37	
	Gynaecologists		
'Psychiatrists should deal with psychosis and neurosis'	Physicians	3.09	<0.02
	Surgeons	2.61	
	Gynaecologists		

Large discrepancies between the psychiatric morbidity of patients attending non-psychiatric departments of general hospitals and their actual rate of referral to the psychiatrist has been repeatedly shown. A number of reasons could account for this. The estimates of psychiatric abnormality may be excessive and include many that do not require referral; the psychiatric disability may not be recognized; if recognized it may be treated by the non-psychiatric specialist or the GP; the psychiatric service may be inadequate; referral may be prevented by the attitude of the non-psychiatric consultant or the unfavourable reaction, actual or supposed, of the patient. The following reasons, in order of frequency, were given by the consultants for not asking for a psychiatric opinion:

1. Patient's dislike of referral.
2. To avoid the label of 'mental case'.

3. Lack of readily available psychiatric facilities.
4. 'The treatment of neurotic patients is the job of any doctor.'
5. Consultant's unsatisfactory rapport with psychiatrist.

Younger consultants more often expressed dissatisfaction with existing psychiatric services at certain hospitals.

In further work, the results of which are now being analysed, we proposed to examine:

1. The prevalence of psychiatric disorder among patients attending medical, surgical, and gynaecological clinics.
2. The attitudes of these patients to psychiatry and psychiatric referral.
3. The actual referral practice of the consultants as opposed to their expressed attitudes.

The provisional results suggest that patients are better disposed to psychiatry than generally assumed by non-psychiatric consultants: in our sample only 7 per cent had an unfavourable attitude and 13 per cent disliked the idea of being referred to a psychiatrist. About 90 per cent expressed a preference for treatment in the psychiatric unit of a district general hospital rather than in a mental hospital.

We concluded that general hospital psychiatric units should aim to improve the relationship between psychiatry and other specialties, so that referral practice can meet the needs of the patient.

## **6. Forecasting (9)**

The lack of adequate forward planning in the first twenty years of the NHS has had consequences which are obvious to see. The subjectivity of purely clinical forecasting has been illustrated by Palmer (16). In the USA estimates of bed needs per 1,000 population varied from 3·8 to 8·0, and at any particular time the appropriate number seemed to be the number in existence. The old adage about the wise physician not giving a prognosis is even more applicable to the research worker, but we felt that it is necessary to abandon such defensive attitudes. This fifteen-year forecast of psychiatric bed requirements is therefore made with the obligatory reservation that it is only a statement of what can be expected if the conditions (clinical, social, and administrative) under which it is calculated continue to operate. As these are unlikely to remain static, any forecast of future bed needs should be kept under constant review.

To predict psychiatric bed requirements in the area studied we used (1) the longitudinal method of the rundown of admission cohorts (Table 3); and (2) the cross-sectional method, ie, a yearly census from

**Table 11.** Yearly census of Edmonton patients in psychiatric beds.

	1966	1967	1968	1969	1970
Male	76	77	80	67	57
Female	113	101	86	84	92
Both	189	178	166	151	149
Bed use per 1,000 population	2.05	1.93	1.80	1.64	1.62

1966 to 1970 of all Edmonton patients occupying a psychiatric bed.

We have then divided the resident hospital population in the following groups:

Short-stay:	under 3 months
Intermediate-stay:	3 months to 1 year
Medium-stay:	1-10 years
Long-stay:	over 10 years.

**Table 12.** Edmonton patients by length of stay.

	1966	1967	1968	1969	1970
<3 months	36	29	26	25	26
3-12 months	25	20	13	11	13
1-10 years	52	50	53	43	41
>10 years	76	79	74	72	69
All	189	178	166	151	149

The justification to separate the first two groups rests on their different diagnostic distribution and treatment needs.

**Table 13.** Short- and intermediate-stay Edmonton patients in hospital on 29 September 1970.

<i>Patients</i>	Length of stay		<i>p</i>
	<i>Short</i> ( <i>N</i> = 26)	<i>Intermediate</i> ( <i>N</i> = 13)	
<b>DIAGNOSIS</b>			
Affective	13	2	<0.02
Schizophrenic	6	2	
Organic	3	8	
Personality/neurotic disorder	4	1	
<b>MAIN REASON FOR STAY IN HOSPITAL</b>			
Treatment	24	2	<0.001
Rehabilitation	1	6	
Prolonged care	1	5	

The number of short- and intermediate-stay patients has remained approximately constant in the last three censuses (Table 12). The necessary bed provision was calculated on the basis of this apparently stabilized bed usage, though it was clear that at least a few patients from the intermediate group could have left hospital earlier if other facilities (for example, in hostels and sheltered workshops) had been available. The longitudinal study (Table 3) has shown that in about ten years the original cohort is reduced to 1 per cent of the initial number, and beyond this length of stay separation is by death only (Table 4). We have therefore chosen ten years as the dividing line between medium- and long-stay patients. Forecasts were made for the medium- and long-stay groups on the basis of these observations, for the last-named taking into consideration the known higher mortality rate of psychiatric patients which, in our sample, amounted to a 50 per cent excess over the general population.

The figures obtained, representing 100 per cent bed occupancy, were scaled up to correspond to a more realistic figure of 85 per cent for short-stay and 95 per cent for intermediate-stay and medium-stay patients.

**Table 14.** Bed needs in 1985 per 1,000 of population.

<i>Length of stay</i>	Bed occupancy	
	100%	<i>Adjusted for different groups</i>
Short	0.282	0.324
Intermediate	0.141	0.148
Medium	0.346	0.363
Long	0.152	0.152
All	0.921	0.987

In conclusion the total bed provision predicted as needed in 1985 in the area studied amounts to about 1 per 1,000 population. On the basis of present plans, the units in district general hospitals will accommodate only half this number or, in terms of length of stay, those who need continuous care for a period not exceeding one year. It follows that additional provision should be made for the other half, those staying for more than one year, who in their vast majority still need sheltered life conditions though generally only minimal medical and nursing care.

## 7. Concluding remarks

I should like to end this paper with reflections on some basic problems and false antitheses in medical care research.

**a. LOCAL OR GENERAL**

Work of this type necessarily relies on statistical evidence. However, large numbers often mean variability in the source, mode of collection, completeness and consistency of data, thus reducing their reliability. Intensive studies have the advantage of homogeneity in the criteria on which information and findings are based, but a reduction in numbers limits their statistical value, and the local nature of the information restricts their general applicability.

**b. QUANTITY OR QUALITY**

While estimating the quantity of particular aspects of the service, one brings into it implicitly its quality. Evaluation of change is therefore essential, but the difficulties of making a quantitative prediction are dwarfed by the methodological problems of comparing two complex and unequally developed systems of care, neither of which is uniform or static in its pattern of organization. Theoretically a system which uses limited financial and human resources in the most economic way is less likely to stretch them beyond therapeutic effectiveness. However, on present evidence one is not entitled to speak of superiority, only of feasibility.

**c. MORALE OR ADMINISTRATIVE SYSTEM**

The effectiveness of any system of care, and particularly of a psychiatric one, is greatly influenced by factors which are difficult or impossible to quantify. These are the qualities of enthusiasm and drive of capable leadership which are transmitted to the members of caring professions that make out the psychiatric team (17). A new departure in the organization of medical care often has a built-in Hawthorne effect, particularly when the leader of the team is also its initiator. The general applicability of the particular method depends, however, on its intrinsic characteristics without assuming more than average qualities of leadership.

**d. HOSPITAL OR COMMUNITY**

The shift in emphasis from hospital to community care rests on good clinical grounds, but there is little doubt that financial considerations have provided much of the impetus for change. New administrative divisions (between hospital and community, medical and social services, psychiatric and geriatric work) may lead to an imbalance of resources and a no man's land of care between the sometimes arbitrarily defined areas of responsibility. This should be offset by a concerted effort to create a service suited to the real needs of the particular patient group rather than following traditional financial or professional divisions.

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## ***Mental illness, general practice, and the National Health Service***

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The determination of the extent of psychiatric illness in a community is important from more than one standpoint. Perhaps understandably within the framework of a health service, some of the better publicized estimates in the UK have been concerned with economics. Such statements as that between one-quarter and one-third of all illnesses treated by medical practitioners fall into this category, and have been supported by studies of industrial sickness records (1): on the basis of such reports it was computed in the 1950s that about 80 million days' work are lost each year in this country through mental illness, corresponding to a loss of some £120 million a year in wages and a correspondingly larger loss in terms of production (2). In 1962 Vickers estimated the direct cost of the psychiatric services to be not less than £200 million a year, emphasizing that this figure took no account of the cost to local authorities, education and penal authorities and voluntary organizations (3).

Lord Taylor, while also attempting to calculate the material cost of mental illness, was one of the first to underline the burden being carried by the GP in the process (4). In their 1965 publication, *The Cost of Medical Care*, the Office of Health Economics (5) included the estimate of the number of patients under the care of the three branches of the NHS shown in Table 1.

The point which emerges so clearly from this table was underlined by the author's comment: 'The figures for the general practitioner service refer only to the mentally disabled patients and exclude the large hinterland of transient episodes of mental ill-health. . . . For every patient in hospital suffering from mental illness there are two in the community: the local authorities look after only one-tenth of this number.' Comparable findings have been reported from other studies which have taken a global look at the community care of the mentally

Table 1

	<i>Mentally ill</i>	<i>Mentally subnormal</i>
Hospitals	140,000	60,000
General practitioner	310,000	40,000
Local authority	40,000	80,000

sick: of the the interviews conducted in Martin and Rehin's survey, for example, 10.3 per cent of the patients were in hospital, 21.4 per cent under extramural psychiatric care, and 31.6 per cent under the care of their GPs (6).

Despite evidence of this type, however, there has been surprisingly little work focused on the general practice morbidity survey as a source of data for charting the incidence and distribution of mental disease in the community and for exploring the potential role of the GP in the general field of medical care. In the conditions of an NHS the family doctor is very well placed for the purpose by virtue of his position as the purveyor of primary medical care to a defined population. To the extent that he can be regarded as a personal physician, he also enjoys the major asset of direct access to the medical history and social background of his patients. Often his assessment of any given case is based not merely on observations made at a single interview but on professional contact with the patient extending back over years. Moreover, his special relationship with his patients confers on him a unique advantage in gaining their co-operation, and in eliciting those personal confidences which may be essential for a realistic appraisal of their complaints. In the words of the Gillie Report: 'the function of the family doctor in co-ordinating the resources of hospital and community care on behalf of his patient is potentially greater today than ever before. He alone can consider prevention, diagnosis, and treatment of disease in the individual in relation to his family and working background' (7).

But notwithstanding the obvious attractions pertaining to the uses of general practice surveys for studying morbidity in the community, there are a number of theoretical and practical difficulties attaching to this method of research. Many of these are reflected in the startling variations in the reported figures on psychiatric illness, varying from 65 per cent to around 4 per cent. While some of this disagreement may be explicable in terms of true differences of prevalence a closer scrutiny of the original data makes it apparent that the variation is much more a reflection of such factors as criteria of measurement, diagnostic schemata, methods of sampling, and medical attitudes.

Particular attention has been paid to these issues in the series of studies which have been mounted by the General Practice Research Unit at the Institute of Psychiatry over the past fifteen years (8).



Much of our work has understandably been focused on what we call 'conspicuous' morbidity, defined as 'illnesses or disabilities severe enough to lead to medical consultation and conforming to recognized clinical patterns for identification by the doctor'. In some measure, therefore, the degree of severity of a condition serves as a screening factor for identification by the practitioner. On the one hand, transient and/or trivial conditions may never reach him, though our work suggests that this occurs less frequently than might be expected. On the other hand, some relatively severe conditions, for example chronic psychosis, mental subnormality, alcoholism, or psychopathy, may be underestimated in general practice investigations. In general, however, the whole range of the so-called 'minor' mental disorders is comprehensively covered by the GP survey which, furthermore, has the additional advantage of helping the investigator tackle one of the more vexing problems in the sphere of mental disorder, namely the detection of a psychiatric 'case'. For operational purposes this becomes an individual whose symptoms, behaviour, distress, or discomfort leads to a medical consultation at which a psychiatric diagnosis is made by a qualified physician.

One final general comment need be made on the 'extent' of the mental disorder. While this term is usually taken to refer to the notions of prevalence or inception-rates, it should ideally embrace a variety of related concepts. These include duration, severity, outcome, response to treatment, and the neglected question of the relations between mental illness and other forms of morbidity. We have investigated all these aspects of the problem at different times, and here I would like to select six of the more important findings with obvious implications for this symposium.

1. Of some 15,000 patients at risk during a 12-month period rather more than 2,000 (approximately 14 per cent) consulted their doctor at least once for a condition diagnosed as entirely or largely psychiatric in nature. The bulk of these patients would be classifiable in the *International Classification of Diseases* as suffering from neurotic or personality disorders which therefore take their place among the commoner conditions in general practice.

2. No more than about 1 in 20 of the patients identified in the survey had been referred to any of the mental health facilities despite what the GPs freely acknowledged to be the unsatisfactory nature of the treatment which they were able to provide.

3. The demographic, social, and diagnostic contours of this population are quite different from those provided by hospital statistics. Corresponding discrepancies are found in respect of outcome and therapeutic responses. Thus our data show that a large proportion of

psychiatric morbidity encountered in general practice is made up of chronic disorders, and in a seven-year follow-up study more than half the cohort exhibited a very poor outcome in terms of recurrence or chronicity.

4. Emotional disorders were found to be associated with a high demand for medical care. Those patients identified as suffering from psychiatric illness attended more frequently and exhibited higher rates of general morbidity and more categories of illness per head than the remainder of the patients consulting their doctors.

5. The medical treatment of mental illness in general practice is often haphazard and inadequate. In our survey no therapeutic measures were recorded in nearly a quarter of all cases recorded; 1 patient in 8 received nothing more than unsystematically prescribed psychotropic drugs; psychological treatment or referral to psychiatrists was used in less than 5 per cent of cases and most often by psychotherapeutically minded GPs.

6. The social management of psychiatric cases, for example, referral to social agencies, was still less satisfactory, despite the fact that the practitioners recognized and identified a social factor in about one-third of cases.

Since the publication of our findings surprisingly similar figures have been furnished by workers as far apart as in Australia (9) and Austria (10), and it is appropriate to touch on the implications of such data within the framework of the NHS. As the outsider sometimes sees more of the game it is instructive to look at the situation through the eyes of someone who has had an opportunity to learn about the workings of the service at first hand. For the purpose I would refer to the views of a prominent American psychiatrist, Professor Knight Aldrich, who spent a sabbatical year in this country during the 1960s. He subsequently published an interesting account of his experiences in an attempt to account for the divergent paths taken by British and American psychiatry since the Second World War (11).

The National Health Service [he wrote] has influenced British Psychiatry in a number of ways. In the first place, it gave a boost to mental hospital psychiatry by giving mental hospitals equal recognition with other hospitals. By eliminating the cleavage and class distinction we still have in the United States between private and public hospitals, the National Health Service upgraded the public mental hospital, and at the same time made the consultant's position professionally more attractive. Until recently it has been easier therefore, to attract imaginative psychiatrists to mental hospitals in Britain and with relatively increased resources these psychiatrists have been able to carry out experiments in psychiatric hospital care with much more freedom than was possible before.

Most informed observers would probably agree with this opinion. With regard to the complementary extramural services, however, Aldrich's perspective emerges as more controversial. This was not due to any disagreement over the size and importance of the burden of mental ill health in the community. In a review of our monograph on psychiatric illness in general practice he accepted the figures but at the same time expressed concern over their implications for what he called 'the safety valve of referral to a psychiatrist for psychotherapy which for the most part our British counterparts lack' (12). He elaborated the point as follows:

... the National Health Service has indirectly limited the development of out-patient psychiatry per se by maintaining the general practitioner rather than the specialist as the major purveyor of community care. . . . In Great Britain, most psychiatrists seem content with their roles; most general practitioners do not seem to want to relinquish their neurotic patients, and most patients so far are not objecting. . . . I suspect that there may be a rising demand, spearheaded by the influential citizens of tomorrow, who are students today, for reasonably sophisticated diagnosis-orientated psychotherapy—something a good deal more than simple reassurance, advice of symptom-orientated reconditioning—to be included in the range of treatments offered to everyone.

These conclusions, in my opinion, demonstrate how an interested, intelligent observer can see a great deal of the game and yet altogether miss its point. Our own conclusions, based on the data from our studies, went in quite the reverse direction:

Administrative and medical logic alike suggest that the cardinal requirement for improvement of the mental health services in this country is not a large expansion and proliferation of psychiatric agencies, but rather a strengthening of the family doctor in his therapeutic role. It would, however, be naive to contemplate such a development without an awareness of its implications for other aspects of the practitioner's function not directly connected with mental illness. The family doctor's role in the treatment of psychiatric disorders can be defined clearly only in the perspective of his larger relationship to society (8).

To substantiate this view, however, it will be necessary to pay attention to two factors: first, the GPs themselves and, secondly, their working conditions. On the former point Martin and Rehin have passed a pessimistic verdict:

It seems clear that no simple generalization can sum up either the attitudes of general practitioners to psychiatry or the extent to which they are prepared to involve themselves in the domiciliary care of patients with a psychiatric disorder. In all probability, there is a spectrum of attitudes and preferred roles, with at one extreme end the kind of general practitioner who might not unkindly be described as a psychiatrist *manqué*. A Member of the College of General Practitioners, an enthusiastic participant in seminars on psychiatry and human relations, he is intensely interested in psychodynamics and knowledgeable about environmental stresses; he regards the treatment of psychiatric disturbance as among the most rewarding aspects of general practice, recognizes wide opportunities in the extension of community care, and would be glad to have a social worker attached to

his practice. But not very many family doctors fall into this category yet—certainly not as many as one in ten, perhaps no more than one in twenty. At the other extreme of this spectrum is the practitioner who finds contact with mental illness unattractive, even distasteful; who is not wholly convinced that neurosis really is illness, who at least makes a very sharp distinction between the psychological and the physical, and who clearly allocates a higher medical priority to the latter, and resents any suggestion of enlarged responsibilities in the former sphere. He too represents a minority of general practitioners, though probably a rather larger minority. The combinations of attitudes represented by these polar opposites probably reflect quite basic personality differences; educational experiences are likely to sharpen and focus them rather than bridge the gap between them. But the large majority of general practitioners lies between these extremes. If we take a long-term view, this is where reform in medical education may be expected to have its main impact . . . but it must be emphasized that the implications concern the next generation of practitioners. As far as the immediate future is concerned the evidence available suggests that general practitioners as a whole are unlikely yet to make a major contribution to the development of community mental health services.

For my own part, I would suggest that this outlook pays too much attention to the doctor's personality and training, and too little to the milieu in which he works. My view is based less on the plethora of official and semi-official documents with which we have been bombarded over the past few years, of which 'The Organisation of Group Practice' is merely the latest, than on what can surely be expected of the better forms of teamwork in primary medical care within the health service. The fourth principle of the New Health Service set out in the 1970 Green Paper on the NHS, that 'the service should be centred on the family doctor team', is nowhere more applicable than to the psychological aspects of ill-health. I suspect that at present such teams are most likely to be found in rural or semi-rural areas where the social matrix of the community is well understood and where the general practitioners, most of them lying somewhere between Martin and Rehin's two extremes, can even now construct a do-it-yourself system adapted to local needs. For example, in one such practice which I have been privileged to attend as an observer, there are 3 partners, 2 nurse-midwives, 1 health visitor, and 3 nurse-dispensers serving 7,000 patients in four villages. Their weekly meeting is a field-exercise in clinical anthropology and from my observations I would underline two points. First, the practice carries a large psychiatric load but makes relatively few calls on the area mental health services. Secondly, the doctors and their colleagues recognize fully from experience what we have been at great pains to try and demonstrate, namely that full justice can be done to these psychiatric disorders only by placing in a medico-social or socio-medical context rather than regarding them as exclusively medical disorders. For this reason the need is for the type of social

worker who is attuned to the practice requirements rather than for the relatively remote members of the local social service department.

The social component of mental ill-health is nowhere more apparent than from the vantage point of general practice. The Seebohm Report has made it essential for us to examine this issue in depth, and the time may well be ripe for attention to be paid to one recommendation in the Report which occurs, interestingly enough, in the chapter on implications outside the local authority services and is therefore technically outside the committee's terms of reference:

... it is clear to us that it is now time for an over-all assessment of psychiatric services and the resources they should have, into their function in society, the contribution that they should make both within and outside the N.H.S., how much of their skill and time should be devoted to training of other workers in the helping professions and to 'counselling' and how much to direct diagnosis and treatment of the very large numbers in the population with serious—not to mention minor—mental disorders (13).

Provided that due regard be paid to the potential contribution of primary medical care the consequences of such an undertaking could well lend practical support to Sir George Godber's opinion that we can look to social action as well as scientific research for advances in psychiatry (14).

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## ***Social correlates of psychiatric illness in the community<sup>1</sup>***

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General practice surveys have indicated that a high proportion of minor psychiatric disorders are found in conjunction with social difficulties (1); in particular, the association is conspicuous among patients with chronic neurotic illness (2, 3). This empirical finding suggests the possibility of an approach to treatment and management based on social supportive measures. In order to examine the question more systematically, a controlled study was undertaken of the social adjustment and functioning of a sample of chronic neurotic patients drawn from a general practice population.

### **1. Design and method**

For this purpose, two standardized measuring instruments were utilized: a psychiatric interview which had been constructed specifically for use in general practice and community surveys (4), and a semi-structured social interview which can be administered independently. Both have been found to give reliable ratings when used in a joint-interview situation by members of the General Practice Research Unit, Institute of Psychiatry.

The patients were selected from the registered lists of eight practices in Croydon and south-east London, by means of a special record of all surgery consultations kept for one month by each practitioner in turn. The index group was drawn from the patients given psychiatric diagnoses, and subsequently confirmed at interview as having had psychiatric symptoms for at least twelve months. Patients with schizophrenic and senile psychoses were excluded, as representing different types of medico-social problem ('major' as opposed to

1. Paper read at the Mental Health Research Conference, 10 November 1971, Nuffield Provincial Hospitals Trust.

**Table 1.** Patient-response and outcome of interview: index and control groups.

	<i>Index</i>	<i>Control</i>
Refused or failed to attend	24	34
Number interviewed	161	104
Discarded as unsuitable	36	19
Refused social interview	10	4
Accepted cases: Matched	81	81
Not matched	34	—
Total number contacted	185	138

'minor' psychiatric illness). On the other hand, patients with depressive syndromes were included regardless of formal psychiatric diagnosis.

The control patients were selected from among the remaining surgery-attenders, and individually matched with the index patients for sex, age-group (to within five years), social class, marital status, and occupational category. Each was given the standardized psychiatric interview in exactly the same way as the index patients; any with evidence of clinical psychiatric disorder were discarded from the study, an alternative control being selected in each instance. Since the value of the study depended largely upon the direct comparability of the two matched groups over a wide range of social variables, no control patient was accepted who could not be rated on the same combination of items as the paired index patient.

Both index and control patients were interviewed at home by social research workers who did not know to which group any individual patient belonged. In every case, except where the patient was living alone, another member of the household participated in the interview as a key informant.

Case-selection continued until 81 pairs of patients had been interviewed. At this point, the differences between the social profiles of the two groups were so marked that the laborious matching procedure could be terminated. For follow-up purposes, however, a further 34 psychiatric patients were interviewed, making a total of 115.

## 2. Findings

The patient-response to the inquiry, together with the proportions discarded as unsuitable, is outlined in Table 1.

Thus, altogether 34 of 185 potential index patients (18.4 per cent) and 38 of 138 potential controls (27.5 per cent) were lost at some stage because of their failure to co-operate. Of the patients given the standardized psychiatric interview, 36 out of 161 potential index cases (22.4 per cent) and 19 out of 104 potential controls (18.3 per



**Table 2.** Psychiatric interview ratings: aggregate scores for 81 matched pairs.

<i>Reported symptoms</i>	<i>M (N=20)</i>		<i>F (N=61)</i>		<i>Probability level (sexes combined)</i>
	<i>Index</i>	<i>Control</i>	<i>Index</i>	<i>Control</i>	
Somatic symptoms	29	4	98	23	0.01
Fatigue	26	3	91	28	0.01
Sleep disturbance*	43	8	101	28	0.01
Irritability	29	1	72	14	0.01
Loss of concentration	21	4	67	8	0.01
Despondency	26	1	100	7	0.01
Anxiety	34	1	115	24	0.01
Phobias	12	2	75	21	0.01
Obsessions	23	2	62	13	0.01
Depersonalization	0	0	24	0	—
<b>MANIFEST ABNORMALITIES</b>					
Slow, lacking spontaneity	5	0	7	0	—
Suspicious, defensive	10	3	11	4	0.05
Histrionic	5	1	29	5	0.01
Depressed mood	28	0	76	4	0.01
Depressive thought content	25	1	73	4	0.01
Anxious, agitated	36	2	113	16	0.01
Hypochondriacal	14	3	60	16	0.01
Elated	0	0	0	1	—
Flat or incongruous mood	2	0	2	0	—
Delusional state	3	1	7	0	0.05
Hallucinated	0	0	0	0	—
Intellectually impaired	3	1	3	2	NS

\* Score weighted for dependence on hypnotics.

cent) were discarded as unsuitable: the former because they were not confirmed as chronic psychiatric cases; the latter because at interview they were found to have psychiatric symptoms.

Table 2 shows that the index and control groups were clearly differentiated in terms of psychiatric item scores. The distribution of symptoms and abnormalities observed at interview among the index patients suggests a preponderance of depressive and anxiety reactions, which is in keeping with the diagnostic breakdown for this group (5).

In a preliminary analysis, the social adjustment ratings have been dealt with in two ways: first, they have been combined into 'area' ratings each corresponding to a major aspect of the patient's life, viz: housing, finances, occupation, social contacts and leisure activities, personal interaction, parenthood. Secondly, they have been grouped into three broad categories, designated respectively material conditions, social management, and social role-satisfaction. Each of these latter groups cuts across the area ratings: material conditions, for example, comprises ratings for housing conditions, household income, handicaps to social activities, etc. Tables 3 and 4 summarize the distributions of these two sets of social adjustment ratings for the index and control groups.

**Table 3.** Social interview ratings: mean area scores for 81 matched pairs.

	M (N = 20)		F (N = 61)	
	Index	Control	Index	Control
Income and finances	0.50	0.08	0.53	0.15
Occupation	1.24	0.22	0.76	0.37
Housing conditions	0.96	0.46	0.64	0.29
Social and leisure activities	1.27	0.52	1.19	0.69
Personal interaction*	1.14	0.66	0.99	0.54
Parenthood	0.39	0.30	0.99	0.45

\* Including marital adjustment.

**Table 4.** Social interview ratings: mean scores of categories of social dysfunction, 81 matched pairs.

	M (N = 20)		F (N = 61)	
	Index	Control	Index	Control
Material deficiencies	1.00	0.71	0.95	0.68
Social management problems	0.85	0.25	0.73	0.26
Role-dissatisfaction	1.17	0.30	0.99	0.37

The two tables indicate that there were large differences between the groups, the index patients having a relative excess of social dysfunction; moreover, the differences appeared to extend across all areas of the patients' life-activities. Statistical testing of the inter-group differences for individual item scores<sup>1</sup> showed them to be significant, at least at the 5 per cent level, for all items entering into the social management and role-satisfaction ratings. In contrast, insignificant differences were found for four of the six items entering into the material conditions rating. The over-all difference on this rating was accounted for largely by the two remaining items, housing conditions and household income. In view of the fact that the two groups of patients had been matched for social class, this disparity remains of some interest.

A separate analysis is being undertaken of the relationship between clinical and social ratings within the sample of 115 psychiatric patients. The over-all clinical score shows little correlation with that for material conditions ( $r = +0.13$ ), but significant positive correlations with social management ( $r = +0.37$ ) and with social role-satisfaction ( $r = +0.32$ ).

1. Since the number of patients who could be given a rating varied for each individual item, no statistical test could be applied directly to the grouped scores shown in Tables 3 and 4.

### 3. Discussion

These findings confirm the existence of a strong positive association between non-psychotic psychiatric disturbance and various forms of social difficulty. Taken together with what is known about the extent of minor psychiatric disorder in the community, they emphasize the need for close co-operation between general medical, psychiatric, and social service agencies. How this is to be achieved remains an open question. Both the Seeborn Report (6) and the recent official publication on group practice (7) have recommended closer liaison between GPs and social workers; in particular, for an integrated approach to the kinds of psychosocial problem touched on in this inquiry. It must be said, however, that neither among GPs nor in social service departments is the climate of opinion entirely favourable for such co-operation.

A recent survey of general practitioners in one London borough (8) found that only 14 per cent of them were definitely interested in the possibility of a social worker attachment; while a further 27 per cent were in favour of regular meetings and case-discussion. At the same time, the example set by one or two social service departments has shown that successful attachment schemes can grow up from small beginnings (9). The experience of an experimental study in one group practice has convinced us of the feasibility of this kind of attachment scheme as well as of its practical importance for the management of a wide range of psychiatric disturbances. To obtain more representative findings, however, the effects of such schemes must be studied in defined service areas.

#### ACKNOWLEDGEMENTS

This study formed part of a research programme sponsored by the Department of Health and Social Security. I am indebted to the Mental Health Research Fund, who supported my own contribution, and to my colleagues Professor M. Shepherd, Dr M. R. Eastwood, Mrs R. Fitzgerald, and Mrs V. Howard, who collaborated in the work of the inquiry. Finally, I am grateful to all the GPs whose patience and co-operation rendered the investigation possible.

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## ***Residential provision for mentally handicapped adults***

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### **1. Introduction**

The Mental Health Act, 1959, placed a duty on local authorities to provide a comprehensive range of community services for the mentally handicapped. Most authorities have concentrated on providing training facilities as a first priority, and the demand for training centre places has to some extent been met. The need for residential accommodation is, however, still overwhelmingly great. At the end of 1969, according to the White Paper, *Better Services for the Mentally Handicapped*,<sup>1</sup> only 43 of the 174 local authorities in England and Wales had residential accommodation of their own for both mentally handicapped adults and mentally handicapped children. Twenty-eight authorities still had no residential accommodation of their own for either age-group. Hence the renewed call in *Better Services for the Mentally Handicapped* for local authorities to provide such residential accommodation. One authority that responded in more than a cursory manner to the earlier call of the Mental Health Act, 1959, to provide a range of services for the mentally handicapped was Lancashire County Council. During the 1960s Lancashire County Council set up a variety of services for the mentally handicapped, including 16 mixed-sex hostels for mentally handicapped adults. A research project was begun in 1965 to evaluate the care provided by these hostels and the situation of their residents as compared to that of patients in mental subnormality hospitals. The observations of the present paper are based in the main on the findings of this research project from 1965 to 1968. These findings will be related wherever possible to current thinking on services for the mentally handicapped as set out in the recent White Paper.

1. Cmnd. 4683, June 1971 (HMSO).

## **2. Intake of hostel residents according to their previous place of residence**

At the inception of the Lancashire hostel-building programme it was thought that large numbers of residents would enter the hostels from mental subnormality hospitals. The number of patients eventually discharged to the hostels was, however, considerably less than originally anticipated. This was due in the first place to a lack of agreement and understanding between hospital and local authority personnel as to the nature and purpose of hostels and the sort of patient who might benefit from hostel residence. Hospitals tended to put forward patients in their 50s, 60s, or even 70s, often with a long history of institutionalization. For such patients transfer to a hostel might be seen as a reward for years of work on the wards. Most hostels, however, were hoping for younger patients with reasonable prospects of rehabilitation and employment in the community at large. Hospitals seemed disinclined to put forward younger patients due to fears of sexually promiscuous behaviour in establishments that were to be mixed-sex. Hospitals seemed disinclined also to put forward lower-grade (severely subnormal) patients on the assumption that such patients would not adapt to a hostel environment. This again excluded from consideration many patients whom the local authority might have been willing to accept. Had there been more precise specification of the aims of the hostel service and the sort of person being catered for, much of this confusion might have been avoided.

The number of hostel residents discharged from subnormality hospitals was further limited by hostels not always being willing to accept patients unless the hospital in question guaranteed to readmit them if they proved unsuitable as hostel residents. Hospitals were often not willing to give such a guarantee. Joint planning and co-operation between hospital and local authority personnel as advocated in *Better Services for the Mentally Handicapped* should do much to obviate this difficulty.

A third factor limiting the number of patients discharged to the Lancashire hostels from mental subnormality hospitals was the demand for hostel places from mentally handicapped people living at home (with one or both parents), with relatives or friends, or in other residential establishments in the community (children's hostels, voluntary homes, etc.). The proportion of residents admitted to the Lancashire hostels from the community at large increased from 31 per cent of all admissions in 1965 to 69 per cent of all admissions in 1967 (1). The main reason for admissions to the hostels from the

community at large was the loss through death or, less often, long-term hospitalization of the key person (usually the resident's mother) previously caring for the resident. Twenty-three per cent of the 186 admissions direct from the community to the 14 Lancashire County Council hostels operative at the beginning of 1968 fell into this category. Other major reasons for admissions to the hostels direct from the community at large were incapacity or illness of the key person previously caring for the resident (17 per cent of all admissions from the community at large up to the beginning of 1968), and behaviour problems such that the resident had become beyond this person's control (16 per cent of all admissions from the community at large up to the beginning of 1968). The 'behaviour problems' leading to hostel admission consisted mainly of aggressive outbursts and temper tantrums. Significantly more severely subnormal (as opposed to mildly subnormal) residents were admitted to the hostels from the community at large than from mental subnormality hospitals, and residents admitted from the community at large were also significantly younger than those from mental subnormality hospitals ( $p < 0.01$  in each case). There was also a tendency ( $0.10 > p > 0.05$ ) for residents admitted from the community at large to come from a higher social class, as judged by father's occupation, than residents admitted from mental subnormality hospitals, which suggests that middle-class families are more willing to place a mentally handicapped relative in residential care when this takes the form of a community-based hostel rather than the traditional mental subnormality hospital.

Admitting residents to hostels directly from the community at large can be regarded as a 'preventive' use of hostels, ie it prevents mentally handicapped people in need of residential accommodation but not in need of hospital facilities or nursing care from being admitted to mental subnormality or other hospitals simply for want of anywhere else to go. Should the person's health or behaviour deteriorate then admission to a hostel may prevent admission to a hospital only temporarily, but for the majority of residents admitted to the Lancashire hostels direct from the community the hostels have become long-term homes. Admission of residents from the community at large rather than from mental subnormality hospitals has continued since 1967, for whenever a hostel vacancy arises there is invariably someone living at home or elsewhere for whom hostel care seems highly desirable. In view of this there is a risk that until more hostels are provided the claims of hospital patients potentially suitable for discharge to hostels will be disregarded. Such patients may well remain on waiting-lists for transfer to hostels indefinitely.

### **3. Criteria and procedure for selecting hostel residents**

There is no general agreement from one local authority to the next as to criteria for selecting residents for mental health hostels. Those in charge of admissions to any particular hostel however tend to have very definite ideas as to the sort of person who will (or, more often, will not) fit amicably into the social organization of that hostel. Few hostels (the Lancashire hostels included) accept residents who are incontinent or who are not able to go out to work or to attend a training centre or other such establishment during the week. Some hostels set an upper age limit for admissions (for example 50 years of age), and some hostels will not accept residents with a history of epilepsy. Some hostels cater only for the mildly subnormal; others cater only for the severely subnormal; still others take in residents of all degrees of handicap. It would be foolish to try and lay down rigid or comprehensive criteria for the selection of hostel residents since different hostels will be catering for different needs. It would, however, be advantageous if people were less ready automatically to exclude certain categories of people from consideration as hostel residents. Thus Kushlick (2) has challenged the widespread belief that hostels are not intended for or should not be expected to take in residents who are severely incontinent, or who have severe behaviour disorders, or who are unable to attend a training centre or to go out to work but simply 'stay at home' all day.

With regard to the procedure for the selection of hostel residents this is typically carried out by medical, administrative, or social work staff. Residential staff, the people most intimately involved with the residents, are typically not involved at all. Thus Apte (3) in a study of 25 short-stay hostels for the mentally ill found that in only 6 of these 25 was the warden given any say in the selection of residents. Four of these 6 hostels were run by voluntary bodies, which characteristically give more responsibility to wardens than do local authorities. Many hostel wardens would like a say in resident selection but the objection to this is that wardens may have personal prejudices against candidates put forward as potential residents. While this may be true such prejudices are not going to disappear simply because someone else does the selecting, and staff and residents do have to live together. Hence it would seem desirable for wardens to play some part in the selection procedure.



#### **4. Residential accommodation for the aged mentally handicapped**

The majority of local authority hostels for mentally handicapped adults accept residents from the age of 16 upwards with no upper age limit, although there tends to be a bias against admitting people who are 'too old'. Residents have, however, been admitted who are in their 70s. Hostel staff often feel that whereas they can 'do something' with younger residents in the way of social rehabilitation and the development of personal and social skills they 'can't do anything' with older residents other than provide them with a place in which to live. Older residents are thus often seen by staff as 'less rewarding'. To admit only younger residents, however, leads to problems of its own. If the hostel is newly established, and is to be a long-term home for most of the residents, then in time it will be a hostel of predominantly aged residents all of whom may be making considerable and perhaps excessive demands on staff time and patience. And if there is an upper age limit on admissions (typically 50 years of age) what is to happen to mentally handicapped people older than this who are in need of residential care? Are they to be hospitalized even although not in need of hospital facilities or nursing care? Or do we set up special hostels or residential homes for the aged mentally handicapped? Ordinary old people's homes do not seem a likely prospect for large numbers of the aged mentally handicapped due to the demand for places in such homes from non-mentally handicapped people, although some local authorities do set aside a proportion of places in their old people's homes for the mentally infirm. The Lancashire hostels manage to cope adequately with a resident population of widely varying ages and older residents are not required or expected to leave unless or until they are in need of nursing or other care that the hostel cannot provide. Problems can arise, however, when older residents become incapable of putting in a full day's work at the training centre, although they are otherwise still quite acceptable as hostel residents. Some rearrangement of staff hours and duties could enable such people to stay at home in the hostel all day, possibly helping with the housework if they are sufficiently capable and so inclined. It is surely anomalous that mentally handicapped people over retirement age are not able officially to 'retire' but must continue to attend a training centre five days a week in order to qualify for hostel residence.

## **5. Residents' contacts with family and friends**

One argument in favour of community care for the mentally handicapped is that in the community a person can maintain contact with family and friends. Mental subnormality hospitals tend to be geographically remote, or set back from the road and away from the public gaze. In either case this fosters social isolation. It is possible, however, for residents in community-based hostels or residential homes to be just as socially isolated as patients in the most remote mental subnormality hospital if they neither receive nor pay any visits. A study was undertaken in Lancashire to determine whether mentally subnormal adults transferred from mental subnormality hospitals to the Lancashire hostels were less socially isolated from family, friends, and the local community than comparable mentally subnormal adults (matched for age, sex, grade of subnormality, and length of institutionalization) still in hospital (4). The one variable on which the two groups differed significantly was the distance of their next-of-kin from their present place of residence. The hostel group lived significantly closer to their next-of-kin ( $p < 0.001$ ), it being county policy to place residents in hostels as close to their own home areas as possible. The hostel group had significantly more contact with family, friends, and the local community than did the hospital group ( $p < 0.001$ ,  $p < 0.05$ , and  $p < 0.001$  respectively). Hence on the argument that social isolation is in itself detrimental to mental health these results can be taken as a vindication of the policy of community care for the mentally handicapped. The most striking thing, however, about the contacts of both hostel residents and hospital patients with outside friends was that 76 per cent of the former group and 92 per cent of the latter group had no outside friends at all.

With regard to contacts with family a later study (5) found that for residents with families definitely interested in their well-being (as rated by hostel and local authority personnel) family contacts were significantly more frequent for residents with next-of-kin less than 10 miles from the hostel than for residents with next-of-kin more than 10 miles from the hostel ( $p < 0.001$ ). This amply vindicates the policy of having hostels as locally based as possible as far as residents with families definitely interested in their well-being are concerned. For residents with families not particularly interested or definitely not interested in their well-being, family contacts are infrequent in any case, and independent of the distance of the hostel from the resident's next-of-kin ( $p > 0.20$ ). This is not to say, however, that one need not worry about placing these residents in hostels near their own home areas. Although a resident's family may show little interest in him at one stage there is always the possibility that their interest may revive,

and if this happens then geographical proximity would facilitate contact. And even if a hostel resident entirely lacks effective kin he will still have more meaningful contacts with his own home area than anywhere else.

## **6. Views of the mentally handicapped themselves**

In the summer of 1966 there were 316 residents (252 mentally handicapped and 64 mentally ill) in the 13 Lancashire County Council hostels for mentally disordered adults then in operation. Of these residents 57 per cent had come to the hostels from hospitals, 25 per cent from their own homes, and the remaining 18 per cent from other residential accommodation in the community at large. Of these 316 residents, 304 were interviewed in an attempt to assess their attitudes and feelings with regard to their present and past situations, and with regard to the type of residential care they themselves might prefer (6). Of former hospital patients, 88 per cent preferred hostels to hospital. Typical of the reasons given for such a preference were 'you are more free here'; 'you get better food here'; 'they lock you up in hospital'. Hostel accommodation was also preferred to other residential accommodation in the community. Hostel accommodation was not preferred to living at home ('home is of course best of all', as one resident put it). A longing to live at home was expressed to a like degree by all residents irrespective of their previous place of residence and irrespective of whether they had a home any more. Even residents who had been in hospital for more than thirty years and who had had no contact with their families for many years expressed a desire to go back home. Belief in home and family seemingly transcends all abandonment, rejection, and neglect.

Each of the hostels had an adult training centre alongside which the majority of residents (90 per cent) attended. Of those attending training centres 55 per cent would have preferred to be in outside employment, mainly for such reasons as 'there is more money in a job'; 'you can meet new people out at work'; 'the things we do here in the training centre are dull and boring and not proper work'. Many of the residents expressing a desire for a job were certainly being unrealistic, but a considerable number did seem fit for outside employment (and were acknowledged as being thus fit by training centre staff) given a suitable job and a 'sympathetic employer'. More attention could be paid to the finding of jobs for the mentally handicapped, whether hostel residents or not, for having a job, no matter how menial, helps prevent the segregation of the handicapped and enables the handicapped to feel more normal members of society.

## **7. The ultimate purpose of services for the mentally handicapped**

Official statements concerning services for the mentally handicapped (7, 8) lead one to the conclusion that the ultimate purpose of such services is to enable the mentally handicapped to lead as normal a life as possible and to develop their potential, however limited, to the utmost. The extent to which local authority and other services achieve either or both of these goals is a matter of some consequence: if they are not being achieved, or only partly achieved, then some reorganization of services may be desirable. In this connection it has been observed (9) that in many hostels staff tend to do things for the residents (washing their hair, lacing their shoes, etc.) that many residents could with training, or even without training, do for themselves. Staff tend also to supervise residents' activities (bathing, dressing, leisure-time pursuits) unnecessarily, in the sense that the residents are demonstrably capable of undertaking these activities satisfactorily without supervision. This tendency for staff to do things for residents that the residents might well do for themselves is acknowledged by some hostel wardens, but it is apparently a very difficult thing to eradicate. Most staff have no special training for the job, and junior staff in particular (who often have most to do with the residents) tend to have but a limited appreciation of the over-all aims of hostel care. The net result is that the residents' independence in many areas is quashed rather than nurtured and this effectively prevents them from developing their potential to the full.

With regard to leading as normal a life as possible, staff routines and administrative convenience can militate against hostel residents doing various household chores that people normally do at home. People living at home can usually make a cup of tea if they feel like it, for example, which is not always possible in a hostel. A further point is that few people living at home have their place of work on their very doorstep, within their own grounds. It has always been official policy to have hostels and training centres on separate sites, but in many cases the difficulty or the expense of finding separate sites has led to the two establishments being built adjacent. This may be administratively convenient, but it is unfortunate from the point of view of providing hostel residents with as normal an environment as possible.

## **8. Misplacement of residents in mental health hostels**

The White Paper, *Better Services for the Mentally Handicapped*, notes that lack of experience in the running of hostels may lead to hostel

places being misused in the sense that people are in them who could manage with far less support. It can also happen that people who could manage with far less support are occupying hostel places simply because the hostel has been successful in achieving its aim of developing the independence of residents who were initially in need of a sheltered environment, and no real thought has been given to what happens to these residents now. It is ultimately against the resident's own best interests to stay in a hostel if he no longer needs the support that a hostel provides. Not only is such a person stunting his own potential development but he is also blocking a place that could usefully be taken up by someone else. One problem that arises here is that hostels are generally so comfortable in material terms that residents can understandably be reluctant to leave. It is also not unknown for staff to discourage residents who could lead a more independent life from leaving a hostel, due either to a misunderstanding on the part of staff as to the whole aim of hostel care or to a misguided belief that one ought not to 'break up the happy home'. What seems needed here is some sort of review mechanism whereby residents are periodically assessed and once deemed fit for a more independent way of life they would then *have* to move on to some less sheltered form of accommodation provided either by the local authority or privately. The need for a range of residential accommodation has long been recognized, and one form of alternative accommodation that might suit such people is a group home, ie a residential home for perhaps 6-10 people, without residential staff, but with some support and supervision from social work or other agencies. A number of such homes exist for the mentally ill but relatively few for the mentally handicapped. Mentally handicapped people who have moved on from hostels to a group home are generally reported as showing marked gains in personal independence, which after all is one of the things that community care for the mentally handicapped is all about.

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## ***Evaluating residential services for the mentally handicapped***

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### **1. Introduction**

For the past seven years I and my colleagues have been working on a method of evaluating the effectiveness of different forms of residential care for the mentally handicapped. The approach to the problem was first described in 1967 (1). Developments since that date are described in the annual report on our work to the Medical Research Council and the Department of Health and Social Security, 1970.

This paper outlines the history of the current research and describes the stage that has been reached.

Before describing in some detail the way in which the method has evolved, a summary is presented of the over-all strategy used, and the stage we have now reached.

Space does not permit the acknowledgement here of the contributions to our work of others in the field of service evaluation. We have, however, tried to combine and extend the epidemiological approach to mental handicap pioneered by E. O. Lewis (2) in his classical survey of 1929, the work of Professor T. McKeown (1958) (3), in his assessment of service needs among people in hospitals and other forms of residential care, the work of Professor Jack Tizard (1960) (4) in his experimental evaluation of an alternative form of care for mentally handicapped children, the measurement of the problems of families with a mentally handicapped child at home pioneered by Tizard and Jacqueline Grad (5) from the MRC's Social Psychiatry Research Unit in 1961, the evaluation of different policies of existing psychiatric services in Chichester and Salisbury undertaken by Jacqueline Grad and Peter Sainsbury (6) from the MRC's Clinical Psychiatric Research Unit (1963) and the work of Tizard, Raynes, King, and Yule (1966) (7) in evolving objective measures of the quality of residential care.

## **2. Summary of the method used and progress to date**

Briefly, the method consists of:

1. Assessing the size and nature of the over-all problem by means of an epidemiological survey which includes people, both in residential care (including hospitals), and at home. This is undertaken with the collaboration of personnel (medical, nursing, social work, etc.) in hospital (RHB and HMC), local authority, and voluntary service.

2. Establishing, with service personnel, an ongoing epidemiological register which can be computerized.

3. Advising service personnel, on the basis of the data generated and other data available, to set up, in parts of the epidemiological area, alternative forms of care ('experimental'), which would be predicted to achieve the defined service aims more simply and effectively than existing ('control') services in other areas which are demographically comparable.

This phase involves defining:

- a. Service aims which can be measured.

- b. Testable hypotheses on how and why the aims are more or less likely to be achieved by using different methods of care.

- c. Measurable criteria of effectiveness: these include changes in the ability of the people themselves, and in the level of problems experienced by their families, the administrative problems and costs of setting up and running the different forms of service.

- d. Measurable criteria of the quality of care.

All measures must be reliable (ie replicable), valid (ie measure the phenomena that they claim to measure), and relevant to both researchers and service personnel. This phase also includes the development of an over-all operational policy by which the 'experimental' service is likely to achieve its aims and a training programme to enable staff to carry it out.

4. Collecting baseline data on 'experimental' and 'control' people and their families before the new service begins so that subsequent changes can be measured.

The method as described, has the serious limitation that the new 'experimental' service has some built-in advantages over the existing 'control': 1. It is new. 2. Its staff are likely to be enthusiastic, specially selected, and newly trained. 3. Its policies have been very carefully worked out. 4. It has prestigious backing. 5. It may have more resources (eg staff) than 'control' services.

A method attempting to reduce the bias inherent in this approach has been devised which also has the advantage that it serves to meet administrative and service needs. This consists of attempting, at the



same time, to implement in the 'control' service, the new operational policies defined for the 'experimental' facilities. This:

1. Provides a way of innovating existing services.
2. Avoids isolation of existing services from new, prestigious facilities.
3. Provides, from a research point of view, opportunities for: developing scales of quality of care; testing hypotheses on the factors which determine specific components of 'good' or 'poor' care. These factors become more obvious when attempts are made to introduce new standards in existing services.
4. Involves both service and research personnel in the design and implementation of the policy and its operational measurement.

This approach has been followed in the Wessex Project on Mental Subnormality:

1. The data generated by the epidemiological survey have also been used for planning and development purposes by the Department of Health. The Wessex Schedules and the classification of handicaps evolved in Wessex have now been adopted by the Department in its first National Census of the residents' incapacities. They are also being used in the MRC Social Psychiatry Research Unit's Camberwell Register. The Wessex Register has provided data on mortality rates among mentally subnormal people with different clinical conditions and capacity ratings. When computerized it will provide still more data on the natural history of, and service-usage by, different categories of people with mental handicap. The Register will also be used for measuring changes in the capacities of people.

2. It has been possible to obtain sufficient collaboration from service personnel to set up 'experimental' facilities to serve only a strictly defined geographical area, and to create 'control' areas served only by existing services. It has been feasible to collect the baseline data on the people and their families, and to begin identifying the factors that appear to affect whether or not defined operational policies and aims are achieved.

The observations of Raynes and King (8) that size of institution or living unit are not key determinants of quality of care in residential settings, and their objective scale of quality of care, have opened the way to exploring the relevance of other factors. Preliminary findings from Wessex, reported to the Royal Society of Health (9) suggest that low staff-resident ratios in residential settings, can, irrespective of the size of the unit, its physical resources, and the training of the staff, result in all of the characteristics of 'poor' quality care, anti-therapeutic methods of managing residents, and lead to spurious

'over-crowding' because of the inability of the staff or residents to make use of available accommodation. They also suggest mechanisms whereby the methods of managing residents in these circumstances may, indeed, produce complications of the underlying pathology which have previously been considered sequelae or manifestations of the natural history of the underlying pathology.

3. The first experiment has already shown that it is possible to care for *all*<sup>1</sup> of the severely subnormal children of *all* types of handicap, from a total population of 100,000, in a locally based converted house with 21 places staffed (albeit at a ratio higher than that found in hospitals for the subnormal) without specially trained nurses, and with a GP providing the primary medical care. The comparisons of progress of children and families in 'experimental' and 'control' units, and the administrative problems and costs will be made at a later stage. The number of children for whom residential care has been sought, and the distribution of their handicaps, is very close to what was predicted from our epidemiological survey.

4. Our schedules for measuring the abilities of the children and the problem levels of their families are being used by the MRC Social Psychiatry Research Unit in their evaluation of a new unit at the Bethlem Royal Hospital.

### **3. The history of the present researches**

#### **a. THE ADMINISTRATIVE PROBLEM**

Our research strategy has developed out of the need to solve administrative problems.

In 1959 the Wessex Regional Hospital Board was created to provide and administer hospital services for a population of about two million living in the county boroughs of Bournemouth, Portsmouth, Southampton, and the counties of Dorset, Hampshire, the Isle of Wight, and a third of Wiltshire. This area had previously been administered by the South-West Metropolitan RHB.

The effect of this change on the hospital services for the mentally subnormal was considerable. In addition to sharing the national problem of a shortage of places and growing waiting-list for care, the Wessex Region was actually losing places because up to 1959 a large number of mentally subnormal people from the area had been hospitalized outside the Region's new boundaries. While no pressure was put on the Board to remove its patients from the hospitals outside, as Wessex patients in these hospitals died or were discharged, their places could no longer be filled with other Wessex citizens.

1. See p. 97.

Thus the Board faced overcrowding in, and growing waiting-lists for, hospital places. Its senior officers approached Professor Jack Tizard for his advice on the number and type of places required to meet the needs in the Region.

After examining the available administrative data, Professor Tizard advised the Board to undertake a prevalence survey of mental subnormality in the Region as the data available from the hospitals and LHAs were insufficient for the purpose of determining needs.

#### *b.* SETTING UP THE RESEARCH

A steering committee was set up consisting of representatives from the Wessex RHB, MRC, Department (then Ministry) of Health, University of Southampton, consultants in subnormality and child psychiatry, LHA, and general practice.

The study was originally funded for three years by the Department of Health and the Nuffield Provincial Hospitals Trust Fund. I was invited to direct the survey and began work in May 1963. I had previously undertaken a more limited prevalence survey of mental subnormality in Salford LHA (10).

Miss Gillian Cox, a social scientist, joined in July 1963, and remained with me until the end of 1970. We had another research assistant and an administrative assistant.

#### *c.* THE RESEARCH OPPORTUNITIES PRESENTED BY THE ADMINISTRATIVE PROBLEM

It was felt that the method of estimating a regional health service need from epidemiological studies of the population 'at risk' could usefully be pioneered on the problem of the severely subnormal (SSN). This condition has certain qualities which make it relatively easy to use as a pilot for other conditions:

1. While it is rare, about 4 per 1,000 children, 1.75 per 1,000 adults, the numbers generated by a total population of two million (about 4,000) were large enough to enable generalizations to be made, but small enough to handle from a research point of view.

2. The incapacity is severe enough to ensure that, in a society with compulsory education, virtually all SSN children surviving to school age are identified by the agencies because of the severe educational problems they present.

3. The pathology associated with the condition is present at birth or arises soon after, and, in spite of the wide range of capacities among adults, very few ever marry, set up independent households, or are employed in open industry. Follow-up and identification is

relatively easy because cases identified in childhood will always be 'cases' and very few new 'cases' arise at late ages.

4. All SSN people and their families appear to come to the notice of the special services for the mentally subnormal (medical, social work, and educational), and all of the handicapped who survive long enough eventually go into institutional care. In other morbid or handicapping conditions many of the affected people never reach the services.

5. Change in the capacity of SSN people is slow and can be followed more easily than in conditions where it is more rapid.

There was also evidence (10) that a large, detailed study of the 'administrative' prevalence of SSN such as that proposed in the Wessex Region would provide a useful estimate of the 'true' prevalence of this condition. Also, as the over-all population of the Wessex Region had demographic characteristics similar to those of England and Wales, results from Wessex were likely to apply to the whole country.

#### *d. THE RESEARCH STRATEGY*

The need was seen at that time to describe in some detail the social and physical characteristics of people both at home and in institutions. It would be possible to measure the proportions of people in each incapacity category who were living at home and in institutions, by the type of services they were receiving or were not receiving.

From these data it was hoped that it would be possible to see how many people in hospitals appeared not to need 'hospital care', and how many people living at home had characteristics suggesting the need at some time in the future of 'hospital type' care.

It was appreciated that cross-sectional data from a point-prevalence survey could provide only a crude idea of 'need' for various types of care. However, it was hoped that they would provide better guides than any available.

In addition it was hoped that longitudinal studies on mortality, natural history, and service usage might follow the prevalence study, and that these would help to complement the cross-sectional data.

The plan was that any recommended norms for institutional need based on the data on point-prevalence *would be tested by providing services to the recommended levels and seeing how these services met the needs in practice.*

The functions, siting, and optimal size of administrative and living units for the subnormal had been the subject of untested debate for over a hundred years. It was intended that any facilities set up as a result of the survey might be provided in a manner which would

allow their empirical evaluation, and also the development of methods suitable for the evaluation of other services.

*It turned out that all these hopes were realized.*

**e. THE AIMS OF THE RESEARCH**

The aims of the 1963 prevalence study were therefore:

1. To undertake a census of administratively recognized mental subnormality among people in and (in the case of those in institutions) from the Wessex Region who were alive on 1 July 1963.

2. To describe the characteristics of the people so identified which were relevant to determining the size and the nature of the problem of meeting residential care needs, these to include: age, IQ (IQ under 50 or SSN; IQ 50 and over or MSN); social and physical characteristics (continence, mobility); ability to feed, wash, dress, speak, read, write, count, see, hear; behaviour problems; employment level among adults; associated clinical and aetiological factors; and the type of services used (institution or home care); and whether or not they were receiving formal education or training). Simple, reliable, and valid scales of social and physical characteristics were devised to measure, record, and compute these phenomena easily. People living at home were identified from the records of the seven LHAs in the Region. Hospitals outside the Region were approached to identify Wessex patients if they (the hospitals) were known by LHAs to have any residents from within Wessex. Private institutions outside Wessex were routinely approached in LA areas contiguous with the Region. All hospitals, hostels, and private homes in the Wessex Region were approached. Existing administrative, clinical, and psychological information on all people identified was abstracted from available records. Up-to-date information on the social and physical characteristics was collected specially from the people who knew the handicapped person best: nurses in hospitals, teachers in training centres and schools, and parents (via mental health social workers) of handicapped people living at home but not attending schools or training centres.<sup>1</sup>

The information was collected in this way on some 6,000 people. It was coded, punched, and tabulated, first by hand-sort (11) and later by computer (13).

1. All information was collected on people in residential care (hospital or other), and the clinical and aetiological material on these people was provided by the medical staff. Clinical and aetiological material on those living at home was abstracted from LHA records only on those aged under 20. Among those living at home, social and physical information was collected specially on all children and SSN people, and on all those attending LHA training centres. It was also collected on a 1-in-5 sample of MSN adults living at home, but not attending training centres.

These results have since been extensively used by the Wessex RHB and the Department of Health as well as by LHAs within and outside the Region. The scales for measuring and recording social and physical incapacities are currently being used by the MRC Social Psychiatry Research Unit in the Camberwell Register, and in a national census of hospital patients by the Department of Health.

Some of the findings include:

1. A picture of the extent of different categories of incapacity among the recognized mentally subnormal in defined populations.
2. A close estimate of the 'true' prevalence of severe subnormality.
3. A comparison of the incapacities of those in institutions (mainly hospitals for the subnormal) on the one hand and those living at home on the other.
4. The high proportion of relatively able SSN adults (continent, ambulant, no severe behaviour disorders)<sup>1</sup> who could feed, wash, and dress themselves without help but who were in hospitals. The high proportion of children at home with very severe handicaps.
5. The high proportion of subjects, both at home and in hospital, who were receiving no formal training or education.
6. The relationship between these capacity scores and such major clinical signs as Down's syndrome, cerebral palsy, epilepsy, etc.

The survey findings indicated that there was a wide range of possible ways in which residential facilities could be provided if they were to aim to serve *total populations* of different sizes: for example, for children 25 places per 100,000, 250 per million, 500 per 2 million. The logistic implications of each of these possible choices for the children, their families, and the agencies (educational, social work, medical) concerned in different aspects of care became clearer and showed that the old controversy of large versus small institutions was a sterile over-simplification of the many problems involved.

#### *f.* THE REGISTER OF MENTAL SUBNORMALITY

Although committed only to undertake a point-prevalence study, in the hope that further support would be secured at the end of the three-year grant, we decided to set up a register:

*a.* Of all *new* cases coming to the notice of the Wessex LHAs and the hospitals and private homes in the Region.

1. The abbreviation CAN is used for people who are continent, ambulant, and have no severe behaviour disorders. The abbreviation CANT is used for the remaining people who are non-ambulant or have the additional handicaps of severe incontinence or severe behaviour disorders.

b. Of continuing changes among *all* people on the register. Changes among people in institutions outside the Region are included.

This was intended to provide longitudinal data on mortality, natural history and service-usage among the mentally subnormal from a total population of two million in the Region. The collaboration of the personnel in all of the agencies to continue supplying data of the type collected in the survey was secured.

This has been maintained up to the present time, and seven years of continuous data are now being computerized for analysis.

In 1968 data on four and a half years of mortality, admissions to and discharges from institutions' care were analysed by hand and used to estimate:

1. Future prevalence of severe mental subnormality.
2. Future institutional needs for the Region (14, 15).

These data showed that while the prevalence rates for SSN adults will continue to rise, the increase will be greatest among the most able (and most numerous) CAN category. The rate will remain virtually stable among the most severely handicapped non-ambulant adults: the deaths over a period of four and a half years among non-ambulant adults and among non-ambulant children in cohorts moving over the same period into adulthood, were equal to the numbers of such children surviving into adulthood. The data were used by the RHB to plan future services and are being used by the Department to plan nationally.

The accuracy of these predictions will be tested when the register data, now being computerized, can be retrieved. These details are now available on about 10,000 cases. The computer files will shortly contain progress data on these cases over a period of up to seven years, and allow a detailed cohort analysis to be undertaken.

#### g. THE EVALUATIVE STUDY

The possibility that the prevalence data could be used in an evaluative study of different forms of residential care for the severely subnormal was outlined in the early stages of the prevalence survey (11) and in more detail later (12).

In 1966 a Wessex RHB Working Party (16) proposed that future residential facilities in the Region be provided in small, locally based units serving the mentally subnormal from total populations of 100,000 rather than in the form of a large hospital serving a total population of 500,000 or one million. These included a number of children's and adult units of 25 places, each serving a total population of 100,000. The children's units were to take care of *all* the SSN children from the population who required institutional care; the

adult units were to take 25 of the 40 SSN adults (per 100,000 total population) who were continent, ambulant, with no severe behaviour disorders, and who could feed, wash, and dress themselves.<sup>1</sup>

At this stage it was necessary, in addition to getting the numbers right, to define aims for the units. These were to ensure the maximum progress of residents, the relief of the problems of their families and the achievement of a defined quality of care. An operational policy designed to implement these aims was defined for these new units (16, 13).

It was decided to provide these units in such a way that they might be experimentally evaluated. The evaluation was to take the form of a 'feasibility' trial in which the new units would be compared with existing institutional care. The RHB's original intention was to provide 12-16 such units each serving a total population of 100,000.

These would be experimental areas. A demographically comparable area of population 100,000 was to serve as the control. The first two of these new units were planned for Southampton and Portsmouth because they each have total populations of about 200,000. It was decided to divide them both into two demographically comparable areas, one served by the new unit and the other control side served by existing hospital units.

There was no ethical problem involved in the experimental design, since it was inevitable that some people would be served by new and others by existing services. The experimental design merely required that those people eligible for the new service were defined geographically. It was pointed out that this did not create a precedent in methods of delivering services: access to any particular school in a town has long been decided on the area of residence, within the town, of the child's family.

We were fairly confident that selection of experimental and control groups on this basis would be as close to randomization as one can come in this type of service trial, particularly if the areas were comparable in age, social class, and type-of-housing distributions. It appears virtually impossible to randomize in any other way for a 'long-term' service of this sort, because the new units were designed to serve the local population. To have subjects whose families were not living locally would have defeated that aim of the new units which was to encourage parental participation in the care of their children. Randomization within the local area, in addition to creating 'political' difficulties, would also have reduced the numbers available.

The Board's Report was accepted by the relevant committees between 1966 and 1967 and the Department of Health gave permission for the setting up of two 'experimental' children's hostels, one in

1. See p. 101.



Southampton and one in Portsmouth. Permission on the remainder of the proposals was delayed, both because of the doubts about the feasibility of the new units and because of the fact that, although provided and staffed by RHBs the units appeared to be undertaking what was regarded as LHA responsibilities.<sup>1</sup>

This research was funded by the five-year MRC grant in 1967.

The team had to wait some time before the units to be evaluated were set up and staffed. The first hostel opened in Southampton in January 1970; the second opened in Portsmouth in December 1970.

The intervening period was used:

1. To ensure that the units would indeed be available for evaluation.
2. To develop and refine the research design.
3. To pre-pilot the schedules used for evaluating the new and existing units.
4. To collect the base-line data on 'control' and 'experimental' subjects in Southampton and Portsmouth before the new units were opened.

#### *h.* THE RESEARCH DESIGN

Since we planned to evaluate the 'effectiveness' of a new type of unit we had first to define this. We defined the 'effectiveness' of a service as the extent to which its 'aims' were met.

The aims were defined as:<sup>2</sup>

1. Client-oriented (progress of affected subjects and relief of the burdens of their families).
2. Administrative-oriented (the delivery of defined quality of care with 'reasonable' effort and cost).

The criteria of effectiveness were therefore:<sup>3</sup>

- 1a. Measures of change in the cognitive and social abilities of the subjects.
- b. Measures of change in the family problems arising from the impact of the handicapped person on the family.
- c. Measures of change in the families' experience with the relevant services and of their degree of satisfaction with these contacts.

1. Decisions were eventually taken to set up six children's and four adult hostels. A new MRC-DHSS grant up to 1976 will allow us to replicate these studies on two further hostels.

2. See references 1 and 17 for details.

3. See reference 18 for the details of criteria, hypotheses to be tested, the division of Southampton into experimental and control areas, the characteristics of the experimental and control children arising from this method of selection.

2a. Measures of change in quality of care.

b. Descriptions and, where possible, measures of administrative problems involved in staffing and servicing.

c. Costs: capital running and, if possible, cost effectiveness.

The stages of the research plan were:

1. Divide the area into two demographically comparable areas of 100,000.

2. Identify *all* SSN children aged 12 and under and their families in the experimental and demographically comparable control area: both those at home and those in institutions.

3. Collect baseline information of the children's abilities and their family problems.

4. Arrange for:

a. The transfer, from existing units to the new units, of *all* children from the experimental side of the town who are in existing units (the control children from the other side remain in existing units).

b. The admission to the experimental unit of children on the waiting-list who are at home on that side of the town (the control waiting-list children to be admitted, where possible, to existing units).

5. Observe, measure, and record the quality of care, the routines used to deliver this, and the impact of these on the children.

6. Keep records of and describe such administrative problems as staffing, servicing, and controlling standards in the new and existing units.

7. Measure the running costs of the units.

8. Repeat 3 at intervals of eighteen months to measure changes among children and parents.

9. Compare the progress among the families and the children in the following groups:

a. Those in the new units.

b. Those in the existing units.

c. Those living at home.

10. Relate the degree of progress 9 to the quality of care 5, problems 6, and costs 7.

The results of this study will, in addition to measuring the feasibility of the new units compared with existing units:

1. Test the adequacy of the 'norms' of institutional needs in defined populations: if they are inadequate, there will be a waiting-list for residential care in the experimental area and/or the problem levels of families with children at home will appear unacceptably high.

2. Test the validity of the scales developed for measuring:
  - a. The incapacities of the subjects.
  - b. The problems and experiences of the families.
  - c. The quality of residential care.
3. Present a detailed epidemiological picture of:
  - a. The detailed abilities at any age of a total population of SSN children, and their progress over a three-year period.
  - b. The problem level and experience of their families and three-year changes in these.
  - c. Three years of service usage by these subjects and their families.

The formulation of the research problem was, therefore, that if the new forms of unit are feasible:

1. It will be administratively possible to set them up, staff, and service them.
2. They will be able to receive and cope with all of the needs for this service presented by the total population served.
3. The children in the 'experimental' area served will do at least as well as or better than those in 'control' (existing) forms of care.
4. The families in the 'experimental' area will have as few or fewer burdens, and as satisfactory or more satisfactory experience of the services, than those whose children receive 'control' (existing) forms of care.
5. The quality of care in the 'experimental' units will be at least as good or better than most in 'control' units.
6. It will be no more, or possibly less, difficult to introduce and maintain 'good' quality care in the 'experimental' than in the 'control' units.

## **4. Progress of evaluation study**

### **a. IDENTIFICATION OF SUBJECTS AND FAMILIES**

This has been done in Southampton and Portsmouth. All recognized SSN children aged 12 or under in August 1969 (Southampton) or in August 1970 (Portsmouth) were identified from the Register and from the records of LHA's mental health departments, school health and psychological service, and the hospitals for the subnormal.

Families were approached by letters from the MOH, consultants in subnormality, or the paediatrician for permission for the research team to test the IQ of the children, and to interview the hospital staff

and the parents about their child. Only 3 out of nearly 200 families refused to co-operate<sup>1</sup>.

#### *b. MEASURES OF EFFECTIVENESS*

##### *Progress of children*

**1. The schedule for measuring the detailed capacities of the children** has been designed, pre-piloted, tested for reliability, and used in baseline assessments completed on the children in Southampton and Portsmouth. The children have also been tested on the Minnesota Preschool Intelligence Test.

**2. Family problems. The schedule for measuring family problems** and experience with facilities for residential care has been designed, pre-piloted, tested for reliability, and data have been collected on the families of the above children.

This schedule includes:

Basic demographic information on family composition and social class; household resources (car, telephone, washing machine, indoor WC, domestic help, etc); knowledge of and, where appropriate, history of use of residential care facilities (this includes a description of their experience of the residential care facilities: before, at, and after admission and also their degree of satisfaction with the use of services); problems of the family likely to be aggravated by the presence of a handicapped child, for example, sleep, getting children to bed, getting them up, preparation of meals, eating, shopping, cleaning, washing, travelling on public transport, going out in the evenings and at week-ends, holidays, health of other members of the family, help from husband in the care of the affected child, etc.

The problems of coding, transcribing, punching, and analysing these data are being dealt with.

Ratings of the problem levels and experiences of residential care for coding have still to be finalized.

These measures will be repeated twice at eighteen-month intervals to observe changes.

#### *c. SETTING UP THE NEW LOCALLY BASED UNITS*

The unit in Southampton has been operational since 1 January 1970. Except for two parent refusals and a clinical decision in one case, the children who were in existing units, and whose families are resident on the eastern side of Southampton, have been transferred to the new unit. All children at home on the eastern side of Southampton who

1. Similar data have now been collected on institutionalized children and those who have received temporary care from Poole, Dorset, and a control area in south-east Hampshire.

were on the waiting-list for admission to existing hospitals have also been admitted to the new unit. The negative qualities of residential care are being avoided and full use is being made of LA educational facilities, GP and district general hospital facilities on the occasions in which these are needed.

The second unit serving the southern half of Portsmouth opened in December 1970. *All* children geographically eligible have been admitted. The defined negative qualities of residential care are being avoided. The same is true of the third unit which opened in April 1971 in Poole.

*d. QUALITY OF RESIDENTIAL CARE AND FACTORS ASSOCIATED WITH THE QUALITY OF CARE*

1. Measures. We are using the Raynes and King scale in the first instance, ie measures of rigidity of routine, block treatment of residents, depersonalization of residents, and social distance between staff and residents.

2. As this is felt to be insufficiently sensitive, we are developing our own scale.

*a.* We have evolved a technique for recording the staff routine from the time the children get up in the morning until they go to bed.

This is superimposed on a plan of the living unit and enables one to get simultaneously, a picture of the positions of staff and children at any time of the day. The logistic constraints on possible activities can be deduced from these descriptions. This information, together with data on unit resources and staff timetables, has been obtained on the new units and on four of the control existing units. The information has been validated by observation.

These data are now being analysed.

*b.* We are also interested in the impact of the staff routine on the children themselves.

This has so far been observed in two ways:

*i.* Examination of our description of the staff routines allows us to estimate the possible limits of staff-patient contact at any time of the day. In one pre-pilot example, between 6.15 am and 7.00 am 30 adults, who are unable to dress or wash themselves, are woken up in the dormitory, dressed, taken to the WCs and bathroom for washing, tooth-cleaning, hair-brushing as well as toileting, and then taken to the day-room by 7.00 am. The record also shows that only 3 nursing staff are on at this time with this group of adults. Each staff member therefore processes, on average, 10 people in 45 minutes, and each person is processed in an average of 4.5 minutes. The corollary would be that, before or after being processed, each person spends 40.5 of the 45 minutes waiting for the next move of the group. By

knowing how long the dressing takes in the dormitory, and the toileting takes in the WCs and bathroom, time spent waiting in dormitory or toilets can be estimated.

Having analysed the over-all routine on the living unit: the details at any stage of the routine can be observed directly. In the above example it was found that adult patients not initially mentioned in the list of resources, were in fact helping. This has led to appropriate modifications in the methods used for describing routines on the living units.

ii. Videotapes of children in standard situations. All children in residential care and all children living at home and on the waiting-list for residential care have been filmed in the standard situation of the midday meal and the toileting that follows immediately after it. Children who have moved from home to residential care, or from existing to new units, have been filmed in both settings. This enables us to observe the differences in impact on the same child of different routines of management: the child's abilities cannot have influenced his management because these have not had time to change.

The pictures have still to be analysed and a system of scoring the routine's impact worked out. The record allows first, a measure of staff-child contact, and second, a measure of the extent to which the subject's behaviour is either encouraged, discouraged, or ignored by staff. In one example two children, who in existing units were tied to a chair or radiator to stop them getting up and wandering or stealing other children's food at lunch-time, and who were fed by staff, were filmed shortly after arriving in a new unit. Here they were not tied, but a member of staff sat next to them and held them back in their seats when they tried to get up and wander around. They sat down for the meal and fed themselves.

This new method of observation, as well as showing the importance of the staff-child ratio, has also helped to analyse the inherent logistic problems entailed in running a living unit and revealed some of the key problems which need to be solved before these can be changed. Thus, if nursing staff have to serve the food and feed the helpless patients; and there are not enough left over to sit down at the table, with the over-active children, these children must be secured to something to prevent them from upsetting the routine.

Some of our preliminary findings are described in a recent paper (9).

## **5. Research design developments**

We have had, as a result of our early findings, to re-examine the assumptions basic to our research design. We have concluded that in

any comparisons of the relative effectiveness of more than one form of service, it is most useful if the personnel delivering all forms of service have common declared aims (both negative and positive) with respect to a definable morbid condition or group of conditions, within a definable population 'at risk'. The defined objectives should include both 'client-oriented' aims (ie a reduction in mortality, morbidity, incapacity among subjects, and of burdens among their families) as well as, where possible, 'administrative-oriented' aims (ie the components of the service being tested, by which it is predicted that the 'client-oriented' aims will be achieved). The aims and service components under test should also be understood by the research team undertaking the evaluation because the research team's task is to devise scales for measuring the extent to which the aims are achieved.

Agreement of the service personnel on the aims and the service components under test by the service makes it more likely that the research will produce valid, meaningful answers. Thus failure to achieve agreed aims is then more likely to be due to ineffectiveness of the defined components of the service under test, than from the fact that personnel delivering the service are either against the defined objectives, or pursuing other and conflicting aims.

Such agreement seems particularly important when testing the 'feasibility', as defined above, of *new* forms of service by comparing them with *existing forms*. New forms of service have, in the initial stages, inherent temporary advantages over existing forms. A reasonably long period of evaluation may allow time for such advantages as higher morale, prestigious backing, and publicity to 'wear off'.

However, advantages of a carefully worked out operational policy of staff specially trained to carry out the policy, or of additional resources, are likely to last longer. Therefore, where possible, it is important that every effort be made to confer these additional advantages on existing services during the trial. If, despite active attempts to do so, it is difficult or impossible during the trial to confer these advantages on existing units, the features of existing units which appear to prevent this can also be more closely studied. It is likely, after aims have been agreed, that administrative and service personnel will observe more rigorously than otherwise the rules relating to experimental and control groups during the period of the trial.

## **6. Preliminary findings which have led to the change in design**

Thus, we hypothesized that *all* of the SSN children at present in comprehensive hospitals for the subnormal under continuous medical

and nursing care could be dealt with at least as well in locally based units staffed by people trained in child-care with a short three-months' training in mental subnormality. They would have the support of a local GP. Educational and social work needs would be met from the LA's services for those children who lived at home with their parents. Specialist medical needs would be met, where needed, from the district general hospital in the same way as they were for children at home.

The results so far show that, not only has the first new unit been able to cope with *all* of the children<sup>1</sup> eligible (including 7 non-ambulant, 5 with severe behaviour disorders plus severe incontinence, 4 who are severely incontinent, 2 who are CAN), but that the quality of care avoids the negative characteristics defined in the operational policy. These policies are being carried out in a converted house with furnishings and fittings similar to an ordinary house. On the other hand, the control units associated with the comprehensive hospitals for the subnormal where the children are under continuous medical and qualified nursing care, show *all* of the 'anti-therapeutic' features of care: 'rigidity', 'block-treatment', 'depersonalization', and 'social distance'.

We will not know, until the children and their families have been re-assessed and their progress compared, whether the new units have also been more effective on these criteria. We have, however, been able to begin looking at the reasons why the negative qualities occur in existing hospital units but are avoided in the new units.

Evidence of possible reasons began to emerge from our observations of the routines followed in existing units and the first new unit. Then, as a result of the work of the Department's Post Ely Committee which investigated the conditions in hospitals for the mentally subnormal, the RHB and HMC adopted for the subnormality hospitals in the Wessex Region the operational policy already accepted for the new units. We had an opportunity both of seeing that these aims were not always agreed by the hospital's key officers, and of observing the difficulties of implementing these policies in the existing units.

The main reasons for the differences in quality of care between new and existing units do not appear to be *directly* associated with the fact that new units are locally based and existing are not. Nor, however, do the factors often blamed by the key officers of large comprehensive hospitals (shortage of trained nursing and specialist medical staff, 'overcrowding', or the profound handicaps and behaviour disorders of the residents) appear of major importance.

1. One child with frequent *status epilepticus* could not be admitted because the unit's staff were not legally allowed to administer injections of anti-convulsants.



Thus, the new unit which avoids 'anti-therapeutic' features in its routine has *no* trained nursing staff, shares the specialist medical staff with the existing units, and has children as severely handicapped and disturbed as any hospital unit. In addition, only one of the existing children's units is 'overcrowded' by defined standards. The main factor which appears to limit the implementation of 'therapeutic' features in the routine on the living unit, whether this is a ward of a comprehensive hospital or a locally based unit, appears to be the ratio at any time of the day of child-care staff (whatever their qualifications) to the children being cared for. (It appears that this is also an important factor determining the household routine of a family caring for a child at home.)

Given the limits set by staff availability, the location of the living unit (in the middle of a population centre or away from it) and the type of unit (hospital, or family home) appear to determine how far the strategies used can 'legitimately' depart from 'normally accepted' standards of child care. The location of the unit may partially determine the availability of child-care staff: ie they may be more easily available in the middle of population centres than away from them. The type of unit (hospital or private home) may determine the traditional way in which people relate to one another (staff of different professions, or from different levels in their hierarchy, to one another, or of staff to residents) and the way in which decisions are taken. However, definitions of 'legitimacy', norms of child care, and the traditional ways of relating or decision-making can all be changed.

Thus, in the new unit the staff-child ratios allow 1 member of staff to every 5 children at any time of the day, and particularly at 'peak' periods such as waking, dressing, washing, and toileting; eating; going to bed. In no existing unit does the staffing level equal this. Indeed, by tradition in existing units, it may often be much lower at 'peak' times. For example, night-staff (ratio 1 : 20 or 50 children) may have to wake, dress, wash, and toilet the children before day-staff arrive (in the new unit day-staff do this) and staff take their meals off the living unit at the children's meal times (in the new unit staff eat with the children).

Below certain levels of staff there appears to be little margin for flexibility of the routine which remains the same every day of the week and month of the year (rigidity); for acquiring, distributing, maintaining, or processing individual clothes or toys (depersonalization), or for making meaningful relationships with individual children (social distance) because as many as 10-20 children are simultaneously being looked after, washed, dressed, toiletted (block treated), by one member of staff on existing units.

The availability of staff to children also limits the use of available accommodation because simultaneous use of more than one room requires simultaneous availability in each room of staff. Indeed, 'overcrowding' during the day may be the result of lack of staff rather than of accommodation if children must be maintained in the only staffed rooms.

The limits imposed by staff-child ratio appear to increase with increasing richness and therefore vulnerability of the fabric, furnishings, fittings, decorations, and other contents of the living unit, ie given a constant number of mobile children, more staff are needed if there are soft furnishings like curtains, carpets, soft armchairs; fittings like book shelves, cupboards; wallpapers, tablecloths; cutlery, crockery, ornaments, and toys. In the absence of staff to protect these objects from exploration by the children, or to prevent the children from injury from some of the contents, one of three strategies may be followed: the child may be moved from the environment, the child may be mechanically restrained within the environment, or the environment may be cleared of vulnerable or dangerous contents.

The admission of children to care outside the home can be usefully understood in this way rather than as a means of instituting therapy. The parents are eventually limited in the extent to which they can denude the home environment or mechanically restrain the child by the needs of other family members and by the neighbourhood norms of child-rearing and house-furnishing. The existing hospital units 'cope' with the child within the limits of staff numbers by denuding the environment; by mechanically restraining the child and by means of the 'anti-therapeutic' regime. These strategies have apparently been 'legitimate' in hospitals: particularly in those which are remote from population centres. Staff levels in new living units are high enough to avoid these strategies in the presence of the rich environments needed to conform with neighbourhood values.

It is still widely believed that there are children who need, in their interest, long-term hospital care, ie specialist medical and nursing care which cannot be provided in their own homes or in 'domestic type' units in the population centres, but which can be provided in specialist hospitals. Our preliminary findings suggest that, at present, the main factor determining the admission to existing hospital units is lack of sufficient staff to care for the child in domestic type environments (such as family or welfare homes) and with methods that conform to neighbourhood norms.

Conversely, it is widely believed that 'anti-therapeutic' routines either cannot be avoided in large bureaucratic organizations in general, or in hospitals in particular, or that this can only be done by such methods as retraining staff at living unit level (ward nurses) and

'changing their attitudes' and roles from 'nursing' to 'child care' or 'teaching' personnel.

Our preliminary evidence suggests otherwise. First, in the new locally based Southampton unit, the specially trained non-nursing staff keep all of the children in one of the three available play-rooms (ie 'block treatment') when the staff-child ratio falls below the average levels. Second, a trial staff increase during one morning shift on a very poorly designed and equipped hospital ward for 80 adults (36 very SSN) allowed the staff, during the course of that shift, to implement a completely new routine which considerably reduced the components of 'rigidity', 'block-treatment', and 'social distance'. Avoidance of 'depersonalization' would have required new stocks of personal clothing, etc.

The implementation of the new operational policy for *all* hospitals will allow us to measure changes in the quality of care on living units and to begin to identify factors encouraging or hindering the introduction of new policies.

There are at least two other features which appear to encourage 'anti-therapeutic' behaviour on the existing living units, and which could be modified during the course of the trial. The first is the lack of authority at living-unit level to influence decisions which affect the management of the residents. Some examples are: the purchasing, maintenance, and laundry of the children's clothes and toys; hiring, distribution, and firing of living-unit staff; admission, transfer, and discharge of children; communication with the families of the children and outside agencies. These decisions are now taken centrally by personnel who have limited contact with the living units in general and the children in particular. In new units some of these decisions are taken by the living-unit staff.

Secondly, the residents in existing living-units do not come from a defined area in which their kin are living. Indeed, many of the people in existing large comprehensive hospitals do not, at present, even come from the larger catchment area the hospital is supposed to serve. This has arisen because, for many years, people have been admitted to a hospital or a living unit where there is an available bed. Collaboration of living-unit staff with LA agencies (social welfare and education) is rendered logistically very difficult because residents on any living unit come from many LA areas. Eleven of the hospitalized children transferred to the first new unit because their families live on the eastern half of Southampton were found in 7 different living units: 4 of these units were in 2 large hospitals each situated within 5 miles of Southampton. The remaining 3 units, 2 private homes, and an annexe of one hospital are between 30 and 40 miles on either side of Southampton. There is no reason why people in existing units

should not be relocated on a geographical basis if this is believed to be in their interest.

## **7. Future proposals for research on mental subnormality**

This project continues up to 1976. This period will be used first to complete the computerization of the register, to analyse and publish the data on changes in prevalence, natural history, mortality, and service usage, and secondly to complete the feasibility study of the new units and to write this up.

A useful follow-up period for the study of new units is three years. Thus, the final collections of data on the children and their families in connection with the first and second units will take place respectively in 1973 and 1974. As the RHB plans to open two more units early in 1972, a two-year study of these units will be included. The final data on these will also be collected in 1974 and analysed and written up together with the other data during 1975. The collection of data on the children and their families is now completely routinized. The data already collected are now being prepared for analysis by computer. By the time of the follow-ups these mechanisms should also have been routinized, so that additional data can be quickly and easily processed and analysed.

Data on four new units will allow a comparison of outcomes between subjects using new or existing units. They might also allow a comparison of outcomes between the new units themselves.

The implementation of any of the aims of the new operational policy in existing units will enable us to begin to sort out those components of 'poor' care which can be more easily avoided in existing units from those which appear to require greater effort or a different form of service.

### **a. EVALUATION OF COMMAND 4683 LOCALLY BASED UNITS FOR ADULTS**

The Command Paper 4683 (19) has defined a new comprehensive service based on existing epidemiological data. A major aspect of this document involves placing the responsibility for over half of the people at present being cared for in existing hospitals for the mentally handicapped with the local authority departments of social service.

It has been suggested that this document relegates the future role of hospitals for the mentally handicapped to the custodial care of the profoundly retarded and severely behaviour disordered children and adults for whom there is neither hope nor therapeutic possibility (20). This criticism implies that neither the new locally based, home-like

and therapeutic hospital units, nor the 'sectorized' (ie geographically selected) wards proposed for existing hospitals in Command 4683 are feasible.

Experience so far with such units for children suggests that they are feasible and present major therapeutic possibilities. However, there is no documented experience of such units for profoundly retarded or severely behaviour disordered adults. As these adults outnumber the children by about four to one, an early feasibility trial of such adult units is urgently needed.

The Coldeast and Tatchbury Mount Hospital Management Committee has therefore decided to open such a unit in October 1972. Thus the first 25-place locally based unit on a district general hospital site in Christchurch originally intended and purpose built for SSN adults who were CAN and who could feed, wash, and dress themselves, will now be used for the most profoundly handicapped and behaviour disordered men and women from this area.

The research team has been asked to evaluate the unit. The research design will be the same as that used for the children's units. The control groups will consist of geographically selected adults with similar capacities either in a newly 'sectorized' ward of an existing hospital, or scattered, as at present, in a number of wards of two or three existing hospitals.

#### *b.* EXTENSION OF THIS METHOD OF EVALUATION

The evaluative methods which have so far been piloted on the comparatively small and reasonably well-defined problem of severe mental handicap are now to be tested on the much larger and complex problem of care of the elderly. This project, funded by the MRC and the DHSS will be a severe test of this approach.

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## ***The future needs for research in mental health***

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Some indication of the research being supported by the DHSS, often jointly with the MRC or voluntary bodies, was given in *Portfolio for Health* (1) where parts of the mental health research programme were reviewed, in the context of the DHSS's programme as a whole. It is hoped that this article will go one stage further, by promoting discussion on the research being undertaken, and identifying new areas which require study.

There is considerable discussion at the present time on the place of government in sponsorship of research. Perhaps this is neither the time nor the place to continue the discussion, but it may be worth recalling that the function of the DHSS is to advise the Secretary of State on such matters as are relevant to the provision of the services for which he has a responsibility to Parliament. It is, therefore, apparent that the DHSS's interest are of a practical nature, although of course it is recognized that fundamental research of a biochemical nature may in the long term have more to offer to those patients suffering from schizophrenia than, for example, socially or psycho-analytically orientated research. For the purposes of promoting discussion, it is suggested that three main areas of research may be identified, as being of special concern and interest to the DHSS. These are epidemiology, the responses of individuals to treatment, and operational research.

The problems of mental health are widespread. So much so, that no one research group has a complete epidemiological picture of all the mental health problems in an area. It would appear that this is necessarily so, because of the size of the problem, and that provided typical geographical areas are identified for study, the results are usually found to be generalizable for purposes of general policy

planning. For example, the results obtained by Roth and his co-workers in Newcastle upon Tyne (2) in respect of mental disorders in the aged, showed a remarkable similarity to those obtained in Swansea (3) and Sweden. Similarly the studies of Kushlick in Wessex, the Wings in Camberwell (4), and McCoull on the Newcastle Regional Hospital Board area (5), all in respect of the mentally handicapped, showed similar findings, although the surveys were concerned with administrative rather than true prevalence. Work has also been undertaken into the incidence of schizophrenia and other mental disorders of sufficient severity to require referral to the specialist services, and these are being studied over a period of time by the use of registers, of which the Department is supporting four, at Nottingham, Camberwell, Oxford, and Wessex (the last for mental handicap only). A report (6) has been published giving quantitative details of the development of hospital and local authority services in Nottingham. We have therefore a fairly fully developed information system on the epidemiological aspects of the more serious and overt types of mental disorder. Further these studies have made use of both the census and cohort techniques, the latter consisting of continuing surveillance of the group identified by the census. The Newcastle study on bed usage by the elderly (7) is a particularly interesting example of the use of the cohort technique, the results of which will have great practical importance in the planning and development of services.

It is suggested therefore that there is a good deal of epidemiological information about mental health problems which come to the notice of the hospital services. The main areas of childhood (8), middle life, and old age (2) appear to be covered for mental illness, and the knowledge of mental handicap now available is very considerable. Perhaps the only serious gaps in our quantitative and qualitative knowledge of mental illness relate to adolescents and the younger preschool child (the latter only recently being identified as a separate group having special treatment needs), and the minor psychiatric disorders which are rarely referred to the specialist services. Working in the latter area, Shepherd has gone some way to delineating the characteristics of mental illness as seen in general practice, but further work of an epidemiological orientation would appear to be required to gain factual information about the natural history of mental disorder in the family.

Turning now from the problems of the acquisition of information about groups, to the problems of treating individuals, it is clear that the introduction of new methods of treatment may have profound implications for the way in which services are provided. For example, although the reduction in the resident population of mental hospitals



had begun before the advent of the phenothiozines and other powerful drugs (such as the anti-depressive agents), there can be little doubt that these pharmacological advances have had an important part to play in the development of community-orientated psychiatry. Similarly the more recent introduction of long-acting parenterally administered phenothiozines has raised the possibility of better control of the symptoms of schizophrenia, while treating the patient outside hospital. Careful studies are required to evaluate the precise usefulness of such drugs (9) if enthusiasm is not to blind scientific judgement, and useful treatment methods are not to be partly discredited.

While the professional journals contain many papers concerned with the use of drugs, there are two methods of physical treatment, about which the information held at the DHSS is extremely sparse, and about the usefulness of which there appears to be lack of consensus on the part of practising psychiatrists. The first is ECT, the second is leucotomy. On the former, opinion ranges from those who never use it, to those who employ it frequently and could not envisage clinical practice without it. There is a general opinion that its use is on the decline, although apart from a study sponsored by the MRC (10), and leaving aside the studies which have compared the value of unilaterally applied treatment as compared with the standard method (11), little appears to have been written about this method of treatment in recent years, and nothing apparently which compares in effectiveness with other forms of treatment. From a practical point of view, the Department has an administrative interest in the long-term future of ECT, as a treatment method, as the ECT suite at present forms an integral and costly part of the new units to be provided in the district general hospitals. While, in theory, it is possible to use such suites for other purposes when they are not in use for ECT, in practice this rarely happens.

So far as leucotomy is concerned, the position has been recently reviewed (12). While there would appear to be a general consensus that this method of treatment is of limited applicability, and then only when all other methods have failed, the work of Knight (13) may re-open the question as to whether it has not a wider application than at present, now that improved surgical and anaesthetic techniques have made mortality experience from the operation negligible.

For the purposes of this paper I propose to define *operational* research in the psychiatric field as that which is concerned with the methods of providing services to the mentally disordered. It may range on the one hand from consideration of the number of beds and day-places required to treat a certain group of individuals in hospital, to the professional attitudes and staff training needs of doctors, nurses, and social workers on the other. When considering this very

practical field of endeavour, it may be worth while to mention some of the major administrative changes which are in progress or are likely to happen shortly, and to try and assess the consequences of these changes.

## **1. Health centre development**

Perhaps the most significant development in the organization of primary medical care for decades, has been taking place over the last five years. General practitioners have begun to group themselves in health centres in increasing numbers. There are now 229 health centres functioning in England and Wales, 71 more have been approved, and a further 130 are being planned. With the establishment of practice from health centres, a great number of opportunities for extending preventive measures into the community would appear to open up. Nursing and social worker attachment to general practice become possible to a greater extent than before, and because of the almost total coverage of the population by the general medical services (95 per cent of persons are on a doctor's list) assessment of the value of preventive measures become possible. For example, the major problem facing health services in England and Wales today, may be judged to be that of the elderly. Certainly, so far as psychiatric services are concerned, the highest age-specific admission rates by far, are for the elderly. It is all too common an experience that a substantial proportion of the elderly are admitted to hospital in a crisis situation. Yet the value of regular visiting of an at risk group, say elderly ladies aged 80 and over living alone, has still to be assessed. However, at the other extreme of life, the value of visiting at risk mothers and children is scarcely questioned, and there is a danger that the concept of 'at risk' may become so generalized that many healthy people are visited unnecessarily.

So far as social workers are concerned, a small experimental scheme of attachment of social workers to a general practice is being evaluated by Shepherd and his co-workers, and a report may be expected soon. More such studies are clearly needed in a wide variety of areas, so that the advantages and limitations of providing social services in this way can be assessed.

## **2. Social services**

The Local Authority Social Services Act was passed by Parliament in 1970, and directors of social services are now engaged in planning their departments and deploying staff. Mental health services have a long tradition of effective professional co-operation between doctors,

nurses, and social workers. At the present time, it is difficult to predict what precise arrangements will be made for the co-operation between health and social services so far as the mentally ill and handicapped are concerned. Clearly joint consideration of problems will be required, both at the level of policy formulation be it local or national, and in the prosecution of research if the results are to be acceptable to the professions concerned, and to be useful in the formulation of policy. Present policy, based on the Royal Commission on Mental Health and the subsequent Mental Health Act, 1959, encourages hospitals to be more precisely concerned with their therapeutic functions and not to offer residential accommodation, for those for whom specialist medical and nursing care is not required. These considerations are particularly relevant to the mentally handicapped, and aged persons. In many areas surveys have been carried out, usually under medical aegis, of the suitability of patients to be in hospital and particularly with the mentally handicapped, large numbers are found who need not be there. While this type of exercise was and is of some value, and had particular relevance when the remit of the local health department was wider than it now is and many of the then welfare departments were under medical control, in future, it would seem mandatory that assessment by social work colleagues is included in any such research. In other words, perhaps the biggest need, whether in research or in administration, is for interdisciplinary work, in the identification of problems and in making provision.

There would also appear to be a need to develop social profiles by which individuals could be identified and grouped. Such measures should have proven reliability and validity. Initially they would undoubtedly be of first use in the research field, but in due course it may be hoped that they will be used by social workers in much the same way and for the same purposes as medical practitioners use the diagnostic terms.

As the mental hospitals continue to run down and to be replaced by units in general hospitals, there will be a need to look in greater detail at the social and residential needs of the chronically mentally ill person. Many such people will undoubtedly require rehabilitation or long-term sheltered work, and some will require hostel placement. The scope of the arrangements required to meet these needs will, it is suggested, be an area for joint assessment by the medical and social work professions. Already some studies have been undertaken (14) but more are required in a variety of localities.

### 3. Nursing services

It may be argued that numerically the largest therapeutic potential available to the mental health services is the nurses. The Standing Mental Health Advisory Committee publication on the role of the mental nurse suggested that there was a need to experiment on expanding the role of the nurse, and it seems clear that in the future the role of the mental nurse will be both more rewarding and more exacting than before. Whitehead (15) describes one such development in the role of the nurse, and points to the advantages to both patients and staff when the custodial role is succeeded by a more positive and outward-looking one. Other possible roles for the nurse include involvement in behaviour therapy and psychotherapy. Much more needs to be known about the professional attitudes of nurses, the required skills, and how these can be acquired and deployed for the benefit of patients.

In this short paper, it has not been possible to suggest other than in broad outline the nature of the research which may be required to improve the quality of the mental health services. The main task for the future would appear to be in identifying the issues in terms which the professional workers concerned are likely to agree upon, and this suggests that yet closer collaboration between doctors, social scientists and social workers is required.

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## ***Postscript***

### ***A commentary on the discussion***

THE EDITOR

#### **1. Reflections on the theme of action**

The proposed reorganization of the administrative framework of the NHS imposes responsibilities as well as offering opportunities, and where the opportunities are greatest the responsibilities are heaviest. The mental health services are not only being offered well-deserved and greatly needed preference in the allocation of resources, but also the chance to change their pattern fundamentally. It seems certain that care is to be shifted from the familiar, isolated, monolithic institution to a variety of community-centred smaller hospitals, hostels, day-hospitals, and domiciliary services. Nobody can be sure how these novelties will work, and indeed few of them are yet in existence. Though a start has been made with some of these modifications, it will be many years before, for instance, the proposed closure of the large mental hospitals is completed. This interval and the variety of the new forms of care give opportunity for experiment, and it is essential that the results of these pioneer projects should be adequately analysed and assessed to help administrators in the health departments and in the local authorities to plan for the future.

The administrator must rely on the research worker for facts and figures (as hard as can be collected) and also for more subjective advice drawn from practical experience. But politics is the art of the possible, and though the administrator is anxious for guide-lines from research studies, as a policy-maker he is also concerned with balancing priorities and scarcities. For him data supplied by research are not directives for action but valuable aids to choice. On the other hand, the research worker is not concerned with these administrative preoccupations. His job is to find answers that are as complete, fair, and accurate as possible, and for this task his independence is of paramount importance. Even if some of his answers are disregarded

today, they may be accepted tomorrow, for a changing society such as ours will never find a final model for its medical and social services.

## **2. Difficulties of technique**

Research on mental health care is beset with variables and imponderables and is inevitably often dependent on personal judgments, and sometimes personal prejudices. The fact that mental defectives are a shade less variable than the rest of us explains why much early research was done among them. With a rising population of old people, a probable concealed iceberg of mental illness among the general population, and new and changing methods of treatment even apparently 'hard' estimates, such as the number of beds needed in a particular area or for a particular purpose, are not easy to reach. More complex evaluations and assessments are still more difficult, and it is daunting to be called on to decide how many places should be in day-hospitals or hostels or how many families are capable of coping with disabled members. But provided difficulties are honestly admitted, tentative answers are not to be despised, and indeed may be more useful than cast-iron confirmations of the obvious.

From the discussion of past studies some useful points emerged. Comparisons within an area at least cut down the variables and are more likely to prove a solid basis for forecasts of need than comparisons of similar institutions scattered all over the country, for national averages conceal local needs. Again the number of out-patients attendances is likely to be a less fallible criterion of the use of a unit than the number of new out-patients which may be distorted by the referral habits of a few GPs. Replicable descriptions of diseases and classifications of patients are valuable but still blunt tools which should be sharpened. Degree of incontinence was mentioned several times as a crude but valid criterion of the kind of care needed by geriatric and mental defective patients. More and better indicators of the quality of patient care are also being sought.

As the mental health services spread outside the hospital walls, and patients are no longer segregated in one institution for long periods, but move from one unit to another or live in their own homes, follow-up services become increasingly necessary. Here the cohort system is providing effective results and the Camberwell and Wessex registers have shown that it is possible to keep in touch with patients

and worth doing so. Problems of selection and the formation of control groups are not so acute as in some other areas of research. Where places are so severely limited, patients are not excluded from a new unit but chosen to join it.

Experimental units, besides providing information have a therapeutic value, for they often stimulate the staff of older institutions to adopt new methods even in more prosaic surroundings. For this reason it would be wise to spread the experimental units throughout the country, which would also ensure that they operated within the context of the whole service and not in sheltered nooks. Enthusiasm and drive are essential qualities in a man or woman who starts an experimental unit, and in assessing its long-time value, allowance must be made for the disappearance of the pioneer and his replacement by an efficient, but perhaps less dedicated, director.

Imprecise and scant information apparently handicaps the mental health services of all Western European countries, and it is comforting to learn that the monitoring of our own is already the envy of our future EEC colleagues.

### **3. Answers through questions?**

The discussion, as was intended, produced more questions than answers, and the chief areas of uncertainty were staffing, the selection of patients, and general practice.

People with many different professional skills have already been drawn into the mental health service, and the need for practical co-operation will have to be recognized in any reorganization. Over twenty years ago, within a less helpful framework, Macmillan showed at Nottingham how much integration can be achieved with intelligence and goodwill. Without these attributes the most flexible framework may achieve less than expected. But clearly any new scheme should at least allow people to work easily together under authorities sharing common catchment areas.

But the health professions will not only have to join forces and work together; they will also have to welcome into their team many so-called 'untrained' workers, for without these the service could founder for lack of manpower. Experimental projects have proved that many people without formal training, but with the right human qualities and practical experience, are specially suited to help in the day-to-day care of the very young and the very old and as guides to the patient on his way back to the community. Others given limited



training can tackle limited areas of care with efficiency and good sense. But these recruits will only be successful and find satisfaction in their jobs if they are appreciated for the real contribution they can make rather than merely tolerated as cheap stopgaps. They will also need the understanding support of their professional colleagues. The warden of a hostel, for example, may feel unhappily isolated in his position of limited authority, while a motherly attendant may tend to help her charges rather than help them to help themselves and may have to learn when to lend a listening ear rather than a helping hand.

Variety in forms of care is making it possible to match patient to accommodation, and increasing the importance of who is to be responsible for selection. Is the geriatrician or the psychiatrist to decide the placing of a confused old person? Joint assessment and integrated care is accepted as sensible, but there is less certainty that comprehensive assessment units are practical or necessary. Again a hostel is more likely to run smoothly if the warden is allowed some say in the choice of residents, instead of having docilely to accept anyone assigned to him. Doubts were expressed by some, and rebutted by others, whether welfare homes are always put to the best use. Do some select pleasant residents, who could really still manage to live independently, at the expense of border-line patients who may prove less easy to manage? Are the long-term results of day-hospital and rehabilitation units really encouraging and are they getting the right patients? For the inevitable small group of long-stay patients may not a well-run institution offer a more stimulating life than a knife-edge existence in the community? Domiciliary visits are necessary to assess whether a family, perhaps in itself not very stable, can stand the strain of accepting a returning member. But most patients themselves, sometimes quite unrealistically, choose 'back home' to all other forms of care. It is, however, notable that most long-term patients prefer to remain where they are, wherever that may be, to any suggested move.

By far the most insistent question-marks hang over the work of the family doctor among the mentally ill. It is difficult to estimate the total number of patients and their degree of disability because of the doctors' attitude to psychiatry. Some are enthusiastic, some are ambivalent, some are disappointed. These variations can disturb the calculations of the most hardened statistician. But if the domiciliary services become stronger and waiting-lists at hospitals and clinics

shorter, the family doctors may turn to the service with more consistency, confident of securing immediate help for their patients. As it is, they often cope themselves, and at present an unknown but certainly large number of people are being looked after in general practice without benefit of the mental health service. If they are not cured at least they are often shown how to tolerate their disability and how to live with it.

With the present absence of knowledge the way is open in almost every direction for research. Useful studies could be made for a start on such subjects as the referral habits of doctors, the role of the psychiatric social worker in general practice, what ultimately happens to the patients, and, perhaps most significant of all, psychiatric illness among children. But in a specialty still run largely by individualists, for mobile and often resistant patients the task will not be easy.

Above all there is a need for continuing dialogue between those drawn to research and those engaged in care and treatment in hospital and community.